TITLE 13: INSURANCE

CHAPTER 1: INSURANCE GENERAL PROVISIONS

PART 1 : ADMINISTRATIVE PROVISIONS

13.1.1.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.1.1.2 SCOPE:

This rule applies to all rules adopted by the superintendent of insurance as parts of Title 13 of the New Mexico Administrative Code.

[7/1/97; Recompiled 11/30/01]

13.1.1.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.1.1.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.1.1.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.1.1.6 OBJECTIVE:

The purpose of this rule is to set forth provisions that apply to all rules adopted by the superintendent of insurance.

[7/1/97; Recompiled 11/30/01]

13.1.1.7 DEFINITIONS:

As used throughout Title 13, the following terms have the following meanings:

A. "Department" means the department of insurance of the state corporation commission or its successor.

B. "Insurance code" has the meaning given in Section 59A-1-3 NMSA 1978.

C. "Insurer" has the meaning given in Section 59A-1-8 NMSA 1978 and includes any entity whose acceptance of risk subjects it to the Insurance Code, unless a different definition is given in a specific rule.

D. "Person" has the meaning given in Section 59A-1-10 NMSA 1978.

E. "State" has the meaning given in Section 59A-1-11 NMSA 1978.

F. "Superintendent" has the meaning given in Section 59A-1-12 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.1.1.8 REFERENCES TO OTHER DOCUMENTS:

When a rule issued by the superintendent relating to insurance refers to another rule, regulation, statute, or other document, the reference, unless stated specifically to the contrary, is continuous and intended to refer to all amendments of the rule, regulation, statute, or document.

[7/1/97; Recompiled 11/30/01]

13.1.1.9 INTERPRETATION OF TERMS:

Unless the context otherwise requires:

A. Singular/plural: Words used in the singular include the plural; words used in the plural include the singular;

B. Gender: Words used in the neuter gender include the masculine and the feminine. The personal pronoun in either gender may be used in these rules to refer to any person, firm or corporation.

C. Permissive/mandatory: May is permissive; shall and must are mandatory.

[7/1/97; Recompiled 11/30/01]

13.1.1.10 USE OF DEPARTMENT-PRESCRIBED FORMS:

The department has prescribed forms to carry out certain requirements of these rules. Department-prescribed forms must be used when a form exists for the purpose, unless these rules state otherwise or the superintendent waives this requirement. The superintendent will accept filings made on photocopies of department forms, provided they are legible.

[7/1/97; Recompiled 11/30/01]

13.1.1.11 ADDRESS FOR FILING DOCUMENTS:

A. By mail: Superintendent of Insurance, P.O. Box 1269, Santa Fe, NM 87504-1269

B. In person: New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Office of the Chief Clerk, P.E.R.A. Building, 1120 Paseo de Peralta, at the corner of Old Santa Fe Trail, Santa Fe, New Mexico.

[7/1/97; Recompiled 11/30/01]

13.1.1.12 SEVERABILITY:

If any provision of any rule in Title 13 adopted by the superintendent of insurance, or the application of any provision to any person or circumstance, is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected thereby.

[7/1/97; Recompiled 11/30/01]

PART 2 : INSURANCE BULLETINS

13.1.2.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission,] Department of Insurance, Post Office Box 1269 Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.1.2.2 SCOPE:

This rule applies to all insurers and insurance professionals in New Mexico.

[7/1/97; Recompiled 11/30/01]

13.1.2.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-10 and 59A-4-3 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.1.2.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.1.2.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.1.2.6 OBJECTIVE:

The purpose of this rule is to establish a procedure for the superintendent to request information pursuant to a provision of the insurance code or of a rule adopted by the department, to publish general notice of requirements under the law, and to issue orders generally applicable to large numbers of insurers.

[7/1/97; Recompiled 11/30/01]

13.1.2.7 DEFINITIONS:

A **"bulletin"** is a statement, inquiry, or order of broad or general interest or application that does not in itself create new law but which may require certain actions to be performed under existing law.

[7/1/97; Recompiled 11/30/01]

13.1.2.8 USE OF BULLETINS:

A. The superintendent may issue bulletins requiring any person or company subject to regulation by the department:

(1) to comply with requests from the superintendent to provide information useful in the lawful enforcement or administration of any provision of a rule adopted by the department or of the Insurance Code;

(2) to respond to an inquiry from the superintendent with respect to any transaction or matter within the scope of the superintendent's supervision;

(3) to comply with an order requiring that certain actions be performed.

B. The superintendent may issue bulletins:

(1) indicating his understanding of the meaning of a statute or rule;

(2) indicating his understanding of the applicability of a statute or rule;

(3) providing an explanation of how a statute or rule is to be administered in practice;

(4) in response to inquiries from insurers, insurance professionals or the public clarifying ambiguous terms or requirements of existing law.

[7/1/97; Recompiled 11/30/01]

13.1.2.9 PROCEDURE FOR ISSUING BULLETINS:

Bulletins shall be numbered, dated and signed by the superintendent. Bulletins shall be effective on the date issued, unless a different effective date is specified in the bulletin.

[7/1/97; Recompiled 11/30/01]

13.1.2.10 REVIEW PROCEDURE:

Any person aggrieved by a bulletin may request a hearing before the superintendent in accordance with Section 59A-4-15 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

PART 3: PRIVACY OF NONPUBLIC PERSONAL INFORMATION

13.1.3.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[13.1.3.1 NMAC - N, 2-25-02]

13.1.3.2 SCOPE:

This rule applies to:

A. Nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family or household purposes from licensees. This rule does not apply to information about

companies or about individuals who obtain products or services for business, commercial or agricultural purposes; and

B. All nonpublic personal health information.

[13.1.3.2 NMAC - N, 2-25-02]

13.1.3.3 STATUTORY AUTHORITY:

NMSA 1978, Section 59A-2-9 (1997) and Section 59A-2-9.3 (2001).

[13.1.3.3 NMAC - N, 2-25-02]

13.1.3.4 DURATION:

Permanent.

[13.1.3.4 NMAC - N, 2-25-02]

13.1.3.5 EFFECTIVE DATE:

February 25, 2002 unless a later date is cited in the history note at the end of a section.

[13.1.3.4 NMAC - N, 2-25-02]

13.1.3.6 OBJECTIVE:

This rule governs the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the NMPRC Insurance Division and is intended to afford individuals greater privacy protections than those provided in the Gramm-Leach-Bliley Financial Modernization Act (GLBA), Pub. L. 106-102, 113 Stat. 1338, 1415-17 (1999) (codified at 15 U.S.C.A. Section 6716). This rule:

A. Requires a licensee to provide notice to individuals about its privacy policies and practices;

B. Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates or nonaffiliated third parties without authorization from the affected individual; and

C. Provides methods for individuals to authorize a licensee to disclose nonpublic personal information to affiliates or nonaffiliated third parties.

D. The examples in this rule and the sample clauses in 13.1.3.28 NMAC are not exclusive. Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this rule.

[13.1.3.6 NMAC - N, 2-25-02]

13.1.3.7 DEFINITIONS:

As used in this rule, unless the context requires otherwise:

A. "Affiliate" means a company that controls, is controlled by or is under common control with another company.

B. "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice. Examples:

(1) Reasonably understandable. A licensee makes its notice reasonably understandable if it:

(a) Presents the information in the notice in clear, concise sentences, paragraphs and sections;

(b) Uses short explanatory sentences or bullet lists whenever possible;

(c) Uses definite, concrete, everyday words and active voice whenever possible;

(d) Avoids multiple negatives;

(e) Avoids legal and highly technical business terminology whenever possible; and

(f) Avoids explanations that are imprecise and readily subject to different interpretations.

(2) Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

(a) Uses a plain-language heading to call attention to the notice;

(b) Uses a typeface and type size that are easy to read;

(c) Provides wide margins and ample line spacing;

(d) Uses boldface or italics for key words; and

(e) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(3) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either:

(a) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(b) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

C. "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

D. "Superintendent" means the New Mexico Superintendent of Insurance.

E. "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship or similar organization.

F. "Consumer" means an individual who seeks to obtain, obtains or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative. Examples:

(1) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(2) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(3) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(4) An individual is a licensee's consumer if:

(a) the individual is a beneficiary of a life insurance policy underwritten by the licensee; the individual is a claimant under an insurance policy issued by the licensee; the individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or the individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

(b) the licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under 13.1.3.17 NMAC, 13.1.3.18 NMAC, and 13.1.3.19 NMAC.

(5) Provided that the licensee provides any initial, annual and revised notices required under 13.1.3.8 NMAC, 13.1.3.9 NMAC and 13.1.3.12 NMAC to the plan sponsor, group or blanket insurance policyholder, group annuity contractholder, or workers' compensation policyholder, and further provided that the licensee does not disclose nonpublic personal information about such an individual other than as permitted under 13.1.3.17 NMAC, 13.1.3.18 NMAC and 13.1.3.19 NMAC, an individual is not the consumer of the licensee solely because he or she is:

(a) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;

(b) Covered under a group or blanket insurance policy or group annuity contract issued by the licensee; or

(c) A claimant under a workers' compensation policy.

(6) The individuals described in subparagraphs (a) through (c) of paragraph (5) of subsection F of 13.1.3. 7 NMAC are consumers of a licensee if the licensee does not meet all the conditions of paragraph (5) of subsection F of 13.1.3.7 NMAC. In no event shall the individuals, solely by virtue of the status described in subparagraphs (a) through (c) of paragraph (5) of subsection F of 13.1.3.7 NMAC, be deemed to be customers for purposes of this rule.

(7) An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee.

(8) An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

G. "Consumer reporting agency" has the same meaning as in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

H. "Control" means:

(1) Ownership, control or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

(2) Control in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the company; or

(3) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the Superintendent determines.

I. "Customer" means a consumer who has a customer relationship with a licensee.

J. "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes. Examples:

(1) A consumer has a continuing relationship with a licensee if:

(a) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(b) The consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

(2) A consumer does not have a continuing relationship with a licensee if:

(a) The consumer applies for insurance but does not purchase the insurance;

(b) The licensee sells the consumer travel insurance in an isolated transaction;

(c) The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(d) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(e) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(f) The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with

the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or rule, communication at the direction of a state or federal authority, or promotional materials;

(g) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(h) For the purposes of this rule, the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

K. "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)). Financial institution does not include:

(1) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 *et seq.*);

(2) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 *et seq.*); or

(3) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

L. "Financial product or service" means a product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)). Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

M. "Health care" means:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests or counseling that:

(a) Relates to the physical, mental or behavioral condition of an individual; or

(b) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs or any other tissue; or

(2) Prescribing, dispensing or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

N. "Health care provider" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law, or a health care facility.

O. "Health information" means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

(1) The past, present or future physical, mental or behavioral health or condition of an individual;

(2) The provision of health care to an individual; or

(3) Payment for the provision of health care to an individual.

P. "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state. Insurance service includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for a insurance product or service.

Q. "Licensee" means all licensed insurers, agents, brokers, solicitors, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the New Mexico Insurance Code other than pursuant to Chapter 206 of the Laws of 2001 (Senate Bill 556, as amended).

(1) A licensee is not subject to the notice and authorization requirements for nonpublic personal financial information set forth in 13.1.3.8 NMAC through 13.1.3.21 NMAC if the licensee is an employee, agent or other representative of another licensee ("the principal") and:

(a) The principal otherwise complies with, and provides the notices required by, the provisions of this rule; and

(b) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this rule.

(2) Subject to the provisions of this paragraph, "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed surplus lines

broker in this state, but only in regard to the surplus lines placements placed pursuant to NMSA 59A-14-1 et seq. A surplus lines broker or surplus lines insurer shall be deemed to be in compliance with the notice and authorization requirements for nonpublic personal financial information set forth in 13.1.3.8 NMAC through 13.1.3.19 NMAC provided:

(a) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under 13.1.3.17 NMAC, except as permitted by 13.1.3.18 NMAC or 13.1.3.19 NMAC; and

(b) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

"Neither the U.S. brokers that handled this insurance nor the insurers that have underwritten this insurance will disclose nonpublic personal information concerning the buyer to nonaffiliates of the brokers or insurers except as permitted by law."

R. "Nonaffiliated third party" means any person except a licensee's affiliate; or a person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person). Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in Section 4(k)(4)(H) or insurance company investment activities of the type described in Section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)).

S. "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

T. "Nonpublic personal financial information" means personally identifiable financial information; and any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available.

(1) Nonpublic personal financial information does not include:

(a) Health information;

(b) Publicly available information, except as included on a list described above in this section; or

(c) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

(2) Examples of lists.

(a) Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

(b) Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

U. "Nonpublic personal health information" means health information:

(1) That identifies an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

V. "Personally identifiable financial information" means any information a consumer provides to a licensee to obtain an insurance product or service from the licensee; about a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer. Examples:

(1) Information included. Personally identifiable financial information includes:

(a) Information a consumer provides to a licensee on an application to obtain an insurance product or service;

(b) Account balance information and payment history;

(c) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(d) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(e) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(f) Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and

(g) Information from a consumer report.

(2) Information not included. Personally identifiable financial information does not include:

(a) Health information;

(b) A list of names and addresses of customers of an entity that is not a financial institution; and

(c) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.

W. "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state or local law.

(1) Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(a) That the information is of the type that is available to the general public; and

(b) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

(2) Examples.

(a) Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

(b) Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service

provider or a site operator requires a fee or a password, so long as access is available to the general public.

(c) Reasonable basis. A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded. A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

[13.1.3.7 NMAC - N, 2-25-02]

13.1.3.8 INITIAL PRIVACY NOTICE TO CONSUMERS REQUIRED FOR NONPUBLIC PERSONAL FINANCIAL INFORMATION:

A. Initial notice requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(1) Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in subsection E of 13.1.3.8 NMAC; and

(2) Consumer. A consumer, when the licensee requests authorization to disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party other than disclosures listed in 13.1.3.18 NMAC and 13.1.3.19 NMAC for which no authorization is required.

B. When initial notice to a consumer is not required. A licensee is not required to provide an initial notice to a consumer under paragraph (2) of subsection A of 13.1.3.8 NMAC if:

(1) The licensee does not request authorization to disclose any nonpublic personal information about the consumer to any nonaffiliated third party, other than disclosures listed in 13.1.3.18 NMAC and 13.1.3.19 NMAC for which no authorization is required, and the licensee does not have a customer relationship with the consumer; or

(2) A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all

licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

C. When the licensee establishes a customer relationship.

(1) General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

(2) Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

(a) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(b) Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

D. Existing customers. When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of subsection A of 13.1.3.8 NMAC as follows:

(1) The licensee may provide a revised policy notice, under 13.1.3.12 NMAC, that covers the customer's new insurance product or service; or

(2) If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under subsection A of 13.1.3.8 NMAC.

E. Exceptions to allow subsequent delivery of notice.

(1) A licensee may provide the initial notice required by paragraph (1) of subsection A of 13.1.3.8 NMAC within a reasonable time after the licensee establishes a customer relationship if:

(a) Establishing the customer relationship is not at the customer's election; or

(b) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(2) Examples of exceptions.

(a) Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(b) Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(c) No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

F. Delivery. When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to 13.1.3.13 NMAC.

[13.1.3.8 NMAC - N, 2-25-02]

13.1.3.9 ANNUAL PRIVACY NOTICE TO CUSTOMERS REQUIRED FOR NONPUBLIC PERSONAL FINANCIAL INFORMATION:

A. General rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of 12 consecutive months during which that relationship exists. A licensee may define the 12 consecutive-month period, but the licensee shall apply it to the customer on a consistent basis. **Example:** A licensee provides a notice annually if it defines the 12 consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year one the licensee shall provide an annual notice to that customer by December 31 of year two.

B. Exception to the general rule. A licensee that provides nonpublic personal information in accordance with Sections 13.1.3.17 NMAC, 13.1.3.18 NMAC, and 13.1.3.19 NMAC and has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent notice sent to consumers in accordance with 13.1.3.8 NMAC shall not be required to provide a subsequent annual notice under this section until such time as the licensee fails to comply with any criteria described in this subsection. Notice of a change in a licensee's privacy policy shall be sent 90 days after the effective date of the change.

C. Termination of customer relationship. A licensee is not required to provide a privacy notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship. **Examples:**

(1) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

(2) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than to provide privacy notices, material required by law or rule, or promotional materials.

(3) For the purposes of this rule, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(4) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

D. Delivery. When a licensee is required by this section to deliver a privacy notice, the licensee shall deliver it according to 13.1.3.13 NMAC.

[13.1.3.9 NMAC - N, 2/25/2002; A, 3/1/2022]

13.1.3.10 INFORMATION TO BE INCLUDED IN PRIVACY NOTICES REQUIRED FOR NONPUBLIC PERSONAL FINANCIAL INFORMATION:

A. General rule. The initial, annual and revised privacy notices that a licensee provides under 13.1.3.8 NMAC, 13.1.3.9 NMAC and 13.1.3.12 NMAC shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(1) The categories of nonpublic personal financial information that the licensee collects;

(2) The categories of nonpublic personal financial information that the licensee will disclose if authorization is obtained from the consumer whose nonpublic personal financial information is sought to be disclosed;

(3) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under 13.1.3.18 NMAC and 13.1.3.19 NMAC;

(4) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customer, other than those parties to whom the licensee discloses information under 13.1.3.18 NMAC and 13.1.3.19 NMAC;

(5) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under 13.1.3.17 NMAC (and no other exception in 13.1.3.18 NMAC and 13.1.3.19 NMAC applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

(6) An explanation of the consumer's right under subsection A of 13.1.3.14 NMAC to authorize or not to authorize the disclosure of nonpublic financial personal information to nonaffiliated third parties;

(7) Any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

(8) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information; and

(9) Any disclosure that the licensee makes under subsection B of 13.1.3.10 NMAC.

B. Description of parties subject to exceptions. If a licensee discloses nonpublic personal financial information as authorized under 13.1.3.18 NMAC and 13.1.3.19 NMAC, the licensee is not required to list those exceptions in the initial or annual privacy notices required by 13.1.3.8 NMAC and 13.1.3.9 NMAC. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

C. Examples.

(1) Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(a) Information from the consumer;

(b) Information about the consumer's transactions with the licensee or its affiliates;

(c) Information about the consumer's transactions with nonaffiliated third parties; and

(d) Information from a consumer reporting agency.

(2) Categories of nonpublic personal financial information a licensee discloses.

(a) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in paragraph (1) of subsection C of 13.1.3.10 NMAC, as applicable, and provides a few examples to illustrate the types of information in each category. These might include: information from the consumer, including application information, such as assets and income and identifying information, such as name, address and social security number; transaction information, such as information about balances, payment history and parties to the transaction; and information from consumer reports, such as a consumer's creditworthiness and credit history.

(b) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(3) Categories of affiliates and nonaffiliated third parties.

(a) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties if the licensee identifies the types of businesses in which they engage.

(b) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(c) A licensee also may categorize the affiliates and nonaffiliated third parties using more detailed categories.

(4) Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in 13.1.3.17 NMAC to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of paragraph (5) of subsection A of 13.1.3.10 NMAC if it:

(a) Lists the categories of nonpublic personal financial information it will disclose if authorization is obtained from the consumer whose nonpublic personal information is sought to be disclosed, using the same categories and examples the licensee used to meet the requirements of paragraph 2 of subsection A of 13.1.3.10 NMAC, as applicable; and

(b) States whether the third party is a service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or a financial institution with whom the licensee has a joint marketing agreement.

(5) Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under 13.1.3.18 NMAC and 13.1.3.19 NMAC, the licensee may simply state the fact, in addition to the information it shall provide under paragraphs (1), (8) and (9) of subsection A of 13.1.3.10 NMAC and subsection B of 13.1.3.10 NMAC.

(6) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(a) Describes in general terms who is authorized to have access to the information; and

(b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

D. Short-form initial notice with notice regarding request for authorization for non-customers.

(1) A licensee may satisfy the initial notice requirements in paragraph (2) of subsection A of 13.1.3.8 NMAC and subsection C of 13.1.3.11 NMAC for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers a notice regarding request for authorization as required in 13.1.3.11 NMAC.

(2) A short-form initial notice shall:

(a) Be clear and conspicuous;

(b) State that the licensee's privacy notice is available upon request; and

(c) Explain a reasonable means by which the consumer may obtain that notice.

(3) The licensee shall deliver its short-form initial notice according to 13.1.3.13 NMAC. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to 13.1.3.13 NMAC.

(4) Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

(a) Provides a toll-free telephone number that the consumer may call to request the notice; or

(b) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

E. Future disclosures. The licensee's notice may include:

(1) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

(2) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

F. Sample clauses. Sample clauses illustrating some of the notice content required by this section are included in 13.1.3.28 NMAC.

[13.1.3.10 NMAC - N, 2-25-02]

13.1.3.11 NOTICE TO CONSUMERS REGARDING REQUEST FOR AUTHORIZATION:

A. Form of notice. If a licensee is required to provide notice under subsection A of 13.1.3.14 NMAC, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to authorize disclosures under that section. The notice shall state:

(1) That the licensee may only disclose nonpublic personal information about its consumer if the licensee first obtains authorization from the consumer; and

(2) That the consumer has the right to authorize or not to authorize the disclosure.

B. Examples. A licensee provides adequate notice that the consumer has the right to authorize or not to authorize the disclosure of nonpublic personal information if the licensee:

(1) Identifies all of the categories of nonpublic personal information the licensee will disclose if authorization is obtained from the consumer whose nonpublic personal information is sought to be disclosed and all of the categories of affiliated and nonaffiliated third parties to whom the licensee will disclose the information, as described in paragraphs (2) and (3) of subsection A of 13.1.3.10 NMAC, and states that the consumer has the right to authorize or not to authorize the disclosure of that information; and

(2) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the authorization would apply.

C. Notice required when request for authorization delivered subsequent to initial notice. If a licensee provides the notice to consumers regarding request for authorization later than required for the initial notice in accordance with 13.1.3.8 NMAC, the licensee shall also include a copy of the initial notice with the request for authorization in writing or, if the consumer agrees, electronically.

D. Joint relationships.

(1) If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee shall provide notices and an authorization form to each joint consumer.

(2) An authorization signed by all joint consumers must be obtained by the licensee before it may disclose any nonpublic personal information, except as otherwise authorized in this rule or in accordance with an exception in 13.1.3.17 NMAC, 13.1.3.18 NMAC or 13.1.3.19 NMAC.

E. Delivery. When a licensee is required to deliver a notice by this section, the licensee shall deliver it according to 13.1.3.13 NMAC.

[13.1.3.11 NMAC - N, 2-25-02]

13.1.3.12 REVISED PRIVACY NOTICES FOR NONPUBLIC PERSONAL FINANCIAL INFORMATION:

A. General rule. Except as otherwise authorized in this rule, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer other than as described in the initial notice that the licensee provided

to that consumer under 13.1.3.8 NMAC or in the authorization obtained from the consumer, unless:

(1) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(2) The licensee has provided to the consumer a new notice to consumers regarding request for authorization and a new authorization; and

(3) The licensee has obtained authorization from the consumer whose nonpublic personal financial information is sought to be disclosed.

B. Examples. Except as otherwise permitted by 13.1.3.17 NMAC, 13.1.3.18 NMAC and 13.1.3.19 NMAC, a licensee shall provide a revised notice if it requests authorization to disclose:

(1) a new category of nonpublic personal information;

(2) nonpublic personal information to a new category of nonaffiliated third party; or

(3) nonpublic personal information about a former customer to a nonaffiliated third party, if that former customer has not previously authorized the disclosure.

C. Delivery. When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to 13.1.3.13 NMAC.

[13.1.3.12 NMAC - N, 2-25-02]

13.1.3.13 DELIVERY:

A. How to provide notices. A licensee shall provide any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

(1) Examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(a) Hand-delivers a printed copy of the notice to the consumer;

(b) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(c) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service; or

(d) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(2) Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(a) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(b) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

B. Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(1) The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

(2) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

C. Oral description of notice insufficient. A licensee may not provide any notice required by this rule solely by orally explaining the notice, either in person or over the telephone.

D. Retention or accessibility of notices for customers.

(1) For customers only, a licensee shall provide the initial notice required by paragraph (1) of subsection A of 13.1.3.8 NMAC, the annual notice required by subsection A of 13.1.3.9 NMAC, and the revised notice required by 13.1.3.12 NMAC so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

(2) Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

(a) Hand-delivers a printed copy of the notice to the customer;

(b) Mails a printed copy of the notice to the last known address of the customer; or

(c) Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

E. Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

F. Joint relationships. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of subsection A of 13.1.3.8 NMAC, subsection A of 13.1.3.9 NMAC and subsection A of 13.1.3.12 NMAC, respectively, by providing one notice to those consumers jointly.

[13.1.3.13 NMAC - N, 2-25-02]

13.1.3.14 LIMITS ON DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION:

A. Conditions for disclosure. Except as otherwise authorized in this rule, a licensee may not, directly or through any affiliate, disclose any nonpublic personal health information to any party, including affiliates, and may not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(1) The licensee has provided to the consumer any initial notice as required under 13.1.3.8 NMAC regarding nonpublic personal financial information;

(2) The licensee has provided to the consumer a notice as required in 13.1.3.11 NMAC; and

(3) An authorization is obtained from the consumer whose nonpublic personal information is sought to be disclosed.

B. Application to all consumers and all nonpublic personal information.

(1) A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

(2) Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving authorization from the consumer.

C. Partial authorization. A licensee may allow a consumer to select certain nonpublic personal information or certain affiliates or nonaffiliated third parties with respect to which the consumer wishes to authorize disclosure of specified nonpublic personal information.

[13.1.3.14 NMAC - N, 2-25-02]

13.1.3.15 LIMITS ON REDISCLOSURE AND REUSE OF NONPUBLIC PERSONAL INFORMATION:

A. Nonpublic personal financial information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial or other institution under an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC, the licensee's disclosure and use of that information is limited as follows:

(1) The licensee may disclose the information to the affiliates of the financial or other institution from which the licensee received the information;

(2) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

(3) The licensee may disclose and use the information pursuant to an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(4) Example. If a licensee receives information from a nonaffiliated financial or other institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

B. Nonpublic personal financial information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC, the licensee may disclose the information only:

(1) To the affiliates of the financial or other institution from which the licensee received the information;

(2) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(3) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(4) Example. If a licensee obtains a customer list from a nonaffiliated financial or other institution outside of the exceptions in 13.1.3.18 NMAC or 13.1.3.19 NMAC:

(a) The licensee may use that list for its own purposes; and

(b) The licensee may disclose that list to another nonaffiliated third party only if the financial or other institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial or other institution from which the licensee received the list, consistent with the authorization of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC, such as to the licensee's attorneys or accountants.

C. Nonpublic personal financial information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC, the third party may disclose and use that information only as follows:

(1) The third party may disclose the information to the licensee's affiliates;

(2) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

(3) The third party may disclose and use the information pursuant to an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

D. Nonpublic personal financial information a licensee discloses pursuant to consumer authorization outside of an exception. If a licensee discloses nonpublic personal information to a nonaffiliated third party pursuant to 13.1.3.14 NMAC, the third party may disclose the information only:

(1) To the licensee's affiliates;

(2) To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(3) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

E. Nonpublic personal health information.

(1) If a licensee receives nonpublic personal health information from an affiliate or a nonaffiliated third party under an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC, the licensee may disclose and use the information pursuant to an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(2) If a licensee receives nonpublic personal health information other than under an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC, the licensee may disclose the information only to any other person, if the disclosure would be lawful if made directly to that person by the individual from whom the licensee received the information.

(3) If a licensee discloses nonpublic personal heath information to an affiliate or to a nonaffiliated third party under an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC, the affiliate or third party may only disclose and use that information pursuant to an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(4) If a licensee discloses nonpublic personal health information to an affiliate or a nonaffiliated third party pursuant to 13.1.3.14 NMAC, the affiliate or third party may disclose the information only to any other person if the disclosure would be lawful if the licensee made it directly to that person.

[13.1.3.15 NMAC - N, 2-25-02]

13.1.3.16 LIMITS ON SHARING ACCOUNT NUMBER INFORMATION FOR MARKETING PURPOSES:

A. General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

B. Exceptions. Subsection A of 13.1.3.16 NMAC does not apply if a licensee discloses a policy number or similar form of access number or access code:

(1) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(2) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(3) To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

C. Examples.

(1) Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(2) Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

[13.1.3.16 NMAC - N, 2-25-02]

13.1.3.17 EXCEPTION TO AUTHORIZATION REQUIREMENT FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION FOR SERVICE PROVIDERS AND JOINT MARKETING:

A. General rule.

(1) The notice and authorization requirements in 13.1.3.11 NMAC and 13.1.3.14 NMAC do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(a) Provides the initial notice in accordance with 13.1.3.8 NMAC; and

(b) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC in the ordinary course of business to carry out those purposes.

(2) Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of subparagraph (b) of paragraph (1) of subsection A of 13.1.3.17 NMAC if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in 13.1.3.18 NMAC or 13.1.3.19 NMAC in the ordinary course of business to carry out that joint marketing.

B. Joint marketing. The services a nonaffiliated third party performs for a licensee under subsection A of 13.1.3.17 NMAC may include disclosures of nonpublic personal

financial information for the purpose of marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions. A licensee shall not disclose nonpublic personal health information for joint marketing pursuant to 13.1.3.17 NMAC unless the licensee has first obtained authorization from the consumer whose nonpublic personal health information is sought to be disclosed for joint marketing.

C. Definition of "joint agreement." For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor a financial product or service.

[13.1.3.17 NMAC - N, 2-25-02]

13.1.3.18 EXCEPTIONS TO NOTICE AND AUTHORIZATION REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION FOR PROCESSING AND SERVICING TRANSACTIONS:

A. Exceptions for processing transactions at consumer's request. The requirements for initial notice in paragraph (2) of subsection A of 13.1.3.8 NMAC, for notice and authorization in 13.1.3.11 NMAC and 13.1.3.14 NMAC, and service providers and joint marketing in 13.1.3.17 NMAC do not apply if the licensee discloses nonpublic personal information only to the extent necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:

(1) Servicing or processing an insurance product or service that a consumer requests or authorizes;

(2) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

(3) A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or

(4) Reinsurance or stop loss or excess loss insurance.

B. "Necessary to effect, administer or enforce a transaction" means that the disclosure is:

(1) Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(2) Required, or is a usual, appropriate or acceptable method:

(a) To carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(b) To administer, adjust, manage, or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(c) To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(d) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(e) To underwrite insurance at the consumer's request;

(f) To perform the following insurance functions: policy placement or issuance, account administration, detecting, reporting, investigating or preventing actual or potential fraud, material misrepresentation or criminal activity, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), loss control, risk management, case management, disease management, quality assurance, quality improvement, performance evaluation, provider credentialing verification, peer review activities, participating in research projects, grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business or operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the U.S. Department of Health and Human Services; disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process; or

(g) In connection with the authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means; the transfer of receivables, accounts or interests therein; or the audit of debit, credit or other payment information.

[13.1.3.18 NMAC - N, 2-25-02]

13.1.3.19 OTHER EXCEPTIONS TO NOTICE AND AUTHORIZATION REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION:

A. Exceptions to authorization requirement. The requirements for initial notice to consumers in paragraph (2) of subsection A of 13.1.3.8 NMAC, for notice and authorization in 13.1.3.11 NMAC and 13.1.3.14 NMAC, and service providers and joint marketing in 13.1.3.17 NMAC do not apply when a licensee discloses nonpublic personal information:

(1) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

(2) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction; to protect against or prevent actual or potential fraud or unauthorized transactions; for required institutional risk control or for resolving consumer disputes or inquiries; to persons holding a legal or beneficial interest relating to the consumer; or to persons acting in a fiduciary or representative capacity on behalf of the consumer;

(3) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

(4) To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

(5) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or from a consumer report reported by a consumer reporting agency;

(6) In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

(7) To comply with federal, state or local laws, rules and other applicable legal requirements; to comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities; or to

respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law; or

(8) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation policy.

B. Revocation of authorization. A consumer may revoke an authorization at any time by informing the licensee in writing of the revocation.

[13.1.3.19 NMAC - N, 2-25-02]

13.1.3.20 AUTHORIZATIONS:

A. A valid authorization to disclose nonpublic personal information pursuant to 13.1.3.14 NMAC shall be in written or electronic form separate from that used for any other purpose and shall contain all of the following:

(1) The identity of the consumer or customer who is the subject of the nonpublic personal information;

(2) A specific description of the types of nonpublic personal information to be disclosed;

(3) Specific descriptions of the parties to whom the licensee discloses nonpublic personal information, the purpose of the disclosure and how the information will be used;

(4) The signature of the consumer or customer who is the subject of the nonpublic personal information or the individual who is legally empowered to grant authority and the date signed; and

(5) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

B. An authorization for the purposes of this rule shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four (24) months.

C. A consumer or customer who is the subject of nonpublic personal information may revoke an authorization provided pursuant to this rule at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

D. A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal information.

[13.1.3.20 NMAC - N, 2-25-02]

13.1.3.21 AUTHORIZATION REQUEST DELIVERY:

A notice to consumers regarding request for authorization and an authorization form shall be delivered to a consumer pursuant to 13.1.3.13 NMAC. A notice to consumers regarding request for authorization and an authorization form are not required to be delivered to a consumer or included in any other notices unless the licensee intends to disclose nonpublic personal information pursuant to 13.1.3.14 NMAC.

[13.1.3.21 NMAC - N, 2-25-02]

13.1.3.22 RELATIONSHIP TO FEDERAL RULES:

Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rule as promulgated by the U.S. Department of Health and Human Services (the "federal rule"), if a licensee complies with all requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provisions of this rule with respect to nonpublic personal health information.

[13.1.3.22 NMAC - N, 2-25-02]

13.1.3.23 RELATIONSHIP TO STATE LAWS:

Nothing in this rule shall preempt or supercede existing state law related to medical records, health or insurance information privacy.

[13.1.3.23 NMAC - N, 2-25-02]

13.1.3.24 PROTECTION OF FAIR CREDIT REPORTING ACT:

Nothing in this rule shall be construed to modify, limit or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this rule regarding whether information is transaction or experience information under Section 603 of that Act.

[13.1.3.24 NMAC - N, 2-25-02]

13.1.3.25 NONDISCRIMINATION:

A licensee shall not unfairly discriminate against any consumer because that consumer has not granted authorization for the disclosure of his or her nonpublic personal information pursuant to the provisions of this rule.

[13.1.3.25 NMAC - N, 2-25-02]

13.1.3.26 SEVERABILITY:

If any section or portion of a section of this rule or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected.

[13.1.3.26 NMAC - N, 2-25-02]

13.1.3.27 TWO-YEAR GRANDFATHERING OF SERVICE AGREEMENTS:

Until December 31, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of subparagraph (b) of paragraph (1) of subsection A of 13.1.3.17 NMAC, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before December 31, 2000.

[13.1.3.27 NMAC - N, 2-25-02]

13.1.3.28 SAMPLE CLAUSES:

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A. Categories of information a licensee collects (all institutions): A licensee may use this clause, as applicable, to meet the requirement of paragraph (1) of subsection A of 13.1.3.10 NMAC to describe the categories of nonpublic personal information the licensee collects. Sample Clause:

We collect nonpublic personal information about you from the following sources:

Information we receive from you on applications or other forms;

Information about your transactions with us, our affiliates or others; and

Information we receive from a consumer reporting agency.

B. Categories of information a licensee discloses with consumer authorization (institutions that disclose outside of the exceptions): A licensee may use one of these clauses, as applicable, to meet the requirement of paragraph (2) of subsection A of 13.1.3.10 NMAC to describe the categories of nonpublic personal information the

licensee discloses with consumer authorization. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in 13.1.3.17 NMAC, 13.1.3.18 NMAC and 13.1.3.19 NMAC.

(1) Alternative 1:

If authorized by you, we may disclose the following kinds of nonpublic personal information about you:

Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];

Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premiums, and payment history"]; and

Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

(2) Alternative 2:

If authorized by you, we may disclose all of the information that we collect, as described [describe location in the notice, such as "above" or "below"].

C. Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions): A licensee may use this clause, as applicable, to meet the requirements of paragraphs (2), (3), and (4) of subsection A of 13.1.3.10 NMAC to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses with consumer authorization and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses with consumer authorization. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in 13.1.3.18 NMAC and 13.1.3.19 NMAC. Sample Clause:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

D. Categories of parties to whom a licensee discloses with consumer authorization (institutions that disclose outside of the exceptions): A licensee may use this clause, as applicable, to meet the requirement of paragraph (3) of subsection A of 13.1.3.10 NMAC to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information with consumer authorization. This clause may be used if the licensee discloses nonpublic personal information with consumer authorization other than as permitted by the exceptions in

13.1.3.17 NMAC, 13.1.3.18 NMAC and 13.1.3.19 NMAC, as well as when permitted by the exceptions in 13.1.3.18 NMAC and 13.1.3.19 NMAC. Sample Clause:

If authorized by you, we may disclose nonpublic personal information about you to the following types of third parties:

Financial service providers, such as [provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents"];

Non-financial companies, such as [provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]; and

Others, such as [provide illustrative examples, such as "non-profit organizations"].

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

E. Service provider/joint marketing exception: A licensee may use one of these clauses, as applicable, to meet the requirements of paragraph (5) of subsection A of 13.1.3.10 NMAC related to the exception for service providers and joint marketers in 13.1.3.17 NMAC. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

(1) Alternative 1:

We may disclose the following nonpublic personal financial information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];

Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premium, and payment history"]; and

Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

(2) Alternative 2:

We may disclose all of the nonpublic personal financial information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

F. Explanation of authorization right (institutions that disclose outside of the exceptions): A licensee may use this clause, as applicable, to meet the requirement of paragraph (6) of subsection A of 13.1.3.10 NMAC to provide an explanation of the consumer's right to authorize or not to authorize the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee requests authorization to disclose nonpublic personal information other than as permitted by the exceptions in 13.1.3.17 NMAC, 13.1.3.18 NMAC and 13.1.3.19 NMAC. Sample Clause:

We may only disclose nonpublic personal information if you sign and return the enclosed authorization. If you prefer that we not disclose nonpublic personal information about you, you should not return the enclosed authorization form.

G. Confidentiality and security (all institutions): A licensee may use this clause, as applicable, to meet the requirement of paragraph (8) of subsection A of 13.1.3.10 NMAC to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information. Sample Clause:

We restrict access to nonpublic personal information about you to [provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]. We maintain physical, electronic, and procedural safeguards that comply with federal rules to guard your nonpublic personal information.

[13.1.3.28 NMAC - N, 2-25-02]

PART 4: PUBLIC RULE HEARINGS

13.1.4.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance.

[13.1.4.1 NMAC - N, 7/1/2019]

13.1.4.2 SCOPE:

This rule applies to all proceedings within the New Mexico office of superintendent of insurance in which the superintendent adopts rules pursuant to the State Rules Act, Sections 14-4-1 through 14-4-11 NMSA 1978 (1967, as amended through 2017).

[13.1.4.2 NMAC - N, 7/1/2019]

13.1.4.3 STATUTORY AUTHORITY:

Section 14-4-5.8 NMSA 1978; 1.24.25.8 NMAC.

[13.1.4.3 NMAC - N, 7/1/2019]

13.1.4.4 DURATION:

Permanent.

[13.1.4.4 NMAC - N, 7/1/2019]

13.1.4.5 EFFECTIVE DATE:

July 1, 2019, unless a later date is cited at the end of a section.

[13.1.4.5 NMAC - N, 7/1/2019]

13.1.4.6 OBJECTIVE:

To provide procedural rules for public rule hearings for use by the New Mexico office of superintendent of insurance consistent with the State Rules Act and to facilitate public engagement with the superintendent's rulemaking process in a transparent, organized, and fair manner.

[13.1.4.6 NMAC - N, 7/1/2019]

13.1.4.7 DEFINITIONS:

This rule adopts the definitions found in Section 14-4-2 NMSA 1978 and in 13.1.1.7 NMAC. In addition:

A. "Final order" also means "concise explanatory statement" as described in Section 14-4-5.5 NMSA 1978;

B. "Logical outgrowth" occurs when a final rule differs from the proposed rule if interested parties should have anticipated that the change was possible, and thus reasonably should have filed their comments on the subject during the notice-and-comment period;

C. "OSI" means the New Mexico office of superintendent of insurance

D. "Recommended decision" means the written decision of any designated hearing officer which contains a description of the rulemaking proceeding, a summary of any written comments submitted to the superintendent, a summary of any oral comments made at the public hearing, any analysis or conclusions of the designated

hearing officer, and recommendations to the superintendent concerning adoption, rejection, or amendment of the proposed rule.

[13.1.4.7 NMAC - N, 7/1/2019]

13.1.4.8 INITIATION OF THE RULEMAKING PROCESS BY THE SUPERINTENDENT:

A. The rulemaking process may be initiated by the superintendent through a notice for a rule hearing that is publicly posted pursuant to this rule.

B. The superintendent shall proceed with the rulemaking process by posting public notice, publishing the proposed rule for comment, and setting a public rule hearing in accordance with the State Rules Act and any other applicable law.

C. Once the superintendent initiates the rulemaking process, the superintendent must maintain a record as prescribed in Section 14-4-5.4 NMSA 1978.

[13.1.4.8 NMAC - N, 7/1/2019]

13.1.4.9 INITIATION OF THE RULEMAKING PROCESS BY THE PUBLIC:

A. Any person may file a petition for rulemaking with the superintendent.

B. A petition for rulemaking shall be made in writing and include an explanation of the purpose or statement of reasons for the proposed rule. A petition shall include a citation to the legal authority authorizing the superintendent to adopt the rule and a copy of or citation to technical information, if any, that serves as the basis for the proposed rule. A petition should be as clear as possible and may include the proposed rule in underline and strikethrough format, consistent with requirements of the state records administrator.

C. The superintendent shall, if required by law, consider the petition and make a determination within 30 calendar days whether to grant or deny the petition. If the superintendent denies the petition, the superintendent shall issue a final order explaining the reason for denial. No affirmative duty to respond to a public petition is created by these rules. If a public right to petition the superintendent exists in the insurance code, the superintendent must follow all timelines or responses governed by the insurance code.

D. Once the superintendent initiates the rulemaking process, the superintendent must maintain a record as prescribed in Section 14-4-5.4 NMSA 1978.

[13.1.4.9 NMAC - N, 7/1/2019]

13.1.4.10 RULEMAKING NOTICE:

The superintendent shall provide to the public, as defined in Section 14-4-2 NMSA 1978, notice of the proposed rulemaking a minimum of 30 calendar days prior to the public rule hearing and in accordance with requirements of Section 14-4-5.2 NMSA 1978.

[13.1.4.10 NMAC - N, 7/1/2019]

13.1.4.11 WRITTEN COMMENT PERIOD:

A. The public comment period must be at least 30 calendar days, beginning after publication of the notice in the New Mexico register and issuance of the rulemaking notice. The superintendent shall not adopt a proposed rule before the end of the public comment period.

B. As long as the public comment period is at least 30 calendar days, the public comment period will close for initial comments at 4:00 p.m. on the day of the public hearing, or on the last day of the public hearing if the public hearing extends for more than one day. For purposes only of responses to written comments or oral comments at the public hearing, the public response period will extend at least 10 calendar days beyond the public hearing or close of the 30 day comment period, whichever is later, unless the necessity of adopting or publishing the rule by a certain date makes the extension of the public response period impractical.

C. A person may submit, by mail or electronic form, written comments or responses to comments on a proposed rule, and those comments or responses shall be made part of the record. Written comments may be submitted through the end of the public comment period, and responses to comments may be submitted for an additional 10 days, unless the necessity of adopting or publishing the rule by a certain date makes a response period impractical.

D. The superintendent may decide to amend the comment period, or response period, if the superintendent provides to the public, as defined in Section 14-4-2 NMSA 1978, notice of the changes.

E. The superintendent shall post all written comments and responses on the OSI website, as soon as practicable, and no more than three business days following receipt to allow for public review. All written comments and responses received by the superintendent shall also be available for public inspection at the main office of OSI.

[13.1.4.11 NMAC - N, 7/1/2019]

13.1.4.12 PUBLIC HEARING:

A. Prior to adopting a proposed rule, the superintendent must hold a public rule hearing. The purpose of the hearing is to provide all interested persons a reasonable opportunity to submit data, views or arguments orally or in writing on the proposed rule.

The superintendent, at the superintendent's discretion, directly or through a designated hearing officer, may determine whether to hold more than one hearing.

B. The superintendent may act as the hearing officer or designate an individual hearing officer to preside over the hearing. The hearing officer may ask questions and provide comments for clarification purposes only, but should refrain from providing opinions or engaging in discussion regarding the merits of the proposed rule or any public comment presented. All written comments submitted during the public comment period, as well as any written comments submitted during the hearing, will be made part of the record.

C. Individuals wishing to provide public comment or submit information at the hearing must state their name and any relevant affiliation for the record and be recognized before presenting. Public comment shall not be taken under oath unless required by law or separate rule. Any individual who provides public comment at the hearing may be questioned by the superintendent or hearing officer or, at the discretion of the superintendent or hearing officer, or as otherwise provided by law, by other persons at the hearing.

D. The hearing shall be conducted in a fair and equitable manner. The superintendent or hearing officer may determine the format in which the hearing is conducted (e.g. introduction of each part or section one at a time for comment), but the hearing will be conducted in a simple and organized manner that facilitates public comment and a clear rulemaking record.

E. The rules of evidence do not apply to public rule hearings and the superintendent or hearing officer may, in the interest of efficiency, exclude or limit comment or questions deemed irrelevant, redundant, or unduly repetitious.

F. The superintendent must hold the hearing in a venue that reasonably accommodates all persons who wish to participate or observe, and appropriate audio equipment should be secured to ensure all in attendance can hear the proceeding and be heard when presenting comment. Reasonable efforts shall be made to accommodate the use of audio and video recording devices. Hearings shall be open to the public, but are not subject to the New Mexico Open Meetings Act.

G. The hearing shall be recorded by any stenographic method in use in the district court or by audio recording.

[13.1.4.12 NMAC - N, 7/1/2019]

13.1.4.13 RULEMAKING RECORD AND ADOPTION OF RULE:

A. The superintendent shall maintain a record of the rulemaking proceeding as required in Section 14-4-5.4 NMSA 1978, and any written comment, document, or other exhibit entered into the record during the rule hearing shall be labeled clearly. Pre-filed

written comments are part of the rulemaking record without the need for formal admission. Pre-filed comments include, but are not limited to: the petition; public notices of the rulemaking, including any lists of individuals to whom notice was mailed or sent electronically; the proposed rule in underline and strikethrough format; and any written comment submitted during the comment period prior to the rule hearing. Written comments or other documents introduced during the hearing should be admitted into the record after being marked as an exhibit.

B. If the rule hearing is conducted by a designated hearing officer, the complete rulemaking record, including any memoranda summarizing the contents of the hearing, if written, shall be compiled and forwarded to the superintendent with sufficient time to review. The superintendent shall review the rulemaking record and the hearing officer's recommended decision before rendering a final decision on the proposed rule.

C. The superintendent may adopt, amend, or reject the proposed rule. Any amendments to the proposed rule must fall within the scope of the current rulemaking proceeding. Amendments to a proposed rule are within the scope of the rulemaking if the amendments:

(1) are a logical outgrowth of the rule proposed in the notice; or

(2) are proposed, or are reasonably suggested, by comments made during the comment period, and the 10 day response period after the close of the comment period has been provided; and

(a) any person affected by the adoption of the rule, if amended, should have reasonably expected that any change from the published proposed rule would affect that person's interest; or

(b) the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule.

D. The date of adoption of the proposed rule shall be the date the final order is signed by the superintendent, unless otherwise specified in the final order.

E. The final order may adopt by reference some or all of any recommended decision and shall include by reference or otherwise, but not be limited to, the following:

(1) citation to specific statutory or other authority authorizing the rule;

(2) effective date of the rule;

(3) date of adoption of the rule, if different than the date of the final order;

(4) reasons for adopting the rule, including any findings otherwise required by law of the superintendent, and a summary of any independent analysis done by the superintendent;

(5) reasons for any change between the published proposed rule and the final rule; and

(6) reasons for not accepting substantive arguments made through public comment.

[13.1.4.13 NMAC - N, 7/1/2019]

13.1.4.14 FILING AND PUBLICATION; EFFECTIVE DATE:

A. Within 15 calendar days after the date of adoption of a rule, the superintendent shall file the adopted rule with the state records administrator and shall provide to the public the adopted rule and final order in accordance with the State Rules Act.

B. Unless another date is stated in the superintendent's final order, or otherwise provided by law, the effective date of the rule shall be the date of publication in the New Mexico register.

[13.1.4.14 NMAC - N, 7/1/2019]

13.1.4.15 EMERGENCY RULES:

The superintendent shall comply with the rulemaking procedures in Section 14-4-5.6 NMSA 1978, regarding the promulgation of emergency rules.

[13.1.4.15 NMAC - N, 7/1/2019]

PART 5: FORMAL ADMINISTRATIVE HEARINGS

13.1.5.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance.

[13.1.5.1 NMAC - N, 7/1/2019]

13.1.5.2 SCOPE:

Except as otherwise provided, the rules in this part govern every adjudicatory proceeding conducted pursuant to a notice of hearing issued by the superintendent of insurance on any matter delegated to the superintendent under the Insurance Code, and to any request for hearing submitted to the superintendent, unless a more specific statutory or regulatory provision applies to the specific hearing type being conducted.

The rules in this part do not apply to (1) an informal hearing conducted pursuant to Section 59A-4-18 NMSA 1978 and its implementing rules, (2) if the law governing a request for hearing requires the superintendent to commence the hearing fewer than 91 days from the hearing request, or (3) to any hearing governed by 13.10.17 NMAC.

[13.1.5.2 NMAC - N, 7/1/2019]

13.1.5.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[13.1.5.3 NMAC - N, 7/1/2019]

13.1.5.4 DURATION:

Permanent.

[13.1.5.4 NMAC - N, 7/1/2019]

13.1.5.5 EFFECTIVE DATE:

July l, 2019 unless a later date is specified at the end of a section.

[13.1.5.5 NMAC - N, 7/1/2019]

13.1.5.6 OBJECTIVE:

The purpose of this rule is to provide procedures to govern formal administrative hearings held before the superintendent.

[13.1.5.6 NMAC - N, 7/1/2019]

13.1.5.7 DEFINITIONS:

A. "Attorney" for purposes of this rule, "attorney" means only an individual who is licensed to practice law in New Mexico or who has requested temporary licensure under the New Mexico supreme court's *pro hac vice* rules.

B. "Day or Days" shall be interpreted as follows, unless otherwise specified:

(1) "Business day" means Monday through Friday, excluding any days that state offices are officially closed;

(2) one to five days means only business days; and

(3) six days or more means calendar days, including weekends and state holidays.

C. "Hearing" means an on-the-record adjudicatory proceeding before the superintendent or the before a hearing officer appointed by the superintendent.

D. "Hearing officer" is the superintendent, or a person designated by the superintendent pursuant to Section 59A-2-7 NMSA 1978, to serve as a neutral decision maker in a proceeding.

E. "Order" means any directive, command, determination of a disputed issue, or ruling on a disputed matter issued by the superintendent or a hearing officer in a proceeding governed by these rules.

F. "OSI" means the New Mexico office of superintendent of insurance.

G. "Party" means a person who participates in a proceeding governed by these rules by order of the superintendent.

H. "Pleading" means any written request, motion, or proposed action filed by a party in a docketed proceeding, as set forth in 13.1.5.10 NMAC.

I. "Proceeding" means any formal adjudicatory proceeding, case or hearing conducted by the superintendent pursuant to these rules.

J. "Request for hearing" means a formal written request for an opportunity to appear before the superintendent and offer testimony, to call witnesses, present evidence and ask questions, that is submitted by a person with respect to a particular matter where OSI has statutory or regulatory authority to conduct an adjudicatory proceeding.

K. "Sua Sponte" means any determination of the superintendent or of his designee made without prompting of the parties.

L. "Superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

[13.1.5.7 NMAC - N, 7/1/2019]

13.1.5.8 REVISION OF STANDING ORDERS:

The superintendent may issue or withdraw standing procedural orders addressing general practice issues and filing protocols for the handling of matters to be adjudicated before the superintendent. Such standing orders will be available for public inspection at

OSI office facilities, on the OSI website, and in any applicable information provided with a notice of hearing. Parties appearing before the superintendent are expected to comply with standing orders.

[13.1.5.8 NMAC - N, 7/1/2019]

13.1.5.9 REQUESTING A HEARING:

A. Written request required. Any person seeking a hearing before the superintendent shall file a written request for a hearing using the form available on the OSI website or as otherwise directed by the superintendent. The request shall include all of the following:

(1) a brief summary identifying the nature of the dispute;

(2) the applicable statute, rule, bulletin or order in dispute in the matter;

(3) a statement of the jurisdictional basis for the superintendent to adjudicate the matter;

(4) the triggering action of the superintendent, such as an order, denial, suspension, revocation, penalty, fine, rule, or interpretative publication;

(5) the requestor's reason for challenging that action or inaction; and

(6) the mailing address of the requestor.

B. Request rejected. The superintendent may reject any request for hearing if the superintendent lacks jurisdiction to adjudicate the matter; the matter is moot; or the request for hearing is procedurally or substantively deficient.

(1) If a request for hearing is rejected, the superintendent will notify the requestor in writing with a brief explanation of the rejection.

(2) If the request for hearing is deficient for any reason other than lack of subject matter jurisdiction of mootness, the requestor may correct any deficiency and resubmit the request for hearing.

C. Designation of hearing officer and docket. Upon receipt of a request for hearing that contains all information required by Subsection A of this section and over which the superintendent has jurisdiction, the superintendent may designate a hearing officer to preside in the matter based on the knowledge, expertise, experience, efficiency, and staffing needs of the office. The superintendent may subsequently reassign the matter to a different hearing officer, if necessary. The superintendent shall assign a docket number to be referenced in all subsequent communications and filings concerning the matter.

D. Intervenors. Any person showing that they will be substantially and specifically affected by the proceeding shall be allowed to intervene as a party in the whole or any portion of the proceeding.

(1) Whether to allow intervention for any other interested person is at the sole discretion of the superintendent.

(2) OSI staff may intervene in any proceeding as a matter of right by filing a notice of intervention.

[13.1.5.9 NMAC - N, 7/1/2019]

13.1.5.10 REPRESENTATION AT HEARING, FORMAL ENTRY OF APPEARANCE, SUBSTITUTION OF COUNSEL, AND WITHDRAWAL FROM REPRESENTATION:

A. Representation. Unless otherwise expressly authorized by statute, only the person challenging the action or a bona fide majority owner if the party is a business entity, or that person's attorney may represent the person in a proceeding.

B. Entry of appearance. Any attorney wishing to represent a party shall file a formal written entry of appearance in the docket of the proceeding. The entry of appearance shall list the attorney's mailing address, phone and fax number (if any), and an email address (if any). Any attorney wishing to substitute in for a previous attorney shall file a substitution of counsel containing the same information required in the initial entry of appearance.

C. Withdrawal. An attorney who intends to withdraw from representation of a party must do so in accordance with the rules of professional conduct.

(1) Withdrawing counsel must file in the docket a written request to withdraw from representation that indicates when counsel notified the party of the withdrawal, and of the date and time of the scheduled hearing.

(2) The superintendent may deny a request to withdraw from representation only when withdrawal would have a clear, materially adverse effect on the represented party's interests and impede the conduct of a full, fair, and efficient hearing.

[13.1.5.10 NMAC - N, 7/1/2019]

13.1.5.11 FILING OF PLEADINGS:

A. Opening the docket. A docket shall be opened in the OSI records management system immediately upon the superintendent's determination that the requestor shall be granted a hearing.

(1) The superintendent shall direct that the requestor's original request for hearing be filed to the docket.

(2) The superintendent shall establish the caption for the docket, which caption shall be used thereafter for any matters pertaining to the hearing. The caption shall establish the nature of the matter and shall include the docket number.

(3) Every written document that is submitted to the superintendent or exchanged between the parties for consideration, including pleadings such as motions, responses and objections, all evidentiary documents and any other filings shall include the caption and shall be filed to the docket.

B. Public access. Unless otherwise determined by the superintendent upon consideration of a request by a party for confidentiality, all dockets shall be open for public inspection.

C. Filing restrictions and service.

(1) OSI shall accept filings through mail, facsimile, or electronic mail.

(2) Any item that is filed to the docket shall also be contemporaneously served upon all parties of record and on the hearing officer.

(3) All filings shall include a certificate of service that documents the method of service used. A represented party shall only be served through counsel.

(4) Electronic and in-person filing shall be accepted on business days between 8:00 and 4:00 pm. Pleadings shall be marked as filed on the business day that OSI receives the pleading.

D. Filing requirements.

(1) All motions, except motions made on the record during the hearing or a continuance request made in a genuine unforeseen emergency circumstance (such as an unexpected accident, force majeure, or major medical emergency occurring in such close proximity to the date of the scheduled hearing that a written motion cannot be completed), shall be in writing and shall state with particularity the grounds and the relief sought.

(2) Absent any order to the contrary, no pleading shall exceed 10 pages, excluding the caption and certificate of service, of double-spaced (except for block quotations), 12-point font. Only relevant excerpts of a motion exhibit shall be filed, with the pertinent portions highlighted, underlined, or otherwise emphasized. All exhibits and attachments shall identify the total number of pages, and consecutive page numbers (*e.g.*, "Page 1 of 10"). Only single-sided documents shall be accepted for filing or into a record at a hearing.

E. Request for concurrence. Before submission of any motion, request for relief or request for continuance, the requesting party shall make reasonable efforts to consult with each other party about that party's position on the motion unless the nature of the pleading is such that it can be reasonably assumed the requested relief would be opposed. The moving party shall state the position of each other party in the pleading.

F. Responses to pleadings.

(1) Unless a different deadline has been established by the hearing officer, each non-moving party shall have 14 days to file a written response to a pleading.

(2) If a deadline for filing would fall on a non-business day, the deadline shall be the next business day.

(3) The hearing officer shall have the discretion to extend or shorten the response deadline.

(4) Failure to file a response in opposition may be presumed to be consent to the relief sought.

(5) The hearing officer is not required to make a default ruling on any motion if the relief sought could be contrary to the facts or law on the issues.

G. In the event of a procedural defect or other error with the manner, method, or content of a submitted pleading, the hearing officer or records manager may communicate such error to the filing party and withhold filing of the pleading until the moving party remedies the procedural defect. Examples of a procedural defect include, but are not limited to, failure to certify service, failure to comply with the page limitations, failure to confer with other parties, failure to use the form or follow the specific filing method required by OSI, submission of double-sided documents, failure to properly number pages, failure to use the correct caption of reference the assigned docket number, or failure to comply with an applicable standing order.

[13.1.5.11 NMAC - N, 7/1/2019]

13.1.5.12 PREHEARING CONFERENCES, STATUS CONFERENCES, AND STATUS CHECKS:

A. Purpose of prehearing conferences. The hearing officer may direct representatives for all parties to meet together or with the hearing officer present for a prehearing conference to consider any or all of the following:

(1) simplify, clarify, narrow or resolve the pending issues;

(2) stipulations and admissions of fact and of the contents and authenticity of documents;

(3) expedition of discovery and presentation of evidence, including, but not limited to, restriction on the number of exhibits and expert, economic or technical witnesses;

(4) matters of which administrative notice shall be taken; and

(5) such other matters as may aid in the orderly and expeditious disposition of the proceeding, including disclosure of the names of witnesses and the identity of documents or other physical exhibits which will be introduced in evidence in the course of the proceeding.

B. Conduct of prehearing conferences.

(1) Prehearing conferences conducted by the hearing officer may be electronically, but not stenographically, recorded. Should a party request that the recording be transcribed, that party shall pay any costs of transcription.

(2) The hearing officer may issue a written order that recites the results of the conference. Such order shall include rulings upon matters raised at the conference, together with appropriate directions to the parties. The order shall control the subsequent course of the proceeding, unless superseded by a subsequent order.

C. Status conferences.

(1) The hearing officer may require the parties to submit a written report of any conference ordered to be conducted between the parties updating the status of the proceeding in light of the conference.

(2) The hearing officer may conduct a status conference upon the request of either party or on the hearing officer's own initiative, at which time the hearing officer may require the parties, attorneys, or authorized representatives, to provide information regarding the status of a proceeding.

[13.1.5.12 NMAC - N, 7/1/2019]

13.1.5.13 HEARING LOCATION, TIME AND PLACE, NOTICE OF HEARING:

A. Location.

(1) In the absence of any statutory requirements to the contrary, all hearings conducted by OSI shall occur in Santa Fe, unless the hearing officer orders the parties to appear at another location in New Mexico.

(2) The parties may express a mutual preference for location of the hearing in their request for hearing.

(3) In selecting a location other than Santa Fe, the hearing officer shall consider and give weight to the location and wishes of the parties, witnesses, access for a hearing officer with expertise in the matter, and the scheduling and staffing needs of OSI.

(4) If selection of a location other than Santa Fe would cause an unreasonable, undue burden to any party, that party may file a written objection to the selected location within 10 days of issuance of the notice of hearing, articulating the reasons supporting the objection. The hearing officer shall promptly review the objection and, upon a showing of an unreasonable, undue burden, may move the hearing to another more reasonable location and the superintendent may designate another hearing officer if necessary.

B. Notice. OSI shall notify the parties to the hearing of the date, time and, place scheduled for the hearing at least fourteen days before the scheduled hearing. This notice shall be directed to the party's attorney, or to the last known address of any unrepresented party. Notice will be sent by US mail unless the parties have requested an alternate method of notification that is acceptable to OSI.

[13.1.5.13 NMAC - N, 7/1/2019]

13.1.5.14 TELEPHONIC, VIDEOCONFERENCE AND OTHER EQUIVALENT ELECTRONIC METHOD HEARINGS:

A. If not otherwise prohibited by statute, rule, or court ruling, the hearing officer may conduct the hearing in person or by telephone, videoconference, or other equivalent electronic method. The hearing officer shall cause a stenographic or audio recording to be made of all proceedings involving the presentation of evidence, points, authorities or argument pertaining to the merits of the matter before the hearing officer.

B. If the hearing is to be conducted by telephone, videoconference or other equivalent electronic method, the notice shall so inform the parties. Either party may file a written objection to conducting the hearing by telephone, videoconference, or other equivalent electronic method within 10 days of the notice of hearing. Failure to timely object to the conduct of a hearing by telephone, videoconference, or other equivalent electronic method constitutes consent to the hearing proceeding in that manner and waiver of any other applicable statutory in county hearing requirement.

C. Upon receipt of a timely objection, the hearing officer shall consider the applicable legal requirements; the location of the parties and witnesses; the complexity of the particular matter; the availability of necessary electronic equipment for conduct of a full and fair hearing by telephone, videoconference, or other equivalent electronic method; and the basis of the objection in determining whether the hearing should occur at a specific location rather than by telephone, videoconference, or other equivalent electronic method.

D. Provided that the requesting party has not previously demanded an in-person hearing or otherwise objected to conducting the matter by telephone, videoconference, or other equivalent electronic methods, any party may request to appear directly or have a witness on their behalf appear by telephone, videoconference, or alternative electronic means by filing a request at least three business days before the scheduled hearing. The filing of a request to appear by telephone, videoconference, or other alternative electronic method shall be deemed as a total and complete waiver of any in-person hearing right, and deemed as consent for all parties, all witnesses, and the hearing officer to appear by telephone, videoconference, or other equivalent electronic methods.

E. All parties appearing by telephone, videoconference, or other electronic method shall provide the hearing officer with a working email address or facsimile number for the exchange of all documentary evidence before or during the hearing.

F. Failure to follow the hearings officer's instructions for participating in the hearing by telephone, videoconference, or other equivalent electronic method will be treated as a non-appearance at the hearing.

G. Any technical issues shall be promptly reported to the hearing officer.

H. In the event that technical or other computer problems prevent a hearing by videoconference or other electronic method from occurring or otherwise interferes with maintaining or developing a complete record at the hearing, the parties agree and consent that the assigned hearing officer may continue the matter to a different time before expiration of the statutory deadline, may order the parties to appear for an in-person hearing, or may conduct the remaining portion of the hearing by telephone.

I. If the assigned hearing officer determines during the course of the hearing, either *sua sponte* or upon argument of a party, that an in-person hearing is necessary to adequately complete the record, address credibility issues, or is otherwise necessary to ensure a full or fair hearing process, the hearing officer may recess a hearing occurring by telephone, videoconference, or other equivalent electronic method and reconvene the proceeding as an in-person hearing.

[13.1.5.14 NMAC - N, 7/1/2019]

13.1.5.15 CONTINUANCES:

A. At the request of a party, a witness, or upon the hearing officer's own determination, a hearing may be continued for good cause. The hearing officer shall consider only written continuance requests made at least three working days prior to the scheduled hearing absent extraordinary, unforeseen circumstances that the requesting party or witness could not have known earlier. An order to grant or deny the request may be issued prior to the scheduled hearing or if there is insufficient time to issue an order prior to the scheduled hearing, the hearing officer may grant or deny the request on the record at the hearing. No continuance request shall be granted unless there is

adequate time to provide notice to the parties, subpoena witnesses and conduct the rescheduled hearing before expiration of any statutory jurisdictional deadline.

B. Within the jurisdictional time limits set by statute, the superintendent or hearing officer may *sua sponte* continue any matter as necessary to address OSI staffing needs, to ensure efficient and adequate use of state resources, and to manage the hearing docket. To this end, the hearing officer may contact the parties to inquire about the status of a scheduled case.

C. No case shall be continued, even with a showing of good cause or an emergency circumstance, beyond any mandatory, applicable jurisdictional time limit on the case.

[13.1.5.15 NMAC - N, 7/1/2019]

13.1.5.16 ATTIRE AT HEARING:

All attorneys and other authorized representatives must be attired in a dignified, professional manner at all times during the hearing. Witnesses shall dress in a respectful manner. No attire or dress as to create a distraction to the orderly conduct of the hearing will be permitted.

[13.1.5.16 NMAC - N, 7/1/2019]

13.1.5.17 BURDEN OF PROOF, PRESENTATION OF CASE, EVIDENCE:

A. Burden of proof. Unless otherwise specified by statute, the burden of proof in a proceeding is the preponderance of evidence.

B. Presentation order. The party with the burden of proof in the case shall ordinarily present their case first, followed by the opposing party, if any, unless the hearing officer makes reasonable exceptions related to the availability of the witnesses, representatives or other scheduling concerns.

C. Opening statements. The hearing officer may require or allow opening statements as the circumstances justify. Opening statements are not ordinarily evidence, but without objection, may be adopted as evidence by sworn oath of the party-witness who made the opening statement.

D. Testimony under oath. All testimony must be given under oath and shall be subject to questioning of each other party. The hearing officer may also ask questions of the witness as appropriate. At the hearing officer's discretion, redirect and re-cross may be allowed.

E. Closing arguments. The parties may make closing arguments, either orally at the conclusion of the case or, upon order of the hearing officer, in writing after conclusion of the hearing.

F. Post-hearing briefs. The hearing officer may also order the parties to submit further briefing on any issue in the case, and to submit proposed findings of fact and conclusions of law. The hearing officer shall establish a timeline for submission of any post-hearing pleadings, including time for the parties to exchange briefs, as the hearing officer finds necessary. No decision-writing deadline commences until the parties have submitted any ordered post-hearing briefing or submission.

G. Rules of evidence.

(1) Formal rules of evidence and civil procedure shall not apply in a proceeding unless otherwise expressly and specifically required by statute, regulation, or order of the hearing officer. The rules of evidence and civil procedure pertaining to privilege shall always apply regardless of the level of formality in a particular proceeding.

(2) Relevant and material evidence shall be admissible. Irrelevant, immaterial, unreliable, or unduly repetitious evidence may be excluded.

(3) A party may offer exhibits, such as records of transactions.

(a) The party shall have the exhibits numbered by the stenographer prior to the hearing.

(b) The party shall provide copies of the evidence to the stenographer, all parties and to the hearing officer.

(c) Exhibits must be introduced and explained by a witness, who must be prepared to answer questions from the parties and the hearing officer.

(d) The hearing officer shall be asked by the party offering an exhibit to accept the exhibit into evidence. The hearing officer may be asked to consider all exhibits introduced by a witness at the conclusion of that witness's testimony or at the conclusion of that party's case in chief.

(e) The stenographer shall retain on copy of all exhibits that are admitted and shall make them a part of the record.

(4) The hearing officer shall consider and give appropriate weight to all relevant and material evidence admitted in rendering a final decision on the merits of a matter.

H. Taking notice.

(1) The hearing officer may take administrative notice of facts not subject to reasonable dispute that are generally known within the community, capable of accurate

and ready determination by resort to sources whose accuracy cannot be reasonably disputed, or as provided by an applicable statute.

(2) The hearing officer may take administrative notice at any stage in the proceeding, whether *sua sponte* or at the request of a party.

(3) A party may dispute the propriety of taking administrative notice, including the opportunity to refute a noticed fact.

I. Objections.

(1) A party objecting to evidence, qualifications of an expert, a line of questioning, or the response shall timely and briefly state the grounds for the objection.

(2) Rulings on objections may be addressed on the record at the time of the objection, reserved for ruling in a subsequent written order, or noted as a continuing, ongoing objection for which ruling is reserved to later in the proceeding.

J. Audio or video evidence. Any party wishing to submit a video or audio recording into the record shall provide a complete tangible, playable copy that can be retained as part of the record.

K. Size of exhibits. In general, documentary evidence shall be no larger than 8.5 inches by 11 inches unless expressly allowed by the hearing officer. The hearing officer may admit larger documentary exhibits presented at hearing, provided the proponent of such exhibits provides the hearings officer with a copy of the exhibit reduced to 8.5 inches by 11 inches. After the hearing at which the exhibit was admitted, the reduced copy shall be substituted for the larger exhibit and made part of the record of the hearing. Arrangements to provide a reduced copy of a large exhibit shall be undertaken in advance of the hearing. Failure by the proponent to provide a reduced copy shall be deemed a withdrawal of the exhibit.

L. Substitutions for objects. In lieu of the introduction of tangible objects as exhibits, the hearing officer may require the moving party to submit a photograph, video, or other appropriate substitute such as a verbal description of the pertinent characteristics of the object for the record.

[13.1.5.17 NMAC - N, 7/1/2019]

13.1.5.18 WITNESSES, EXPERT WITNESSES, AND INVOCATION OF THE RULE:

A. Use of witnesses. Any person having relevant, material knowledge related to one of the issues in a hearing may testify as a witness under oath in a proceeding. Upon affirming the oath, the witness may be questioned by any party and by the hearing officer.

B. Method of appearance. Unless a more specific provision applies, witnesses are ordinarily expected to appear in the same manner or by the same method as the parties in a proceeding, absent express preapproval of the hearing officer allowing an appearance by a different method. For example, if the hearing is scheduled to be conducted in person in a specific place, the witnesses are also ordinarily expected to appear in person at that same place; however, if the matter is set to occur by telephone or videoconference, then the witnesses may ordinarily appear by telephone of videoconference.

C. Hearing officer as a witness. The current or previously assigned hearing officer in a matter shall not be called and shall not be a witness in the proceeding.

D. Use of expert witnesses.

(1) If either party intends to call and treat a particular witness as an expert witness in the proceeding, the party must identify the purported expert to the other parties and to the hearing officer at least seven days before the scheduled hearing, or with sufficient time before completion of the discovery deadline specified in a scheduling order to allow for deposition.

(2) The party shall include the scope of that expert's purported testimony relative to the proceeding, the expert's credentials, and a listing of any materials the expert reviewed as part of reaching his or her expert opinion.

(3) The opposing party may file a response in opposition before the hearing or challenge the designation of the witness as an expert when the expert is called to testify.

E. Use of exclusionary rule. At the hearing, any party can invoke the exclusionary rule to exclude all witnesses other than the real party in interest, their representative, one main case agent, and any designated expert witness from the proceeding until the time of the witness's testimony. If the rule has been invoked, the witnesses shall not discuss their testimony with each other until the conclusion of the proceeding. When the rule has been invoked, any witness who remains in the hearing after conclusion of their testimony shall not be recalled as a witness in the proceeding, except that any witness may observe the testimony of an expert witness and be recalled to provide any subsequent rebuttal testimony.

F. OSI staff as experts.

(1) The hearing officer may request one or more members of OSI staff to be present at the hearing to assist the hearing officer with any matters within the expertise of the staff person.

(2) The staff person may be called as a witness by the hearing officer and examined by the parties and the hearing officer.

(3) Any party may call the staff person as a witness.

(4) Each other party shall have the opportunity to cross-examine a staff person who is called as a witness. In the discretion of the hearing officer, the hearing officer my permit re-direct or re-cross-examination of the staff person.

(5) The hearing officer shall not discuss the case with the staff person outside the hearing or off the record.

(6) Any staff person requested to be present by the hearing officer shall not be subject to the exclusionary rule.

[13.1.5.18 NMAC - N, 7/1/2019]

13.1.5.19 HEARING OFFICER POWERS AND RESPONSIBILITIES:

A. General authority. The superintendent may preside over OSI's hearings or may designate a hearing officer to preside instead.

B. Duties of the hearing officer. The hearing officer shall conduct fair and impartial hearings, take all necessary action to avoid delay in the proceedings and maintain order. The hearing officer shall have the powers necessary to carry out these duties, including the following:

(1) to administer or have administered oaths and affirmations;

(2) to cause depositions to be taken;

(3) to require the production or inspection of documents and other items;

(4) to require the answering of interrogatories and requests for admissions;

(5) to rule upon offers of proof and receive evidence;

(6) to regulate the course of the hearings and the conduct of the parties and their representatives therein;

(7) to issue a scheduling order, schedule a prehearing conference for simplification of the issues, or any other proper purpose;

(8) to schedule, continue and reschedule hearings;

(9) to consider and rule upon all procedural and other motions appropriate in proceeding, including qualification of expert witnesses and admission of exhibits;

(10) to require the filing of briefs on specific legal issues prior to or after the hearing;

(11) to cause a docket to be opened and a complete record of a hearing to be made;

(12) to make and issue decisions and procedural orders;

(13) to issue subpoenas in the name of the superintendent;

(14) if acting on behalf of the superintendent, to issue a recommendation to the superintendent regarding the final resolution of the matter; and

(15) to appropriately sanction, up to exclusion, indecorous, obstinate, recalcitrant, obstreperous, unethical, unprofessional or other improper conduct that interferes with the conduct of a fair and orderly hearing or the development of a complete record.

C. Independence of the hearing officer. In the performance of these functions, the hearing officer shall not be responsible to or subject to the direction of any other officer, employee or agent of OSI, except that a hearing officer appointed by the superintendent shall be subject to the direction of the superintendent.

D. *Ex parte* communication. In the performance of these functions, the hearing officer is prohibited from engaging in any improper *ex parte* communications about the substantive issues with any party on any matter. An improper *ex parte* communication occurs when the hearing officer discusses or otherwise communicates regarding the substance of a case without the opposing party being present, except that it is not an improper *ex parte* communication for the hearing officer to go on the record with only one party when the other party has failed to appear at a scheduled hearing.

E. Final order. After a thorough review of the record and any recommendation prepared by a designated hearing officer, the superintendent shall issue a final order. No party or member of OSI staff shall engage in any *ex parte* communication with the superintendent in an attempt to influence his final decision.

[13.1.5.19 NMAC - N, 7/1/2019]

13.1.5.20 CLOSED OR PUBLIC HEARING, SEALED RECORDS, AND DELIBERATIVE NOTES OF HEARING OFFICER:

A. Closed hearings. Unless otherwise provided by law, ordered by the hearing officer for good cause, or required to prevent disclosure of confidential information, all hearings and the record are open to the public. Any party to a proceeding may submit a written request to close the hearing and the record to the public, which shall be granted if authorized by statute, regulation, or rules recognized by law to preserve confidentiality

or to protect a party from harassment or reprisal. Any proceedings and records that involve an individual's medical issues shall be closed to the public.

B. Open hearings. If the hearing is open to the public, members of the public and the media may attend the hearing so long as they do not interrupt, interfere with or impede the orderly, fair, and efficient hearing process. With prior consent of the hearing officer, media members may record the proceeding from a fixed location in the hearing room. The hearing officer may direct any member of the public, including media members, to leave the proceeding if they engage in any conduct that interferes with the hearing officer's ability to maintain order, develop the record, and provide a fair and efficient hearing process. The proceedings shall be made available telephonically to members of the public, including the media, upon prior request.

C. Sealed records. Upon request of any party, and upon a showing of good cause, the hearing officer shall seal a particular exhibit, document, or portions of a witness's testimony from public disclosure if such items contain statutorily-protected confidential information, privileged information, or otherwise contain private identification information of a party or third party that is immaterial to a substantive issue in the proceeding or if its materiality is substantially outweighed by the prejudice of public release of the information. Upon issuance of an order sealing such documents or exhibits, these records shall remain under seal throughout the proceeding and shall be returned to the submitting party at the conclusion of the appeal period or the appeal. The opposing party shall be entitled to promptly review these documents in preparing for the hearing, and may rely on those documents during the hearing as necessary to ensure a fair hearing process; however, the opposing party shall not maintain its own copy of the sealed document after conclusion of the hearing nor reveal, discuss, or disclose the contents of these sealed documents to any other party outside of the hearing process.

D. Notes of deliberation. The hearing officer's notes taken during the course of the hearing, notes generated during the decision-making process, and any draft orders or draft decisions are confidential as part of the deliberative process and are not subject to public disclosure.

[13.1.5.20 NMAC - N, 7/1/2019]

13.1.5.21 SUBPOENAS:

Any request for issuance of subpoenas in matters subject to these rules shall be guided by Rule 45 of the rules of civil procedure for the district courts of New Mexico, except where provisions of that rule conflict with the powers of the superintendent. Any subpoena issued shall be in the name of the superintendent. The party requesting the subpoena shall prepare a proposed subpoena, submit the proposed subpoena to each other party and to the hearings officer for approval, and shall timely and reasonably serve the subpoena on the person or entity subject to the subpoena. Unless good cause is shown for a shorter period, a subpoena shall provide at least 10 days- notice before compelled attendance at a hearing or deposition, and at least 10 days- notice before

compelled production of materials. All returns or certificates of service on served subpoenas shall be filed in the docket of the proceeding, copied to the opposing party, and be made part of the record of the proceeding.

[13.1.5.21 NMAC - N, 7/1/2019]

13.1.5.22 LANGUAGE INTERPRETERS:

A party to a proceeding who needs language interpreter services for translation of one language into another is responsible for arranging such service for the hearing. While the person serving as an interpreter need not be a court-certified interpreter in order to provide interpretation at a hearing, any person serving as an interpreter in a matter before the superintendent must be approved by the hearing officer and shall affirm the interpreter's oath applicable in New Mexico courts. Upon reasonable notice by the party, any interpreter required to be provided under the American with Disabilities Act shall be provided for by the superintendent.

[13.1.5.22 NMAC - N, 7/1/2019]

13.1.5.23 FAILURE TO APPEAR:

A. Entry of default order. If a party fails to appear for a properly noticed hearing, either in person, through a permissible representative or telephonically with prior approval of the hearing officer, the person waives the right to protest or challenge the action that is the subject of the hearing notice. The matter shall go on the record for the limited purpose of addressing notice and non-appearance, and a final order shall be entered based on the waiver of the hearing by failing to appear.

B. Evidence of notice. In considering the non-appearance and whether the person received appropriate notice necessitating issuance of the order, the hearing officer may consider the contents of the docket, information conveyed to or known by OSI, information related to mailing, including mail tracking, returned receipt information, and notes written on returned envelopes of the United States postal service or other mail tracking services, and arguments offered by any present party, all of which may be addressed on the record of the hearing or in any subsequent order.

C. Written order required. Oral rulings based on a party's failure to appear are not final until reduced to writing. The hearing officer may issue a different written order as new information arises after the hearing regarding whether the notice of hearing was properly sent to the correct address or otherwise properly served.

[13.1.5.23 NMAC - N, 7/1/2019]

13.1.5.24 RECONSIDERATION:

A. Time to file. A party may file a motion for reconsideration within 15 days after the date of the final order. Any other party may file a response no more than 15 days after the motion for reconsideration was filed. Motions for reconsideration that are not filed within this deadline may be denied automatically. A timely filed motion for reconsideration shall be decided based on the merits, whether or not a response is filed.

B. Posture. The prevailing party shall not file a motion for reconsideration. However, if a requested action is granted in part and denied in part, either party may file a motion for reconsideration.

C. Basis for motion. Motions for reconsideration shall not endeavor to present new evidence previously available, or discoverable through reasonable diligence, to the parties before the hearing. Motions for reconsideration shall not reargue the weight of evidence already ruled nor reiterate legal arguments already ruled upon. However, a motion for reconsideration may address gross factual or legal errors or omissions contained in the final decision and order.

[13.1.5.24 NMAC N, 7/1/2019]

13.1.5.25 APPEALS FOLLOWING HEARING:

Each order issued by the superintendent shall include information about the appeal process for the type of case at issue. Once the appeal is filed in the appropriate court, the appealing party shall provide a court-endorsed copy of the appeal to the superintendent so that the OSI records manager can prepare and submit the proper record.

[13.1.5.25 NMAC - N, 7/1/2019]

13.1.5.26 REQUESTING COPIES OF EXHIBITS, AUDIO, OR THE ADMINISTRATIVE RECORD:

Any party may access and copy any writing filed to the docket. Copies of an audio recording or written transcript of the proceeding shall be arranged through the stenographic service. OSI may charge a reasonable fee for copies made, consistent with its fee schedule under the Inspection of Public Records Act. OSI may also require the requesting party to submit a computer storage device, such as a compact disc, dvd disc, blu-ray disc, usb drive, or other tangible device for copying of any audio or video recording that is part of the administrative record.

[13.1.5.26 NMAC - N, 7/1/2019]

PART 6: INFORMAL ADMINISTRATIVE HEARINGS

13.1.6.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance.

[13.1.6.1 NMAC - N, 7/1/2019]

13.1.6.2 SCOPE:

The rules in this part govern every informal proceeding conducted pursuant to a notice of hearing issued by the Superintendent of Insurance pursuant to Section 59A-4-18 NMSA 1978.

[13.1.6.2 NMAC - N, 7/1/2019]

13.1.6.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-4-18 NMSA 1978.

[13.1.6.2 NMAC - N, 7/1/2019]

13.1.6.4 DURATION:

Permanent.

[13.1.6.4 NMAC - N, 7/1/2019]

13.1.6.5 EFFECTIVE DATE:

July 1, 2019 unless a later date is specified at the end of a section.

[13.1.6.5 NMAC - N, 7/1/2019]

13.1.6.6 OBJECTIVE:

The purpose of this part is to provide rules of procedure to govern informal hearings before the superintendent.

[13.1.6.6 NMAC - N, 7/1/2019]

13.1.6.7 DEFINITIONS:

These rules incorporate the definitions found in 13.1.5.7 NMAC.

[13.1.6.7 NMAC - N, 7/1/2019]

13.1.6.8 REQUESTING A HEARING:

A. Written request required. Any person seeking an informal hearing before the superintendent shall file a written request using the form available on the OSI website or as otherwise directed by the superintendent. The request shall include the language **"Request for Informal Hearing"** and the following:

(1) all of the items listed in Paragraphs (1) through (6) of Subsection A of 13.1.5.9 NMAC; and

(2) one of the following:

(a) a written protest or request for hearing challenging that action or inaction; or

(b) a request for the superintendent to issue an order declaring the rights or obligations of the requestor under a specific statute, rule or bulletin within the jurisdiction of the superintendent, and concrete facts showing the requestor's interest in the declaration.

B. Request rejected. The superintendent shall reject any request for an informal hearing if the request relates to a matter that requires the superintendent to act in fewer than 91 days after the request is made, or for any of the reasons listed in Subsection B of 13.1.5.9 NMAC.

(1) If a request for hearing is rejected, the superintendent will notify the requestor in writing with a brief explanation of the rejection.

(2) If the request for hearing is deficient for any reason, the requestor may correct any deficiency and resubmit the request for hearing.

(3) If the superintendent otherwise determines that it would be more appropriate for the matter to proceed as a formal hearing under rule 13.1.5 NMAC, the superintendent may convert the request for informal hearing to a request for formal hearing upon written notice to the requestor.

C. Designation of hearing officer and docket. The superintendent shall proceed as set forth in Subsection C of 13.1.5.9 NMAC.

D. Waiver of right. A request for an informal hearing constitutes a waiver of any right the requestor may have to a hearing under any other provision of the Insurance Code, or its implementing rules, unless the superintendent, *sua sponte*, or for good cause shown, orders the hearing to proceed pursuant to 13.1.5 NMAC.

E. Intervenors. Request to intervene shall be handled as set forth in Subsection D of 13.1.5.9 NMAC.

F. Characterization of request. A hearing request that does not include the language "Request for Informal Hearing" will be treated as a request for a formal hearing governed by 13.1.5 NMAC.

[13.1.6.8 NMAC – N, 7/1/2019]

13.1.6.9 INFORMAL HEARING PROCESS AND DECISION:

Any matter or question that is the subject of a notice of an informal hearing shall be determined based solely on the exhibits and pleadings submitted to the superintendent pursuant to these rules. The superintendent shall have 45 days to determine the matter or question following the date set for closing the record. The date set for closing the record shall not be more than 45 days or less than 30 days after issuance of the notice of an informal hearing.

[13.1.6.9 NMAC - N, 7/1/2019]

13.1.6.10 REPRESENTATION AT HEARING, FORMAL ENTRY OF APPEARANCE, SUBSTITUTION OF COUNSEL, AND WITHDRAWAL FROM REPRESENTATION:

Rules pertaining to legal representation at hearing are as set forth in 13.1.5.10 NMAC.

[13.1.6.10 NMAC - N, 7/1/2019]

13.1.6.11 FILING OF PLEADINGS:

Rules pertaining to filing for pleadings are as set forth in 13.1.5.11 NMAC.

[13.1.6.11 NMAC - N, 7/1/2019]

13.1.6.12 CONTINUANCES:

Rules pertaining to handling of continuances are as set forth in 13.1.5.15 NMAC.

[13.1.6.12 NMAC - N, 7/1/2019]

13.1.6.13 BURDEN OF PROOF, PRESENTATION OF CASE, EVIDENCE:

Rules pertaining to burden of proof, conduct of the case and use of evidence are as set forth in 13.1.5.17 NMAC, with the following modifications:

A. A party may submit written arguments any time before the record closes, or as otherwise ordered by the hearing officer.

B. If OSI staff has not already entered an appearance, the hearing officer may request briefing from OSI staff, subject to the right of any party to object or respond to the submission.

[13.1.6.13 NMAC - N, 7/1/2019]

13.1.6.14 HEARING OFFICER POWERS AND RESPONSIBILITIES:

A. General authority. The superintendent may preside over OSI's hearings or may designate a hearing officer to preside instead.

B. Duties of the hearing officer. The hearing officer shall have the duty to conduct fair and impartial hearings, to take all necessary action to avoid delay in the proceedings and to maintain order. The hearing officer shall have the powers necessary to carry out these duties as set forth in Paragraphs (1) through (15) of Subsection B of 13.1.5.19 NMAC, to the extent applicable for informal hearings.

C. Independence of the hearing officer. In the performance of these functions, the hearing officer shall not be responsible to or subject to the direction of any other officer, employee or agent of OSI, except that a hearing officer appointed by the superintendent shall be subject to the direction of the superintendent.

D. *Ex-parte* communication. The rules pertaining to ex-parte communication for an informal hearing are as set forth in 13.1.5.19 NMAC.

E. Final order. After a thorough review of the record and any recommendation prepared by a designated hearing officer, the superintendent shall issue a final order. No party or member of OSI staff shall engage in any *ex parte* communication with the superintendent in an attempt to influence his final decision.

[13.1.6.14 NMAC - N, 7/1/2019]

13.1.6.15 CLOSED OR PUBLIC HEARING, SEALED RECORDS, AND DELIBERATIVE NOTES OF HEARING OFFICER:

The rules pertaining to public access to hearings and related records are as set forth in 13.1.5.20 NMAC.

[13.1.6.15 NMAC - N, 7/1/2019]

13.1.6.16 RECONSIDERATION:

Rules pertaining to requests of reconsideration are as set forth in 13.1.5.24 NMAC.

[13.1.6.16 NMAC - N, 7/1/2019]

13.1.6.17 APPEALS FOLLOWING HEARING:

Rules pertaining to appeals following hearing are as set forth in 13.1.5.25 NMAC.

[13.1.6.17 NMAC - N, 7/1/2019]

13.1.6.18 REQUESTING COPIES OF EXHIBITS, AUDIO, OR THE ADMINISTRATIVE RECORD:

Rules pertaining to requests for copies of hearing-related matters following hearing are as set forth in Section 13.1.5.26 NMAC.

[13.1.6.18 NMAC - N, 7/1/2019]

CHAPTER 2: INSURANCE COMPANY LICENSING AND OPERATION

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: INSURANCE HOLDING COMPANIES

13.2.2.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance ("OSI").

[13.18.3.1 NMAC – Rp, 13.18.3.1 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.2 SCOPE:

This rule applies to all insurers and affiliates subject to the Chapter 59A, Article 37, NMSA 1978 ("the Insurance Holding Company Law").

[13.2.2.2 NMAC – Rp, 13.2.2.2 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.3 STATUTORY AUTHORITY:

Authority for this rule derives from the superintendent's powers under Section 59A-2-9 NMSA 1978 and from the Insurance Holding Company Law, Chapter 59A, Article 37, NMSA 1978.

[13.2.2.3 NMAC – Rp, 13.2.2.3 NMAC, 7/24/2018]

13.2.2.4 DURATION:

Permanent.

[13.2.2.4 NMAC – Rp, 13.2.2.4 NMAC, 7/24/2018]

13.2.2.5 EFFECTIVE DATE:

July 24, 2018, unless a later date is cited at the end of a section.

[13.2.2.5 NMAC – Rp, 13 NMAC 2.2.5, 7/24/2018]

13.2.2.6 OBJECTIVE:

The purpose of this rule is to specify the contents of the statements required to be filed with the superintendent pursuant to the Insurance Holding Company Law.

[13.2.2.6 NMAC – Rp, 13.2.2.6 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.7 DEFINITIONS:

The following terms have the meaning given, unless the context otherwise requires. Other terms used in this rule have the meanings given in the Insurance Holding Company Law or in Chapter 59A, NMSA 1978 ("the Insurance Code.").

A. "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller and any other individual performing functions corresponding to those performed by such officers under whatever title.

B. "Group-wide supervisor"means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the superintendent under Section 13.2.2.23 NMAC to have sufficeient signaificant contacts with the internationally active insurance group.

C. "Internationally active insurance group" means an insurance holding company system that 1) includes an insurer registered under Section 59A-37-11 NMSA 1978; and 2) meets the following criteria:

(1) premiums written in at least three countries;

(2) the percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's total gross written premiums; and

(3) based on a three-year rolling average, the total assests of the insurance holding company system are at least $50,000,000,000 or the total gross written premiums of the insurance holding company system are at least $10,000,000,000.

D. "NAIC" means the national association of insurance commissioners;

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

F. "SEC" means the United States securities and exchange commission.

G. "Superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization; and

H. "ultimate controlling person" means a person that is not controlled by any other person.

[13.2.2.7 NMAC – Rp, 13.2.2.7 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.8 SUBSIDIARIES OF DOMESTIC INSURERS:

The authority to invest in subsidiaries under Subsection B of Section 59A-37-3 NMSA 1978 is in addition to any authority to invest in subsidiaries which may be contained in any other provision of the Insurance Code.

[13.2.2.8 NMAC – Rp, 13.2.2.8 NMAC, 7/24/2018]

13.2.2.9 ADEQUACY OF SURPLUS:

In determining the adequacy and reasonableness of an insurer's surplus, no single factor is necessarily controlling. The superintendent will consider the net effect of all factors set forth in Section 59A-37-21 NMSA 1978 and other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the superintendent will consider the extent to which each of these factors varies from company to company. In determining the quality and liquidity of investments in subsidiaries, the superintendent will consider the individual subsidiary and may discount or disallow its valuation to the extent that individual investments so warrant.

[13.2.2.9 NMAC – Rp, 13.2.2.9 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.10 GENERAL REQUIREMENTS FOR PREPARING STATEMENTS:

A. Format: Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by the Insurance Holding Company Law. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the item numbers and captions of all items required, but the text of the items may be omitted, provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

B. Number of copies:

(1) The applicant shall file two complete copies of each form, including exhibits and all other papers and documents filed as a part of the statement.

(2) A copy of Form C, included at 13.2.2.14 NMAC, shall be filed in each state in which an insurer is authorized to do business, if the insurance commissioner of that state has notified the insurer of its request in writing, in which case the insurer has 20 days from receipt of the notice to file such form.

C. Filing methods: Forms shall be filed with the examinations bureau at OSI by personal delivery, mail, commercial courier, or as instructed on the OSI website.

D. Signatures: At least one of the copies shall be signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

E. Electronic preparation: Forms shall be prepared electronically.

F. Readability: Forms shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies.

G. Language and currency: Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency shall be converted into United States currency.

H. Extension of time to file: If it is impractical to furnish any required information, document or report at the time it is required to be filed, a separate document may be filed with the superintendent:

(1) identifying the information, document or report in question;

(2) stating why filing it at the time required is impractical; and

(3) requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the superintendent enters an order denying the request within 60 days after receiving it.

I. Additional information: In addition to the information expressly required to be included in each statement, the superintendent may request such further material information [~~,if any,~~] as may be necessary to make the information contained in the statement not misleading. The person filing may also file such exhibits as it may desire

in addition to those expressly required by the statement. The exhibits shall be marked so as to indicate clearly the subject matters to which they refer.

J. Changes to statements: Changes to statements shall include on the top of the cover page the phrase: "Change No. [insert number] to Form [insert letter]" and shall indicate the date of the change and not the date of the original filing.

K. Hearing on a Consolidated Basis: If an applicant requests a hearing on a consolidated basis under Subsection D of Section 59A-37-6 NMSA 1978, in addition to filing the Form A with the superintendent, the applicant shall file a copy of Form A with the NAIC in electronic form.

[13.2.2.10 NMAC – Rp, 13.2.2.10 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.11 OPTIONS PERMITTED IN FORMS:

A. Incorporation by reference:

(1) Information required by any item of Form A, Form B, Form D, Form E, or Form F may be incorporated by reference in answer or partial answer to any other item.

(2) Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E or Form F, provided the document is filed as an exhibit to the statement.

(3) Excerpts of documents may be filed as exhibits if the documents are extensive.

(4) Documents currently on file with the superintendent which were filed within the past three years need not be attached as exhibits.

(5) References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item.

(6) Matter shall not be incorporated by reference in any case where the incorporation would render the statement incomplete, unclear or confusing.

B. Summaries: Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the superintendent which was filed within three years and may be qualified in its entirety by such reference.

C. Omissions: In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties, the dates of execution, or other details, a copy of only one of the documents need be filed, together with a schedule identifying the omitted documents and setting forth the material details in which the omitted documents differ from the filed documents.

[13.2.2.11 NMAC – Rp, 13.2.2.11 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.12 FORM A:

A. When required: A person required by Section 59A-37-4 NMSA 1978 to file a statement shall furnish the required information on Form A in accordance with the requirements of this rule. Such a person shall also furnish the required information on Form E, hereby made a part of this rule and described in 13.2.2.16 NMAC.

B. Amendments: The applicant shall promptly advise the superintendent of any changes in the information furnished on Form A arising subsequent to the date upon which the information was furnished but prior to the superintendent's disposition of the application.

C. Information to be furnished in Form A:

(1) Caption: Place the following caption at the top of the cover page:

FORM A

STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER FILED WITH THE NEW MEXICO SUPERINTENDENT OF INSURANCE

(2) Domestic insurers: Provide the name and state of domicile of the domestic insurer being acquired.

(a) if the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of Subsection A of Section 59A-37-4 NMSA 1978, the name of the domestic insurer should be indicated as follows: "ABC Insurance Company, a subsidiary of XYZ Holding Company."

(b) where a Subsection A of Section 59A-37-4 NMSA 1978 insurer is being acquired, references to "the insurer" in this section shall refer to both the domestic subsidiary insurer and the person being acquired.

(3) Applicant: State the name of the acquiring person.

(4) Date: Provide the filing date of the statement.

(5) Designation of agent: State the name, title, address and telephone number of the individual to whom notices and correspondence concerning this statement should be addressed.

(6) Method of acquisition: Provide the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

(7) Identity and background of the applicant:

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as the person and any of its predecessors shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, the nature of the proceedings and the date when commenced.

(8) Identity and background of individuals associated with the applicant: On the biographical affidavit, include a third party background check and state the following with respect to 1) the applicant if an individual or 2) all persons who are directors, executive officers or owners of ten percent or more of the voting securities of the applicant, if the applicant is not an individual:

(a) name and business address;

(b) present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) material occupations, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal,

state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith; and

(d) whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

(9) Nature, source and amount of consideration:

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties to it, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating to the transaction.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, the applicant shall specifically request that the lender's identity be kept confidential.

(10) Future plans of insurer: Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate the insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

(11) Voting securities to be acquired: State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Paragraph (8) of Subsection C of 13.2.2.12 NMAC plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

(12) Ownership of voting securities: State the amount of each class of any voting security of the insurer that is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates of any persons listed in Paragraph (8) of Subsection C of 13.2.2.12 NMAC.

(13) Contracts, arrangements, or understandings with respect to voting securities of the insurer: Give a full description of any contracts, arrangements or

understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Paragraph (8) of Subsection C of 13.2.2.12 NMAC is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom the contracts, arrangements or understandings have been entered into.

(14) Recent purchases of voting securities: Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Paragraph (8) of Subsection C of 13.2.2.12 NMAC during the 12 calendar months preceding the filing of this statement. Include in the description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any shares so purchased are hypothecated.

(15) Recent recommendations to purchase: Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Paragraph (8) of Subsection C of 13.2.2.12 NMAC, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Paragraph (8) of Subsection C of 13.2.2.12 NMAC during the 12 calendar months preceding the filing of this statement.

(16) Agreements with broker-dealers: Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard to such solicitation.

(17) Financial statements and exhibits:

(a) List the financial statements, exhibits and three-year financial projections of the insurer or insurers that are attached to this statement as appendices.

(b) The financial statements shall include the annual financial statements of the persons identified in Subparagraph (c) of Paragraph (7) of Subsection C of 13.2.2.12 NMAC for the preceding five fiscal years (or for such lesser period as the applicant and its affiliates and any of their predecessors shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if the information is available. The statements may be prepared on either an individual basis, or, unless the superintendent otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business. The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the

financial statements need not be certified, provided they are based on the annual statement of the person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of the state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or 13.2.2.10 NMAC.

(18) Agreement requirements for enterprise risk management: Applicant agrees to provide to the best of its knowledge and belief, the information required by Form F within 15 days after the end of the month in which the acquisition of control occurs.

(19) Signature and certification: The following signature and certification are required at the end of Statement A.

Pursuant to the requirements of Section 59A-37-4 NMSA 1978, [insert name of applicant] has caused this application to be duly signed on its behalf in the city of [insert name of city] and state of New Mexico on [insert date].

(SEAL)

_____

(Name of Applicant)

BY:_____

_____

(Title)

Attest:

_____

(Signature of Officer)

_____

(Title)

The undersigned deposes and says that they have duly executed the attached application dated [insert date], for and on behalf of [insert name of applicant]; that they are the [insert title of deponent] of such company; and that they are authorized to execute and file this instrument. Deponent further says that they are familiar with the instrument and its contents, and that the facts set forth in the instrument are true to the best of their knowledge, information and belief.

_____

(Signature of deponent)

_____

(Typed name and title of deponent)

[13.2.2.12 NMAC – Rp, 13.2.2.12 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.13 FORM B:

A. When required: An insurer required by Section 59A-37-11 NMSA 1978 to file an annual registration statement shall file Form B in accordance with the requirements of this rule.

B. Filings on behalf of affiliates: Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers that are required to register under Section 59A-37-11 NMSA 1978.

C. Additional information permitted: A registration statement may include information not required by this rule regarding any insurer in the insurance holding company system even if the insurer is not authorized to do business in this state.

D. When copy of domiciliary registration permitted: In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report that it is required to file in its state of domicile, provided:

(1) the statement or report contains substantially similar information required to be furnished on Form B; and

(2) the filing insurer is the principal insurance company in the insurance holding company system. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

E. Filings by unauthorized insurers: With the prior approval of the superintendent, an unauthorized insurer may follow any of the procedures that could be done by an authorized insurer under Subsections B, C and D of 13.2.2.13 NMAC.

F. Consolidated filings and alternative registration: Any insurer may take advantage of the provisions of Sections 59A-37-16 and 17 NMSA 1978 without obtaining the prior approval of the superintendent. The superintendent, however, reserves the right to require individual filings if the superintendent deems such filings necessary in the interest of clarity, ease of administration or the public good.

G. Information to be furnished in Form B:

(1) Caption: Place the following caption at the top of the cover page:

FORM B

INSURANCE HOLDING COMPANY ANNUAL REGISTRATION STATEMENT FILED WITH THE NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE

(2) Registrant: State the name of the registrant filing the statement.

(3) Other registrants: State the name and address of each insurance company on whose behalf the statement is being filed.

(4) Date: Provide the filing date of the statement.

(5) Designation of agent: State the name, title, address and telephone number of the individual to whom notices and correspondence concerning this statement should be addressed.

(6) Identity and control of registrant: Furnish the exact name of each insurer registering or being registered, the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

(7) Organizational chart: Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate that is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing, indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

(8) The ultimate controlling person: Provide the following information about the ultimate controlling person in the insurance holding company system:

(a) name;

(b) home office address;

(c) principal executive office address;

(d) the organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;

(e) the principal business of the person;

(f) the name and address of any person who holds or owns ten percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and

(g) if court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of the proceedings and the date when commenced.

(9) Biographical information: Furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, the individual's principal occupation and all offices and positions held during the past five years, and any conviction for crimes other than minor traffic violations.

(10) Transactions and agreements: Briefly describe the following agreements in force, and transactions currently outstanding or that have occurred during the last calendar year between the registrant and its affiliates in such a manner as to permit the proper evaluation of the transaction by the superintendent. Include at least the following information with respect to each: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and the relationship of the affiliated parties to the registrant. No information need be disclosed if such information is not material for purposes of Section 59A-37-11 NMSA 1978. Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of one percent or less of the registrant's admitted assets as of the 31st day of December next preceding shall be deemed not material.

(a) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the registrant or of the registrant by its affiliates;

(b) purchases, sales or exchanges of assets;

(c) transactions not in the ordinary course of business;

(d) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;

(e) all management agreements, service contracts and all cost-sharing arrangements;

(f) reinsurance agreements;

(g) dividends and other distributions to shareholders;

(h) consolidated tax allocation agreements; and

(i) any pledge of the registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

(11) Litigation or administrative proceedings: Provide a brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

(a) criminal prosecutions or administrative proceedings by any government agency or authority that may be relevant to the trustworthiness of any party to the proceedings; and

(b) proceedings that may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganization.

(12) Statement regarding plan or series of transactions: The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

(13) Financial statements and exhibits:

(a) List under this item the financial statements and exhibits to be attached to this statement as appendices.

(b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or ther legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year. If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the superintendent otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

(c) Other than with respect to the foregoing, such financial statements shall be filed in a standard form and format adopted by the NAIC, unless an alternative form is accepted by the superintendent. Documentation and financial statements filed with the SEC or audited GAAP financial statements shall be deemed to be an appropriate form and format.

(d) Unless the superintendent otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the annual statement of the insurer filed with the insurance department of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

(e) Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with the standards for review of personal financial statements published in the *Personal Financial Statements Guide* by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting practices.

(f) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or 13.2.2.10 NMAC.

(14) Signature and certification: The following signature and certification are required at the end of Form B.

Pursuant to the requirements of Section 59A-37-12 NMSA 1978, registrant has caused this annual registration statement to be duly signed on its behalf in the city of [insert name of city] and state of New Mexico on [insert date].

(SEAL)

BY:_____

_____

(Title)

_____

(Name of Applicant)

Attest:

_____

(Signature of Officer)

_____

(Title)

The undersigned deposes and says that they have duly executed the attached annual registration statement dated [insert date], for and on behalf of [insert name of registrant]; that they are the [insert title of deponent] of such company and that they are authorized to execute and file this instrument. Deponent further says that they are familiar with the instrument and its contents, and that the facts set forth in the instrument are true to the best of their knowledge, information and belief.

_____

(Signature of deponent)

_____

(Typed name and title of deponent)

[13.2.2.13 NMAC – Rp, 13.2.2.13 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.14 FORM C:

A. When required: An insurer required by Section 59A-37-11 NMSA 1978 to file an annual registration statement shall file Form C in accordance with the requirements of this rule.

B. Where filed: An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the commissioner of that state.

C. Information to be furnished in Form C:

(1) Caption: Place the following caption at the top of the cover page:

FORM C

SUMMARY OF CHANGES TO REGISTRATION STATEMENT FILED WITH THE

NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE

(2) Registrant: State the name of the registrant filing the statement.

(3) Other registrants: State the name and address of each insurance company on whose behalf the statement is being filed.

(4) Date: Provide the filing date of the statement.

(5) Designation of agent: State the name, title, address and telephone number of the individual to whom notices and correspondence concerning this statement should be addressed.

(6) Changes: Furnish a brief description of all items in the current annual registration statement that represent changes from the prior year's annual registration statement in such a manner as to permit the proper evaluation of the changes by the superintendent. Include specific references to item numbers and captions in the annual registration statement and to the terms contained in them.

(a) Changes in Paragraph (7) of Subsection G of 13.2.2.13 NMAC. Changes in the percentage of each class of voting securities held by each affiliate need only be included where such changes result in ownership or holdings of ten percent or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

(b) Changes in Paragraph (9) of Subsection G of 13.2.2.13 NMAC. Include this information only if an individual is, for the first time, made a director or executive officer of the ultimate controlling person; an individual is named president of the ultimate controlling person; or a director or executive officer terminates his or her responsibilities with the ultimate controlling person.

(c) Changes in Paragraph (10) of Subsection G of 13.2.2.13 NMAC. If a transaction disclosed on the prior year's annual registration statement has been changed, describe the nature of such change. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction. The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

(7) Signature and certification: The following signature and certification are required at the end of Form C:

Pursuant to the requirements of Section 59A-37-12 NMSA 1978 [insert name of registrant] has caused this annual registration statement to be duly signed on its behalf in the city of [insert name of city] and state of New Mexico on [insert date].

(SEAL)

_____

(Name of applicant)

BY:_____

Attest:

_____

(Signature of officer)

_____

(Title)

The undersigned deposes and says that they have duly executed the attached annual registration statement dated [insert date], for and on behalf of [insert name of registrant]; that they are the [insert title of deponent] of such company; and that they are authorized to execute and file this instrument. Deponent further says that they are familiar with the instrument and its contents, and that the facts set forth in the instrument are true to the best of their knowledge, information and belief.

_____

(Signature of deponent)

_____

(Typed name and title of deponent)

[13.2.2.14 NMAC – Rp, 13.2.2.14 NMAC, 7/24/2018]

13.2.2.15 FORM D:

A. When required: An insurer required to give notice of a proposed transaction pursuant to Section 59A-37-20 NMSA 1978 shall file Form D in accordance with the requirements of this rule.

B. Information to be furnished in Form D:

(1) Caption: Place the following caption at the top of the cover page:

FORM D

PRIOR NOTICE OF A TRANSACTION FILED WITH THE NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE

(2) Registrant: State the name of the registrant filing the statement.

(3) Other registrants: State the name and address of each insurance company on whose behalf the statement is being filed.

(4) Date: Provide the filing date of the statement.

(5) Designation of agent: State the name, title, address and telephone number of the individual to whom notices and correspondence concerning this statement should be addressed.

(6) Identity of parties to transaction: Furnish the following information for each of the parties to the transaction:

(a) name;

(b) home office address;

(c) principal executive office address;

(d) the organizational structure, i.e. corporation, partnership, individual, trust, etc.;

(e) a description of the nature of the parties' business operations;

(f) relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties; and

(g) where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

(7) Description of the transaction: Furnish the following information for each transaction for which notice is being given:

(a) a statement as to whether notice is being given under Paragraphs (1) through (5) of Subsection B of Section 59A-37-20 NMSA 1978;

(b) a statement of the nature of the transaction; and

(c) the proposed effective date of the transaction.

(8) Sales, purchases, exchanges, loans, extensions of credit, guarantees or investments:

(a) Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

(b) If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

(c) If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

(d) No notice need be given if the maximum amount that can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than:

(i) in the case of non-life insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders; or

(ii) in the case of life insurers, three percent of the insurer's admitted assets, each as of the 31st day of December next preceding.

(9) Loans or extensions of credit to a non-affiliate:

(a) If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

(b) No notice need be given if the loan or extension of credit is less than:

(i) in the case of non-life insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders; or

(ii) in the case of life insurers, three percent of the insurer's admitted assets, each as of the 31st day of December next preceding.

(10) Reinsurance:

(a) If the transaction is a reinsurance agreement or modification of a reinsurance agreement as described by Paragraph (3) of Subsection B of Section 59A-37-20 NMSA 1978, or a reinsurance pooling agreement or modification thereto as described by Paragraph (3) of Subsection B of Section 59A-37-20 NMSA 1978, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

(b) No notice need be given for reinsurance agreements or modifications if the reinsurance premium or a change in the insurer's liabilities or the projected reinsurance premium or change in the insurer's liabilities in any of the next three years

in connection with the reinsurance agreement or modification is less than five percent of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding. Notice shall be given for all reinsurance pooling agreements including modifications thereto.

(11) Management, service agreements, and cost-sharing arrangements:

(a) For management and service agreements, furnish:

(i) a brief description of the managerial responsibilities or services to be performed; and

(ii) a brief description of the agreement, including a statement of its duration, together with the brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

(b) For cost-sharing arrangements, furnish:

(i) a brief description of the purpose of the agreement;

(ii) a description of the period of time during which the agreement is to be in effect;

(iii) a brief description of each party's expenses or costs covered by the agreement;

(iv) a brief description of the accounting basis to be used in calculating each party's costs under the agreement;

(v) a brief statement as to the effect of the transaction upon the insurer's policyholder surplus;

(vi) a statement regarding the cost allocation methods that specifies whether proposed charges are based on "cost or market;" and if market based, the rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable; and

(vii) a statement regarding compliance with the *NAIC Accounting Practices and Procedural Manual* regarding expense allocation.

(12) Signature and certification: The following signature and certification are required at the end of Form D:

Pursuant to the requirements of Section 59A-37-20 NMSA 1978 [insert name of applicant] has caused this application to be duly signed on its behalf in the city of [insert name of city] and state of New Mexico on [insert date].

(SEAL)

_____

(Name of applicant)

BY:_____

_____

(Title)

Attest:

_____

(Signature of officer)

_____

(Title)

The undersigned deposes and says that they have duly executed the attached application dated [insert date], for and on behalf of [insert name of applicant]; that they are the [insert title of deponent] of such company; and that they are authorized to execute and file this instrument. Deponent further says that they are familiar with the instrument and its contents, and that the facts set forth in the instrument are true to the best of their knowledge, information and belief.

_____

(Signature of deponent)

_____

(Typed name and title of deponent)

[13.2.2.15 NMAC – Rp, 13.2.2.15 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.16 FORM E:

A. When required: If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant to Subsection A of Section 59A-37-4 NMSA 1978, that person shall file a pre-acquisition notification using Form E, which was developed pursuant to Paragraph (1) of Subsection C Section 59A-37-29 NMSA 1978.

Additionally, if a non-domiciliary insurer licensed to do business in New Mexico is proposing a merger or acquisition pursuant to Section 59A-37-4 NMSA 1978, that person shall file a pre-acquisiton notification using Form E. No pre-acquisition notification form need be filed if the acquisition is beyond the scope of Section 59A-37-4 NMSA 1978 as set forth in Subsection B of Section 59A-37-29 NMSA 1978,

In addition to the information required by Form E, the superintendent may require an expert opinion as to the competitive impact of the proposed acquisition.

B. Information to be furnished in Form E:

(1) Caption: Place the following caption at the top of the cover page:

FORM E

PRE-ACQUISITION NOTIFICATION REGARDING THE POTENTIAL COMPETITIVE IMPACT OF A PROPOSED MERGER OR ACQUISITION BY A NON-DOMICILIARY INSURER DOING BUSINESS IN NEW MEXICO OR BY A DOMESTIC INSURER

(2) Applicant: State the name of the acquiring or merging person.

(3) Other person involved in merger or acquisition: State the name of the other person involved in the merger or acquisition.

(4) Date: Provide the filing date of the statement.

(5) Designation of agent: State the name, title, address and telephone number of the individual to whom notices and correspondences concerning this statement should be addressed.

(6) Identity of persons involved: State the names and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.

(7) Identity of persons affiliated with persons involved: State the names and addresses of the persons affiliated with those listed in Item (6). Describe their affiliations.

(8) Nature and purpose of proposed merger or acquisition: State the nature and purpose of the proposed merger or acquisition.

(9) Nature of business: State the nature of the business performed by each of the persons identified in Paragraphs (6) and (7) of Subsection B of 13.2.2.16 NMAC.

(10) Market and market share:

(a) For purposes of this question, "market" means direct written insurance premium in New Mexico for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

(b) For each person identified in Paragraphs (6) and (7) of Subsection B of 13.2.2.16 NMAC, state specifically what market and market share in each relevant insurance market the persons currently enjoy in New Mexico and provide historical market and market share data for the past five years including the source of such data.

(c) Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of New Mexico as stated in Section 59A-37-29 NMSA 1978. If the proposed acquisition or merger would violate competitive standards, provide justification that the acquisition or merger would not substantially lessen competition or create a monopoly in New Mexico.

[13.2.2.16 NMAC – Rp, 13.2.2.16 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.17 FORM F:

A. When required: The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to Section 59A-37-30 shall furnish the required information on Form F.

B. **Information to be furnished on Form F**:

(1) Caption: Place to following caption at the top of the cover page:

FORM F

ENTERPRISE RISK REPORT

(2) Registrant/applicant: State the name of the registrant or applicant filing the statement.

(3) Other registrants/applicants: State the name and address of each insurance company on whose behalf, or related to which, the statement is being filed.

(4) Date: Provide the filing date of the statement.

(5) Designation of agent: State the name, title, address and telephone number of the individual to whom notices and correspondences concerning this statement should be addressed.

(6) Enterprise risk: The registrant/applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in Subsection D of Section 59A-37-2 NMSA 1978, provided

such information is not disclosed in the *Insurance Holding Company System Annual Registration Statement* filed on behalf of itself or another insurer for which it is the ultimate controlling person:

(a) any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;

(b) acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;

(c) any changes of shareholders of the insurance holding company system exceeding ten percent or more of voting securities;

(d) developments in various investigations, regulatory activities or litigation that may have significant bearing or impact on the insurance holding company system;

(e) business plan of the insurance holding company system and summarized strategies for the next 12 months;

(f) identification of material concerns of the insurance holding company system raised by a supervisory college, if any, in the last year;

(g) identification of insurance holding company system capital resources and material distribution patterns;

(h) identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook);

(i) information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

(j) identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The registrant/applicant may attach the appropriate form most recently filed with the SEC, provided the registrant/applicant includes specific references to those areas listed in Paragraph (6) of Subsection B of 13.2.2.17 NMAC for which the form provided responsive information. If the registrant/applicant is not domiciled in the United States, it may attach its most recent audited financial statement filed in its country of domicile, provided the registrant/applicant includes specific reference to those areas in Paragraph (6) for which the financial statement provides responsive information.

(7) Obligation to report: If the registrant/applicant has not disclosed any information pursuant to Paragraph (6) of Subsection B of 13.2.2.17 NMAC, the registrant/applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Paragraph (6).

[13.2.2.17 NMAC – Rp, 13.2.2.17 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.18 FORM G:

A. When required: Subject to Section 59A-37-22 NMSA 1978 a registered insurer shall file Form G to report to the superintendent all dividends and other distributions to shareholders within 15 business days following the declaration of such dividends or distributions.

B. Information to be furnished in Form G:

(1) Caption: Place the following caption at the top of the cover page:

FORM G

NOTICE OF DECLARATION OF DIVIDENDS OR OTHER DISTRIBUTIONS TO SHAREHOLDERS

(2) Applicant: Provide the name and address of the insurer filing the report.

(3) Calculations: Provide a copy of the calculations determining the proposed dividends. The work paper shall include the following information:

(a) the amounts, dates and form of payment of all dividends or distributions (including regular dividends, but excluding distributions of the insurer's own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

(b) surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;

(c) if the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;

(d) if the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-month periods; and

(e) if the insurer is not a life insurer, the dividends paid to stockholders, excluding distributions of the insurer's own securities in the preceding two calendar years.

[13.2.2.18 NMAC – Rp, 13.2.2.18 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.19 FORM H:

A. When required:

(1) A person claiming that they do not, or will not upon the taking of some proposed action, control another subject person shall file Form H in accordance with this rule.

(2) A person requesting termination of registration shall file Form H in accordance with this rule.

B. A request for termination of registration shall be deemed to have been granted unless the superintendent, within thirty days after receipt of the request, notifies the registrant otherwise.

C. Information required in Form H:

(1) Caption: Place the following caption at the top of the cover page:

FORM H

DISCLAIMER OF AFFILIATION OR REQUEST FOR TERMINATION OF REGISTRATION

(2) Disclaimant: Provide the name, address, and telephone number and email of the person disclaiming affiliation or requesting termination of registration.

(3) Subject person: Provide the name, address, and telephone number and email of the person no longer affiliated with or subject to the control of the disclaimant.

(4) Voting securities: Provide the number of authorized, issued and outstanding voting securities of the subject person.

(5) Shares held by disclaimant: With respect to the disclaimant and all affiliates of the disclaimant, indicate the number and percentage of shares of the subject person's voting securities which are held of record or known to be beneficially owned, and the number of shares the disclaimant has a right to acquire, directly or indirectly.

(6) Affiliations: Describe all material relationships and bases for affiliation between the subject person and disclaimant and all affiliates of the disclaimant.

(7) Explanation: State why the disclaimant should not be considered to control the subject person.

[13.2.2.19 NMAC – Rp, 13.2.2.19 NMAC, 7/24/2018]

13.2.2.20 FORM I:

A. When required: A domestic insurer required by Section 59A-37-22 NMSA 1978 to give prior notice to the superintendent of the declaration of any extraordinary dividend or any other extraordinary distribution to its shareholders shall file Form I in accordance with the requirements of this rule.

B. Information to be furnished in Form I:

(1) Caption: Place the following caption at the top of the cover page:

FORM I

REQUEST FOR APPROVAL OF EXTRAORDINARY DIVIDENDS OR ANY OTHER EXTRAORDINARY DISTRIBUTION TO SHAREHOLDERS

(2) Applicant: Provide the name and address of the insurer filing the request.

(3) Amount: State the amount of the proposed dividend.

(4) Payment date: Indicate the date established for payment of the dividend.

(5) Mode of payment: State whether the dividend is to be paid in cash or other property and, if in property, describe the property, its cost, and its fair market value, and explain the basis for valuation.

(6) Calculations: Provide a copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

(a) the amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

(b) Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;

(c) if the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;

(d) if the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-month periods; and

(e) if the insurer is not a life insurer, the dividends paid to stockholders, excluding distributions of the insurer's own securities in the preceding two calendar years.

(7) Balance sheet: Provide a balance sheet and statement of income for the period intervening from the last annual statement filed with the superintendent and the end of the month preceding the month in which the request for dividend approval is submitted.

(8) Effect on surplus: Provide a brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

[13.2.2.20 NMAC – Rp, 13.2.2.20 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.21 SUPERVISORY COLLEGES:

A. Participation by superintendent. With respect to any insurer registered under Section 59A-37-11 NMSA 1978, and in accordance with Subsection C below, the superintendent may participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with these rules. The superintendent may, with respect to supervisory colleges:

(1) Initiate the establishment of a supervisory college;

(2) Clarify the membership and participation of other supervisors in the supervisory college;

(3) Clarify the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(4) Coordinate the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing;

(5) Establish a crisis management plan; and

(6) Take other reasonable actions within the scope of the superintendent's authority.

B. Expenses. A registered insurer subject to this section shall be liable for and shall pay the reasonable expense of the superintendent's participation in a supervisory college in accordance with Subsection C below, including reasonable travel expenses. For purpose of this section, a supervisory college may be covered as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the superintendent may establish regular assessment to the insurer for the payment of these expenses.

C. Supervisory College. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with Section 59A-37-23 NMSA 1978, the superintendent may participate in a supervisory college with other regulators charged with supervision of the insurer of its affiliates, including other state, federal and international regulatory agencies. The superintendent may enter into agreements in accordance with Section 59A-37-23 NMSA 1978 providing the basis for cooperation between the superintendent and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the superintendent to regulate or supervise the insurer or its affiliates within the superintendent's jurisdiction.

[13.2.2.21 NMAC – N, 10/01/2020]

13.2.2.22 GROUP-WIDE SUPERVISION OF INTERNATIONALLY ACTIVE INSURANCE GROUPS:

A. The superintendent may act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the superintendent may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(1) Does not have substantial insurance operations in the United States;

(2) Has substantial insurance operations in the United States, but not in this state; or

(3) Has substantial insurance operations in the United States and this state, but the superintendent has determined pursuant to the factors set forth in Subsections B and F of this section that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the superintendent make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

B. In cooperation with other state, federal and international regulatory agencies, the superintendent will identify a single group-wide supervisor for an internationally active insurance group. The superintendent may determine that the superintendent is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the superintendent may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The superintendent shall consider the following factors when making a determination or acknowledgment under this subsection:

(1) The place of domicile of the insurers within the internationally active insurance group that holds the largest share of the group's written premiums, assets or liabilities;

(2) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;

(3) The location of the executive offices or largest operational offices of the internationally active insurance group;

(4) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the superintendent determines to be:

(a) Substantially similar to the system of regulation provided under the laws of this state, or

(b) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the superintendent with reasonably reciprocal recognition and cooperation.

(6) However, a regulatory official identified in this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. Acknowledgement of the group-wide supervisor shall be made after consideration of the factors listed in Paragraph (1) through (5) above, and shall be made in cooperation with and subject to the acknowledgement of other regulatory officials involved with supervision of a member of the internationally active insurance group, and in consultation with the internationally active insurance group.

C. Notwithstanding any other provisions of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the superintendent shall acknowledge that regulatory official as the group-wide supervisor.

However, in the event of material change in the internationally active insurance group that results in either:

(1) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets or liabilities; or

(2) This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, then the superintendent shall make a determination or acknowledgement as to the appropriate group-wide supervisor for such internationally active insurance group pursuant to Subsection B.

D. Pursuant to Section 59A-37-23 NMSA 1978, the superintendent is authorized to collect from any insurer registered pursuant to Section 59A-37-11 NMSA 1978, all information necessary to determine whether the superintendent may act as the group-wide supervisor of an internationally active insurance group or if the superintendent may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the superintendent, the superintendent will notify the insurer registered pursuant to Section 59A-37-11 NMSA 1978, and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than 30 days to provide the superintendent with additional information pertinent to the pending determination. The OSI will publish on its website the identity of internationally active insurance groups that the superintendent has determined are subject to group-wide supervision by the superintendent.

E. If the superintendent is the group-wide supervisor for an internationally active insurance group, the superintendent is authorized to engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risk within the internationally active insurance group to ensure that:

(a) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management, and

(b) Reasonable and effective mitigation measures are in place;

(2) Request from any member of an internationally active insurance group subject to the superintendent's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

(a) Governance, risk assessment and management,

(b) Capital adequacy, and

(c) Material intercompany transactions;

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(4) Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of Section 59A-37-24 NMSA 1978, through supervisory colleges as provided in this rule or otherwise;

(5) Enter into agreements with or obtain documentation from any insurer registered under Section 59A-37-11 NMSA 1978, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the superintendent's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the superintendent.

F. If the superintendent acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the superintendent may reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(1) The superintendent's cooperation is in compliance with the laws of this state; and

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the superintendent's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the superintendent is authorized to refuse recognition and cooperation.

G. The superintendent may enter into agreements with or obtain documentation from any insurer registered under Section 59A-37-11 NMSA 1978, any affiliate of the insurer, and other state, federal and international regulatory agencies for members of

the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

H. A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the superintendent's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

I. All information, data, reports and workpapers filed with and collected by the superintendent pursuant to this section will be obtained in accordance with Section 59A-4-5 NMSA 1978 and subject to the confidentiality provisions of Section 59A-4-11 and 59A-37-24, NMSA 1978, and the stricter of these provisions shall apply.

[13.2.2.22 NMAC – N, 10/01/2020]

13.2.2.23 SEVERABILITY CLAUSE:

If any provision of this rule or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of this rule which can be given effect without the invalid provision or application, and to that end, the provisions of this rule are severable.

[13.2.2.23 NMAC – Rn & A, 13.2.2.21 NMAC, 10/01/2020]

PART 3: ANNUAL STATEMENT REQUIREMENTS

13.2.3.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.2.3.2 SCOPE:

This rule applies to all domestic, foreign and alien companies authorized to transact the business of insurance in the state of New Mexico.

[7/1/97; Recompiled 11/30/01]

13.2.3.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.2.3.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.2.3.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.2.3.6 OBJECTIVE:

The purpose of this rule is to clarify the reporting requirements for annual statements required by Sections 59A-5-29 and 59A-5-29.1 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.2.3.7 DEFINITIONS:

[RESERVED]

13.2.3.8 ELECTRONIC FILING REQUIRED:

A. **NAIC filing:** Each authorized insurer shall file a copy of each annual statement and quarterly statement of the insurer with the national association of insurance commissioners in both hard copy and on diskette. This requirement applies to the extent that the national association of insurance commissioners has issued a diskette submission directive or has otherwise approved or prescribed an applicable diskette format for the particular class of insurer.

B. **Superintendent filing:** Each domestic insurer shall file a copy of each annual and quarterly stateme1nt of the insurer with the superintendent in both hard copy and on diskette.

[7/1/97; Recompiled 11/30/01]

PART 4: USE OF COMMERCIAL DEPOSITORIES FOR STATUTORY DEPOSITS

13.2.4.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[7/1/97; 13.2.4.1 NMAC - Rn & A, 13 NMAC 2.4.1, 6/14/07]

13.2.4.2 SCOPE:

This rule applies to all statutory deposits required in order to be qualified to transact the business of insurance and security deposits required to be registered as a service contract provider in the state of New Mexico.

[7/1/97; 13.2.4.2 NMAC - Rn & A, 13 NMAC 2.4.2, 6/14/07]

13.2.4.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-5-18, 59A-5-19, 59A-10-4, 59A-10-5, 59A-14-4 and 59A-58-6 NMSA 1978.

[7/1/97; 13.2.4.3 NMAC - Rn & A, 13 NMAC 2.4.3, 6/14/07]

13.2.4.4 DURATION:

Permanent.

[7/1/97; 13.2.4.4 NMAC - Rn, 13 NMAC 2.4.4, 6/14/07]

13.2.4.5 EFFECTIVE DATE:

August 24, 1987, unless a later date is cited at the end of a section.

[8/24/87, 12/4/87, 7/1/97; 13.2.4.5 NMAC - Rn & A, 13 NMAC 2.4.5, 6/14/07]

13.2.4.6 OBJECTIVE:

The purpose of this rule is to assist insurance companies and service contract providers making statutory deposits with detailed instructions to meet those statutory requirements and to provide rules governing a commercial depository receiving these statutory deposits.

[8/24/87, 12/4/87, 7/1/97; 13.2.4.6 NMAC - Rn & A, 13 NMAC 2.4.6, 6/14/07]

13.2.4.7 DEFINITIONS:

Depository means the financial institution designated by the state treasurer and approved by the superintendent to receive and hold deposits required by the Insurance Code.

[7/1/97; 13.2.4.7 NMAC - Rn, 13 NMAC 2.4.7, 6/14/07]

13.2.4.8 SEGREGATION OF DEPOSITS:

Each of the following types of deposits shall be separately maintained in the books and records of the depository:

A. special deposits required under New Mexico law;

B. special deposits required under the laws of any state other than New Mexico; and

C. general deposits required under the laws of New Mexico or of any other state.

[8/24/87, 12/4/87, 7/1/97; 13.2.4.8 NMAC - Rn, 13 NMAC 2.4.8, 6/14/07]

13.2.4.9 MANNER OF HOLDING DEPOSITS:

All deposit accounts shall be held in the designated depository in the name of the "superintendent of insurance of the state of New Mexico, custodian for (name) insurance company (general/special/other deposit account)". Securities deposited in the account may be held:

A. in "book entry" form in depository's account with the federal reserve;

B. in nominee name of depository, depository's corresponding bank, or the clearing corporation retained by depository; or

C. in the account name specified above.

[8/24/87; 13.2.4.9 NMAC - Rn, 13 NMAC 2.4.9, 6/14/07]

13.2.4.10 SAFEKEEPING RECEIPTS:

Safekeeping receipts evidencing the holding of any security at an institution other than the designated depository shall be accepted only with the prior express written approval of the superintendent upon a showing of exceptional circumstances.

[8/24/87; 13.2.4.10 NMAC - Rn, 13 NMAC 2.4.10, 6/14/07]

13.2.4.11 ASSETS ELIGIBLE FOR DEPOSIT:

All statutory deposits required by the New Mexico Insurance Code shall be comprised solely of securities which are:

A. described and permitted by Section 59A-10-3 NMSA 1978 as the same may be amended from time to time, and either:

(1) traded on a national securities exchange and for which daily "bid" prices are regularly published and available;

(2) public obligations as defined in Section 59A-9-6 NMSA 1978 or

(3) certificates of deposit in solvent state and national banks or trust companies whose principal office is located in New Mexico, provided that no deposit shall include certificates of deposit aggregating more than $100,000 under the valuation method described herein;

B. all public obligations other than direct obligations of the United States government shall:

(1) have a Standard and Poors bond rating of "AA" or greater, a Moody's bond rating of "Aa" or better; or

(2) be designated in a current Kinney's information systems preferred bond service as "escrowed to maturity" and "secured in 100% direct U.S. government";

(3) all other bonds or other evidences of obligation other than certificates of deposit shall have astandard and poors or moody's bond rating of "A" or better;

(4) no security shall be eligible hereunder which shall provide for a scheduled return or partial return of principal prior to maturity.

[8/24/87, 12/4/87; 13.2.4.11 NMAC - Rn, 13 NMAC 2.4.11, 6/14/07]

13.2.4.12 VALUATION OF DEPOSITS:

All securities deposited pursuant to the New Mexico Insurance Code shall be valued at their fair market value as of the valuation date.

[8/24/87; 13.2.4.12 NMAC - Rn, 13 NMAC 2.4.12, 6/14/07]

13.2.4.13 RELEASE OF DEPOSITS, OR OF PROCEEDS OR PRINCIPAL OF DEPOSITS:

Depository shall not release nor pay to any person any security held as a deposit hereunder, or any proceeds of the sale of, or payments of principal upon, such securities, except upon written direction of the superintendent, or upon order of a court of competent jurisdiction in an action to which the superintendent is a party.

[8/24/87; 13.2.4.13 NMAC - Rn, 13 NMAC 2.4.13, 6/14/07]

13.2.4.14 REPORTING REQUIREMENTS:

Depository shall promptly furnish:

A. to the superintendent:

(1) not later than three (3) days after completion of any transaction with respect to a deposit held by depository hereunder, a report of the transaction in a form approved by the superintendent, except that no report shall be made to the superintendent of a transaction involving solely a receipt of, or payment to insurer of, income on the securities;

(2) monthly, a security transaction listing and security inventory for each deposit, subtotaled by the deposit account, in a form satisfactory to the superintendent;

B. to the insurer depositing the securities:

(1) not later than three (3) days after completion of any transaction, a report of the transaction in a form approved by the superintendent;

(2) not less often than annually, a complete accounting of the securities held and of all transactions which occurred since the latest accounting; and

C. to the superintendent, the state treasurer of the state of New Mexico, and the state auditor of the state of New Mexico, all such other and further reports and records as may be reasonable or necessary for performance of their duties under law.

[8/24/87; 13.2.4.14 NMAC - Rn, 13 NMAC 2.4.14, 6/14/07]

13.2.4.15 COLLATERAL SECURITY:

Depository shall promptly furnish to the superintendent evidence of pledge of collateral security in such reasonable form and amount as the superintendent may demand.

[8/24/87; 13.2.4.15 NMAC - Rn, 13 NMAC 2.4.15, 6/14/07]

13.2.4.16 FEES CHARGED BY DEPOSITORY:

Total compensation and reimbursement to be received by depository for its services as described in this rule shall be an annual fee not greater than two-tenths of one percent (0.2)$) of the face amount of securities held by depository, plus New Mexico gross receipts tax as agreed upon by the superintendent and the state treasurer, or such lesser amount as may be agreed between depository and an individual insurer.

[8/24/87; 13.2.4.16 NMAC - Rn & A, 13 NMAC 2.4.16, 6/14/07]

13.2.4.17 RELATIONSHIP BETWEEN DEPOSITORY AND INSURER OR SERVICE CONTRACT PROVIDER:

A. Depository may, by agreement between itself and an insurer or service contract provider, accept such other or further additional duties to an insurer or service contract provider as may be agreed between them, provided that no provision of any such agreement shall be effective to impair, diminish or otherwise affect any right or power of the superintendent or the state of New Mexico under this rule or applicable law.

B. All compensation or reimbursement due to depository shall be the sole liability and responsibility of insurer or service contract provider, and no claim shall be made upon the superintendent or the state of New Mexico, either by depository or by insurer or service contract provider, for collection or payment of any such amounts.

[8/24/87; 13.2.4.17 NMAC - Rn & A, 13 NMAC 2.4.17, 6/14/07]

13.2.4.18 SURETY BONDS IN LIEU OF SPECIAL DEPOSITS:

Surety bonds submitted in lieu of special deposits shall be issued by a surety company qualified to transact surety business within the state of New Mexico, provided that such surety company shall not control, be controlled by, or be under common control with the insurer or service contract provider for which the bond is submitted.

[8/24/87; 13.2.4.18 NMAC - Rn & A, 13 NMAC 2.4.18, 6/14/07]

PART 5: ANNUAL AUDITED FINANCIAL REPORTS

13.2.5.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[7/1/97; 13.2.5.1 NMAC - Rn, 13 NMAC 2.5.1 & A, 1/1/2010; A, 10/01/2020]

13.2.5.2 SCOPE:

A. Every insurer shall be subject to this rule.

B. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this rule for the year, unless the superintendent makes a specific finding that compliance is necessary for the superintendent to carry out statutory responsibilities.

C. Insurers having assumed premiums pursuant to contracts or treaties of reinsurance of $1,000,000 or more are not exempt.

D. Foreign or alien insurers filing the audited financial report in another state, pursuant to that state's requirement for filing of audited financial reports, which has been found by the superintendent to be substantially similar to the requirements herein, are exempt from this rule if:

(1) a copy of the audited financial report, communication of internal control related matters noted in an audit, and the accountant's letter of qualifications that are filed with the other state are filed with the superintendent in accordance with the filing dates specified in this rule respectively; and

(2) a copy of any notification of adverse financial condition report filed with the other state is filed with the superintendent within the time specified in this rule.

E. Foreign or alien insurers required to file management's report of internal control over financial reporting in another state are exempt from filing the report in this state provided the other state has substantially similar reporting requirements and the report is filed with the commissioner of the other state within the time specified.

[1/1/94; 13.2.5.2 NMAC - Rn, 13 NMAC 2.5.2 & A, 1/1/2010; A, 10/01/2020]

13.2.5.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, and Chapter 59A Article 37 NMSA 1978 ("the Insurance Holding Company Law").

[1/1/94; 13.2.5.3 NMAC - Rn, 13 NMAC 2.5.3, 1/1/2010; A, 10/01/2020]

13.2.5.4 DURATION:

Permanent.

[7/1/97; 13.2.5.4 NMAC - Rn, 13 NMAC 2.5.4, 1/1/2010]

13.2.5.5 EFFECTIVE DATE:

January 1, 1994, unless a later date is cited at the end of a section.

[1/1/94, 7/1/97; 13.2.5.5 NMAC - Rn, 13 NMAC 2.5.5 & A, 1/1/2010]

13.2.5.6 OBJECTIVE:

The purpose of this rule is to ensure robust surveillance of the financial condition of insurers by requiring: (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants; (2) communication of internal control related matters noted in an audit; and (3) management's report of internal control over financial reporting.

[1/1/94; 13.2.5.6 NMAC - Rn, 13 NMAC 2.5.6 & A, 1/1/2010; A, 10/01/2020]

13.2.5.7 DEFINITIONS:

A. An **"affiliate"** of, or person **"affiliated"** with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

B. "Audit committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, and audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of this rule at the election of the controlling person. If an audit committee in not designated by an insurer, the insurer's entire board of directors shall constitute the audit committee.

C. "Audited financial report" means and includes all items specified in 13.2.5.10, 13.2.5.11 and 13.2.5.12 NMAC.

D. "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

E. "Independent audit committee member" has the same meaning as described in Subsection D of 13.2.5.16 NMAC.

F. "**Independent certified public accountant"**("ICPA") means a certified public accountant or accounting firm in good standing with the American institute of certified public accountants ("AICPA") and in all states in which the ICPA is licensed to practice, who maintains compliance with the AICPA Independence Rule and its interpretations, including the Conceptual Framwork for Independence. For Canadian and British companies, it means a Canadian-charted or British-charted accountant.

G. "Insurer" means an authorized insurer, an eligible surplus lines insurer, and a registered risk retention group, unless the context clearly indicates otherwise.

H. "Group of insurers" means those licensed insurers included in the reporting requirements of the Insurance Holding Company Law or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

I. "Internal audit function" means a person or persons who provide independent, objective and reasonable assurance designed to add value and improve an

organization's operations and accomplish its objectives through a systemic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

J. "Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in 13.2.5.23 NMAC and includes those policies and procedures that:

(1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in Subsections A and B of 13.2.5.22 NMAC and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(3) provide reasonable assurance regarding prevention or timely detection of authorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in 13.2.5.23 NMAC.

K. "NAIC" means the national association of insurance commissioners.

L. "SEC" means the united states securities and exchange commission.

M. "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

N. "Section 404 report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant.

O. "SOX compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002:

(1) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934);

(2) the audit committee independence requirements of Section 301 (Section 10A (m)(3) of the Securities Exchange Act of 1934); and

(3) the internal control over financial reporting requirements of Section 404 (item 308 of SEC regulation S-K).

[1/1/94; 13.2.5.7 NMAC - Rn, 13 NMAC 2.5.7 & A, 1/1/2010; A, 10/01/2020]

13.2.5.8 CONFLICT WITH OTHER PROVISIONS:

This rule shall not prohibit, preclude or in any way limit the superintendent from ordering, conducting or performing examinations of insurers under the Insurance Code or other OSI rules.

[1/1/94; 13.2.5.8 NMAC - Rn, 13 NMAC 2.5.8, 1/1/2010; A, 10/01/2020]

13.2.5.9 FILING DATES AND EXTENSIONS:

A. An insurerer shall have an annual audit by an independent certified public accountant and shall file an annual audited financial report and management's report of internal control over financial reporting with the superintendent on or before June 1 for the year ended December 31 immediately preceding. The superintendent may require an insurer to file an audited financial report and management's report of internal control over financial reporting earlier than June 1 with ninety days advance notice to the insurer.

B. The superintendent may grant extensions of the June 1 filing date for 30-day periods for good cause shown. The request for extension shall be submitted in writing not less than 10 days prior to the filing date. The insurer and its independent certified public accountant shall show the reasons for requesting such extension in sufficient detail to permit the superintendent to make an informed decision with respect to the requested extension.

C. An insurer required to file an annual audited financial report pursuant to this rule shall designate a group of individuals as constituting its audit committee, as defined in 13.2.5.7 NMAC. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of this rule at the election of the controlling person consistent with 13.2.5.16 NMAC.

[1/1/94; 13.2.5.9 NMAC - Rn, 13 NMAC 2.5.9 & A, 1/1/2010; A, 10/01/2020]

13.2.5.10 REPORT PERIOD:

The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended, in conformity with statutory accounting practices prescribed or otherwise permitted by the department of insurance of the insurer's state of domicile.

[1/1/94; 13.2.5.10 NMAC - Rn, 13 NMAC 2.5.10, 1/1/2010]

13.2.5.11 REPORT FORM:

The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the superintendent. The financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. The comparative data may be omitted in the first year in which an insurer is required to file an audited financial report.

[1/1/94; 13.2.5.11 NMAC - Rn, 13 NMAC 2.5.11, 1/1/2010]

13.2.5.12 CONTENTS OF REPORT:

The annual audited financial report shall include the following:

A. report of independent certified public accountant;

B. balance sheet reporting admitted assets, liabilities, capital and surplus;

C. statement of operations;

D. statement of cash flows;

E. statement of changes in capital and surplus;

F. notes to financial statements, including:

(1) those required by the appropriate NAIC annual statement instructions and the NAIC accounting practices and procedures manual;

(2) a reconciliation of differences, if any, between the annual audited financial report filed pursuant to this rule and the annual statement filed pursuant to Section 59A-5-29 NMSA 1978, with a written description of the nature of these differences;

(3) a summary of ownership and relationships of the insurer and all affiliated companies; and

(4) any other notes required by generally accepted accounting principles; and

G. accountant's letter of qualifications, as described in 13.2.5.13 NMAC.

[1/1/94; 13.2.5.12 NMAC - Rn, 13 NMAC 2.5.12 & A, 1/1/2010; A, 10/01/2020]

13.2.5.13 REGISTRATION OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT:

A. An insurer required by this rule to file an annual audited financial report must, within 60 days after becoming subject to such requirement, register with the superintendent, in writing, the name and address of the ICPA or accounting firm retained to conduct the annual audit required by this rule

B. An insurer shall obtain a letter from the ICPA, and submit a copy to OSI stating that the ICPA is aware of the provisions of the insurance code and the rules of the insurance department of the insurer's state of domicile that relate to accounting and financial matters and affirming that the ICPA will express an opinion on the financial statement in terms of conformity to the statutory accounting practices prescribed or otherwise permitted by that department, specifying such exceptions as the ICPA may believe appropriate.

[1/1/94; 13.2.5.13 NMAC - Rn, 13 NMAC 2.5.13, 1/1/2010; A, 10/01/2020]

13.2.5.14 DISMISSAL OR RESIGNATION OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT:

A. If an accountant who was the ICPA for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall notify the superintendent in writing of this event within five business days.

B. The insurer shall also furnish the superintendent with a separate letter of disagreement within ten business days of the notice of dismissal or resignation, which shall contain the following:

(1) the letter shall state whether, in the 24 months preceding such event, there were any disagreements with the former ICPA on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which would have caused the accountant to make reference in the ICPA opinion to the subject matter of the disagreement if the disagreement had not been resolved to the satisfaction of the former ICPA; and

(2) the insurer must report in the letter all disagreements that occurred at the decision-making level (i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report), whether resolved to the former ICPA's satisfaction or not resolved to the former ICPA's satisfaction.

C. The insurer shall send a copy of the letter of disagreement to the former ICPA and request in writing that the former ICPA furnish a letter addressed to the insurer stating whether the ICPA agrees with the statements contained in the insurer's letter of disagreement and, if not, stating the reasons for disagreement. The insurer shall furnish a copy of the responsive letter from the former ICPA to the superintendent.

[1/1/94; 13.2.5.14 NMAC - Rn, 13 NMAC 2.5.14, 1/1/2010; A, 10/01/2020]

13.2.5.15 QUALIFICATIONS OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT:

A. The superintendent shall not recognize a person or firm as a qualified ICPA if the person or firm:

(1) is not in good standing with the AICPA and in all states in which the ICPA is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

B. Except as otherwise provided in this rule, the superintendent shall recognize an ICPA as qualified as long as the ICPA conforms to the standards of the profession, as contained in the code of professional ethics of the AICPA and rules and regulations and code of ethics and rules of professional conduct of the New Mexico board of public accountancy, or similar code.

C. A qualified ICPA may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Chapter 59A, Article 41, NMSA 1978 the mediation or arbitration provisions shall operate at the option of the statutory successor.

D. The lead or coordinating audit partner having primary responsibility for the audit may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may make application to the superintendent for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least 30 days before the end of the calendar year. The superintendent may consider the following factors in determining if the relief should be granted:

(1) number of partners, expertise of the partners or the number of insurance claims in the currently registered firm;

(2) premium volume of the insurer; or

(3) number of jurisdictions in which the insurer transacts business.

E. An insurer shall file, with its annual statement filing, the approval for relief from this section with the states in which it is licensed or doing business and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

F. The superintendent shall neither recognize as a qualified ICPA, nor accept an annual audited financial report, prepared in whole or in part by, a natural person who:

(1) has been convicted of fraud, bribery, a violation of the racketeer influenced and corrupt organizations act, 18 U.S.C. Sections 1961 to 1968, or any dishonest conduct or practices under federal or state law;

(2) has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this rule; or

(3) has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this rule.

G. The superintendent may hold a hearing, as provided in Chapter 59A, Article 4, NMSA 1978 to determine whether an ICPA is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing an opinion on the financial statements in the annual audited financial report made pursuant to this rule and require the insurer to replace the ICPA with another whose relationship with the insurer is qualified within the meaning of this rule.

H. The superintendent shall not recognize as a qualified ICPA, nor accept an annual audited financial report, prepared in whole or in part by an ICPA who provides to an insurer, contemporaneously with the audit, the following non-audit services:

(1) bookkeeping or other services related to the accounting records or financial statements of the insurer;

(2) financial information systems design and implementation;

(3) appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(4) actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The ICPA may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to the audit procedures during an audit of the insurer's financial statements. An ICPA's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met:

(a) neither the ICPA nor the ICPA's actuary has performed any management functions or made any management decisions;

(b) the insurer has competent personnel (or engages a third party actuary) to estimate the reserves for which management takes responsibility; and

(c) the ICPA's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(5) internal audit outsourcing services;

(6) management functions or human resources;

(7) broker or dealer, investment adviser, or investment banking services;

(8) legal services or expert services unrelated to the audit; or

(9) any other services that the superintendent determines, by rule, are impermissible.

I. In general, the principles of independence with respect to services provided by the qualified ICPA are largely predicated on three basic principles, violations of which would impair the ICPA's independence. The principles are that the ICPA cannot function in the role of management, cannot audit its own work, and cannot serve in an advocacy role for the insurer.

J. An insurer having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from Subsection H of this section. The insurer shall file with the superintendent a written statement discussing the reasons why the insurer should be exempt from these provisions. If the superintendent finds, upon review of this statement, that compliance with this rule would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

K. A qualified ICPA who performs the audit may engage in other non-audit services, including tax services, that are not described in Subsection H of this section or that do not conflict with Subsection I of this section, only if the activity is approved in advance by the audit committee, in accordance with Subsection L of this section.

L. All auditing services and non-audit services provided to an insurer by the qualified ICPA of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to non-audit services if the insurer is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity or:

(1) the aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent of the total amount of fees paid by the insurer to its qualified ICPA during the fiscal year in which the non-audit services are provided;

(2) the services were not recognized by the insurer at the time of the engagement to be non-audit services; and

(3) the services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

M. The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by Subsection L of this section. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

N. An ICPA is not qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the ICPA and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. An insurer may make application to the superintendent for relief from the above requirement on the basis of unusual circumstances. This subsection shall only apply to partners and senior managers involved in the audit.

O. The insurer shall file, with its annual statement filing, the approval for relief from Subsection N of this section with the states in which it is licensed or doing business and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

[1/1/94; 13.2.5.15 NMAC - Rn, 13 NMAC 2.5.15 & A, 1/1/2010; A, 10/01/2020]

13.2.5.16 REQUIREMENTS FOR AUDIT COMMITTEE:

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity.

A. The audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant, including resolution of disagreements between management and the accountant regarding financial reporting, for the purpose of preparing or issuing the audited financial report or related work pursuant to this rule. Each accountant shall report directly to the audit committee.

B. The audit committee of an insurer or group of insurers shall be responsible for overseeing the insurer's audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities.

C. Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection F of this section and Subsection C of 13.2.5.7 NMAC.

D. In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, the law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

E. If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

F. To exercise the election of the controlling person to designate the audit committee for purposes of this rule, the ultimate controlling person shall provide a written notice to the superintendent. Notification shall be made prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the superintendent by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

G. The audit committee shall require the accountant that performs for an insurer any audit required by this rule to report to the audit committee in accordance with the requirements of SAS 61, communication with audit committees, or its replacement, including:

(1) all significant accounting policies and material permitted practices;

(2) all material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(3) other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

H. If an insurer is a member of an insurance holding company system, the reports required by Subsection G may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

I. The proportion of independent audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 - $300,000,000	**Over $300,000,000 - $500,000,000**	**Over $500,000,000**
No minimum requirements.	Majority (50% or more) of members shall be independent.	Supermajority of members (75% or more) shall be independent.

J. An insurer with direct written and assumed premium, excluding premiums reinsured with the federal crop insurance corporation and federal flood program, less than $500,000,000 may make application to the superintendent for a waiver from the requirements of this section based upon hardship.

[13.2.5.16 NMAC - N, 1/1/2010; A, 10/01/2020]

13.2.5.17 INTERNAL AUDIT FUNCTION REQUIREMENTS:

A. Function. An insurer or group of insurers shall establish an internal audit function providing independent, objective and reasonable assurance to the audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regualtions.

B. Independence. In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function shall have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

C. Reporting. The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the intenal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

D. Additional Requirements. If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

E. Exemption. An insurer may be exempt from the requirements of this section only if:

(1) the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the federal corp insurance coporation and federal flood program, less than $500,000,000); or,

(2) if the insurer is a member of a group of insurers that has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with federal crop insurance corporation and federal flood program, less than $1,000,000,000.

[13.2.5.17 NMAC - N, 10/01/2020]

13.2.5.18 ROTATION OF ACCOUNTANTS REQUIRED:

A. No partner or other person responsible for rendering a report may act in that capacity for more than five consecutive years. Following any such period of service the person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of two years.

B. An insurer may make application to the superintendent for relief from this rotation requirement on the basis of unusual circumstances. The superintendent may consider the following factors in determining if the relief should be granted:

(1) the number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(2) the premium volume of the insurer; and

(3) the number of jurisdictions in which the insurer transacts business.

[13.2.5.18 NMAC - Rn & A, 13.2.5.17 NMAC, 10/01/2020]

13.2.5.19 CONSOLIDATED OR COMBINED AUDITS:

An insurer may make written application to the superintendent for approval to file consolidated or combined annual audited financial reports in lieu of separate annual audited financial reports if the insurer is part of a group of insurance companies which utilizes a pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidated or combined worksheet shall be filed with the report, as follows:

A. amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet;

B. amounts for each insurer subject to this section shall be stated separately;

C. noninsurance operations may be shown on the worksheet on a combined or individual basis;

D. explanations of consolidated and eliminated entries shall be included; and

E. a reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

[13.2.5.19 NMAC – Rn, 13.2.5.18 NMAC, 10/01/2020]

13.2.5.20 SCOPE OF EXAMINATION AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT:

A. The superintendent will not accept any annual audited financial report prepared in whole or in part by any person or firm that is not recognized as a qualified ICPA.

B. The examination of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards.

C. The ICPA shall use such other procedures illustrated in the NAIC's financial condition examiner's handbook as the ICPA may deem necessary.

[13.2.5.20 NMAC - Rn & A, 13.2.5.19 NMAC, 10/01/2020]

13.2.5.21 REPORT OF ADVERSE FINANCIAL CONDITION:

A. An insurer shall require its ICPA to report, in writing, within five business days to the board of directors or its audit committee any determination by the ICPA that the insurer has materially misstated its financial condition as reported to the superintendent as of the balance sheet date currently under examination or that the insurer does not meet the minimum capital and surplus requirements of the New Mexico Insurance Code as of that date.

B. An insurer who has received a report of adverse financial condition shall forward a copy of the report to the superintendent within five business days of receiving it and shall furnish to the ICPA evidence that the report of adverse financial condition was forwarded to the superintendent.

C. If the ICPA fails to receive such evidence within the required five business day period, the independent certified public accountant shall furnish to the superintendent a copy of its report of adverse financial condition within the next five business days.

D. No ICPA shall be liable in any manner to any person for any statement made in connection with this section if such statement is made in good faith compliance with this section.

E. If the ICPA, subsequent to the date of the audited financial report filed pursuant to this rule, becomes aware of facts which might have affected that report, then the ICPA has the obligation to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the

[13.2.5.21 NMAC - Rn & A, 13.2.5.20 NMAC, 10/01/2020]

13.2.5.22 REPORT ON UNREMEDIATED MATERIAL WEAKNESSES IN INTERNAL CONTROLS:

A. Within 60 days after the filing of the annual audited financial statements, an insurer shall submit to the superintendent a written report prepared by the ICPA describing any unremediated material weaknesses in the insurer's internal control structure noted by the ICPA during the audit. SAS No. 112, Communication of Internal Control Structure Matters Noted in an Audit (AU Section 325A of the Professional Standards of the AICPA) requires an ICPA to communicate unremediated material weaknesses (known as "reportable conditions") noted during a financial statement audit to the appropriate persons within an entity. If no unremediated weakness were noted, the communication should so state.

B. An insurer shall provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if such actions are not described in the ICPA's communication.

C. No report on unremediated material weaknesses in internal controls should be issued if the ICPA does not identify unremediated material weaknesses.

[13.2.5.22 NMAC - Rn & A, 13.2.5.21 NMAC, 10/01/2020]

13.2.5.23 MANAGEMENT'S REPORT OF INTERNAL CONTROL OVER FINANCIAL REPORTING:

A. An insurer required to file an audited financial report pursuant to this rule that has annual direct written and assumed premiums, excluding premiums reinsured with the federal crop insurance corporation and federal flood program, of $500,000,000 or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in this rule. The report shall be submitted to the superintendent along with the communication of internal control related matters noted in an audit described in this rule. Management's report of internal control over financial reporting shall be as of December 31 immediately preceding.

B. Notwithstanding the premium threshold in this section the superintendent may require an insurer to submit management's report of internal control over financial reporting if the insurer is in any risk based capital level event, or if the insurer meets one or more of the standards of an insurer deemed to be in hazardous financial condition.

C. An insurer or a group of insurers that is: (1) directly subject to Section 404; (2) part of a holding company system whose parent is directly subject to Section 404; (3) not directly subject to Section 404, but is a SOX compliant entity; or (4) a member of a holding company system whose parent is not directly subject to Section 404, but is a SOX compliant entity; may file its or its parent's Section 404 report and an addendum in satisfaction of this requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements were included in the scope of the Section 404 report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements excluded from the Section 404 report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 report, the insurer or group of insurers may either file (i) a report required by this section, or (ii) the Section 404 report and a report required by this section for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 report.

D. Management's report of internal control over financial reporting shall include:

(1) a statement that management is responsible for establishing and maintaining adequate internal control over financial reporting:

(2) a statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) a statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;

(4) a statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding; management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting;

(6) a statement regarding the inherent limitations of internal control systems; and

(7) signatures of the chief executive officer and the chief financial officer (or the equivalent position or title).

E. Management shall document and make available upon financial condition examination the basis upon which its assertions, required inthis section, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

F. Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

G. Management's report on internal control over financial reporting, required by this section, and any documentation provided in support thereof during the course of a financial condition examination, will be kept confidential by the OSI in accordance with state law.

[13.2.5.23 NMAC - Rn & A, 13.2.5.22 NMAC, 10/01/2020]

13.2.5.24 INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT'S LETTER OF QUALIFICATIONS:

The ICPA shall furnish the insurer with a letter stating that:

A. that the ICPA is independent with respect to the insurer and conforms to the standards of the profession as contained in the *code of professional ethics* of AICPA and the code of ethics and rules of professional conduct of the New Mexico state board of public accountancy, or similar code;

B. the background and experience in general, and the experience in audits of insurers, of the staff assigned to the examination and whether each is an ICPA (however, nothing in this rule shall be construed as prohibiting the ICPA from utilizing such staff as is deemed appropriate if such use is consistent with generally accepted auditing standards);

C. the ICPA understands that the annual audited financial report and opinion shall be submitted in compliance with this rule and that the superintendent will rely on this information in the monitoring of the financial condition of insurers;

D. the ICPA consents to the requirements of this rule regarding ICPA workpapers and agrees to make them available for review by the superintendent, or the superintendent's designee or appointed agent;

E. the ICPA is properly licensed by an appropriate state licensing authority and is a member in good standing of the AICPA; and

F. the ICPA is in compliance with the requirements of this rule.

[13.2.5.24 NMAC - Rn & A, 13.2.5.23 NMAC, 10/01/2020]

13.2.5.25 INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT'S WORKPAPERS:

A. For purposes of this rule, workpapers are the records kept by the ICPA of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the ICPA's examination of the financial statements of an insurer. Workpapers may include, without limitation, audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the ICPA in the course of the ICPA's examination of the financial statements of an insurer and which support the ICPA's opinion.

B. An insurer required by this rule to submit an audited financial report~~,~~ shall require the ICPA to make available for review by OSI examiners and examiners designated by the superintendent all workpapers prepared during the course of the ICPA's examination and any communications related to the audit between the ICPA and the insurer, at the offices of the insurer, at the OSI or at any other reasonable place designated by the superintendent. The insurer shall require that the ICPA retain the audit workpapers and communications until the OSI has filed a final report of examination covering the period of the audit but no longer than seven years from the date of the audit report.

C. Reviews by OSI examiners shall be considered investigations, and all and communications obtained during the course of such investigations shall be afforded the same confidentiality as examination workpapers generated by the OSI. Photocopies of pertinent audit workpapers may be made and retained by the OSI.

[13.2.5.25 NMAC - Rn & A, 13.2.5.24 NMAC, 10/01/2020]

13.2.5.26 CONDUCT OF INSURER IN CONNECTION WITH THE PREPARATION OF REQUIRED REPORTS AND DOCUMENTS:

A. No director or officer of an insurer shall, directly or indirectly:

(1) make or cause to be made a materially false or misleading statement to an ICPA in connection with any audit, review or communication required under this rule; or

(2) omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this rule.

B. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this rule if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

C. For purposes of Subsection B of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1) to issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances due to material violations of statutory accounting principles prescribed by the superintendet, generally accepted auditing standards, or other professional or regulatory standards;

(2) not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) not to withdraw an issued report; or

(4) not to communicate matters to an insurer's audit committee.

[13.2.5.26 NMAC - Rn & A, 13.2.5.25 NMAC, 10/01/2020]

13.2.5.27 HARDSHIP EXEMPTIONS:

A. Upon written application of any insurer, the superintendent may grant an exemption from compliance with any and all provisions of this rule if the superintendent finds, upon review of the application, that compliance with this rule would constitute a financial or organizational hardship upon the insurer.

B. An exemption may be granted at any time and from time to time for a specified period or periods.

C. Within 10 days from a denial of an insurer's written request for an exemption from this rule, such insurer may request in writing a hearing on its application for an exemption. Such hearing shall be held in accordance with the New Mexico Insurance Code, Chapter 59A, Article 4, NMSA 1978.

[13.2.5.27 NMAC - Rn & A, 13.2.5.26 NMAC, 10/01/2020]

13.2.5.28 CANADIAN AND BRITISH COMPANIES:

A. As regards Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such

companies with their domiciliary supervisory authority, duly audited by an independent chartered accountant.

B. For such insurers, the letter of compliance required by 13.2.5.13 NMAC shall state that the accountant is aware of the requirements relating to the annual audited statement filed with the superintendent pursuant to this rule and shall affirm that the opinion expressed is in conformity with such requirements.

C. For purposes of compliance with this rule, a Canadian insurer may submit to OSI accountants' reports as filed with the Canadian office of superintendent of financial institutions.

[13.2.5.28 NMAC - Rn, 13.2.5.27 NMAC, 11/15/2012; A, 10/01/2020]

PART 6: ACTUARIAL OPINIONS AND MEMORANDUM

13.2.6.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[13.2.6.1 NMAC - Rp 13 NMAC 2.6.1, 10-1-03]

13.2.6.2 SCOPE:

A. This rule shall apply to all life insurance companies and fraternal benefit societies doing business in this State and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities or accident and health insurance business in this state. This rule shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the superintendent shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the superintendent's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

B. This rule shall be applicable to all annual statements filed with the office of the superintendent after the effective date of this rule. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with 13.2.6.9 NMAC, and a memorandum in support thereof in accordance with 13.2.6.10 NMAC, shall be required each year.

[13.2.6.2 NMAC - Rp 13 NMAC 2.6.2, 10-1-03]

13.2.6.3 STATUTORY AUTHORITY:

Section 59A-2-9 and 59A-8-7 NMSA 1978 .

[13.2.6.3 NMAC - Rp 13 NMAC 2.6.3, 10-1-03]

13.2.6.4 DURATION:

Permanent.

[13.2.6.4 NMAC - Rp 13 NMAC 2.6.4, 10-1-03]

13.2.6.5 EFFECTIVE DATE:

October 1, 2003, unless a later date is cited at the end of a section.

[13.2.6.5 NMAC - Rp 13 NMAC 2.6.5, 10-1-03]

13.2.6.6 OBJECTIVE:

The purpose of this rule is to prescribe:

A. Requirements for statements of actuarial opinion that are to be submitted in accordance with Section 59A-8-7 NMSA 1978, and for memoranda in support thereof;

B. Rules applicable to the appointment of an appointed actuary; and

C. Guidance as to the meaning of "adequacy of reserves."

[13.2.6.6 NMAC - Rp 13 NMAC 2.6.6, 10-1-03]

13.2.6.7 DEFINITIONS:

For the purpose of this rule:

A. "actuarial opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with 13.2.6.9 NMAC and with applicable actuarial standards of practice.

B. "actuarial standards board" means the board established by the American academy of actuaries to develop and promulgate standards of actuarial practice.

C. "annual statement" means that statement required by Section 59A-5-29 NMSA 1978 to be filed by the company with the office of the superintendent annually.

D. "appointed actuary" means an individual who is appointed or retained in accordance with the requirements set forth in Subsection C of 13.2.6.8 NMAC to provide the actuarial opinion and supporting memorandum as required by Section 59A-8-7 NMSA 1978.

E. "asset adequacy analysis" means an analysis that meets the standards and other requirements referred to in Subsection D of 13.2.6.8 NMAC .

F. "company" means a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this rule.

G. "qualified actuary" means an individual who meets the requirements set forth in Subsection B of 13.2.6.8 NMAC.

[13.2.6.7 NMAC - Rp 13 NMAC 2.6.7, 10-1-03]

13.2.6.8 GENERAL REQUIREMENTS:

A. Submission of Statement of Actuarial Opinion.

(1) There is to be included on or attached to Page 1 of the annual statement for each year beginning with the year in which this rule becomes effective the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with 13.2.6.9 NMAC.

(2) Upon written request by the company, the superintendent may grant an extension of the date for submission of the statement of actuarial opinion.

B. Qualified Actuary. A "qualified actuary" is an individual who:

(1) Is a member in good standing of the American academy of actuaries;

(2) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American academy of actuaries qualification standards for actuaries signing such statements;

(3) Is familiar with the valuation requirements applicable to life and health insurance companies;

(4) Has not been found by the superintendent (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:

(a) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as a qualified actuary;

(b) Been found guilty of fraudulent or dishonest practices;

(c) Demonstrated his or her incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(d) Submitted to the superintendent during the past five (5) years, pursuant to this rule, an actuarial opinion or memorandum that the superintendent rejected because it did not meet the provisions of this rule including standards set by the actuarial standards board; or

(e) Resigned or been removed as an actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(5) Has not failed to notify the superintendent of any action taken by any superintendent of any other state similar to that under Paragraph (4) above.

C. Appointed Actuary. An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by this rule, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The company shall give the superintendent timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements set forth in Subsection B of this section. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the superintendent timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in Subsection B of this section. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

D. Standards for Asset Adequacy Analysis. The asset adequacy analysis required by this rule:

(1) Shall conform to the standards of practice as promulgated from time to time by the actuarial standards board and on any additional standards under this rule, which standards are to form the basis of the statement of actuarial opinion in accordance with this rule; and

(2) Shall be based on methods of analysis as are deemed appropriate for such purposes by the actuarial standards board.

E. Liabilities to be Covered.

(1) Under authority of Section 59A-8-7 NMSA 1978, the statement of actuarial opinion shall apply to all in force business on the statement date, whether directly issued or assumed, regardless of when or where issued, e.g., reserves of exhibits 8, 9 and 10, and claim liabilities in exhibit 11, Part 1 and equivalent items in the separate account statement or statements.

(2) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in Sections 59A-8-5 and -6 NMSA 1978, the company shall establish the additional reserve.

(3) Additional reserves established under Paragraph (2) of this subsection and deemed not necessary in subsequent years may be released. Any amounts released shall be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

[13.2.6.8 NMAC - Rp 13 NMAC 2.6.8, 10-1-03]

13.2.6.9 STATEMENT OF ACTUARIAL OPINION BASED ON ASSET ADEQUACY ANALYSIS:

A. General Description. The statement of actuarial opinion submitted in accordance with this section shall consist of:

(1) A paragraph identifying the appointed actuary and his or her qualifications (see Paragraph (1) of Subsection B of this section);

(2) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, (see Paragraph (2) of Subsection B of this section) and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(3) A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions, (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see Paragraph (3) of Subsection B of this section), supported by a statement of each such expert in the form prescribed by Subsection E of this section; and

(4) An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Paragraph (6) of Subsection B of this section).

(5) One or more additional paragraphs will be needed in individual company cases as follows:

(a) If the appointed actuary considers it necessary to state a qualification of his or her opinion;

(b) If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

(c) If the appointed actuary must disclose whether additional reserves as of the prior opinion date are released as of this opinion date, and the extent of the release;

(d) If the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

B. Recommended Language. The following paragraphs are to be included in the statement of actuarial opinion in accordance with this section. Language is that which in typical circumstances should be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses his or her professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this section.

(1) The opening paragraph should generally indicate the appointed actuary's relationship to the company and his or her qualifications to sign the opinion. For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as: "I, [name], am [title] of [insurance company name] and a member of the American academy of actuaries. I was appointed by, or by the authority of, the board of directors of said insurer to render this opinion as stated in the letter to the superintendent dated [insert date]. I meet the academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies." For a consulting actuary, the opening paragraph should include a statement such as: "I, [name], a member of the American academy of actuaries , am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the board of directors of [name of company] to render this opinion as stated in the letter to the superintendent dated [insert date]. I meet the academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(2) The scope paragraph should include a statement such as: "I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20[ ]. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis." (See 13.2.6.11 NMAC.)

(3) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as: "I have relied on [name], [title] for [e.g., "anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios" or "certain critical aspects of the analysis performed in conjunction with forming my opinion"], as certified in the attached statement. I have reviewed the information relied upon for reasonableness." A statement of reliance on other experts should be accompanied by a statement by each of the experts in the form prescribed by Subsection E of this section.

(4) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as: "My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement."

(5) If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as: "In forming my opinion on [specify types of reserves] I relied upon data prepared by [name and title of company officer certifying in force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary." The section shall be accompanied by a statement by each person relied upon in the form prescribed by Subsection E of this section.

(6) The opinion paragraph should include a statement such as:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

(a) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

(b) Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

(c) Meet the requirements of the insurance law and regulation of the state of [state of domicile]; and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(d) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below); and

(e) Include provision for all actuarial reserves and related statement items which ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company. (At the discretion of the superintendent, this language may be omitted for an opinion filed on behalf of a company doing business only in this state and in no other state.)

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate standards of practice as promulgated by the actuarial standards board, which standards form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion.

or

The following material changes which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.) Choose one of the above two paragraphs, whichever is applicable.

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

_____

Signature of Appointed Actuary

_____

Address of Appointed Actuary

_____

Telephone Number of Appointed Actuary

_____

Date"

C. Assumptions for New Issues. The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this section.

D. Adverse Opinions. If the appointed actuary is unable to form an opinion, then he or she shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then he or she shall issue an adverse or qualified actuarial opinion explicitly stating the reasons for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

E. Reliance on Information Furnished by Other Persons. If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons the actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

F. Alternate Option.

(1) Section 59A-8-6 NMSA 1978 gives the superintendent broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of Subparagraph (c) of Paragraph (6) of Subsection B of this section, the superintendent may make one or more of the following additional approaches available to the opining actuary:

(a) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile." If the superintendent chooses to allow this alternative, a formal written list of standards and conditions shall be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year shall

apply to statements for that calendar year, and they shall remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

(b) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have verified that the company's request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the superintendent for approval of that request have been met." If the superintendent chooses to allow this alternative, a formal written statement of such allowance shall be issued no later than March 31 of the year it is first effective. It shall remain valid until rescinded or modified by the superintendent. The rescission or modifications shall be issued no later than March 31 of the year they are first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request shall be deemed approved on October 1 of that year if the superintendent has not denied the request by that date.

(c) A statement that the reserves "meet the requirements of the insurance laws and regulations of the state of [state of domicile] and I have submitted the required comparison as specified by this state." (i) If the superintendent chooses to allow this alternative, a formal written list of products (to be added to the table in Item (ii) below) for which the required comparison shall be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year shall apply to statements for that calendar year, and it shall remain in effect until it is revised or revoked. If no list is available, this alternative is not available. (ii) If a company desires to use this alternative, the appointed actuary shall provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under national association of insurance commissioners codification standards. Gross nationwide reserves are the total reserves calculated for the total company in force business directly sold and assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided shall be at least:

(1)	(2)	(3)	(4)	(5)
Product Type	Death Benefit or Account Value	Reserves Held	Codification Reserves	Codification Standard

(iii) The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative. (iv) If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary shall provide detailed disclosure of the specific method and assumptions used in determining the reserves held. (v) The comparison provided by the company is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(2) Notwithstanding the above, the superintendent may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within sixty (60) days of the request or such other period of time determined by the superintendent after consultation with the company, the superintendent may contract an independent actuary at the company's expense to prepare and file the opinion.

[13.2.6.9 NMAC - Rp 13 NMAC 2.6.14 and 13 NMAC 2.6.15, 10-1-03]

13.2.6.10 DESCRIPTION OF ACTUARIAL MEMORANDUM INCLUDING ASSET ADEQUACY ANALYSIS AND REGULATORY ASSET ADEQUACY ISSUES SUMMARY:

A. General.

(1) In accordance with Section 59A-8-7 NMSA 1978, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the superintendent upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the insurance department or subject to automatic filing with the superintendent.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Subsection B of 13.2.6.8 NMAC, with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the superintendent requests a memorandum and no such memorandum exists or if the superintendent finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this rule, the superintendent may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the superintendent.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the superintendent; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the superintendent and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the superintendent pursuant to the statute governing this rule. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this rule for any one of the current year or the preceding three (3) years.

(5) In accordance with Section 59A-8-7 NMSA 1978, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection C of this section. The regulatory asset adequacy issues summary will be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

B. Details of the Memorandum Section Documenting Asset Adequacy Analysis. When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Subsection D of 13.2.6.8 NMAC and any additional standards under this rule. It shall specify:

(1) for reserves:

(a) product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

(b) source of liability in force;

(c) reserve method and basis;

(d) investment reserves;

(e) reinsurance arrangements;

(f) identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;

(g) documentation of assumptions to test reserves for the following: (i) lapse rates (both base and excess); (ii) interest crediting rate strategy; (iii) mortality; (iv) policyholder dividend strategy; (v) competitor or market interest rate; (vi) annuitization rates; (vii) commissions and expenses; and (viii) morbidity. The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(2) for assets:

(a) portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

(b) investment and disinvestment assumptions;

(c) source of asset data;

(d) asset valuation bases; and

(e) documentation of assumptions made for: (i) default costs; (ii) bond call function; (iii) mortgage prepayment function; (iv) determining market value for assets sold due to disinvestment strategy; and (v) determining yield on assets acquired through the investment strategy; (vi) the documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(3) for the analysis basis:

(a) methodology;

(b) rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

(c) rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

(d) criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and

(e) whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis;

(4) summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

(5) summary of results; and

(6) conclusions.

C. Details of the Regulatory Asset Adequacy Issues Summary.

(1) The regulatory asset adequacy issues summary shall include:

(a) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values.

Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(b) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;

(c) The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

(d) Comments on any interim results that may be of significant concern to the appointed actuary;

(e) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested; and

(f) Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

(2) The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

D. Conformity to Standards of Practice. The memorandum shall include a statement: "Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate standards of practice as promulgated by the actuarial standards board, which standards form the basis for this memorandum."

E. Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve. An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

F. Documentation. The appointed actuary shall retain on file, for at least seven (7) years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

[13.2.6.10 NMAC - Rp 13 NMAC 2.6.16 , 10-1-03]

13.2.6.11 TABLE A:

Asset Adequacy Tested Amounts--Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1)+(2)+(3) (4)
Exhibit 8 A Life Insurance					
B Annuities					
C Supplementary Contracts Involving Life Contingencies					
D Accidental Death Benefit					
E Disability - Active					
F Disability - Disabled					
G Miscellaneous					
Total (Exhibit 8 Item 1, Page 3)					
Exhibit 9 A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 9 Item 2, Page 3)					
Exhibit 10					

Premium and Other Deposit Funds (Column 5, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Other (Column 6, Line 14)					
Supplemental Contracts and Annuities Certain (Column 3, Line 14)					
Dividend Accumulations or Refunds (Column 4, Line 14)					
Total Exhibit 10 (Column 1, Line 14)					
Exhibit 11 Part 1 1 Life (Page 3, Line 4.1)					
2 Health (Page 3, Line 4.2)					
Total Exhibit 11, Part 1					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1, 2, 3.1, 3.2, 3.3)					
TOTAL RESERVES					

IMR (General Account, Page ___ Line ___)	
(Separate Accounts, Page ___ Line ___)	
AVR (Page ___ Line ___)	(c)
Net Deferred and Uncollected Premium	

(a) The additional actuarial reserves are the reserves established under Paragraphs (2) of Subsection E of 13.2.6.8 NMAC.
(b) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in Subsection D of 13.2.6.8 NMAC, by means of symbols that should be defined in footnotes to the table.
(c) Allocated amount of Asset Valuation Reserve (AVR).

[13.2.6.11 NMAC - Rp 13 NMAC 2.6.22, 10-1-03]

PART 7: LIFE AND HEALTH REINSURANCE AGREEMENTS

13.2.7.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.2.7.2 SCOPE:

This rule applies to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers which are not subject to a substantially similar rule in their domiciliary state. This rule similarly applies to licensed property and casualty insurers with respect to their accident and health business. This rule does not apply to assumption reinsurance, yearly renewable term reinsurance or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance.

[1/1/94; Recompiled 11/30/01]

13.2.7.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[1/1/94; Recompiled 11/30/01]

13.2.7.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.2.7.5 EFFECTIVE DATE:

January 1, 1994 unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[1/1/94, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.2.7.6 OBJECTIVE:

The superintendent recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus. However, it is improper for a licensed insurer, in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, if all of the significant risks inherent in the business being reinsured are not transferred. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival. The objective of this rule is to prevent:

A. violation of Section 59A-16-8 NMSA 1978 relating to financial statements which do not properly reflect the financial condition of the ceding insurer;

B. violation of Sections 59A-7-11 and 59A-8-3 NMSA 1978 relating to reinsurance reserve credits, thus resulting in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded; and

C. creation of a situation that may be hazardous to policyholders and the people of this state as defined in Section 59A-41-24 NMSA 1978.

[1/1/94; Recompiled 11/30/01]

13.2.7.7 DEFINITIONS:

[RESERVED]

13.2.7.8 ACCOUNTING REQUIREMENTS FOR REINSURANCE CEDED:

No insurer subject to this rule shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the superintendent if, by the

terms of the reinsurance agreement, in substance or effect, any of the following conditions exists:

A. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the company at the time the business is reinsured.

B. The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets.

C. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty.

D. The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded.

E. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from gross premium less expenses realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer or to a reinsurer and a third party which are greater than the direct premiums collected by the ceding company.

F. The treaty does not transfer all of the significant risk inherent in the business being reinsured (Table A [now 13.2.7.14 NMAC] identifies the risks which are considered to be significant for a representative sampling of products or type of business; for products not specifically included in Table A [now 13.2.7.14 NMAC], the risks determined to be significant shall be consistent with this table.);

G. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the superintendent which legally segregates, by contract or contract provision, the underlying assets; however, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment or disintermediation risk may be held by the ceding company without segregation of such assets:

(1) health insurance - long term care/long term disability;

(2) traditional non-par permanent;

(3) traditional par permanent;

(4) adjustable premium permanent;

(5) indeterminate premium permanent;

(6) universal life fixed premium (no dump-in premiums allowed).

(a) The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2\,(I + CG)}{X + Y - I - CG}$$

(b) Where: I is the net investment income (Exhibit 2, Line 16, Column 7); CG is capital gains less capital losses (Exhibit 4, Line 10, Column 6); X is the current year cash and invested assets (Page 2, Line 10A, Column 1) plus investment income due and accrued (Page 2, Line 16, Column 1) less borrowed money (Page 3, Line 22, Column 1); Y is the same as X but for the prior year. (Note that line and exhibit references are for the 1992 annual statement. Be aware that annual statement references may change from year to year);

H. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety days of the settlement date.

I. The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

J. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured; or

K. the reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

[1/1/94; Recompiled 11/30/01]

13.2.7.9 EXCEPTION WITH SUPERINTENDENT APPROVAL:

Notwithstanding 13 NMAC 2.7.8 [now 13.2.7.8 NMAC], an insurer subject to this rule, may, with the prior approval of the superintendent, take such reserve credit or establish such asset as the superintendent deems consistent with the Insurance Code and department of insurance rules or regulations, including actuarial interpretations or standards deemed appropriate by the superintendent.

[1/1/94; Recompiled 11/30/01]

13.2.7.10 FILING REQUIREMENTS:

Agreements entered into after the effective date of this rule which involve the reinsurance of business issued prior to the effective date of the agreements, including any subsequent amendments, shall be filed by the ceding company with the superintendent within thirty days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this rule and any applicable actuarial standards of practice when determining the proper credit to be taken in financial statements filed with the superintendent. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this rule.

[1/1/94; Recompiled 11/30/01]

13.2.7.11 SURPLUS INCREASE REQUIREMENTS:

Any increase in surplus net of federal income tax resulting from arrangements described in 13 NMAC 2.7.10 [now 13.2.7.10 NMAC] shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the capital and surplus account, page 4 of the annual statement) and recognition of the surplus increase as income shall be reflected on a net-of-tax basis on the "reinsurance ceded" line, page 4 of the annual statement as earnings emerge from the business reinsured. [For example, on the last day of calendar year N, company XYZ

pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34 percent tax rate, the net increase in surplus at inception is $13.2 million ($20 million - $6.8 million) which is reported on the "aggregate write-ins for gains and losses in surplus" line in the capital and surplus account. $6.8 million (34 percent of $20 million) is reported as income on the "commissions and expense allowances on reinsurance ceded" line of the summary of operations. At the end of year N+1 the business has earned $4 million. ABC had paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million (66 percent of ($4 million - $1 million - $.5 million) up to a maximum of $13.2 million) on the "commissions and expense allowance on in reinsurance ceded" line of the summary of operations, and $1.65 million on the "aggregate write-ins for gains and losses in surplus" line of the capital and surplus account. The experience refund would be reported separately as a miscellaneous income item in the summary of operations.]

[1/1/94; Recompiled 11/30/01]

13.2.7.12 WRITTEN AGREEMENTS:

A. No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the superintendent, unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

B. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding ninety days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

C. The reinsurance agreement shall provide that:

(1) the agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

(2) any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties.

[1/1/94; Recompiled 11/30/01]

13.2.7.13 EXISTING AGREEMENTS:

Insurers subject to this rule shall reduce to zero by December 31, 1995 any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this rule which, under the provisions of this rule would not be entitled to recognition of the reserve credits or assets; provided, however, that the

reinsurance agreements shall have been in compliance with laws or rules in existence immediately preceding the effective date of this rule.

[1/1/94; Recompiled 11/30/01]

13.2.7.14 TABLE A -- RISK CATEGORIES:

A. Morbidity.

B. Mortality.

C. Lapse: This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

D. Credit Quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

E. Reinvestment (C2). This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

F. Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

+ = Significant 0 = Insignificant	RISK CATEGORY					
	A	B	C	D	E	F
Health insurance - other than LTC/LTD*	+	0	+	0	0	0
Health insurance - LTC/LTD*	+	0	+	+	+	0
Immediate annuities	0	+	0	+	+	0
Single premium deferred annuities	0	0	+	+	+	+
Flexible premium deferred annuities	0	0	+	+	+	+
Guaranteed interest contracts	0	0	0	+	+	+
Other annuity deposit business	0	0	+	+	+	+
Single premium whole life	0	+	+	+	+	+
Traditional non-par permanent	0	+	+	+	+	+
Traditional non-par term	0	+	+	0	0	0
Traditional par permanent	0	+	+	+	+	+
Traditional par term	0	+	+	0	0	0
Adjustable premium permanent	0	+	+	+	+	+

Indeterminate premium permanent	0	+	+	+	+	+
Universal life flexible premium	0	+	+	+	+	+
Universal life fixed premium	0	+	+	+	+	+
Universal life fixed premium - dump-in premiums allowed	0	+	+	+	+	+

* LTC = Long Term Care

LTD = Long Term Disability

[1/1/94; Recompiled 11/30/01]

PART 8: CREDIT FOR REINSURANCE

13.2.8.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance ("OSI").

[13.2.8.1 NMAC – Rp, 13.2.8.1, 7/1/2022]

13.2.8.2 SCOPE:

This rule applies to all domestic insurers.

[13.2.8.2 NMAC – Rp, 13.2.8.2, 7/1/2022]

13.2.8.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978 and the Credit for Reinsurance Act ("CFR Act"), Sections 59A-12E-1 to 59A-12E-18 NMSA 1978.

[13.2.8.3 NMAC – Rp, 13.2.8.3, 7/1/2022]

13.2.8.4 DURATION:

Permanent.

[13.2.8.4 NMAC – Rp, 13.2.8.4, 7/1/2022]

13.2.8.5 EFFECTIVE DATE:

July 1, 2022, unless a later date is cited at the end of a section.

[13.2.8.5 NMAC – Rp, 13.2.8.5, 7/1/2022]

13.2.8.6 OBJECTIVE:

The purpose of this rule is to implement the Credit for Reinsurance Act ("CFR Act"), Sections 59A-12E-1 to 59A-12E-18 NMSA 1978.

[13.2.8.6 NMAC – Rp, 13.2.8.6, 7/1/2022]

13.2.8.7 DEFINITIONS:

As used in this rule:

A. "Annual financial statement" means the statement required by Section 59A-5-29 NMSA 1978.

B. "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator except that, if a court of law appoints a successor in interest to a domestic insurer for whose benefit a letter of credit qualified under 13.2.8.24 NMAC has been established, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver.

C. "Commissioner" means the individual or regulatory agency in a jurisdiction other than New Mexico who has jurisdiction over banking, financial services, the business of insurance, or other relevant business.

D. "Form" means a form, including any applicable instructions, that is posted on the official OSI website or, if the form is generated by an agency or entity other than OSI, an official form to be obtained from such other agency or entity. Forms AR-1, CR-1, CR-F, CR-S and RJ-1 as referenced in this rule will be posted on the official OSI website.

E. "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

F. "Jurisdiction" means any state, district or territory of the U.S. and any lawful national government.

G. "Liabilities" means the assuming insurer's gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers excluding liabilities that are otherwise secured by acceptable means, and shall include:

(1) for business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance:

(a) losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;

(b) reserves for losses reported and outstanding;

(c) reserves for losses incurred but not reported;

(d) reserves for allocated loss expenses; and

(e) unearned premiums; or

(2) for business ceded by domestic insurers authorized to write life, health and annuity insurance:

(a) aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;

(b) aggregate reserves for accident and health policies;

(c) deposit funds and other liabilities without life or disability contingencies; and

(d) liabilities for policy and contract claims.

H. "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the SVO and that either:

(1) represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that:

(a) are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.A. Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and

(b) were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the secretary of housing and urban development pursuant to 12 U.S.C.A. Sections 1709 and 1715-b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the secretary of housing and urban development pursuant to 12 U.S.C.A. Section 1703; or

(2) is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable

projections of payments, or notes meeting the requirements of Subparagraph (1)(a) of this Subsection.

I. "NAIC" means the national association of insurance commissioners.

J. "Obligations" means:

(1) reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

(2) reserves for reinsured losses reported and outstanding;

(3) reserves for reinsured losses incurred but not reported; and

(4) reserves for allocated reinsured loss expenses and unearned premiums.

K. "OECD" means the organization for economic cooperation and development.

L. "Promissory note" when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument.

M. "Qualified U.S. financial institution" has the meaning given in Subsection E of Section 59A-12E-2 NMSA 1978.

N. "Reciprocal jurisdiction" means a jurisdiction, as designated by the superintendent pursuant to Subsection D of 13.2.8.16 NMAC, that meets one of the criteria set forth in Subsection B of 13.2.8.16 NMAC.

O. "Solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction.

P. "Substantially similar standards" means credit for reinsurance standards which the superintendent determines are equal to or exceed the standards of the Credit for Reinsurance Act and this rule.

Q. "Statutory financial statement" means quarterly, annual or other financial statements required by state law.

R. "SVO" means the securities valuation office of the NAIC.

S. "Superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

[13.2.8.7 NMAC – Rp, 13.2.8.7, 7/1/2022]

13.2.8.8 CREDIT FOR REINSURANCE - REINSURER LICENSED IN THIS STATE:

Pursuant to Paragraph (1) of Subsection D of Section 59A-12E-3 NMSA 1978, the superintendent will allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that was licensed in this state as of any date on which statutory financial statement credit for reinsurance is claimed.

[13.2.8.8 NMAC – Rp, 13.2.8.8, 7/1/2022]

13.2.8.9 CREDIT FOR REINSURANCE - ACCREDITED REINSURERS:

A. Pursuant to Paragraph (1) of Subsection D of Sections 59A-12E-3 and 59A-12E-5 NMSA 1978, the superintendent will allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is accredited as a reinsurer in this state as of the date on which statutory financial statement credit for reinsurance is claimed. An accredited reinsurer shall:

(1) File a properly executed Form AR-1 as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records;

(2) File with the superintendent a certified copy of a certificate of authority or other acceptable evidence that it is licensed to transact insurance or reinsurance in at least one state, or, in the case of a U.S. branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(3) File annually with the superintendent a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and

(4) Maintain a surplus as regards policyholders in an amount not less than $20,000,000, or obtain the affirmative approval of the superintendent upon a finding that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.

B. If the superintendent determines that the assuming insurer has failed to meet or maintain any of these qualifications, the superintendent may upon written notice and

opportunity for hearing, suspend or revoke the accreditation. Credit shall not be allowed a domestic ceding insurer under this section if the assuming insurer's accreditation has been revoked by the superintendent, or if the reinsurance was ceded while the assuming insurer's accreditation was under suspension by the superintendent.

[13.2.8.9 NMAC – Rp, 13.2.8.9, 7/1/2022]

13.2.8.10 CREDIT FOR REINSURANCE - REINSURER DOMICILED IN ANOTHER STATE:

A. Pursuant to Paragraph (2) of Subsection D of Section 59A-12E-3 NMSA 1978, the superintendent will allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that as of any date on which statutory financial statement credit for reinsurance is claimed:

(1) Is domiciled in (or, in the case of a U.S. branch of an alien assuming insurer, is entered through) a state that employs standards regarding credit for reinsurance substantially similar to those applicable under the Act and this rule;

(2) Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

(3) Files a properly executed Form AR-1 with the superintendent as evidence of its submission to this state's authority to examine its books and records.

B. The provisions of this Section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

[13.2.8.10 NMAC – Rp, 13.2.8.10, 7/1/2022]

13.2.8.11 CREDIT FOR REINSURANCE - REINSURERS MAINTAINING TRUST FUNDS:

A. Pursuant to Sections 59A-12E-3 and 59A-12E-4 NMSA 1978, the superintendent will allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified U.S. financial institution as defined in Subsection E of Section 59A-12-2 NMSA 1978, for the payment of the valid claims of its U.S. domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the superintendent substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the superintendent to determine the sufficiency of the trust fund.

B. The following requirements apply to the following categories of assuming insurer:

(1) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. domiciled insurers, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Paragraph (2) of this subsection.

(2) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the superintendent with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

(3) The trust fund for a group including incorporated and individual unincorporated underwriters shall consist of:

(a) for reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, funds in trust in an amount not less than the respective underwriters' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group;

(b) for reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this rule, funds in trust in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the U.S.; and

(c) In addition to these trusts, the group shall maintain a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account.

(4) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of rule and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the superintendent:

(a) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or

(b) if a certification is unavailable, a financial statement, prepared by independent public accountants, of each underwriter member of the group.

(5) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of $10,000,000,000 (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC) and which has continuously transacted an insurance business outside the U.S. for at least three years immediately prior to making application for accreditation, shall:

(a) consist of funds in trust in an amount not less than the assuming insurers' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group;

(b) maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group; and

(c) file a properly executed Form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination.

(6) Within 90 days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the superintendent an annual certification of each underwriter member's solvency by the member's domiciliary regulators, and financial statements, prepared by independent public accountants, of each underwriter member of the group.

C. Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the superintendent of the state where the trust is domiciled or the superintendent of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the superintendent of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that:

(1) contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the U.S.;

(2) legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's U.S. ceding insurers, their assigns and successors in interest;

(3) the trust shall be subject to examination as determined by the superintendent;

(4) the trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust; and

(5) no later than February 28 of each year the trustee of the trust shall report to the superintendent in writing setting forth the balance in the trust and listing the trust's investments at the preceding year-end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.

D. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this subsection or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the superintendent with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the superintendent with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.

(1) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.

(2) If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the superintendent with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.

(3) The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

[13.2.8.11 NMAC – Rp, 13.2.8.11, 7/1/2022]

13.2.8.12 INVESTMENT OF TRUST ASSETS:

A. Assets deposited in trusts established pursuant to Subsections A and B of Section 59A-12E-3 NMSA 1978 and this Section shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a qualified U.S. financial institution as defined in Paragraph (1) of Subsection E of Section 59A-12E-2 NMSA 1978, clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by such qualified U.S. financial institution, and investments of the type specified in this subsection, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent of total investments. No

more than twenty percent of the total of the investments in the trust may be foreign investments authorized under Subparagraph (e) of Paragraphs (1) or (3) of this subsection or the equity interest requirements of Subsection B or Subsection D of 13.2.8.12 NMAC, and no more than ten percent of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of Subsections A and B of Section 59A-12E-3 NMSA 1978 shall be invested only as follows:

(1) Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by:

(a) the U.S. or by any agency or instrumentality of the U.S.;

(b) a state of the U.S.;

(c) a territory, possession or other governmental unit of the U.S.;

(d) an agency or instrumentality of a governmental unit referred to in Subparagraphs (b) and (c) of this paragraph if the obligations shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements; or

(e) the government of any other country that is a member of the organization for economic cooperation and development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the securities valuation office of the NAIC.

(2) Obligations that are issued in the U.S., or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:

(a) are rated A or higher (or the equivalent) by a securities rating agency recognized by the securities valuation office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;

(b) are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure

obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or

(c) have been designated as class one or class two by the securities valuation office of the NAIC;

(3) Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the organization for economic cooperation and development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the securities valuation office of the NAIC.

(4) An investment made pursuant to the provisions of Paragraph (1), (2) or (3) of this subsection shall be subject to the following additional limitations:

(a) an investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent of the assets of the trust;

(b) an investment in any one mortgage-related security shall not exceed five percent of the assets of the trust;

(c) the aggregate total investment in mortgage-related securities shall not exceed twenty- five percent of the assets of the trust; and

(d) preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under Paragraphs (2)(a) and (2)(c) of this subsection but shall not exceed two percent of the assets of the trust.

B. Equity Interests. Investments in common shares or partnership interests of a solvent U.S. institution are permissible if:

(1) its obligations and preferred shares, if any, are eligible as investments under this Subsection; and

(2) the equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. §§ 78a to 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the financial industry regulatory authority, or successor organization. A trust shall not invest in equity interests under this paragraph an amount exceeding one percent of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company.

C. Investments in common shares of a solvent institution organized under the laws of a country that is a member of the organization for economic cooperation and development are permissible, if:

(1) All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and

(2) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the organization for economic cooperation and development.

D. An investment in or loan upon any one institution's outstanding equity interests shall not exceed one percent of the assets of the trust. The cost of an investment in equity interests made pursuant to this paragraph, when added to the aggregate cost of other investments in equity interests then held pursuant to this paragraph, shall not exceed ten percent of the assets in the trust.

E. Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the securities valuation office of the NAIC.

F. Investment companies.

(1) Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U.S.C. § 80a, are permissible investments if the investment company:

(a) invests at least ninety percent of its assets in the types of securities that qualify as an investment under Paragraphs (1) through (3) of Subsection D of 13.2.8.11 NMAC or invests in securities that are determined by the superintendent to be substantively similar to the types of securities set forth in Paragraphs (1) through (3) of Subsection D of 13.2.8.11 NMAC; or

(b) invests at least ninety percent of its assets in the types of equity interests that qualify as an investment under Subsection (A) of this section.

(2) Investments made by a trust in investment companies under this rule subsection shall not exceed the following limitations:

(a) an investment in an investment company qualifying under Subparagraph (1)(a) of this section shall not exceed ten percent of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed twenty-five percent of the assets in the trust; and

(b) an investment in an investment company qualifying under Subparagraph (1)(b) of this section shall not exceed five percent of the assets in the trust and the

aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to Subsection A of this section.

G. Letters of credit.

(1) In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the superintendent), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(2) The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

H. A specific security provided to a ceding insurer by an assuming insurer pursuant to 13.2.8.18 NMAC shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this Section.

[13.2.8.12 NMAC – N, 7/1/2022]

13.2.8.13 CREDIT FOR REINSURANCE – CERTIFIED REINSURERS:

A. Pursuant to Sections 59A-12E-7 through 59A-12E-9 NMSA 1978, the superintendent will allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this Section or 13.2.8.14 NMAC. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the superintendent. The security shall be in a form consistent with the provisions of Sections 59A-12E-7 through 59A-12E-9 and Section 59A-12E-16 NMSA 1978 and 13.2.8.19 through 13.2.8.26 NMAC. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

Ratings Security	Required
Secure – 1	0%
Secure – 2	10%
Secure – 3	20%
Secure – 4	50%
Secure – 5	75%
Vulnerable – 6	100%

B. Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.

C. The superintendent will require the certified reinsurer to post one hundred percent, for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer.

D. In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the superintendent. The one-year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:

(1) Line 1: Fire;

(2) Line 2: Allied lines;

(3) Line 3: Farmowners multiple peril

(4) Line 4: Homeowners multiple peril;

(5) Line 5: Commercial multiple peril;

(6) Line 9: Inland marine;

(7) Line 12: Earthquake; and

(8) Line 21: Auto physical damage.

E. Credit for reinsurance under this section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

F. Nothing in this section shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this Section.

[13.2.8.13 NMAC – Rp, 13.2.8.12, 7/1/2022]

13.2.8.14 CERTIFICATION PROCEDURE:

A. The superintendent will post notice on the OSI website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The superintendent will not take final action on the application until at least 30 days after posting the notice required by this paragraph.

B. The superintendent will issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with 13.2.8.13 NMAC. The superintendent will publish a list of all certified reinsurers and their ratings.

C. In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(1) the assuming insurer shall be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction, as determined by the superintendent pursuant to 13.2.8.15 NMAC;

(2) the assuming insurer shall maintain capital and surplus, or its equivalent, of no less than $250,000,000 calculated in accordance with Subsection E, Paragraph (8) of this section. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000;

(3) the assuming insurer shall maintain financial strength ratings from two or more rating agencies deemed acceptable by the superintendent. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the superintendent in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:

(a) Standard & Poor's;

(b) Moody's investors service;

(c) Fitch ratings;

(d) A.M. Best company; or

(e) Any other nationally recognized statistical rating organization.

D. The certified reinsurer shall comply with any other requirements reasonably imposed by the superintendent.

E. Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

(1) The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The superintendent will use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification:

Ratings	Best	S&P	Moody's	Fitch
Secure – 1	A++	AAA	Aaa	AAA
Secure – 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure – 3	A	A+, A	A1, A2	A+, A
Secure – 4	A-	A-	A3	A-
Secure – 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable – 6	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

(2) the business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

(3) for certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);

(4) for certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (for property/casualty reinsurers) or Form CR-S (for life and health reinsurers);

(5) the reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than 90 days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

(6) regulatory actions against the certified reinsurer;

(7) the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in Paragraph (8) below;

(8) for certified reinsurers not domiciled in the U.S., audited financial statements, regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the superintendent will consider audited financial statements for the last two years filed with its non-U.S. jurisdiction supervisor;

(9) the liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding;

(10) a certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The superintendent shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and

(11) Any other information deemed relevant by the superintendent.

F. Based on the analysis conducted under Paragraph (5) of Subsection E of 13.2.8.14 NMAC of a certified reinsurer's reputation for prompt payment of claims, the superintendent may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the superintendent will, at a minimum, increase the security the certified reinsurer is required to post by one rating level under Paragraph (1) of Subsection E of 13.2.8.14 NMAC if the superintendent finds that:

(1) more than fifteen percent of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of 90 days or more which are not in dispute and which exceed $100,000 for each cedent; or

(2) the aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by 90 days or more exceeds $50,000,000.

G. The assuming insurer shall submit a properly executed Form CR-1 as evidence of its submission to the jurisdiction of this state, appointment of the superintendent as an agent for service of process in this state, and agreement to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The superintendent shall not certify any assuming insurer that is domiciled in a jurisdiction that the superintendent has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

H. The certified reinsurer shall agree to meet applicable information filing requirements as determined by the superintendent, both with respect to an initial application for certification and on an ongoing basis. All information submitted by

certified reinsurers which are not otherwise public information subject to disclosure shall be exempted from disclosure under the Inspection of Public Records Act, Chapter 14, Article 4 NMSA 1978, and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:

(1) notification within 10 days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefor; annually, Form CR-F or CR-S, as applicable;

(2) annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in Paragraph (3) below;

(3) annually, the most recent audited financial statements, regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last two years filed with the certified reinsurer's supervisor;

(4) at least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;

(5) a certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and

(6) Any other information that the superintendent may reasonably require.

I. Change in rating or revocation of certification. In the case of a downgrade by a rating agency or other disqualifying circumstance, the superintendent shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of Paragraph (1) of Subsection E of 13.2.8.14 NMAC.

(1) The superintendent shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the superintendent to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.

(2) If the rating of a certified reinsurer is upgraded by the superintendent, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the superintendent shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the superintendent, the superintendent shall require the certified

reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

(3) Upon revocation of the certification of a certified reinsurer by the superintendent, the assuming insurer shall be required to post security in accordance with 13.2.8.18 NMAC in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with 13.2.8.11 and 13.2.8.12 NMAC, the superintendent may allow additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the superintendent to be at high risk of uncollectibility.

[13.2.8.14 NMAC – Rp, 13.2.8.14, 7/1/2022]

13.2.8.15 QUALIFIED JURISDICTIONS:

If, upon conducting an evaluation under this section with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the superintendent determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the superintendent will publish notice and evidence of such recognition in an appropriate manner. The superintendent may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.

A. In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the superintendent will evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The superintendent will determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the superintendent as eligible for certification. A qualified jurisdiction shall agree to share information and cooperate with the superintendent with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the superintendent, include but are not limited to the following:

(1) the framework under which the assuming insurer is regulated;

(2) the structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance;

(3) the substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction;

(4) the form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used;

(5) the domiciliary regulator's willingness to cooperate with U.S. regulators in general and the superintendent in particular;

(6) the history of performance by assuming insurers in the domiciliary jurisdiction;

(7) any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the superintendent has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards;

(8) any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the international association of insurance supervisors or successor organization; and

(9) any other matters deemed relevant by the superintendent.

B. A list of qualified jurisdictions shall be published through the NAIC committee process. The superintendent will consider this list in determining qualified jurisdictions. If the superintendent approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the superintendent will provide thoroughly documented justification with respect to the criteria provided under Paragraphs (1) to (9) of this subsection.

C. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

D. Recognition of certification issued by an NAIC accredited jurisdiction.

(1) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the superintendent has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR- 1 and such additional information as the superintendent requires. The assuming insurer shall be considered to be a certified reinsurer in this state.

(2) Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in this state as of the date it takes effect in the other

jurisdiction. The certified reinsurer shall notify the superintendent of any change in its status or rating within 10 days after receiving notice of the change.

(3) The superintendent may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with Subsection I of 13.2.8.14 NMAC.

(4) The superintendent may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the superintendent suspends or revokes the certified reinsurer's certification in accordance with Subsection I of 13.2.8.14 NMAC, the certified reinsurer's certification shall remain in good standing in this state for a period of three months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in this state.

E. Mandatory funding clause. In addition to the clauses required under 13.2.8.27 NMAC, reinsurance contracts entered into or renewed under this section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer.

F. The superintendent will comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

[13.2.8.15 NMAC – Rp, 13.2.8.15, 7/1/2022]

13.2.8.16 CREDIT FOR REINSURANCE—RECIPROCAL JURISDICTIONS:

A. In accordance with Sections 59A-12E-10 through 59A-12E-12 and Subsections (A) through (D) of Section 59A-12E-13 NMSA 1978, the superintendent will allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a reciprocal Jurisdiction, and that meets the other requirements of this rule.

B. A reciprocal jurisdiction shall be one of the following:

(1) a non-U.S. jurisdiction that is subject to an in-force covered agreement with the U.S., each within its legal authority, or, in the case of a covered agreement between the U.S. and the European Union, is a member state of the European Union. For purposes of this Subsection, a "covered agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as

a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(2) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(3) a qualified jurisdiction, as determined by the superintendent pursuant to Section 59A-12E-8 and Subsection A of Section 59A-12E-9 NMSA 1978 and Subsections A and B of 13.2.8.15 NMAC, and Paragraph (1) of Subsection C of 13.2.8.15 NMAC which is not otherwise described in Paragraph (1) or (2) of this Subsection and which the superintendent determines meets all of the following additional requirements:

(a) provides that an insurer which has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction;

(b) does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to rule by the non-U.S. jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

(c) recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the superintendent of this state or the superintendent of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction; provided, that nothing in this subparagraph shall enhance or limit the authority of the superintendent with respect to the group-wide supervision of insurance holding company systems pursuant to the Insurance Holding Company Law, Chapter 59A, Article 37 NMSA 1978, the rules implementing that law, Title 13, Ch. 2, Part 2 NMAC, Insurance Holding Companies, or other applicable state law; and

(d) provides written confirmation by a competent regulatory authority in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the superintendent in accordance with a memorandum of understanding or similar document between the superintendent and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

C. Credit shall be allowed when the reinsurance is ceded from an insurer domiciled in this state to an assuming insurer meeting each of the following conditions:

(1) the assuming insurer shall be licensed to transact reinsurance by, and have its head office or be domiciled in, a reciprocal jurisdiction;

(2) the assuming insurer shall have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, and confirmed as set forth in Paragraph (10) of this subsection, according to the methodology of its domiciliary jurisdiction, in the following amounts:

(a) no less than $250,000,000; or

(b) if the assuming insurer is an association, including incorporated and individual unincorporated underwriters:

(i) minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000; and

(ii) a central fund containing a balance of the equivalent of at least $250,000,000;

(c) the assuming insurer shall have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows:

(i) if the assuming insurer has its head office or is domiciled in a Reciprocal Jurisdiction as defined in Paragraph (1) of Subsection B of 13.2.8.16 NMAC, the ratio specified in the applicable covered agreement;

(ii) if the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in Paragraph (2) of Subsection B of 13.2.8.16 NMAC, a risk-based capital (RBC) ratio of three hundred percent of the authorized control level, calculated in accordance with the formula developed by the NAIC; or

(iii) if the assuming insurer is domiciled in a reciprocal jurisdiction as defined in Paragraph (3) of Subsection B of 13.2.8.16 NMAC, after consultation with the Reciprocal Jurisdiction and considering any recommendations published through the NAIC committee process, such solvency or capital ratio as the superintendent determines to be an effective measure of solvency.

(3) The assuming insurer shall agree to and provide adequate assurance, in the form of a properly executed Form RJ-1, of its agreement to the following:

(a) the assuming insurer shall agree to provide prompt written notice and explanation to the superintendent if it falls below the minimum requirements set forth in

Paragraph (2) of this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law; and

(b) the assuming insurer shall consent in writing to the jurisdiction of the courts of this state and to the appointment of the superintendent as agent for service of process.

(i) The superintendent may also require that such consent be provided and included in each reinsurance agreement under the superintendent's jurisdiction.

(ii) Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

(4) The assuming insurer shall consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

(5) Each reinsurance agreement shall include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable.

(6) The assuming insurer shall confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state's ceding insurers, and agrees to notify the ceding insurer and the superintendent and to provide one hundred percent security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of Sections 59A-12E-7 through 59A-12E-9 and Section 59A-12E-16 NMSA 1978 and 13.2.8.19 through 13.2.8.26 NMAC.

(7) The assuming insurer shall agree in writing to meet the applicable information filing requirements as set forth in Paragraph (8) of this subsection.

(8) The assuming insurer or its legal successor shall provide, if requested by the superintendent, on behalf of itself and any legal predecessors, the following documentation to the superintendent:

(a) for the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;

(b) for the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor;

(c) prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the U.S.; and

(d) prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in Paragraph (9) of this subsection.

(9) The assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:

(a) more than fifteen percent of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the superintendent;

(b) more than fifteen percent of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a covered agreement; or

(c) the aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a covered agreement.

(10) The assuming insurer's supervisory authority shall confirm to the superintendent on an annual basis that the assuming insurer complies with the requirements set forth in Paragraph (2) of this Subsection.

(11) Nothing in this provision precludes an assuming insurer from providing the superintendent with information on a voluntary basis.

D. The superintendent will timely create and publish a list of reciprocal jurisdictions.

E. A list of reciprocal jurisdictions is published through the NAIC Committee Process. The superintendent's list shall include any Reciprocal Jurisdiction as defined in Paragraphs (1) and (2) of Subsection B of 13.2.8.16 NMAC, and shall consider any other reciprocal jurisdiction included on the NAIC list. The superintendent may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions as provided

by applicable law, rule, or in accordance with criteria published through the NAIC Committee Process.

F. The superintendent may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a reciprocal jurisdiction, as provided by applicable law, rule, or in accordance with a process published through the NAIC Committee Process, except that the superintendent shall not remove from the list a reciprocal jurisdiction that meets the criteria of Paragraph (1) or Paragraph (2) of Subsection B of 13.2.8.16 NMAC. Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed if otherwise allowed pursuant to the CFR Act and this rule.

G. The superintendent will timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit in accordance with this section.

H. If an NAIC accredited jurisdiction has determined that the conditions set forth in Subsection C of this section have been met, the superintendent has the discretion to defer to that jurisdiction's determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subsection. The superintendent may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.

I. When requesting that the superintendent defer to another NAIC accredited jurisdiction's determination, an assuming insurer shall submit a properly executed Form RJ-1 and additional information as the superintendent may require. A state that has received such a request will notify other states through the NAIC Committee Process and provide relevant information with respect to the determination of eligibility.

J. If the superintendent determines that an assuming insurer no longer meets one or more of the requirements under this section, the superintendent may revoke or suspend the eligibility of the assuming insurer for recognition under this section, and:

(1) while an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with 13.2.8.18 NMAC; and

(2) if an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the superintendent and consistent with the provisions of 13.2.8.18 NMAC.

K. Before denying statement credit or imposing a requirement to post security with respect to Subsection J of this Section or adopting any similar requirement that will have substantially the same regulatory impact as security, the superintendent will:

(1) communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in Subsection C of this Section;

(2) provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;

(3) after the expiration of 90 days or less, as set out in Paragraph (2) above, if the superintendent determines that no or insufficient action was taken by the assuming insurer, the superintendent may impose any of the requirements as set out in this subsection; and

(4) provide a written explanation to the assuming insurer of any of the requirements set out in this subsection.

L. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities.

M. Nothing in this section shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

N. Nothing in this section shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

[13.2.8.16 NMAC– Rp, 13.2.8.16, 7/1/2022]

13.2.8.17 CREDIT FOR REINSURANCE REQUIRED BY LAW:

Subsection E of Section 59A-12E-13 NMSA, the superintendent will allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Sections 59A-12E-3 through 59A-12E-13 NMSA 1978, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or rule of that jurisdiction.

[13.2.8.17 NMAC – Rp, 13.2.8.13, 7/1/2022]

13.2.8.18 ASSET OR REDUCTION FROM LIABILITY FOR REINSURANCE CEDED TO AN UNAUTHORIZED ASSUMING INSURER NOT MEETING THE REQUIREMENTS OF SECTIONS 13.2.8.8 THROUGH 13.2.8.17 NMAC:

A. Pursuant to Section 59A-12E-6 NMSA 1978, the superintendent will allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Sections 59A-12E-3 through 59A-12E-15 NMSA 1978 in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the reinsurance contract. The security shall be held in the U.S. subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified U.S. financial institution as defined in Paragraph (2) of Subsection E of Section 59A-12E-2 NMSA 1978. This security may be in the form of any of the following:

(1) cash;

(2) securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(3) clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. institution, as defined in Paragraph (1) of Subsection E of Section 59A-12E-2 NMSA 1978, effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(4) any other form of security acceptable to the superintendent.

B. An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to this section shall be allowed only when the requirements of 13.2.8.27 NMAC and the applicable portions of 13.2.8.19 through 13.2.8.26 NMAC have been satisfied.

[13.2.8.18 NMAC – Rp, 13.2.8.14, 7/1/2022]

13.2.8.19 REQUIRED CONDITIONS FOR TRUST AGREEMENTS QUALIFIED UNDER SECTION 18 OF 13.2.8 NMAC:

A. The trust agreement shall be entered into between the beneficiary, the grantor and a trustee, which shall be a qualified U.S. financial institution as defined in Paragraph (2) of Subsection E of Section 59A-12E-2 NMSA 1978.

B. The trust agreement shall create a trust account into which assets shall be deposited.

C. All assets in the trust account shall be held by the trustee at the trustee's office in the U.S.

D. The trust agreement shall provide that:

(1) the beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

(2) no other statement or document is required to be presented to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

(3) it is not subject to any conditions or qualifications outside of the trust agreement; and

(4) it shall not contain references to any other agreements or documents except as provided for in Subsections J and K of this section.

E. The trust agreement shall be established for the sole benefit of the beneficiary.

F. The trust agreement shall require the trustee to:

(1) receive assets and hold all assets in a safe place;

(2) determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

(3) furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

(4) notify the grantor and the beneficiary within 10 days of any deposits to or withdrawals from the trust account;

(5) upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the

assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

(6) allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

G. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

H. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is domiciled.

I. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying commission to, or reimbursing the expenses of, the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the superintendent), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

J. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence or willful misconduct.

K. Notwithstanding other provisions of this rule, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

(1) to pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

(2) to make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

(3) where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution as defined in Paragraph (2) of Subsection E of Section 59A-12E-2 NMSA 1978 apart from its general assets, in trust for such uses and purposes specified in Paragraphs (1) and (2) above, as may remain executory after such withdrawal and for any period after the termination date.

L. Notwithstanding other provisions of this rule, when a trust agreement is established to meet the requirements of Section 18 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

(1) To pay or reimburse the ceding insurer for:

(a) the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and

(b) the assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement;

(2) to pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; or

(3) Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for the uses and purposes specified in Subparagraphs (a) and (b) of Paragraph (1) above as may remain executory after withdrawal and for any period after the termination date.

M. Either the reinsurance agreement or the trust agreement shall stipulate that assets deposited in the trust account shall be valued according to their current fair

market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. bank and payable in U.S. dollars, and investments permitted by the Insurance Code or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities or accident and health risks, then the provisions required by this paragraph shall be included in the reinsurance agreement.

[13.2.8.19 NMAC – Rp, 13.2.8.15, 7/1/2022]

13.2.8.20 PERMITTED CONDITIONS FOR TRUST AGREEMENTS QUALIFIED UNDER SECTION 18 OF 13.2.8 NMAC:

A. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after the trustee and the beneficiary receive the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

B. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time-to-time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

C. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions that the trustee determines are at least equal in current fair market value to the assets withdrawn and that are consistent with the restrictions in Paragraph (2) of Subsection A of 13.2.8.21 NMAC.

D. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

E. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

[13.2.8.20 NMAC – Rp, 13.2.8.16, 7/1/2022]

13.2.8.21 ADDITIONAL CONDITIONS APPLICABLE TO REINSURANCE AGREEMENTS FOR TRUST AGREEMENTS QUALIFIED UNDER SECTION 18 OF 13.2.8 NMAC:

A. A reinsurance agreement may contain provisions that:

(1) require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

(2) require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

(3) require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

(4) stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(a) to pay or reimburse the ceding insurer for:

(i) the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(ii) the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement; and

(iii) any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;

(b) to make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

B. The reinsurance agreement also may contain provisions that:

(1) give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

(a) the assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(b) after withdrawal and transfer, the current fair market value of the trust account is no less than one hundred-two percent of the required amount.

(2) provide for the return of any amount withdrawn in excess of the actual amounts required for Paragraph 4 of Subsection A of this section, and for interest payments at a rate not in excess of the prime rate of interest on such amounts;

(3) permit the award by any arbitration panel or court of competent jurisdiction of:

(a) interest at a rate different from that provided in Paragraph (2) of this subsection;

(b) court or arbitration costs;

(c) attorney's fees; and

(d) any other reasonable expenses.

[13.2.8.21 NMAC – Rp, 13.2.8.17, 7/1/2022]

13.2.8.22 FINANCIAL REPORTING APPLICABLE TO REINSURANCE AGREEMENTS FOR TRUST AGREEMENTS QUALIFIED UNDER SECTION 18 OF 13.28.8 NMAC:

A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of this rule when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market

value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

[13.2.8.22 NMAC – Rp, 13.2.8.19, 7/1/2022]

13.2.8.23 FAILURE TO IDENTIFY BENEFICIARY APPLICABLE TO REINSURANCE AGREEMENTS FOR TRUST AGREEMENTS QUALIFIED UNDER SECTION 18 OF 13.2.8 NMAC:

The failure of any trust agreement to specifically identify the beneficiary as defined in Paragraph B of 13.2.8.7 NMAC shall not be construed to affect any actions or rights that the superintendent may take or possess pursuant to the provisions of the laws of this state.

[13.2.8.23 NMAC – Rp, 13.2.8.21, 7/11/2022]

13.2.8.24 LETTERS OF CREDIT APPLICABLE TO REINSURANCE AGREEMENTS FOR TRUST AGREEMENTS QUALIFIED UNDER SECTION 18 OF 13.2.8 NMAC:

A. The letter of credit shall be clean, irrevocable, unconditional and issued or confirmed by a qualified U.S. financial institution as defined in Paragraph (1) of Subsection E of Section 59A-12E-2 NMSA 1978. The letter of credit shall contain an issue date and expiration date and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit also shall indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in Subsection A of 13.2.8.27 NMAC.

B. The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

C. The letter of credit shall contain a statement to the effect that the obligation of the qualified U.S. financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

D. The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for a period of no less than 30 days' notice prior to expiration date or nonrenewal.

E. The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, and all drafts drawn thereunder shall be presentable at an office in the U.S. of a qualified U.S. financial institution.

F. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, then the letter of credit shall specifically address and provide for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of Publication 600 or any other successor publication, occur.

G. If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified U.S. financial institution as described in Subsection A of this section, then the following additional requirements shall be met:

(1) the issuing financial institution shall formally designate the confirming qualified U.S. financial institution as its agent for the receipt and payment of the drafts; and

(2) the "evergreen clause" shall provide for 30 days' notice prior to expiration date for nonrenewal.

[13.2.8.24 NMAC – Rp, 13.2.8.22, 7/1/2022]

13.2.8.25 REINSURANCE AGREEMENT PROVISIONS FOR LETTERS OF CREDIT QUALIFIED UNDER SECTION 18 OF 13.2.8 NMAC:

A. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:

(1) require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;

(2) stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(a) to pay or reimburse the ceding insurer for:

(i) the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

(ii) the assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and

(b) any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(3) All of the provisions of this subsection shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

B. Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the reinsurance agreement remain unliquidated and undischarged 10 days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in Subparagraph (a) of Paragraph (2) of Subsection A of 13.2.8.25 NMAC as may remain after withdrawal and for any period after the termination date.

C. Nothing contained in Subsection A of this section shall preclude the ceding insurer and assuming insurer from providing for:

(1) an interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to Paragraph (2) of Subsection A of this section; or

(2) the return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

[13.2.8.25 NMAC – Rp, 13.2.8.23, 7/1/2022]

13.2.8.26 OTHER SECURITY:

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the U.S. subject to withdrawal solely by the ceding insurer and under its exclusive control.

[13.2.8.26 NMAC – Rp, 13.2.8.24, 7/1/2022]

13.2.8.27 REINSURANCE CONTRACT:

Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of Sections (8) through (16), or Section (18) of this rule or otherwise in compliance with Sections 59A-12E-3 through 59A-12E-15 NMSA 1978 after the adoption of this rule unless the reinsurance agreement:

A. includes a proper insolvency clause, which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to Chapter 59A, Article 41 of the Insurance Code.

B. includes a provision pursuant to Sections 59A-12E-3 through 59A-12E-15 NMSA 1978 whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the U.S., has agreed to comply with all requirements necessary to give the court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of the court or panel; and

C. Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.

[13.2.8.27 NMAC – Rp, 13.2.8.25, 7/1/2022]

13.2.8.28 SEVERABILITY:

If any provision of this rule, or the application of the provision to any person or circumstance, is held invalid, the remainder of the rule, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

[13.2.8.28 NMAC - Rp, 13.2.8.27, 7/1/2022]

PART 9: PROPERTY AND CASUALTY ACTUARIAL OPINIONS

13.2.9.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance ("OSI").

[13.2.9.1 NMAC - N, 07/30/2010, A, 7/1/2022]

13.2.9.2 SCOPE:

This rule applies to property and casualty insurance companies conducting business in New Mexico.

[13.2.9.2 NMAC - N, 07/30/2010]

13.2.9.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-5-29 NMSA 1978.

[13.2.9.3 NMAC - N, 07/30/2010]

13.2.9.4 DURATION:

Permanent.

[13.2.9.4 NMAC - N, 07/30/2010]

13.2.9.5 EFFECTIVE DATE:

July 30, 2010 unless a later date is cited at the end of a section.

[13.2.9.5 NMAC - N, 07/30/2010]

13.2.9.6 OBJECTIVE:

The purpose of this rule is to require the annual filing of a statement of actuarial opinion by the appointed actuary of each property and casualty insurance company doing business in New Mexico, and the annual filing of an actuarial opinion summary by the appointed actuary of each property and casualty insurance company domiciled in New Mexico.

[13.2.9.6 NMAC - N, 07/30/2010]

13.2.9.7 DEFINITIONS:

For the purpose of this rule:

A. "actuarial board for counseling and discipline" means the board established by the American academy of actuaries and related U.S. actuarial organizations to strengthen their members' adherence to recognized standards of ethical and professional conduct;

B. "actuarial opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves in accordance with applicable actuarial standards of practice;

C. "actuarial report" means a document or other presentation, prepared as a formal means of conveying the actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the actuary's opinion or findings and that documents the analysis underlying the opinion;

D. "annual statement" means that statement required by Section 59A-5-29 NMSA 1978 to be filed by the company with the office of the superintendent annually;

E. "appointed actuary" means a qualified actuary who was appointed by the company's board of directors, or its equivalent, or by a committee of the board, by December 31 of the calendar year for which the opinion is rendered;

F. "company" means an insurer authorized to write property or casualty insurance under the laws of any state and who files on the property and casualty blank;

G. "qualified actuary" means a person who meets the basic education, experience and continuing education requirements of the Specific Qualification Standards promulgated by the American academy of actuaries, has obtained and maintains an accepted actuarial designation specified by the National Association of Insurance Commissioners Annual Statement Instructions, and is a member of a professional actuarial association that requires adherence to the same Code of Professional Conduct and U.S. Qualification Standards promulgated by the American academy of actuaries, and participates in the actuarial board for counseling and discipline when its association members are practicing in the U.S.; or a member in good standing of the American academy of actuaries who has been approved as qualified for signing casualty loss reserve opinions by the casualty practice council of the American academy of actuaries.

[13.2.9.7 NMAC - N, 07/30/2010, A, 7/1/2022]

13.2.9.8 ACTUARIAL OPINION OF RESERVES AND SUPPORTING DOCUMENTATION:

A. Statement of actuarial opinion. Every property and casualty insurance company doing business in New Mexico, unless otherwise exempted by the superintendent, shall annually submit the opinion of an appointed actuary entitled "statement of actuarial opinion." This opinion shall be filed in accordance with the appropriate national association of insurance commissioners property and casualty annual statement instructions. The request for exemption from this requirement must be made in writing to the New Mexico superintendent before December 31st of each calendar year.

B. Actuarial opinion summary.

(1) Every property and casualty insurance company domiciled in New Mexico that is required to submit a statement of actuarial opinion shall annually submit an

actuarial opinion summary, written by the company's appointed actuary. This actuarial opinion summary shall be filed in accordance with the appropriate national association of insurance commissioners property and casualty annual statement instructions and shall be considered as a document supporting the actuarial opinion required in Subsection A of this section.

(2) A company licensed but not domiciled in New Mexico shall provide the actuarial opinion summary upon request.

C. Actuarial report and workpapers.

(1) An actuarial report and underlying workpapers as required by the appropriate national association of insurance commissioners property and casualty annual statement instructions shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting actuarial report or workpapers at the request of the superintendent or the superintendent determines that the supporting actuarial report or workpapers provided by the insurance company is otherwise unacceptable to the superintendent, the superintendent may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or workpapers.

D. The appointed actuary shall not be liable for damages to any person (other than the insurance company and the superintendent) for any act, error, omission, decision or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary.

[13.2.9.8 NMAC - N, 07/30/2010; A, 11/15/2012]

13.2.9.9 CONFIDENTIALITY:

A. The statement of actuarial opinion shall be provided with the annual statement in accordance with the appropriate national association of insurance commissioners property and casualty annual statement instructions and shall be treated as a public document.

B. Documents, materials and other information.

(1) Documents, materials or other information in the possession or control of the insurance division that are considered an actuarial report, workpapers or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the superintendent in connection with the actuarial report, workpapers or actuarial opinion summary, shall be confidential by law and privileged, shall not be a public record, shall not be subject to inspection, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(2) This provision shall not be construed to limit the superintendent's authority to release the documents to the American academy of actuaries' actuarial board for counseling and discipline so long as the material is required for the purpose of professional disciplinary proceedings and that the actuarial board for counseling and discipline establishes procedures satisfactory to the superintendent for preserving the confidentiality of the documents, nor shall this section be construed to limit the superintendent's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the superintendent's official duties.

C. Neither the superintendent nor any person who received documents, materials or other information while acting under the authority of the superintendent shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection B of this section.

D. In order to assist in the performance of the superintendent's duties, the superintendent:

(1) may share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection B of this section with other state, federal and international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information and has the legal authority to maintain confidentiality; and

(2) may receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the superintendent under this section or as a result of sharing as authorized in Subsection D of this section.

[13.2.9.9 NMAC - N, 07/30/2010]

PART 10: CORPORATE GOVERNANCE ANNUAL DISCLOSURE

13.2.10.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance ("OSI").

[13.2.10.1 NMAC – N, 11/01/2020]

13.2.10.2 SCOPE:

This rule applies to all insurers and insurance groups domiciled in this state.

[13.2.10.2 NMAC – N, 11/01/2020]

13.2.10.3 STATUTORY AUTHORITY:

Sections 59A-1-18 and 59A-2-9, NMSA 1978, Chapter 59A Article 4, NMSA 1978, and Chapter 59A Article 37, NMSA 1978 ("the Insurance Holding Company Law").

[13.2.10.3 NMAC – N, 11/01/2020]

13.2.10.4 DURATION:

Permanent.

[13.2.10.4 NMAC – N, 11/01/2020]

13.2.10.5 EFFECTIVE DATE:

November 1, 2020 unless a later date is cited at the end of a section.

[13.2.10.5 NMAC – N, 11/01/2020]

13.2.10.6 OBJECTIVE:

The purpose of this rule is: to require an insurer or insurance group subject to the requirements of this rule to provide the superintendent with a summary of its corporate governance structure, policies and practices; to outline the requirements for completing and submitting a corporate governance annual disclosure; and to provide for the confidential treatment of the corporate governance annual discloure and related information.

[13.2.10.6 NMAC – N, 11/01/2020]

13.2.10.7 DEFINITIONS:

The following terms have the meaning given, unless the context otherwise requires. Other terms used in this rule have the meanings given in the New Mexico Insurance Code, the Insurance Holding Company Law, or other OSI rules.

A. "Corporate Governance Annual Disclosure" ("CGAD") means a confidential report submitted by an insurer or insurance group made in accordance with the requirements of this rule.

B. "Insurance group" means, for purposes of this rule, those insurers and affiliates included within an insurance holding company system as defined in the Insurance Holding Company Law.

C. "Insurer" has the same meaning given in the Insurance Holding Company Law.

D. "Lead State" means the state where the parent company is domiciled or, if there is no insurance parent, the state where the largest (by direct written premium volume as shown by the last filed annual statement) insurance subsidiary is domiciled.

E. "ORSA Summary Report" means a report filed in accordance with the National Association of Insurance Commissioners Risk Management and Own Risk and Solvency Assessment Model Act ("ORSA").

F. "Senior Management" means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing information to shareholders or regulators and shall include, for example and without limitation, the chief executive officer ("CEO"), chief financial officer ("CFO"), chief operations officer ("COO"), or any other chief executive.

G. "Superintendent" means the New Mexico superintendent of insurance.

[13.2.10.7 NMAC – N, 11/01/2020]

13.2.10.8 CORPORATE GOVERNANCE ANNUAL DISCLOSURE FILING PROCEDURES:

A. An insurer, or an insurance group of which an insurer is a member, shall, no later than June 1 of each calendar year, submit to the superintendent a CGAD that contains the information described in this rule.

B. The CGAD must include a signature of a member of the insurer's or insurance group's senior management attesting that, to the best of that individual's belief and knowledge, the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's board of directors ("board") or the appropriate committee thereof.

C. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by this rule and is permitted to customize the CGAD to provide the most relevant information necessary to permit the superintendent to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.

D. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer or insurance group are overseen collectively and at which the supervision of those factors is coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. If the CGAD is completed at the insurance group level, then it shall be filed with the lead state of the insurance group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the national association of insurance commissioners ("NAIC"). In these instances, a copy of the CGAD shall also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

F. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA summary report, holding company Form B or F filings, securities and exchange commission (SEC) proxy statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is substantially similar to the information described in this rule. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

G. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

[13.2.10.8 NMAC – N, 11/01/2020]

13.2.10.9 CONTENTS OF CORPORATE GOVERNANCE ANNUAL DISCLOSURE:

A. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

B. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following;

(1) The board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current board size and structure; and

(2) The duties of the board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the board's leadership is structured, including a discussion of the roles of CEO and chairman of the board within the organization.

C. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

(1) How the qualifications, expertise and experience of each board member meet the needs of the insurer or insurance group.

(2) How an appropriate amount of independence is maintained on the board and its significant committees.

(3) The number of meetings held by the board and its significant committees over the past year as well as information on director attendance.

(4) How the insurer or insurance group identifies, nominates and elects members to the board and its committees. The discussion should include, for example:

(a) Whether a nomination committee is in place to identify and select individuals for consideration.

(b) Whether term limits are placed on directors.

(c) How the election and re-election processes function.

(d) Whether a board diversity policy is in place and if so, how it functions.

(5) The processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any board or committee training programs that have been put in place).

D. The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors:

(1) Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

(a) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed; and

(b) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

(2) The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(a) Compliance with laws, rules, and regulations; and

(b) Prompt reporting of any illegal or unethical behavior.

(3) The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the superintendent to understand how the organization ensures that compensation programs do not encourage or reward excessive risk taking. Elements to be discussed may include, for example:

(a) The board's role in overseeing management compensation programs and practices.

(b) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(c) How compensation programs are related to both company and individual performance over time;

(d) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(e) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;

(f) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

(4) The insurer's or insurance group's plans for CEO and senior management succession.

E. The insurer or insurance group shall describe the processes by which the board, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's or insurance group's business activities, including a discussion of:

(1) How oversight and management responsibilities are delegated between the board, its committees and senior management;

(2) How the board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks;

(3) How reporting responsibilities are organized for each critical risk area. The description should allow the superintendent to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include, for example, the following critical risk areas of the insurer:

(a) risk management processes (An ORSA summary report filer may refer to its ORSA summary report pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act);

(b) actuarial function;

(c) investment decision-making processes;

(d) reinsurance decision-making processes;

(e) business strategy/finance decision-making processes;

(f) compliance function;

(g) financial reporting/internal auditing; and

(h) market conduct decision-making processes.

F. The insurer or insurance group shall retain and make available, upon examination or upon request of the superintendent, all documentation and other information supporting the CGAD.

[13.2.10.9 NMAC – N, 11/01/2020]

13.2.10.10 CONFIDENTIALITY:

A. Documents, materials and other information, including the CGAD, that are in the possession or control of OSI and that were submitted to OSI pursuant to this rule are confidential as provided by Chapter 59A Article 4, NMSA 1978.

B. To assist in the performance of the superintendent's regulatory duties, the superintendent:

(1) May, upon request, share documents, materials or other CGAD-related information including otherwise confidential, privileged, proprietary and trade secret documents and materials, with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in the Insurance Holding Company System rule, 13.2.2 NMAC, with the NAIC, and with third party consultants pursuant to 13.2.10.11 NMAC, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material or other information and has verified in writing the legal authority to maintain confidentiality; and

(2) May receive documents, materials or other CGAD-related information, including otherwise confidential, privileged, proprietary and trade secret documents and materials, from regulatory officials of other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in the Insurance Holding Company System rule, 13.2.2 NMAC, and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

[13.2.10.10 NMAC – N, 11/01/2020]

13.2.10.11 NATIONAL ASSOCIATION OF INSURANCE COMMISIONERS AND THIRD-PARTY CONSULTANTS:

A. The superintendent may retain, at the insurer's or insurance group's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the superintendent's staff as may be reasonably necessary to assist the superintendent in reviewing the CGAD and related information or the insurer's or insurance group's compliance with this rule.

B. Any persons retained pursuant to Subsection A shall be under the direction and control of the superintendent.

C. The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the superintendent.

D. As part of the retention process, a third-party consultant shall verify to the superintendent that it is free of a conflict of interest and that it has internal procedures in place to comply with the confidentiality standards and requirements of this rule.

E. A written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this rule shall contain the following provisions:

(1) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this rule.

(2) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality.

(3) A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the OSI and the NAIC's or third-party consultant's use of the information is subject to the direction of the superintendent;

(4) A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this rule in a permanent database after the underlying analysis is completed;

(5) A provision requiring the NAIC or third-party consultant to provide prompt notice to the superintendent and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(6) A requirement that the NAIC or a third-party consultant to consent to intervention by an insurer or insurance group in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer or insurance group shared with the NAIC or a third-party consultant pursuant to this rule.

[13.2.10.11 NMAC – N, 11/01/2020]

13.2.10.12 SANCTIONS:

Any insurer or insurance group failing to timely file the CGAD may be subject to the penalty provisions of Section 59A-1-18, NMSA 1978 and other enforcement actions provided by law.

[13.2.10.12 NMAC – N, 11/01/2020]

PART 11: RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT

13.2.11.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance.

[13.2.11.1 NMAC - N, 08/01/2021]

13.2.11.2 SCOPE:

This rule applies to all insurers domiciled in New Mexico unless exempt pursuant to Subsection 11 of this rule.

[13.2.11.2 NMAC - N, 08/01/2021]

13.2.11.3 STATUTORY AUTHORITY:

Authority for this rule derives from the superintendent's powers under Section 59A-1-18 NMSA 1978, Section 59A-2-9 NMSA 1978, Section 59A-2-12 NMSA 1978, Chapter 59A Article 4 NMSA 1978, "Examinations, Hearings and Appeals," Chapter 59A Article 5A NMSA 1978, the "Risk Based Capital Act," and Chapter 57 Article 3A NMSA 1978, the "Uniform Trade Secrets Act."

[13.2.11.3 NMAC - N, 08/01/2021]

13.2.11.4 DURATION:

Permanent.

[13.2.11.4 NMAC - N, 08/01/2021]

13.2.11.5 EFFECTIVE DATE:

August 1, 2021, unless a later date is cited at the end of a section.

[13.2.11.5 NMAC - N, 08/01/2021]

13.2.11.6 OBJECTIVE:

The purpose of this rule is to provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment and to provide guidance and instruction for filing an own risk and solvency assessment with the superintendent.

[13.2.11.6 NMAC - N, 08/01/2021]

13.2.11.7 DEFINITIONS:

The following terms have the meaning given, unless the context otherwise requires. Other terms used in this rule have the meanings given in Chapter 59A Article 4 NMSA 1978.

A. "Guidance manual" means the current version of the own risk and solvency assessment guidance manual developed and adopted by the NAIC and as amended from time to time; provided that a change in the guidance manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NAIC;

B. "insurance group" means those insurers and affiliates included within an insurance holding company system as defined in Subpargraph F of Section 59A-37-2NMSA 1978;

C. "insurer" has the same meaning as set forth in Subparagraph G of Section 59A-37-2 NMSA 1978;

D. "NAIC" means the national association of insurance commissioners;

E. "own risk and solvency assessment" means a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer's or insurance group's current business plan and the sufficiency of capital resources to support those risks;

F. "summary report" means a confidential high-level summary of an insurer's or insurance group's own risk and solvency assessment; and

G. "superintendent" means the superintendent of the New Mexico office of superintendent of insurance.

[13.2.11.7 NMAC - N, 08/01/2021]

13.2.11.8 RISK MANAGEMENT FRAMEWORK:

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which an insurer is a member maintains a risk management framework applicable to the operations of the insurer.

[13.2.11.8 NMAC - N, 08/01/2021]

13.2.11.9 REQUIREMENT FOR OWN RISK AND SOLVENCY ASSESSMENT:

Except as provided pursuant to Section 11 of this rule, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an own risk and solvency assessment consistent with a process comparable to the guidance manual. The own risk and solvency assessment shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

[13.2.11.9 NMAC - N, 08/01/2021]

13.2.11.10 OWN RISK AND SOLVENCY ASSESSMENT SUMMARY REPORT:

A. Upon the superintendent's request, an insurer shall submit to the superintendent an own risk and solvency assessment summary report or any combination of reports that together contain the information described in the guidance manual applicable to the insurer and the insurance group, if any, of which it is a member. The summary report, if requested, shall be due thirty days after the completion of the insurer's most recent own risk and solvency assessment that has been performed in accordance with the insurer's or the insurance group's internal strategic planning process. Upon the superintendent's request, the insurer shall advise the superintendent of the date, annual or otherwise, that the insurer or the insurance group conducts its internal strategic planning process. If the insurer is a member of an insurance group, the insurer shall submit the summary report or summary reports required by this subsection if the superintendent is the lead state commissioner of the insurance group as determined by the procedures within the financial analysis handbook adopted by the NAIC.

B. Each summary report shall include a signature of the insurer's or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting, to the best of the signatory's belief and knowledge, that the insurer applies the enterprise risk management process described in the summary report and that a copy of the summary report has been provided to the insurer's board of directors or the appropriate committee thereof.

C. An insurer may comply with the provisions of Subsection A of this section by providing the most recent and substantially similar summary report or summary reports provided by the insurer or another member of the insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the guidance manual. Any such report in a language other than English shall be accompanied by a translation of that report into the English language.

[13.2.11.10 NMAC - N, 08/01/2021]

13.2.11.11 EXEMPTION:

A. An insurer shall be exempt from the provisions of this rule if:

(1) the insurer has an annual direct written and unaffiliated assumed premium, including international direct and assumed premiums but excluding premiums reinsured with the federal crop insurance corporation and federal flood program, of less than five hundred million dollars ($500,000,000); and

(2) the insurance group of which the insurer is a member has an annual direct written and unaffiliated assumed premium, including international direct and assumed premiums but excluding premiums reinsured with the federal crop insurance corporation and federal flood program, of less than one billion dollars ($1,000,000,000).

B. If an insurer qualifies for exemption pursuant to Paragraph (1) of Subsection A of this section, but the insurance group of which it is a member does not qualify for exemption pursuant to Paragraph (2) of Subsection A of this section, the summary report that may be required pursuant to Section 10 of this rule shall include every insurer within the insurance group.This requirement may be satisfied by the submission of more than one summary report for any combination of insurers; provided that any combination of reports includes every insurer within the insurance group.

C. If an insurer does not qualify for exemption pursuant to the provisions of Paragraph (1) of Subsection A. of this section, but the insurance group of which it is a member qualifies for exemption pursuant to Paragraph (2) of Subsection A of this section, the only summary report that may be required pursuant to Section 10 of this rule shall be the report applicable to that insurer.

D. An insurer that does not qualify for exemption pursuant to Subsection A of this section may apply to the superintendent for a waiver from the requirements of this rule based upon unique circumstances. In deciding whether to grant an insurer's request for waiver, the superintendent may consider the type and volume of business written, ownership and organizational structure and any other factor the superintendent considers relevant to the insurer or insurance group of which it is a member. If an insurer is part of an insurance group with insurers domiciled in more than one state, the superintendent will coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

E. Notwithstanding the exemptions stated in this section:

(1) the superintendent may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment and file a summary report based on unique circumstances, including the type and volume of business written, ownership and organizational structure, federal agency requests and international supervisor requests; and

(2) the superintendent may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment and file a summary report if the insurer has risk-based capital for a company action level event

pursuant to the Risk Based Capital Act or otherwise exhibits qualities of a troubled insurer as determined by the superintendent.

F. If an insurer that qualifies for an exemption pursuant to Subsection A of this section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which it is a member, the insurer shall have one year following the year the threshold is exceeded to comply with the requirements of this rule.

[13.2.11.11 NMAC - N, 08/01/2021]

13.2.11.12 CONTENTS OF OWN RISK AND SOLVENCY ASSESSMENT SUMMARY REPORTS:

A. A summary report shall be prepared consistent with the guidance manual, subject to the requirements of Subsection B of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the superintendent.

B. The review of the summary report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

[13.2.11.12 NMAC - N, 08/01/2021]

13.2.11.13 CONFIDENTIALITY:

A. Documents, materials or other information, including the summary report, in the possession or control of the office of superintendent of insurance that are obtained by, created by or disclosed to the superintendent or any other person pursuant to this rule contain confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information includes proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. Any such documents, materials or other information, including the summary report, shall be treated as confidential trade secrets under the Uniform Trade Secrets Act, and as authorized by Subsection B of Section 59A-2-12 NMSA 1978, are deemed confidential by the superintendent as specifically defined by Subsection D of Section 57-3A-2 NMSA 1978.

B. The documents, materials or other information, including the summary report, submitted pursuant to this rule, shall remain confidential as long as the documents, materials or other information, including the summary report are in the possession or control of the superintendent. The superintendent may use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of

the superintendent's official duties. The superintendent may not otherwise make the documents, materials or other information public without prior written notice to the insurer.

C. In order to assist in the performance of the superintendent's regulatory duties, the superintendent:

(1) may, upon request, share documents, materials or other information related to an own risk and solvency assessment, including the confidential documents, materials or information subject to Subsection A of this section and including proprietary and trade-secret documents and materials, with other state, federal and international financial regulatory agencies, with the NAIC, and with any third-party consultants designated by the superintendent; provided that the recipient agrees in writing to maintain the confidential status of the documents, materials or other information related to an own risk and solvency assessment and has verified in writing the legal authority to maintain confidentiality;

(2) may receive documents, materials or other information related to an own risk and solvency assessment, including confidential documents, materials or information and including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions and from the national association of insurance commissioners, and shall maintain as confidential any documents, materials or information received with notice or the understanding that it is confidential under the laws of the jurisdiction that is the source of the document, material or information; and

(3) shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this rule consistent with this subsection that shall:

(a) specify procedures and protocols regarding the confidentiality and security of information shared with the national association of insurance commissioners or a third-party consultant pursuant to this rule, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidential status of the documents, materials or other information related to an own risk and solvency assessment and has verified in writing the legal authority to maintain confidentiality;

(b) specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this rule remains with the insurer and that the NAIC's or a third-party consultant's use of the information is subject to the direction of the superintendent;

(c) prohibit the NAIC or third-party consultant from storing the information shared pursuant to this rule in a permanent database after the underlying analysis is completed;

(d) require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this rule when subject to a request or subpoena;

(e) require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer that has been shared with the NAIC or a third-party consultant pursuant to this rule; and

(f) in the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

D. The sharing of information and documents by the superintendent pursuant to this rule shall not constitute a delegation of regulatory authority or rulemaking, and the superintendent is solely responsible for the administration, execution and enforcement of the provisions of this rule.

E. No waiver of any applicable privilege or claim of confidentiality of documents, proprietary and trade-secret materials or other information related to an own risk and solvency assessment shall occur as a result of disclosure of that related information, materials or documents to the superintendent under this section or as a result of sharing as described in this rule.

[13.2.11.13 NMAC - N, 08/01/2021]

13.2.11.14 SANCTIONS:

Any insurer failing, without just cause, to timely file the summary report as required in this rule shall be required, after notice and hearing, to pay a penalty of one thousand dollars ($1,000) for each day's delay to be recovered by the superintendent, and the penalty so recovered shall be paid into the general fund of the state of New Mexico. The maximum penalty under this section is one hundred thousand dollars ($100,000). The superintendent may reduce the penalty if the insurer demonstrates to the superintendent that the imposition of the penalty would constitute a financial hardship to the insurer.

[13.2.11.14 NMAC - N, 08/01/2021]

PART 12: HEALTH CARE CONSOLIDATION OVERSIGHT

13.2.12.1 ISSUING AGENCY:

Office of Superintendent of Insurance

[13.2.12.1 NMAC – N/E, 5/15/2024]

13.2.12.2 SCOPE:

This rule applies to any proposed transactions that involve a New Mexico hospital as regulated by the Health Care Consolidation Oversight Act, Chapter 59A, Article 63 NMSA 1978.

[13.2.12.2 NMAC – N/E, 5/15/2024]

13.2.12.3 STATUTORY AUTHORITY:

Authority for this rule derives from the superintendent's powers under Sections 59A-2-9 and from 59A-63-1 et seq., the Health Care Consolidation Oversight Act.

[13.2.12.3 NMAC – N/E, 5/15/2024]

13.2.12.4 DURATION:

This emergency rule expires 180 days from the effective date unless a permanent rule is adopted before that time.

[13.2.12.4 NMAC – N/E, 5/15/2024]

13.2.12.5 EFFECTIVE DATE:

May 15, 2024, unless a later date is cited at the end of a section.

[13.2.12.5 NMAC – N, 5/15/2024]

13.2.12.6 OBJECTIVE:

The purpose of this rule is to establish the standards for meeting the requirements of the health care consolidation oversight act and to provide details related to the superintendent's oversight of proposed transactions.

[13.2.12.6 NMAC – N/E, 5/15/2024]

13.2.12.7 DEFINITIONS:

For the purpose of this rule, the following terms have the following meanings:

A. "acquisition" has the same meaning as defined in Subsection A of Section 59A-63-2 NMSA 1978;

B. "act" means the health care consolidation oversight act, Chapter 59A, Article 63 NMSA 1978;

C. "affiliation" has the same meaning as defined in Subsection B of Section 59A-63-2 NMSA 1978;

D. "authority" has the same meaning as defined in Subsection C of Section 59A-63-2 NMSA 1978;

E. "control" has the same meaning as defined in Subsection D of Section 59A-63-2 NMSA 1978;

F. "essential services" has the same meaning as defined in Subsection E of Section 59A-63-2 NMSA 1978;

G. "health care provider" has the same meaning as defined in Subsection F of Section 59A-63-2 NMSA 1978;

H. "health insurer" has the same meaning as defined in Subsection G of Section 59A-63-2 NMSA 1978;

I. "hospital" has the same meaning as defined in Subsection H of Section 59A-63-2 NMSA 1978;

J. "insurance holding company law" means Chapter 59A, Article 37 NMSA 1078;

K. "management services organization" has the same meaning as defined in Subsection I of Section 59A-63-2 NMSA 1978;

L. "notice" means a notification to the superintendent of a proposed transaction on a form provided by the superintendent, and when completed provides all the information required by Subsection E of 59A-63-2 NMSA 1978;

M. "office" or **"OSI"** has the same meaning as defined in Subsection J of Section 59A-63-2 NMSA 1978;

N. "office of general counsel" means the office of general counsel of the office of superintendent of insurance;

O. "party" or **"parties"** has the same meaning as defined in Subsection K of Section 59A-63-2 NMSA 1978;

P. "person" has the same meaning as defined in Subsection L of Section 59A-63-2 NMSA 1978;

Q. "proposed transaction" means a transaction as defined in Subsection N of Section 59A-63-2 NMSA 1978, that is subject to the review of the superintendent under the act;

R. "significantly modified" means a material change, alteration, or amendment to the scope of the proposed transaction from that outlined in the initial notice, that is significant enough to affect the outcome of the superintendent's determination;

S. "superintendent" has the same meaning as defined in Subsection M of Section 59A-63-2 NMSA 1978;

T. "toll" or **"tolled"** means a suspension of the 120-day time period that begins when the notice of proposed transaction is deemed complete by the superintendent or designee; and

U. "transaction" has the same meaning as defined in Subsection N of Section 59A-63-2 NMSA 1978.

[13.2.12.7 NMAC – N/E, 5/15/2024]

13.2.12.8 APPLICABILITY, OVERSIGHT PROVISIONS AND PRESUMPTION OF CONTROL:

A. The oversight power of the office pursuant to the act applies to proposed transactions that involve a New Mexico hospital.

B. Being subject to the act does not preclude or negate any person regulated pursuant to the insurance hold company law.

C. Control is presumed to exist if a person, directly or indirectly, owns, controls, or holds fifteen percent or more of the power to vote or holds proxies representing fifteen percent or more of the voting securities of any other person.

D. The presumption may be rebutted by a showing in the manner provided by Section 59A-37-19 NMSA 1978 that control does not in fact exist.

[13.2.12.8 NMAC – N/E, 5/15/2024]

13.2.12.9 NOTICE OF PROPOSED TRANSACTION:

A. Parties to a proposed transaction may submit a written request to the office of general counsel via the email provided on the office's website, for a pre-notice conference to determine if they are required to file a notice or to discuss the potential extent of the review with the superintendent or designee.

B. At least one person that is a party to a proposed transaction shall submit to the office via the email provided on the office's website, a written notice of the proposed transaction on the notice of proposed transaction form provided by the superintendent.

C. The notice of the proposed transaction shall include:

(1) a list of the parties, the terms of the proposed transaction and copies of all transaction agreements between any of the parties;

(2) a statement describing the goals of the proposed transaction and whether and how the proposed transaction affects health care services in New Mexico;

(3) the geographic service area of any hospital affected by the proposed transaction;

(4) a description of the groups or individuals likely to be affected by the transaction; and

(5) a summary of the health care services currently provided by any of the parties and any health care services that will be added, reduced or eliminated, including an explanation of why any services will be reduced or eliminated in the service area in which they are currently provided.

D. If a party to the proposed transaction is a health insurer, the notice shall be submitted as an addendum to any filing required by the insurance holding company law, Sections 59A-37-4 through 59A-37-10 NMSA 1978.

[13.2.12.9 NMAC – N/E, 5/15/2024]

13.2.12.10 PAYMENT OF COSTS, REQUIREMENTS FOR CONSULTATION AND EXPERTS:

A. The office shall consult with the authority about the potential effect of the proposed transaction and incorporate the authority's recommendations into the office's final determination.

B. The office may retain actuaries, accountants, attorneys, or other professionals who are qualified and have expertise in the type of transaction under review as necessary to assist the office in conducting its review of the proposed transaction.

C. The office shall notify parties before any costs are incurred when a transaction review requires the use of outside experts, including the estimated cost of the outside expert's services.

D. The parties shall pay the reasonable costs and expenses incurred by the office in the performance of the office's or authority's duties pursuant to the act for costs associated with the office's contracts with experts, unless determined otherwise by the superintendent.

E. The parties shall not effectuate a transaction without the written approval of the superintendent. The submitting party shall notify the office of general counsel in writing

via the email address located on the office's website, when the transaction has been effectuated.

[13.2.12.10 NMAC – N/E, 5/15/2024]

13.2.12.11 REVIEW OF NOTICE AND TOLLING:

A. Upon receipt of a complete notice of a proposed transaction:

(1) the office shall determine if the transaction is urgently necessary to maintain the solvency of a hospital or if there is an emergency that threatens the continued provision of immediate health care services;

(2) in such circumstances, the office may agree to an immediate approval of a transaction with or without conditions;

(3) the office shall inform the authority of the filing of the notice of proposed transaction.

B. Entry into a binding agreement before a transaction is effectuated is not a violation of the act if the transaction remains subject to regulatory review and approval.

C. A notice of a proposed transaction shall be deemed completed by the office on the date when all the information required by the act or requested by the office is submitted by all parties to the transaction, as applicable.

D. The superintendent or designee shall inform the parties and the authority in writing of the date when the notice of a proposed transaction is complete and the 120-day time period for review by the superintendent of designee begins.

E. If the scope of the proposed transaction is determined by the superintendent or designee to be significantly modified from that outlined in the initial notice, the 120-day time period set out in the act shall be restarted by the office.

F. The parties must notify the superintendent in writing via the email provided on the office's website, if the scope of the proposed transaction is significantly modified.

G. The time periods shall be tolled during any time in which the office has requested and is awaiting further information necessary to complete a review, from the parties to a transaction.

[13.2.12.11 NMAC – N/E, 5/15/2024]

13.2.12.12 REVIEW OF PROPOSED TRANSACTION BY THE OFFICE:

A. Within 120-days of receiving a completed notice of a proposed transaction, the office shall complete a review, confer with the authority and either:

(1) approve the proposed transaction;

(2) approve the proposed transaction with conditions; or

(3) disapprove the proposed transaction.

B. In conducting a review of a proposed transaction, the office may consider the likely effect in New Mexico of the proposed transaction on:

(1) the potential reduction or elimination in access to essential services;

(2) the availability, accessibility and quality of health care services to any community affected by the transaction;

(3) the health care market share of a party and whether the transaction may foreclose competitors of a party from a segment of the market or otherwise increase barriers to entry in a health care market;

(4) changes in practice restrictions for licensed health care providers who work at the hospital;

(5) patient costs, including premiums and out-of-pocket costs;

(6) health care provider networks; and

(7) the potential for the proposed transaction to affect health outcomes for New Mexico residents.

C. The review period may be extended if the parties agree to an extension.

[13.2.12.12 NMAC – N/E, 5/15/2024]

13.2.12.13 NOTIFICATION OF DETERMINATION:

A. The superintendent shall notify the submitting party in writing of the office's determination and the reasons for the determination.

B. The office shall approve the proposed transaction after the comprehensive review if the office determines:

(1) the parties to the proposed transaction have demonstrated that the transaction will benefit the public by:

(a) reducing the growth in patient costs, including premiums and out-of-pocket costs; or

(b) maintaining or increasing access to services, especially in medically underserved areas;

(2) the proposed transaction will improve health outcomes for New Mexico residents; and

(3) there is no substantial likelihood of:

(a) a significant reduction in the availability, accessibility, affordability or quality of care for patients and consumers of the health care services; or

(b) anti-competitive effects from the proposed transaction that outweigh the benefits of the transaction.

[13.2.12.13 NMAC – N/E, 5/15/2024]

13.2.12.14 CONFIDENTIALITY:

A. All documents, materials or other information in the possession or control of the office that are obtained by or disclosed to the office or the authority in the course of a review under the act, are confidential.

B. Pursuant to Subsection B of Section 59A-2-12 NMSA 1978:

(1) upon receipt of a written request for a pre-notice conference or a notice of a proposed transaction, the superintendent shall open a confidential case in the office's docketing system to file any and all documents, materials, or other information pertaining to the notice of proposed transaction received by the office;

(2) the superintendent shall open a case in a file hosting service for the parties to produce and share documents in a secure trusted platform for the duration of the review of the proposed transaction, through the post-transaction reporting period;

(3) any written communication related to a proposed transaction shall be deemed confidential by the superintendent; and

(4) a case opened as confidential pursuant to the act, will be closed as confidential by the superintendent after the reporting period has concluded.

[13.2.12.14 NMAC – N/E, 5/15/2024]

13.2.12.15 POST-TRANSACTION REPORTING AND OVERSIGHT:

A. The person that acquired control over the hospital through an approved or conditionally approved transaction shall submit annual reports for three years from the date the transaction is approved, to the office and to the authority on a form provided by the office and via the email provided on the office's website.

B. The report shall:

(1) describe compliance with conditions placed on the transaction, if any;

(2) describe any growth, any decline, and other changes in services provided by the person; and

(3) provide analyses of cost trends and cost growth trends of the hospital.

C. The requirements of this section are not affected by the delayed repeal in Section 59A-63-9 NMSA 1978.

[13.2.12.15 NMAC – N/E, 5/15/2024]

CHAPTER 3: INSURANCE SECURITIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

13.3.2.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.3.2.2 SCOPE:

This rule applies to every person who is directly or indirectly the beneficial owner of more than 10 percent of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such a company.

[7/1/97; Recompiled 11/30/01]

13.3.2.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-36-2 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.3.2.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.3.2.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.3.2.6 OBJECTIVE:

The purpose of this rule is to specify the requirements for filing an initial statement of beneficial ownership of securities.

[7/1/97; Recompiled 11/30/01]

13.3.2.7 DEFINITIONS:

[RESERVED]

13.3.2.8 WHEN STATEMENTS ARE TO BE FILED:

A. Persons who hold any of the relationships specified in 13 NMAC 3.2.2 [now 13.3.2.2 NMAC].are required to file a statement on the form prescribed in this rule by March 1, 1966, or within 10 days after assuming such relationship, whichever date is later.

B. Statements are not deemed to have been filed with the superintendent of insurance until they have actually been received by the superintendent.

[7/1/97; Recompiled 11/30/01]

13.3.2.9 WHERE STATEMENTS ARE TO BE FILED:

One signed copy of each statement shall be filed with the superintendent of insurance, Santa Fe, New Mexico.

[7/1/97; Recompiled 11/30/01]

13.3.2.10 SEPARATE STATEMENT FOR EACH COMPANY:

A separate statement shall be filed with respect to the securities of each company.

[7/1/97; Recompiled 11/30/01]

13.3.2.11 RELATIONSHIP OF REPORTING PERSON TO COMPANY:

Indicate clearly the relationship of the reporting person to the company; for example, "director", "director and vice president", "beneficial owner of more than 10 percent of the company's common stock", etc.

[7/1/97; Recompiled 11/30/01]

13.3.2.12 DATE AS OF WHICH BENEFICIAL OWNERSHIPIS TO BE GIVEN:

The information as to beneficial ownership of securities shall be given as of March 1, 1966, or, in the case of persons who subsequently assume any of the relationships specified in 13 NMAC 3.2.2 [now 13.3.2.2 NMAC], as of the date that relationship was assumed.

[7/1/97; Recompiled 11/30/01]

13.3.2.13 TITLE OF SECURITY:

The statement of the title of a security shall be such as clearly to identify the security even though there may be only one class; for example, "class A common stock", "$6 convertible preferred stock", "5% debentures due 1965", etc.

[7/1/97; Recompiled 11/30/01]

13.3.2.14 NATURE OF OWNERSHIP:

Under "nature of ownership", state whether ownership of the securities is "direct" or "indirect". If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate, in a footnote or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and also from those owned through a different type of indirect ownership.

[7/1/97; Recompiled 11/30/01]

13.3.2.15 STATEMENT OF AMOUNT OWNED:

In stating the amount of securities beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote, or other appropriate manner, the extent of his interest in the partnership, corporation, trust or other entity.

[7/1/97; Recompiled 11/30/01]

13.3.2.16 INCLUSION OF ADDITIONAL INFORMATION:

A statement may include any additional information or explanation deemed relevant by the person filing the statement.

[7/1/97; Recompiled 11/30/01]

13.3.2.17 SIGNATURE:

If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

[7/1/97; Recompiled 11/30/01]

13.3.2.18 FORM ISBOS (1966 EDITION):

INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

(To be filed with the department of insurance pursuant to Section 59A-36-2 NMSA 1978.)

_____

(Name of insurance company)

_____

(Name of person whose ownership is reported)

_____

(Business address of such person) (street) (city) (state) (zip code)

_____

Relationship of such person to company named above. (See 13 NMAC 3.2.11) [now 13.3.2.11 NMAC]

_____

Date of event which requires the filing of this statement. (See 13 NMAC 3.2.12) [now 13.3.2.12 NMAC]

SECURITIES BENEFICIALLY OWNED

TITLE OF SECURITY (See 13 NMAC 3.2.13 [now 13.3.2.13 NMAC]	**NATURE OF OWNERSHIP** (See 13 NMAC 3.2.14) [now 13.3.2.14 NMAC]	**AMOUNT OWNED BENEFICIALLY** (See 13 NMAC 3.2.15) [now 13.3.2.15 NMAC]

REMARKS: (see 13 NMAC 3.2.16) [now 13.3.2.16 NMAC]

Date of statement: _____

I affirm under penalty or perjury that the foregoing is full, true and correct.

_____

Signature

_____

(Signature guaranteed)

[7/1/97; Recompiled 11/30/01]

PART 3: STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP OF SECURITIES

13.3.3.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.3.3.2 SCOPE:

This rule applies to every person who at any time during any calendar month was directly or indirectly the beneficial owner of more than 10 percent of any class of equity security of a domestic stock insurance company, or a director or officer of the company which is the issuer of such securities, and who during such month had any change in his beneficial ownership of any class of equity security of such company.

[7/1/97; Recompiled 11/30/01]

13.3.3.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-36-2 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.3.3.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.3.3.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.3.3.6 OBJECTIVE:

The purpose of this rule is to specify the requirements for filing a statement of changes in beneficial ownership of securities.

[7/1/97; Recompiled 11/30/01]

13.3.3.7 DEFINITIONS:

[RESERVED]

13.3.3.8 WHEN STATEMENTS ARE TO BE FILED:

Statements are required to be filed on the form prescribed in this rule on or before the 10th day after the end of each month in which any change in beneficial ownership has occurred. Statements are not deemed to have been filed with the superintendent of insurance until they have actually been received by him.

[7/1/97; Recompiled 11/30/01]

13.3.3.9 WHERE STATEMENTS ARE TO BE FILED:

One signed copy of each statement shall be filed with the superintendent of insurance, Santa Fe, New Mexico.

[7/1/97; Recompiled 11/30/01]

13.3.3.10 SEPARATE STATEMENT FOR EACH COMPANY:

A separate statement shall be filed with respect to the securities of each company.

[7/1/97; Recompiled 11/30/01]

13.3.3.11 RELATIONSHIP OF THE REPORTING PERSON TO COMPANY:

Indicate clearly the relationship of the reporting person to the company; for example, "director", "director and vice president", "beneficial owner of more than 10 percent of the company's common stock", etc.

[7/1/97; Recompiled 11/30/01]

13.3.3.12 TRANSACTIONS AND HOLDINGS TO BE REPORTED:

Every transaction shall be reported even though purchases and sales during the month are equal or the change involves only the nature of ownership; for example, from direct to indirect ownership. Beneficial ownership at the end of the month of all classes of securities required to be reported shall be shown even though there has been no change during the month in the ownership of securities of one or more classes.

[7/1/97; Recompiled 11/30/01]

13.3.3.13 TITLE OF SECURITY:

The statement of the title of the security shall be such as clearly to identify the security even though there may be only one class; for example, "class A common stock", "$6 convertible preferred stock", "5% debentures due 1965", etc.

[7/1/97; Recompiled 11/30/01]

13.3.3.14 DATE OF TRANSACTION:

The exact date (month, day and year) of each transaction shall be stated opposite the amount involved in the transaction.

[7/1/97; Recompiled 11/30/01]

13.3.3.15 STATEMENT OF AMOUNTS OF SECURITIES:

In stating the amount of the securities acquired, disposed of, or beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, i.e., through a partnership, corporation, trust or other entity, the entire amount of securities involved in the transaction or owned by the partnership, corporation, trust, or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote, or other appropriate manner, the extent of his interest in the transaction or holdings of the partnership, corporation, trust or other entity.

[7/1/97; Recompiled 11/30/01]

13.3.3.16 NATURE OF OWNERSHIP:

Under "nature of ownership", state whether ownership of the securities is "direct" or "indirect". If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate in a footnote, or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and from those owned through a different type of indirect ownership.

[7/1/97; Recompiled 11/30/01]

13.3.3.17 CHARACTER OF TRANSACTION:

If the transaction was with the issuer of the securities, so state. If it involved the purchase of securities through the exercise of options, so state and give the exercise price per share. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or sale, indicate its character; for example, gift, five percent stock dividend, etc., as the case may be. The foregoing information may be appropriately set forth in the table or under "remarks" at the end of the table.

[7/1/97; Recompiled 11/30/01]

13.3.3.18 INCLUSION OF ADDITIONAL INFORMATION:

A statement may include any additional information or explanation deemed relevant by the person filing the statement.

[7/1/97; Recompiled 11/30/01]

13.3.3.19 SIGNATURE:

if the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

[7/1/97; Recompiled 11/30/01]

13.3.3.20 FORM SCBOS (1966 EDITION):

STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP OF SECURITIES

(To be filed with the Department of Insurance pursuant to Section 59A-36-2 NMSA 1978.)

_____

(Name of insurance company)

_____

(Name of person whose ownership is reported)

_____

(Business address of such person) (street) (city) (state) (zip code)

_____

Social security number

_____

Relationship of such person to company named above. (See 13 NMAC 3.3.11) [now 13.3.3.11 NMAC]

STATEMENT FOR CALENDAR MONTH OF _____ , 19____

CHANGES DURING MONTH AND MONTH-END OWNERSHIP

(See 13 NMAC 3.3.12) [now 13.3.3.12 NMAC]

TITLE OF	DATE OF	AMOUNT	AMOUNT	NATURE OF	AMOUNT

SECURITY (See 13 NMAC 3.3.13) [now 13.3.3.13 NMAC]	TRANS-ACTION (See 13 NMAC 3.3.14) [now 13.3.3.14 NMAC]	BOUGHT or otherwise (See 13 NMAC 3.3.15) [now 13.3.3.15 NMAC]	SOLD or otherwise (See 13 NMAC 3.3.15) [now 13.3.3.15 NMAC]	OWNERSHIP (See 13 NMAC 3.3.16) [now 13.3.3.16 NMAC]	OWNED beneficially at end of month (See 13 NMAC 3.3.15) [now 13.3.3.15 NMAC]

REMARKS: (See 13 NMAC 3.3.17) [now 13.3.3.17 NMAC]

_____

Date of statement

I affirm under penalty or perjury that the foregoing is full, true and correct.

_____

Signature

_____

Signature guaranteed

[7/1/97; Recompiled 11/30/01]

PART 4: PROXIES, CONSENTS AND AUTHORIZATIONS OF DOMESTIC COMPANIES

13.3.4.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.3.4.2 SCOPE:

This rule is applicable to each domestic stock insurer which has any class of equity security held of record by 300 or more persons, or any director, officer or employee of such insurer, or any other person; provided, however, that this rule shall not apply to any insurer if ninety-five percent (95%) or more of its equity securities is owned or controlled by a parent or an affiliated insurer and the remaining securities are held of record by less than 500 persons. A domestic stock insurer which files with the securities and exchange commission with respect to any class of securities forms of proxies, consents and authorizations complying with the requirements of the Securities Exchange Act of 1934, as amended, and the applicable regulations promulgated thereunder, shall be exempt from the provisions of this rule with respect to such class of securities. This rule does not apply to the extent its provisions are preempted by the Capital Markets Efficiency Act of 1996, P.L. 104-290, Section 101 et seq.

[7/1/97; Recompiled 11/30/01]

13.3.4.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.3.4.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.3.4.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

13.3.4.6 OBJECTIVE:

The purpose of this rule is to implement Chapter 59A, Article 34 NMSA 1978 by establishing the requirements for solicitation of proxies, consents or authorizations for equity securities by domestic stock insurers covered by this rule.

[7/1/97; Recompiled 11/30/01]

13.3.4.7 DEFINITIONS:

The following definitions apply unless the context otherwise requires:

A. **Affiliate**, or a person affiliated with a specified person, means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

B. **Associate**, used to indicate a relationship with any person, means:

(1) any corporation or organization (other than the issuer or a majority owned subsidiary of the issuer) of which such person is an officer or partner or is, directly or indirectly, the beneficial owner of ten percent (10%) or more of any class of equity securities;

(2) any trust or other estate in which such person has a substantial beneficial interest or as to which such person serves as trustee or in a similar fiduciary capacity; and

(3) any relative or spouse of such person, or any relative of such spouse, who has the same home as such person or who is a director or officer of the issuer or any of its parents or subsidiaries.

C. **Beneficial owner** means any person who, directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares:

(1) voting power including the power to vote, or the power to direct voting of, a security; or

(2) investment power which includes the power to dispose of, or to direct the disposition of, such security.

D. **Control** (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

E. **Issuer** means the issuer of the securities in respect of which a proxy is solicited.

F. **Last fiscal year of the issuer** means the last fiscal year of the issuer ending prior to the date of the meeting for which proxies are to be solicited.

G. **Officer** means the president, secretary, treasurer, any vice president in charge of a principal business function (such as sales, administration or finance) and any other person who performs similar policy-making functions for the insurer.

H. **Parent** of a specified person means an affiliate controlling such person directly or indirectly through one or more intermediaries.

I. **Person** means an individual, a corporation, a partnership, an association, a joint stock company, a trust, any unincorporated organization, or a government or political subdivision thereof. As used in this subsection, the term "trust" shall include only a trust where the interest or interests of the beneficiary or beneficiaries are evidenced by a security.

J. **Proxy** statement means the statement required by 13 NMAC 3.4.10 [now 13.3.4.10 NMAC], whether or not contained in a single document.

K. **Schedule A** means the document described in 13 NMAC 3.4.19 [now 13.3.4.19 NMAC].

L. **Schedule B** means the document described in 13 NMAC 3.4.20 [now 13.3.4.20 NMAC].

M. **Schedule C** means the document described in 13 NMAC 3.4.21 [now 13.3.4.21 NMAC].

N. **Solicitation:**

(1) The terms **solicit** and **solicitation** include:

(a) any request for a proxy whether or not accompanied by or included in a form of proxy;

(b) any request to execute or not to execute, or to revoke, a proxy; or

(c) the furnishing of a form of proxy or other communication to security holders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

(2) The terms do not apply, however, to the furnishing of a form of proxy to a security holder upon the unsolicited request of such security holder, the performance by the issuer of acts required by 13 NMAC 3.4.14 [now 13.3.4.14 NMAC], or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

[7/1/97; Recompiled 11/30/01]

13.3.4.8 PROHIBITIONS AND SCHEDULE REQUIREMENTS:

A. No domestic stock insurer or any director, officer or employee of such insurer, or any other person covered by this rule shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent or authorization in respect to any such class of equity securities in contravention of this rule and schedules A and B of this rule.

B. Unless proxies, consents or authorizations in respect of any class of equity securities of a domestic insurer subject to 13 NMAC 3.4.8.1 [now Subsection A of 13.3.4.8 NMAC] are solicited by or on behalf of the management of such insurer from the holders of record of such securities in accordance with this rule and the schedules hereto prior to any annual or other meeting of such security holders, such insurer shall file with the superintendent and transmit to every security holder who is entitled to vote in regard to any matter to be acted upon at the meeting and from whom a proxy is not solicited a written information statement containing the information specified in schedule C of this rule.

[7/1/97; Recompiled 11/30/01]

13.3.4.9 SPECIFIC APPLICATION OF RULE:

13 NMAC 3.4.16 [now 13.3.4.16 NMAC] rule shall apply to every solicitation that is subject to 13 NMAC 3.4.8 [now 13.3.4.8 NMAC]. 13 NMAC 3.4.7 through 13 NMAC 3.4.15 and 13 NMAC 3.4.17 [now 13.3.4.7 through 13.3.4.15 and 13.3.4.17 NMAC] shall apply to every solicitation that is subject to 13 NMAC 3.4.8 [now 13.3.4.8 NMAC] except the following:

A. Any solicitation made otherwise than on behalf of the issuer where the total number of persons solicited is not more than ten (10).

B. Any solicitation by a person in respect of securities carried in his name or in the name of his nominee (otherwise than as voting trustee) or held in his custody, if such person:

(1) receives no commission or remuneration for such solicitation, directly or indirectly, other than reimbursement of reasonable expenses;

(2) furnishes promptly to the person solicited a copy of all soliciting material with respect to the same subject matter or meeting received from all persons who shall furnish copies thereof for such purpose and who shall, if requested, defray the reasonable expenses to be incurred in forwarding such material; and

(3) in addition, does no more than impartially instruct the person solicited to forward a proxy to the person, if any, to whom the person solicited desires to give a proxy, or impartially request from the person solicited instructions as to the authority to be conferred by the proxy and state that a proxy will be given if no instructions are received by a certain date.

C. Any solicitation by a person in respect of securities of which it is the beneficial owner.

D. Any solicitation through the medium of a newspaper advertisement which informs security holders of a source from which they may obtain copies of a proxy statement, form of proxy and any other soliciting material and does no more than:

(1) name the issuer;

(2) state the reason for the advertisement; and

(3) identify the proposal or proposals to be acted upon by security holders.

E. Any solicitation which the superintendent finds for good cause should be exempted from this rule or any part thereof.

[7/1/97; Recompiled 11/30/01]

13.3.4.10 INFORMATION TO BE FURNISHED SECURITY HOLDERS:

A. No solicitation subject to this rule shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in schedule A.

B. If the solicitation is made on behalf of the issuer and relates to an annual meeting of security holders at which directors are to be elected, each proxy statement furnished pursuant to 13 NMAC 3.4.10.1 [now Subsection A of 13.3.4.10 NMAC] shall be accompanied or preceded by an annual report to security holders as follows:

(1) The report shall contain, in comparative columnar form, such financial statements for the last two fiscal years, prepared on a consistent basis, as will in the opinion of the management adequately reflect the financial position of the issuer at the end of each such year and the results of its operations for each such year. Consolidated financial statements of the issuer and its subsidiaries shall be included in the report if they are necessary to reflect the financial position and results of operations of the issuer and its subsidiaries, but in such case the individual statements of the issuer may be omitted. The superintendent may, upon the request of the issuer, permit the omission of financial statements for the earlier of such two (2) fiscal years upon a showing of good cause therefor.

(2) The financial statements for the last two fiscal years required by 13 NMAC 3.4.10.2.1 [now Paragraph (1) of Subsection B of 13.3.4.10 NMAC] shall be prepared in a manner acceptable to the superintendent.

(3) The report shall include, in comparative columnar form, a summary of issuer's operations, or the operations of the issuer and its subsidiaries consolidated, or both as appropriate, for each of the last five (5) fiscal years of the issuer (or the life of the issuer and its predecessors, if less).

(4) The report shall contain a brief description of the business or businesses done by the issuer and its subsidiaries during the most recent fiscal year which will, in the opinion of management, indicate the general nature and scope of the business of the issuer and its subsidiaries.

(5) The report shall identify each of the issuer's directors and officers and shall indicate the principal occupation or employment of each such person and the name and principal business of any organization by which such person is so employed.

(6) The report shall identify the principal market in which securities of any class entitled to vote at the meeting are traded, stating the range of bid and asked quotations for each quarterly period during the issuer's two most recent fiscal years, and shall set forth each dividend paid during such two-year period.

(7) Subject to the foregoing requirements, the report may be in any form deemed suitable by management and the information required by 13 NMAC 3.4.10.3 through 13 NMAC 3.4.10.6 [now Subsection C through Subection F of 13.3.4.10 NMAC] may be presented in an appendix or other separate section of the report, provided that the attention of security holders is called to such presentation.

(8) 13 NMAC 3.4.10.2 [now Subsection B of 13.3.4.10 NMAC] shall not apply, however, to solicitations made on behalf of the management before the financial statements are available if solicitation is being made at the time in opposition to the management and if the management's proxy statement includes an undertaking in bold fact type to furnish such annual report to all persons being solicited, at least twenty (20) days before the date of the meeting.

C. Two copies of the report sent to security holders pursuant to this section shall be mailed to the superintendent, solely for his information, not later than the date on which such report was first sent or given to security holders or the date on which preliminary copies of solicitation material are filed pursuant to 13 NMAC 3.4.13 [now 13.3.4.13 NMAC], whichever date is later.

D. If the issuer knows that securities of any class entitled to vote at a meeting with respect to which the issuer intends to solicit proxies, consents or authorizations are held of record by a broker, dealer, bank or voting trustee, or their nominees, the issuer shall require of such record holder at least ten (10) days prior to the record date for the meeting of security holders whether other persons are the beneficial owners of such securities and, if so, the number of copies of the proxy and other soliciting material and, in the case of an annual meeting at which directors are to be elected, the number of copies of the annual report to security holders, necessary to supply such material to beneficial owners. The issuer shall supply such record holder in a timely manner with additional copies in such quantities, assembled in such form and at such a place, as the record holder may reasonably request in order to address and send one (1) copy of each to each beneficial owner of securities so held and shall, upon the request of such

record holder, pay its reasonable expenses for mailing such material to security holders to whom the material is sent.

[7/1/97; Recompiled 11/30/01]

13.3.4.11 REQUIREMENTS AS TO PROXY:

A. The form of proxy shall:

(1) indicate in bold face type whether or not the proxy is solicited on behalf of the issuer board of directors, and, if not, by whom it is solicited;

(2) provide a specifically designated blank space for dating the proxy; and

(3) identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the issuer or by security holders.

(4) No reference need be made to proposals as to which discretionary authority is conferred pursuant to 13 NMAC 3.4.11.4 [now Subsection D of 13.3.4.11 NMAC].

B. Means shall be provided in the form of proxy whereby the person solicited is afforded an opportunity to specify by ballot a choice between approval or disapproval of, or abstention with respect to, each matter or group of related matters referred to therein as intended to be acted upon, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified provided the form of proxy states in bold face type how it is intended to vote the shares represented by the proxy in each such case.

C. A form of proxy which provides both for the election of directors and for action on other specified matters shall be prepared so as clearly to provide, by a box or otherwise, means by which the security holder may withhold authority to vote for any nominee for election as a director. Any such form of proxy which is executed by the security holder in such manner as not to withhold authority to vote for the election of all nominees shall be deemed to grant such authority for all nominees for which a vote is not withheld, provided the form of proxy so states in bold face type.

D. A proxy may confer discretionary authority to vote with respect to any of the following matters:

(1) matters which the persons making the solicitation do not know, a reasonable time before the solicitation, are to be presented at the meeting, if a specific statement to that effect is made in the proxy statement or form of proxy;

(2) approval of the minutes of the prior meeting if such approval does not amount to ratification of the action taken at that meeting;

(3) the election of any person to any office for which a bona fide nominee is named in the proxy statement and such nominee is unable to serve or for good cause will not serve;

(4) any proposal omitted from the proxy statement and form of proxy pursuant to 13 NMAC 3.4.15 or 13 NMAC 3.4.16 [now 13.3.4.15 or 13.3.4.16 NMAC];

(5) matters incident to the conduct of the meeting.

E. No proxy shall confer authority: 1) to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement: or 2) to vote at any annual meeting, other than the next annual meeting (or any adjournment thereof), to be held after the date on which the proxy statement and form of proxy are first sent or given to security holders. A person shall not be deemed to be a bona fide nominee and he shall not be named as such unless he has consented to being named in the proxy statement and to serve if elected.

F. The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the securities represented by the proxy will be voted and that where the person solicited specifies by means of a ballot provided pursuant to 13 NMAC 3.4.11.2 [now Subsection B of 13.3.4.11 NMAC] a choice with respect to any matter to be acted upon, the securities will be voted in accordance with specifications so made.

[7/1/97; Recompiled 11/30/01]

13.3.4.12 PRESENTATION OF INFORMATION IN PROXY STATEMENT:

A. The information included in the proxy statement shall be clearly presented and the statements made shall be divided into groups according to subject matter and the various groups of statements shall be preceded by appropriate headings.

B. All proxy statements shall disclose, under an appropriate caption, the date by which proposals of security holders intended to be presented at the next annual meeting must be received by the issuer for inclusion in the issuer's proxy statement and form of proxy relating to that meeting, such date to be calculated in accordance with the provisions of 13 NMAC 3.4.15.1 [now Subsection A of 13.3.4.15 NMAC]. If the date of the next annual meeting is subsequently advanced by more than thirty (30) calendar days or delayed by more than ninety (90) calendar days from the date of the annual meeting to which the proxy statement relates, the issuer shall, in a timely manner, inform security holders of such change, and the date by which proposals of security holders must be received, by any means reasonably calculated to so inform them.

[7/1/97; Recompiled 11/30/01]

13.3.4.13 MATERIAL REQUIRED TO BE FILED:

A. Two (2) preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to security holders concurrently therewith (or the information statement pursuant to schedule C) shall be filed with the superintendent at least ten (10) days prior to the date definitive copies of such material are first sent or given to security holders, or such shorter period prior to that date as the superintendent may authorize upon a showing of good cause therefor.

B. Two (2) preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to security holders subsequent to the proxy statement shall be filed with the superintendent at least two (2) days (exclusive of Saturdays, Sundays and holidays) prior to the date copies of such material are first sent or given to security holders, or such shorter period prior to such date as the superintendent may authorize upon a showing of good cause therefor.

C. Two (2) definitive copies of the proxy statement, form of proxy and all other soliciting material (or the information statement) in the form in which such material is furnished to security holders, shall be filed with, or mailed for filing to, the superintendent no later than the date such material is first sent or given to any security holder.

D. Copies of replies to inquiries from security holders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this section.

E. Notwithstanding the provisions of 13 NMAC 3.4.13.1, 13 NMAC 3.4.13.2 and 13 NMAC 3.4.18.5 [now Subsection A and B of 13.3.4.13 and Subsection E of 13.3.4.18 NMAC], copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the superintendent prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the superintendent as required by 13 NMAC 3.4.13.3 [now Subsection C of 13.3.4.13 NMAC] not later than the date such material is used or published. The provisions of 13 NMAC 3.4.13.1, 13 NMAC 3.4.13.2 and 13 NMAC 3.4.18.5 [now Subsection A and B of 13.3.4.13 and Subsection E of 13.3.4.18 NMAC] shall apply, however, to any reprints or reproductions of all or any part of such material.

F. Where any proxy statement, form of proxy or other material filed pursuant to this rule is amended or revised, one of the copies of such amended or revised material filed pursuant to this rule shall be marked to indicate clearly and precisely the changes effected therein.

[7/1/97; Recompiled 11/30/01]

13.3.4.14 MAILING COMMUNICATIONS FOR SECURITY HOLDERS:

If the management of the issuer has made or intends to make any solicitation subject to this rule, the issuer shall perform such of the following acts as may be duly requested in

writing with respect to the same subject matter or meeting by any security holder who is, or security holders who are, entitled to vote at least one percent (1%) of the votes entitled to be voted on such matter and who shall defray the reasonable expenses to be incurred by the issuer in the performance of the act or acts requested.

A. The issuer shall mail or otherwise furnish to such security holder, as promptly as practicable after the receipt of such request:

(1) a statement of the approximate number of record owners and, to the extent known to the issuer, the approximate number of beneficial owners of any class of securities, any of whom have been or are to be solicited on behalf of the management, or any group of whom the security holder shall designate;

(2) an estimate of the cost of mailing a specified proxy statement, form of proxy or other communication to such owners.

B. Additional mailing requirements:

(1) Copies of any proxy statement, form of proxy or other communication furnished by the security holder shall be mailed by the issuer to such of the security owners specified in 13 NMAC 3.4.14.1.1 [now Paragraph (1) of Subsection A of 13.3.4.14 NMAC] as the security holder shall designate.

(2) Such material furnished by the security holder shall be mailed with reasonable promptness after receipt of the material to be mailed, envelopes or other containers therefor, and postage or payment for postage. The issuer need not, however, mail any such material prior to the first day on which solicitation is made on behalf of the issuer.

(3) The issuer shall not be responsible for such proxy statement, form of proxy or other communication.

C. In lieu of performing the acts specified above, the issuer may, at its option, furnish promptly to such security holder a reasonably current list of the names and addresses of such of the record owners and, to the extent known to the issuer, the beneficial owners as the security holder shall designate and a schedule of the handling and mailing costs if such schedule has been supplied to the issuer.

[7/1/97; Recompiled 11/30/01]

13.3.4.15 PROPOSALS OF SECURITY HOLDERS:

A. If any holder or holders of the securities of an issuer (hereafter referred to as the "proponent") notifies the issuer in writing not less than ninety (90) days before the issuer's annual meeting of his intention to present a lawful proposal for action at a forthcoming meeting of the issuer's security holders and at the time of such notice the

proponent is entitled to vote at least one percent (1%) of the votes entitled to be voted on such proposal, the issuer shall set forth the proposal in its proxy statement and identify it in its form of proxy and provide for the specification of approval or disapproval of such proposal. The proxy statement shall also include the name and address of the proponent.

B. If the issuer opposes any proposal received from a proponent, it shall also, at the request of the proponent, include in its proxy statement a statement of the proponent of not more than 200 words in support of the proposal.

C. The issuer may omit a proposal and any statement in support thereof from its proxy statement and form of proxy under any of the following circumstances:

(1) The proponent has submitted more than one proposal in connection with a particular meeting.

(2) The proposal is more than 300 words in length.

(3) The proposal or the supporting statement is contrary to any section of this rule or the schedules hereto, including 13 NMAC 3.4.16 [now 13.2.4.16 NMAC] which prohibits false or misleading statements in proxy soliciting materials.

(4) The proposal relates to the enforcement of a personal claim or the redress of a personal grievance against the issuer, its management or any other person.

(5) The proposal deals with a matter not significantly related to the issuer's business, a matter beyond the issuer's power to effectuate, a matter relating to the conduct of the ordinary business operations of the issuer, or an election to office.

(6) The proposal is counter to a proposal to be submitted by the issuer at the meeting, the proposal has been rendered moot, or the proposal relates to specific amounts of cash or stock dividends.

(7) The proposal is substantially duplicative of a proposal previously submitted to the issuer by another proponent, which proposal will be included in the management's proxy material for the meeting.

(8) Substantially the same proposal has previously been submitted to security holders in the issuer's proxy statement and form of proxy relating to any annual or special meeting of security holders held within the preceding five (5) calendar years, and received less than five percent (5%) of the total number of votes cast in respect thereof at the time of its most recent submission.

D. If the issuer intends to omit any proposal from its proxy statement and/or forms of proxy, it shall notify the proponent in writing of its intention at least ten (10) days before

the issuer's preliminary proxy material is filed pursuant to 13 NMAC 3.4.13.1 [now Subsection A of 13.3.4.13 NMAC].

[7/1/97; Recompiled 11/30/01]

13.3.4.16 FALSE OR MISLEADING STATEMENTS:

No proxy statement, form of proxy, notice of meeting, information statement, or other communication, written or oral, subject to this rule shall contain any statement which, at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the same meeting or subject matter which has become false or misleading.

[7/1/97; Recompiled 11/30/01]

13.3.4.17 PROHIBITION OF CERTAIN SOLICITATIONS:

No person making a solicitation which is subject to this rule shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the security holder.

[7/1/97; Recompiled 11/30/01]

13.3.4.18 SPECIAL PROVISIONS APPLICABLE TO ELECTION CONTESTS:

A. **Solicitations to which this section applies:** This section applies to any solicitation subject to this rule by any person or group for the purpose of opposing a solicitation subject to this rule by any other person or group with respect to the election or removal of directors at any annual or special meeting of security holders.

B. **Participant or participant in a solicitation:**

(1) For purposes of this section the terms "participant" and "participant in a solicitation" include:

(a) the issuer;

(b) any director of the issuer, and any nominee for whose election as a director proxies are solicited;

(c) any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

(2) For the purpose of this section the terms "participant" and "participant in a solicitation" do not include:

(a) a bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of securities and who is not otherwise a participant;

(b) any person or organization retained or employed by a participant to solicit security holders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties;

(c) any person employed in the capacity of attorney, accountant or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment;

(d) any person regularly employed as an officer or employee of the issuer or any of its subsidiaries or affiliates who is not otherwise a participant; or

(e) any officer or director of, or any person regularly employed by any other participant, if such officer, director or employee is not otherwise a participant.

C. Filing of information required by schedule B:

(1) No solicitation subject to this section shall be made by any person other than the issuer unless at least five (5) business days prior thereto, or such shorter period as the superintendent may authorize upon a showing of good cause therefor, there has been filed with the superintendent, by or on behalf of each participant in such solicitation, a statement in duplicate containing the information specified by schedule B and a copy of any material proposed to be distributed to security holders in furtherance of such solicitation.

(2) Within five (5) business days after a solicitation subject to this section is made by the issuer, or such longer period as the superintendent may authorize upon showing of good cause therefor, there shall be filed with the superintendent, by or on behalf of each participant in such solicitation other than the issuer, a statement in duplicate containing the information specified by schedule B.

(3) If any solicitation on behalf of the issuer or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this section in opposition thereto, a statement in duplicate containing the information specified in schedule B shall be filed with the superintendent, by or on behalf of each participant in such prior solicitation, other than the issuer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(4) If, subsequent to the filing of the statements required by 13 NMAC 3.4.18.1, 13 NMAC 3.4.18.2 and 13 NMAC 3.4.18.3 [now Subsections A, B and C of 13.3.4.18 NMAC]additional persons become participants in a solicitation subject to this section, there shall be filed with the superintendent, by or on behalf of each such person, a statement in duplicate containing the information specified by schedule B,

within three (3) business days after such person becomes a participant, or such longer period as the superintendent may authorize upon a showing of good cause therefor.

(5) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the superintendent.

(6) Each statement and amendment thereto filed pursuant to 13 NMAC 3.4.18.3 [now Subsection C of 13.3.4.18 NMAC] shall be part of the public files of the superintendent.

D. **Solicitations prior to furnishing required written proxy statement:** Notwithstanding the provisions of 13 NMAC 3.4.10.1 [now Subsection A of 13.3.4.10 NMAC], a solicitation subject to this section may be made prior to furnishing security holders a written proxy statement containing the information specified in schedule A with respect to such solicitation, provided that:

(1) The statements required by 13 NMAC 3.4.18.3 [now Subsection C of 13.3.4.18 NMAC] are filed by or on behalf of each participant in such solicitation.

(2) No form of proxy is furnished to security holders prior to the time the written proxy statement required by 13 NMAC 3.4.10.1 [now Subsection A of 13.3.4.10 NMAC] is furnished to such persons; provided, however, that 13 NMAC 3.4.18.4.2 [now Paragraph (2) of Subsection D of 13.3.4.18 NMAC] shall not apply where a proxy statement then meeting the requirements of schedule A has been furnished to security holders.

(3) At least the information specified in 13 NMAC 3.4.18.3.2 and 13 NMAC 3.4.18.3.3 [now Paragraphs (2) and (3) of Subsection C of 13.3.4.18 NMAC] to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to security holders in connection with the solicitation.

(4) A written proxy statement containing the information specified in schedule A with respect to a solicitation is sent or given security holders at the earliest practicable date.

E. **Solicitations prior to furnishing required written proxy statement - filing requirements:** Two copies of any soliciting materials proposed to be sent or given to security holders prior to the furnishing of the written proxy statement required by 13 NMAC 3.4.10.1 [now Subsection A of 13.3.4.10 NMAC] shall be filed with the superintendent in preliminary form at least five (5) business days prior to the date definitive copies of such material are first sent or given to such persons, or such shorter period as the superintendent may authorize upon a showing of good cause therefor.

F. **Notice to superintendent required:** Notwithstanding the provisions of 13 NMAC 3.4.10.2 [now Subsection B of 13.3.4.10 NMAC], two (2) copies of any portion of

the annual report referred to in 13 NMAC 3.4.10.2 [now Subsection B of 13.3.4.10 NMAC] which comments upon or refers to any solicitation subject to this section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the superintendent as proxy material subject to this rule. Such portion of the report shall be filed with the superintendent, in preliminary form, at least five (5) business days prior to the date copies of the report are first sent or given to security holders.

[7/1/97; Recompiled 11/30/01]

13.3.4.19 SCHEDULE A - INFORMATION REQUIRED:

A. **Revocability of proxy:** State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited, or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

B. **Dissenters' rights of appraisal:** Outline briefly any rights of appraisal or similar rights of dissenters with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by dissenting security holders in order to perfect such rights. Where such rights may be exercised only within a limited time after the date of adoption of a proposal, the filing of a charter amendment or other similar act, state whether the person solicited will be notified of such date.

C. **Persons making the solicitation:**

(1) Solicitations not subject to 13 NMAC 3.4.18 [now 13.3.4.18 NMAC]:

(a) If the solicitation is made by the issuer, so state. Give the name of any director of the issuer who has informed the issuer in writing that he intends to oppose any action intended to be taken by the issuer and indicate the action which he intends to oppose.

(b) If the solicitation is made otherwise than by the issuer, so state and give the names of the persons by whom and on whose behalf it is made.

(c) If the solicitation is to be made otherwise than by the use of the mails, describe the methods to be employed. If the solicitation is to be made by specially engaged employees or paid solicitors, state:

(i) the material features of any contract or agreement for such solicitation and identify the parties; and

(ii) the cost or anticipated cost thereof.

(d) State the names of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

(2) Solicitations subject to 13 NMAC 3.4.18 [now 13.3.4.18 NMAC]:

(a) State by whom the solicitation is made and describe the methods employed and to be employed to solicit security holders.

(b) If regular employees of the issuer or any other participant in a solicitation have been or are to be employed to solicit security holders, describe the class or classes of employees to be so employed, and the manner and nature of their employment for such purpose.

(c) If specially engaged employees, representatives or other persons have been or are to be employed to solicit security holders, state:

(i) the material features of any contract or arrangement for such solicitation and identify the parties;

(ii) the cost or anticipated cost thereof; and

(iii) the approximate number of such employees or employees of any other person (naming such other person) who will solicit security holders.

(d) State the total amount estimated to be spent and the total expenditures to date for or in connection with the solicitation of security holders.

(e) State by whom the cost of the solicitation will be borne. If reimbursement will be sought from the issuer, state whether the question of such reimbursement will be submitted to a vote of security holders.

(f) If any such solicitation is terminated pursuant to a settlement between the issuer and any other participant in such solicitation, describe the terms of such settlement, including the cost or anticipated cost thereof to the issuer.

D. **Interest of certain persons in matters to be acted upon:**

(1) Solicitations not subject to 13 NMAC 3.4.18 [now 13.3.4.18 NMAC]. Describe briefly and substantial interest, direct or indirect of each of the following persons in any matter to be acted upon, other than elections to office:

(a) if the solicitation is made on behalf of the issuer, each current director or officer of the issuer.

(b) if the solicitation is made otherwise than on behalf of the issuer, any person who would be a participant in a solicitation (except the issuer, or an officer, director, or nominee of the issuer);

(c) each nominee for election as a director of the issuer; or

(d) each associate of the foregoing persons.

(2) Solicitations subject to 13 NMAC 3.4.18: [now 13.3.4.18 NMAC] Describe briefly any substantial interest, direct or indirect, of each participant (except the issuer) in any matter to be acted upon at the meeting, and include with respect to each participant the information or an adequate summary thereof, required by 13 NMAC 3.4.20.2.1, 13 NMAC 3.4.20.2.2, 13 NMAC 3.4.20.2.6, 13 NMAC 3.4.20.3, 13 NMAC 3.4.20.4.2, and 13 NMAC 3.4.20.4.3 [now Paragraphs (1), (2) and (6) of Subsection B of 13.3.4.20 NMAC, Subsection C of 13.3.4.20 NMAC and Paragraphs (2) and (3) of Subsection D of 13.3.4.20 NMAC] of schedule B.

E. **Voting securities and principal holders thereof:**

(1) State as to each class of voting securities of the issuer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

(2) Give the date as of which the record of security holders entitled to vote at the meeting will be determined. If the right to vote is not limited to security holders of record on that date, indicate the conditions under which other security holders may be entitled to vote.

(3) If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights:

(a) make a statement that they have such rights;

(b) describe such rights;

(c) state the conditions precedent to the exercise thereof; and

(d) if discretionary authority to cumulate votes is solicited, so indicate.

(4) Furnish the following information as of the most recent practicable date, in substantially the tabular form indicated, with respect to:

(a) any person or group of persons who is known to be the beneficial owner of more than five percent (5%) of any class of securities; and

(b) all directors and nominees, naming them, and directors and officers of the issuer as a group, without naming them.

(1) Title Of Class	(2) Name of Beneficial Owner Ownership	(3) Amount and Nature of Beneficial	(4) Percent of Class

(5) If, to the knowledge of the persons on whose behalf the solicitation is made, a change in control of the issuer has occurred since the beginning of its last fiscal year, state the name of the person(s) who acquired control, the amount and the source of the consideration used by such person or persons, the basis of the control, the date and a description of the transaction(s) which resulted in the change of control and the percentage of voting securities of the issuer now beneficially owned directly or indirectly by the person(s) who acquired control; and the identity of the person(s) from whom control was assumed. Describe any arrangements which may at a subsequent date result in a change of control of the issuer.

F. **Directors and executive officers:** If action is to be taken with respect to election of directors, furnish the following information, in tabular form to the extent practicable, with respect to each person nominated for election as a director and each person whose term of office will continue after the meeting. However, if the solicitation is made on behalf of persons other than the issuer, the information required need be furnished only as to nominees of the persons making the solicitation.

(1) Identification of directors and officers: List the names and ages of all directors and officers of the issuer, and all persons nominated or chosen to become directors or officers; indicate all positions and offices with the issuer held by each such person; state his term of office as director and/or officer and any period(s) during which he has served as such; briefly describe any arrangement or understanding between him and any other person or persons (naming such person(s)) pursuant to which he was or is to be selected as a director, officer or nominee. The information regarding officers need not be furnished in proxy or information statements provided that such information is furnished in a separate item in the issuer's annual report to stockholders.

(2) Family relationships: State the nature of any family relationship not more remote than first cousin between any director, officer or person nominated or chosen by the issuer to become a director or officer and also any such family relationship between any such person and any officer or director of any of the issuer's parents, subsidiaries or other affiliates.

(3) Business experience: State the principal occupations and employment during the past five (5) years of each director and each person nominated or chosen to become a director or officer and the name and principal business of any corporation or other organization in which such occupations and employment were carried on.

(4) Directorships: Indicate other directorships held by each director or person nominated or chosen to become a director.

(5) Involvement in certain legal proceedings: Describe any legal proceedings which have occurred during the past five (5) years or which are pending which are material to an evaluation of the ability or integrity of any director, or person nominated to become a director or officer of the issuer.

(6) Describe any of the following relationships which exist:

(a) If the nominee or director is, or has within the last two (2) full fiscal years been, an officer, director or employee of, or owns, or has within the last two (2) fiscal years owned, directly or indirectly, in excess of a one percent (1%) equity interest in any firm, corporation or other business or professional entity:

(i) which has made payments to the issuer or its subsidiaries during the issuer's last full fiscal year or which proposes to make payments to the issuer or its subsidiaries during the current fiscal year in excess of one percent (1%) of the issuer's consolidated gross revenues for its last full fiscal year;

(ii) to which the issuer or its subsidiaries were indebted at any time during the issuer's last fiscal year in an aggregate amount in excess of one percent (1%) of the issuer's total consolidated assets at the end of such fiscal year;

(iii) to which the issuer or its subsidiaries have made payments during such entity's last fiscal year or to which the issuer or its subsidiaries propose to make payments during such entity's current fiscal year in excess of one percent (1%) of such entity's consolidated gross revenues for its last full fiscal year;

(iv) in order to determine whether payments made or proposed to be made exceed one percent (1%) of the consolidated gross revenues of any entity other than the issuer for such entity's last full fiscal year, it is appropriate to rely on information provided by the nominee or director;

(v) in calculating payments for property and services, the following may be excluded: 1) payments where the rates or charges involved in the transaction are determined by competitive bids, or the transaction involves the rendering of services as a public utility at rates or charges fixed in conformity with law or governmental authority; 2) payments which arise solely from the ownership of securities of the issuer and no extra or special benefit not shared on a pro rata basis by all holders of the class of securities is received;

(vi) in calculating indebtedness for purposes of 13 NMAC 3.4.19.6.6.1.2 [now Item (ii) of Subparagraph (a) of Paragraph (6) of Subsection F of 13.3.4.19 NMAC], debt securities which have been publicly offered, admitted to trading on a

national securities exchange, or quoted on the automated quotation system of a registered securities association may be excluded.

(b) The nominee or director is a member or employee of, or is associated with, a law firm which the issuer has retained in the last two (2) full fiscal years or proposes to retain in the current fiscal year where fees paid or anticipated to be paid by the issuer are material to either the law firm, the issuer or both.

(c) The nominee or director is a director, partner, officer or employee of any investment banking firm which has performed services for the issuer other than as a participating underwriter in a syndicate in the last two (2) full fiscal years or which the issuer proposes to have perform services in the current year; or

(d) The nominee or director is a control person of the issuer (other than solely as a director of the issuer).

(7) State whether or not the issuer has standing audit, nominating and compensation committees of the board of directors, or committees performing similar functions. If the issuer has such committees, however designated, identify each committee member, state the number of committee meetings held by each such committee during the last fiscal year and describe briefly the functions performed by such committees. If the issuer has a nominating or similar committee, state whether the committee will consider nominees recommended by shareholders and, if so, describe the procedures to be followed by shareholders in submitting such recommendations.

(8) State the total number of meetings of the board of directors (including regularly scheduled and special meetings) which were held during the last full fiscal year. Name each incumbent director who during the last full fiscal year attended fewer than seventy-five percent (75%) of the aggregate of:

(a) the total number of meetings of the board of directors (held during the period for which he has been a director); and

(b) the total number of meetings held by all committees of the board on which he served (during the periods that he served).

(9) If a director has resigned or declined to stand for re-election to the board of directors since the date of the last annual meeting of shareholders because of a disagreement with the issuer on any matter relating to the issuer's operations, policies or practices, and if the director has furnished the issuer with a letter describing such disagreement and requesting that the matter be disclosed, the issuer shall state the date of resignation or declination to stand for re-election and summarize the director's description of the disagreement. If the issuer believes that the description provided by the director is incorrect or incomplete, it may include a brief statement presenting its views of the disagreement.

(10) With respect to those classes of voting stock which participated in the election of directors at the most recent meeting at which directors were elected:

(a) State the percentage of shares present at the meeting and voting or withholding authority to vote in the election of directors; and

(b) Disclose in tabular format, the percentage of total shares cast for and withheld from the vote for or, where applicable, cast against, each nominee, which, respectively, were voted for and withheld from the vote for, or voted against, such nominee.

(c) When groups of classes or series of classes vote together in the election of a director or directors, they shall be treated as a single class for the purpose of the preceding sentence.

(11) Notes:

(a) Calculate the percentage of shares present at the meeting and voting or withholding authority to vote in the election of directors, referred to in 13 NMAC 3.4.19.6.10.1 [now Subparagraph (a) of Paragraph (10) of Subsection F of 13.3.4.19 NMAC], by dividing the total shares cast for and withheld from the vote for or, where applicable, voted against, the director in respect of whom the highest aggregate number of shares was cast by the total number of shares outstanding which were eligible to vote as of the record date for the meeting.

(b) No information need be given in response to 13 NMAC 3.4.19.6.10 [now Paragraph (10) of Subsection F of 13.3.4.10 NMAC] unless, with respect to any class of voting stock (or group of classes which voted together), five percent (5%) or more of the total shares cast for and withheld from the votes for or, where applicable, cast against any nominee were withheld from the vote for or cast against such nominee.

(c) If an issuer elects less than the entire board of directors annually, disclosure is required as to all directors if five (5%) percent or more of the total shares cast for and withheld from, the vote for, or, where applicable, cast against any incumbent director were withheld from, or cast against the vote for such director at the meeting at which he was most recently elected.

(d) No information need be given in response to 13 NMAC 3.4.19.6.10 [now Paragraph (10) of Subsection F of 13.3.4.19 NMAC] if the issuer has previously furnished to its security holders a report of the results of the most recent meeting of security holders at which directors were elected which includes: 1) a description of each matter voted upon at the meeting and a statement of the percentage of the shares voting which were voted for and against each such matter; and 2) the information which would be called for by 13 NMAC 3.4.19.6.10 [now Paragraph (10) of Subsection F of 13.3.4.19 NMAC]. If an issuer has previously furnished such results to its security

holders, this fact should be set forth in a letter accompanying the filing of preliminary proxy materials with the superintendent.

G. **Remuneration of directors and officers:** Furnish the following information if action is to be taken with regard to: 1) the election of directors; 2) any bonus, profit sharing or other remuneration plan, contract, or arrangement in which any director, nominee for election as a director, or officer of the issuer will participate; 3) any pension or retirement plan in which any such person will participate; or 4) the granting or extension to any such person of any options, warrants or rights to purchase any securities, other than warrants or rights issued to security holders as such, on a pro rata basis. If the solicitation is made on behalf of persons other than the issuer, the information required need be furnished only as to nominees of the person making the solicitation and associates of such nominees.

(1) Current remuneration: Furnish the information required in the table below, in substantially the tabular form specified, concerning all remuneration of the following persons and groups for services in all capacities to the issuer and its subsidiaries during the issuer's last fiscal year, or, in specified instances, certain prior fiscal years:

(a) five (5) officers or directors: each of the five (5) most highly compensated officers or directors of the issuer as to whom the total remuneration required to be disclosed in columns C1 and C2 below, would exceed $50,000, naming each such person; and

(b) all officers or directors. All officers and directors of the issuer as a group, stating the number of persons in the group without naming them.

(c) Specified tabular format:

(A) Name of individual or number of persons in group	(B) Capacities in which served	(C) Cash and cash-equivalent forms of renumeration		(D) Aggregate of contingent forms of remuneration
		(C1) Salaries, fees, director's fees, commissions, and bonuses	(C2) Securities of property insurance benefits or reimbursements, personal benefits	

(d) Information to be included: Columns C-1, C-2, and D of the table should contain with respect to each person or group of persons specified in 13 NMAC 3.4.19.7.1.1 and 13 NMAC 3.4.19.7.1.2 [now Subparagraphs (a) and (b) of Paragraph (1) of Subsection G of13.3.4.19 NMAC] a dollar amount which reflects the total of all

items of remuneration described in the heading to that column including, but not necessarily limited to, those items set forth in the subparagraphs of that column.

COLUMN C Include all Cash and Cash Equivalent Forms of Remuneration received during the fiscal year and all such amounts accrued during the fiscal year which, with reasonable certainty, will be distributed or vested in the future.		COLUMN D Include all contingent forms of remuneration, distribution, vesting and measurement of which is subject to future events. Report only amounts relating to the latest fiscal year, not amounts accrued in previous periods.
COLUMN C-1 Salaries, Bonuses, Fees and Commissions	COLUMN C-2 Securities, Property,Insurance Benefits or Reimbursements, Personal Benefits (Perquisites)	
1. All cash remuneration distributed or accrued in the form of salaries, commissions, bonuses andfees for services rendered	1. Spread between the acquisition price, if any, and fair market price of securities or property acquired under any contract, plan or arrangement.	1. Amount expenses for financial reporting purposes representing non-vested contributions, payments or accruals under any pension or retirement plans,annuities, employment contracts, deferred compensation plans including IRS qualified plans, unless the amount for the individual cannot be separated in which case a footnote is required indicating the percentage which contributions to the plan to participants total remuneration.
2. Compensation earned for services performed in the latest fiscal year even if it is deferred for future payment	2. Cost of any life insurance premiums, health insurance premiums and medical reimbursement plans. Premiums for non-discriminatory plans generally available to all salaried employees are excluded.	2. The amount expensed for financial reporting purposes under any incentive compensation plans (long-term income plans), such as stock appreciation rights, stock options, performance share plans, where payout is based on objective standards or stock values. a. In subsequent years, if the corporation credits compensation expense for financial reporting purposes as a result of a decline in the value of contingent compensation, Column D may be reduced by a corresponding amount. A footnote explaining such action should be included.
3. Payments received in the latest fiscal year but earned in prior years which were deferred until the latest year, if such amounts were not shown in an earlier proxy statement or annual report to stockholders.	3. Personal benefits (perquisites) not directly related to job performance, excluding benefits provided on a non-discriminatory basis, valued on the basis of cost to the insurer of providing such benefits.	3. The amount expensed for financial reporting purposes for any non-vested contribution payment or accrual to stock purchase plans, profit sharing, and thrift plans whether or not they are qualified under the Internal Revenue Code.

	a. If unreasonable effort or expense is required to determine the amounts of personal benefits, they may be omitted if their aggregate value does not exceed $10,000 for each officer. b. If the amount of personal benefits exceed 10% of the amount of total remuneration or $25,000, whichever is less, the amount and a brief description of the benefits must be disclosed in a footnote.	
	4. Vested company contributions to thrift, profit, sharing, pension stock purchase and similar plans.	

(e) Transactions with third parties. 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC], among other things, includes transactions between the issuer and a third party when the primary purpose of the transaction is to furnish remuneration to the persons specified in 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC]. Other transactions between the issuer and third parties in which persons specified in 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC] have an interest, or may realize a benefit, generally are addressed by other disclosure requirements concerning the interest of management and others in certain transactions. 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC] does not require disclosure of remuneration paid to a partnership in which any officer or director was a partner; any such transactions should be disclosed pursuant to these other disclosure requirements, and not as a note to the remuneration table presented pursuant to 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC].

(f) Other permitted disclosure. The issuer may provide additional disclosure through a footnote to the table, through additional columns, or otherwise, describing the components of aggregate remuneration in such greater detail as is appropriate.

(2) Proposed remuneration:

(a) Briefly describe all remuneration payments proposed to be made in the future, pursuant to any existing plan or arrangement to the persons and groups specified in 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC]. As to defined benefit or actuarial plans with respect to which amounts are not included in the table, include a separate table showing the estimated annual benefits payable upon retirement to persons in specified remuneration and years-of-service classifications.

(b) Information need not be furnished with respect to any group life, health, hospitalization or medical reimbursement plans which do not discriminate in favor of

officers or directors of the issuer and which are available generally to all salaried employees.

(3) Remuneration of directors: Describe any standard or special arrangements, stating amounts, by which directors of the issuer are compensated for services as a director.

(4) Options, warrants or rights:

(a) Furnish the information required by 13 NMAC 3.4.19.7.4.2 [now Subparagraph (b) of Paragraph (4) of Subsection G of 13.3.4.19 NMAC] as to all options to purchase securities from the issuer or its subsidiaries which were granted to or exercised by the persons and groups specified in 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC] since the beginning of the issuer's last fiscal year, and as to all options held by such persons as of the latest practicable date. The tabulation shall show as to certain directors and officers and as to all directors and officers as a group:

(i) the amount of options granted since the beginning of the issuer's last full fiscal year;

(ii) the amount of shares acquired since that date through the exercise of options;

(iii) the amount of shares of the same class sold during such period; and

(iv) the amount of shares subject to all unexercised options held as of the most recent practicable date.

(b) Required information:

	Name	Name	Name	All directors and officers as a group
Title of Securities Granted: 19__ to date:				
1. Number of shares	____	____	____	____
2. Average per share option price	$____	$____	$____	$____
Exercised: 19__ to date:				
1. Number of shares	____	____	____	____
2. Aggregate option price of options exercised	$____	$____	$____	$____
3. Aggregate market values of shares on date options	$____	$____	$____	$____

exercised				
Sales: 19__ to date:				
1. Number of shares	____	____	____	____**
Unexercised at 19__:				
1. Number of shares	____	____	____	____
2. Average per share option price	$____	$____	$____	$____

In addition, during the period employees were granted options for ____ shares at an average price per share of $____.

_____

**Sales by directors and officers who exercised options during the period 19__ to date.

Note: All figures should be adjusted, where applicable, in accordance with the terms of the options to reflect stock splits and to give effect to share dividends.

(c) Other tabular presentations are acceptable if they include the necessary data. Tabular presentation may not be needed if only a very few options have been granted.

(d) Where the total market value on the granting dates of the securities called for by all options granted during the period specified does not exceed $10,000 for any officer or director named in answer to 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC], or $40,000 for all officers and directors as a group, 13 NMAC 3.4.19.7 [now Subsection G of 13.3.4.19 NMAC] need not be answered with respect to options granted to such person or group.

(e) Where the total market value on the dates of purchase of all securities purchased through the exercise of options during the period specified does not exceed $10,000 for any such person or $40,000 for such group, 13 NMAC 3.4.19.7 [now Subsection G of 13.3.4.19 NMAC] need not be answered with respect to options exercised by such person or group.

(f) Where the total market value as of the latest practicable date of the securities called for by all options held at such time does not exceed $10,000 for any such person or $40,000 for such group, 13 NMAC 3.4.19.7 [now Subsection G of 13.3.4.19 NMAC] need not be answered with respect to options held as of the specified date by such person or group.

(i) The term "options" as used in 13 NMAC 3.4.19.7.4 [now Paragraph (4) of Subsection G of 13.3.4.19 NMAC] includes all options, warrants or rights, other than those issued to security holders as such on a pro rata basis. Where the average option price per share is called for, the weighted average price per share shall be given.

(ii) The extension, regranting or material amendment of options shall be deemed the granting of options within the meaning of this section.

(iii) If the options relate to more than one class of securities the information shall be given separately for each such class.

(5) Indebtedness of management:

(a) State as to each of the following persons who was indebted to the issuer or its subsidiaries at any time since the beginning of the last fiscal year of the registrant, 1) the largest aggregate amount of indebtedness outstanding at any time during such period, 2) the nature of the indebtedness outstanding and the transaction in which it was incurred, 3) the amount thereof outstanding as of the latest practicable date, and 4) the rate of interest paid or charged thereon:

(i) each director or officer of the issuer;

(ii) each nominee for election as a director; and

(iii) each associate of any such director, officer or nominee.

(b) 13 NMAC 3.4.19.7.5 [now Paragraph (5) of Subsection E of 13.3.4.19 NMAC] does not apply to:

(i) any person whose aggregate indebtedness did not exceed $10,000 or one percent (1%) of the issuer's total assets, whichever is less, at any time during the period specified; or

(ii) indebtedness under an insurance policy.

(6) Transactions with management:

(a) Describe briefly any transaction since the beginning of the issuer's last fiscal year or any presently proposed transactions, to which the issuer or any of its subsidiaries was or is to be a party, in which any of the following persons had or is to have a direct or indirect material interest, naming such person and stating his relationship to the issuer, the nature of his interest in the transaction and, where practicable, the amount of such interest:

(i) any director or officer of the issuer;

(ii) any nominee for election as a director;

(iii) any security holder who is known to the issuer to own of record or beneficially more than ten percent (10%) of any class of the issuer's voting securities; and

(iv) any relative or spouse of any of the foregoing persons, or any relative of such spouse, who has the same home as such person or who is a director or officer of any parent or subsidiary of the issuer.

(b) Also, describe briefly any material legal proceedings to which any such person is a party adverse to the issuer or any of its subsidiaries or has a material interest adverse to the issuer or any of its subsidiaries.

(c) No information need be given in response to 13 NMAC 3.4.19.7.6 [now Paragraph (6) of Subsection G of 13.3.4.19 NMAC] as to any remuneration or other transaction reported in response to 13 NMAC 3.4.19.7.1, 13 NMAC 3.4.19.7.2, 13 NMAC 3.4.19.7.3, 13 NMAC 3.4.19.7.4 or 13 NMAC 3.4.19.7.5 [now Paragraphs (1), (2), (3), (4) or (5) of Subsection G of 13.3.4.19 NMAC], or as to any transaction with respect to which information may be omitted pursuant to these sections.

(d) No information need be given in answer to 13 NMAC 3.4.19.7.6 [now Paragraph (6) of Subsection G of 13.3.4.19 NMAC] as to any transaction where:

(i) the rates or charges involved in the transaction are determined by competitive bids, or at rates or charges fixed in conformity with law or governmental authority;

(ii) the transaction involves services as a bank depository of funds, transfer agent, registrar, trustee under a trust indenture, or similar services;

(iii) the amount involved in the transaction or series of similar transactions, including all periodic installments in the case of any lease or other agreement providing for periodic payments or installments, does not exceed $40,000; or

(iv) the interest of the specified person arises solely from the ownership of securities of the issuer and the specified person receives no extra or special benefit not shared on a pro rata basis by all holders of securities of the class.

(e) It should be noted that 13 NMAC 3.4.19.7 [now Subsection G of 13.3.4.19 NMAC] calls for disclosure of indirect, as well as direct, material interests in transactions. A person who has a position or relationship with a firm, corporation or other entity, which engages in a transaction with the issuer or its subsidiaries may have an indirect interest in such transaction by reason of such position or relationship. However, a person shall be deemed not to have a material indirect interest in a transaction within the meaning of 13 NMAC 3.4.19.7.6 [now Paragraph (6) of Subsection G of 13.3.4.19 NMAC] where:

(i) the interest arises only 1) from such person's position as a director of another corporation or organization (other than a partnership) which is a party to the transaction; or 2) from the direct or indirect ownership by such person and all other persons specified in 13 NMAC 3.4.19.7.6 [now Paragraph (6) of Subsection G of

13.3.4.19 NMAC] of less than a 10 percent (10%) equity interest in another person (other than a partnership) which is a party to the transaction; or 3) from both such position and ownership;

(ii) the interest arises only from such person's position as a limited partner in a partnership in which he and all other persons specified in 13 NMAC 3.4.19.7.6 [now Paragraph (6) of Subsection G of 13.3.4.19 NMAC] had an interest of less than 10 percent; or

(iii) the interest of such person arises solely from the holding of an equity interest (including a limited partnership interest but excluding a general partnership interest) or a creditor interest in another person which is a party to the transaction with the issuer or any of its subsidiaries and the transaction is not material to such other person.

(f) In describing any transaction involving the purchase or sale of assets by or to the issuer or any of its subsidiaries, otherwise than in the ordinary course of business, state the cost of the assets to the purchaser and, if acquired by the seller within two (2) years prior to the transaction, the cost thereof to the seller. Indicate the principle followed in determining the issuer's purchase or sale price and the name of the person making such determination.

(g) Information shall be furnished in answer to 13 NMAC 3.4.19.7 [now Subsection G of 13.3.4.19 NMAC] with respect to transactions not excluded above which involve remuneration from the issuer or its subsidiaries, directly or indirectly, to any of the specified persons for services in any capacity unless the interest of such persons arises solely from the ownership individually and in the aggregate of less than 10 percent (10%) of any class of equity securities of another corporation furnishing the services to the issuer or its subsidiaries.

(7) Transactions with pension or similar plans:

(a) Describe briefly any transactions since the beginning of the issuer's last fiscal year, or any presently proposed transactions, to which any pension, retirement, savings or similar plan provided by the issuer, or any of its parents or subsidiaries was or is to be a part, in which any of the persons specified in 13 NMAC 3.4.19.7.6 [now Paragraph (6) of Subsection G of 13.3.4.19 NMAC] or the issuer or any of its subsidiaries had or is to have a direct or indirect material interest naming such person and stating his relationship to the issuer, the nature of his interest in the transaction and, where practicable, the amount of such interest.

(b) No information need be given in answer to 13 NMAC 3.4.19.7.7 [now Paragraph (7) of Subsection G of 13.3.4.19 NMAC] with respect to:

(i) payments to the plan, or payments to beneficiaries, pursuant to the terms of the plan;

(ii) payment of remuneration for services not in excess of five percent (5%) of the aggregate remuneration received by the specified person during the issuer's last fiscal year from the issuer and its subsidiaries; or

(iii) any interest of the issuer or any of its subsidiaries which arises solely from its general interest in the success of the plan.

(c) 13 NMAC 3.4.19.7.6.3 [now Subparagraph (c) of Paragraph (6) of Subsection G of 13.3.4.19 NMAC] shall apply to 13 NMAC 3.4.19.7.7 [now Paragraph (7) of Subsection G of 13.3.4.19 NMAC].

(d) Without limiting the general meaning of the term "transaction" there shall be included in answer to 13 NMAC 3.4.19.7 [now Subsection G of 13.3.4.19 NMAC]any remuneration received or any loans received or outstanding during the period, or proposed to be received.

H. **Matters related to accounting:** If the solicitation is made on behalf of the issuer and relates to an annual meeting of security holders at which directors are to be elected, or financial statements are included, furnish the following information:

(1) If the issuer's financial statements are not certified by independent public or certified accountants, so state.

(2) If the board of directors has no audit or similar committee, so state.

(3) If the issuer's financial statements are certified by independent public or certified accountants, so state and provide the following information:

(a) The name of the principal accountant selected or being recommended to shareholders for election, approval or ratification for the current year. If no accountant has been elected or recommended, so state and briefly describe the reasons therefor.

(b) The name of the principal accountant for the fiscal year most recently completed if different from the accountant selected or recommended for the current year or if no accountant has been elected or recommended for the current year.

(c) If a change or changes in accountants have taken place since the date of the proxy statement for the most recent annual meeting of shareholders, so state, and if in connection with such change(s) a material disagreement in connection with financial disclosure between the accountant and issuer has occurred the disagreement shall be described. Prior to filing the preliminary proxy materials with the superintendent which contains or amends such description, the issuer shall furnish the description of the disagreement to any accountant with whom the disagreement has occurred. If that accountant believes that the description of the disagreement is incorrect or incomplete, he may include a brief statement, not to exceed 200 words, in the proxy statement presenting his view of the disagreement. This statement shall be submitted to the

issuer within ten (10) business days of the date the accountant receives the issuer's descriptions.

(d) The proxy statement shall indicate whether or not representative of the principal accountants for the current year and for the most recently completed fiscal year are expected to be present at the stockholders' meeting with the opportunity to make a statement if they desire to do so and whether or not such representatives are expected to be available to respond to appropriate questions.

(e) If any change in accountants has taken place since the date of the proxy statement for the most recent annual meeting of shareholders, state whether such change was recommended or approved by:

(i) any audit or similar committee of the board of directors, if the issuer has such a committee; or

(ii) the board of directors, if the issuer has no such committee.

(4) For the fiscal year most recently completed, describe each professional service provided by the principal accountant and state the percentage relationship which the aggregate of the fees for all non-audit services bear to the audit fees, and, except as provided below, state the percentage relationship which the fee for each non-audit service bears to the audit fees. Indicate whether, before each professional service provided by the principal accountant was rendered, it was approved by, and the possible effect on the independence of the accountant was considered by:

(a) any audit or similar committee of the board of directors; and

(b) for any service not approved by an audit or similar committee, the board of directors.

(5) For purposes of this subsection, all fees for services provided in connection with the audit function (e.g. reviews of quarterly reports) may be computed as part of the audit fees. Indicate which services are reflected in the audit fees computation.

(6) If the fee for any non-audit service is less than three percent (3%) of the audit fees, the percentage relationship need not be disclosed.

(7) Each service should be specifically described. Broad general categories such as "tax matters" or "management advisory services" are not sufficiently specific.

(8) Describe the circumstances and give details of any services provided by the issuer's independent accountant during the latest fiscal year that were furnished at rates or terms that were not customary.

(9) Describe any existing direct or indirect understanding or agreement that places a limit on current or future years' audit fees, including fee arrangements that provide fixed limits on fees that are not subject to reconsideration if unexpected issues involving accounting or auditing are encountered. Disclosure of fee estimates is not required.

I. **Bonus, profit sharing and other remuneration plans: pension and retirement plans:** If action is to be taken with respect to any bonus, profit sharing or other remuneration plan or any pension or retirement plan, furnish the following information:

(1) Describe briefly the material features of the plan, identify each class of persons who will participate therein, indicate the approximate number of persons in each such class and state the basis of such participation.

(2) Furnish such information, in addition to that required by 13 NMAC 3.4.19.9 and 13 NMAC 3.4.19.7 [now Subsections I and G of 13.3.4.19 NMAC], as may be necessary to describe adequately the provisions already made pursuant to all bonus, profit sharing, pension, retirement, stock option, stock purchase, deferred compensation or other remuneration or incentive plans, now in effect or in effect within the past five (5) years, for:

(a) each director or officer named in answer to 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC] who may participate in the plan to be acted upon;

(b) all present directors and officers of the issuer as a group, if any director or officer may participate in the plan; and

(c) all employees, if employees may participate in the plan.

(3) If the plan to be acted upon can be amended otherwise than by a vote of stockholders, to increase the cost thereof to the issuer or to alter the allocation of the benefits as between the directors and officers on the one hand and employees on the other, state the nature of the amendments which can be so made.

(4) With regard to any bonus, profit sharing or other remuneration plan, on which action is to be taken, furnish the following information.

(a) State separately the amounts which would have been distributable under the plan during the last fiscal year of the issuer:

(i) to directors and officer; and

(ii) to employees if the plan had been in effect.

(b) State the name and position with the issuer of each person specified in 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC], who will participate in the plan and the amount which each such person would have received under the plan for the last fiscal year of the issuer if the plan had been in effect.

(5) With regard to any pension or retirement plan on which action is to be taken, furnish the following information:

(a) the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid and the estimated annual payments necessary to pay the total amount over such period.

(b) the estimated annual payment to be made with respect to current services;

(c) the amount of such annual payments to be made for the benefit of:

(i) directors and officers;and

(ii) employees;

(d) The name and position with the issuer of each person specified in 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC] who will be entitled to participate in the plan.

(e) The amount which would have been paid or set aside by the issuer and its subsidiaries for the benefit of such person for the last fiscal year of the issuer if the plan had been in effect.

(f) The amount of the annual benefits estimated to be payable to such person in the event of retirement at normal retirement date.

(6) If action is to be taken with respect to the amendment or modification of an existing plan, 13 NMAC 3.4.19.9 [now Subsection I of 13.3.4.19 NMAC] shall be answered with respect to the plan as proposed to be amended or modified and shall indicate any material differences from the existing plan.

(7) The following instruction shall apply to 13 NMAC 3.4.19.9.2 [now Paragraph (2) of Subsection I of 13.3.4.19 NMAC]:

(a) Information need only be given with respect to benefits received or set aside within the past five (5) years.

(b) Information need not be included as to payments made for, or benefits to be received from, group life or accident insurance, group hospitalization or similar group payments or benefits.

(c) If action is to be taken with respect to any plan in which directors or officers may participate, the information called for by 13 NMAC 3.4.19.7.4 [now Paragraph (4) of Subsection G of 13.3.4.19 NMAC] shall be furnished for the last five (5) fiscal years of the issuer and any period subsequent to the end of the latest such fiscal year, in aggregate amounts for the entire period for each such person and group. If any named person, or any other director or officer, purchased securities through the exercise of options during such period, state the aggregate amount of securities of that class sold during the period by such named person and by such named person and such other directors and officers as a group. The information called for by this instruction is in lieu of the information since the beginning of the issuer's last fiscal year called for by 13 NMAC 3.4.19.7.4 [now Paragraph (4) of Subsection G of 13.3.4.19 NMAC]. If employees may participate in the plan to be acted upon, state the aggregate amount of securities called for by all options grated to employees during the five-year period and, if the options were other than "restricted" or "qualified" stock options or options granted pursuant to an "employee stock purchase plan", as the quoted terms are defined in Sections 422 through 424 of the Internal Revenue Code, state that fact and the weighted average option price per share. The information called for by this instruction may be furnished in the form of the table set forth in 13 NMAC 3.4.19.7.4 [now Paragraph (4) of Subsection G of 13.3.4.19 NMAC].

(8) If the plan to be acted upon is set forth in a written document, three copies thereof shall be filed with the superintendent at the time preliminary copies of the proxy statement and form of proxy are filed.

(9) The information called for by 13 NMAC 3.4.19.9.5.3 or 13 NMAC 3.4.19.9.5.5 [now Subparagraph (c) or (e) of Paragraph (5) of Subsection I of 13.3.4.19 NMAC] need not be given as to payments made on an actuarial basis pursuant to any group pension plan which provides for fixed benefits in the event of retirement at a specified age or after a specified number of years of service.

J. **Options, warrants or rights:** If action is to be taken with respect to the granting or extension of any options to purchase securities of the issuer or any subsidiary, furnish the following information:

(1) State:

(a) the title and amount of securities called for or to be called for by such options;

(b) the prices, expiration dates and other material conditions upon which the options may be exercised;

(c) the consideration received or to be received by the issuer or subsidiary for the granting or extension of the options;

(d) the market value of the securities called for or to be called for by the options as of the latest practicable date; and

(e) in the case of options, the federal income tax consequences of the issuance and exercise of such option to the recipient and to the issuer.

(2) State separately the amount of options received or to be received by the following persons, naming each such person:

(a) each director or officer named in answer to 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC];

(b) each nominee for election as a director of the issuer;

(c) each associate of such directors, officers, or nominees; and

(d) each other person who received or is to receive ten percent (10%) or more of such options.

(e) state, also, the total amount of such options received or to be received by all directors and officers of the issuer as a group, without naming them.

(3) Furnish such information, in addition to that required by 13 NMAC 3.4.19.10 and 13 NMAC 3.4.19.7 [now Subsection J and G of 13.3.4.19 NMAC], as may be necessary to describe adequately the provisions already made pursuant to all bonus, profit sharing, pension, retirement, stock option, stock purchase, deferred compensation, or other remuneration or incentive plans, now in effect or in effect within the past five (5) years, for:

(a) each director or officer named in answer to 13 NMAC 3.4.19.7.1 [now Paragraph (1) of Subsection G of 13.3.4.19 NMAC] who may participate in the plan to be acted upon;

(b) all present directors and officers of the issuer as a group, if any director or officer may participate in the plan, and

(c) all employees, if employees may participate in the plan.

(4) For the purpose of 13 NMAC 3.4.19.10 [now Subsection J of 13.3.4.19 NMAC] the term option includes any option, warrant or right.

(5) 13 NMAC 3.4.19.10.2 and 13 NMAC 3.4.19.10.3 [now Paragraphs (2) and (3) of Subsection J of 13.3.4.19 NMAC] do not apply to warrants or rights to be issued to security holders as such on a pro rata basis.

(6) 13 NMAC 3.4.19.9.7 [now Paragraph (7) of Subsection I of 13.3.4.19 NMAC] shall also apply to 13 NMAC 3.4.19.10.3 [now Paragraph (3) of Subsection J of 13.3.4.19 NMAC].

(7) If the options described in answer to 13 NMAC 3.4.19.10 [now Subsection J of 13.3.4.19 NMAC] are issued pursuant to a plan which is set forth in a written document, three copies thereof shall be filed with the superintendent at the time preliminary copies of the proxy statement and form of proxy are filed.

K. **Authorization or issuance of securities otherwise than for exchange:** If action is to be taken with respect to the authorization or issuance of any securities otherwise than for exchange for outstanding securities of the issuer, furnish the following information:

(1) State the title and amount of securities to be authorized or issued.

(2) If the securities are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation, preemptive and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

(3) Describe briefly the transaction in which the securities are to be issued, including a statement as to:

(a) The nature and approximate amount of consideration received or to be received by the issuer; and

(b) The approximate amount devoted to each purpose, as far as is determinable, for which the net proceeds have been or are to be used.

(c) If it is impracticable to describe the transaction in which the securities are to be issued, state the reason, indicate the purpose of the authorization of the securities, and state whether further authorization for the issuance of the securities by a vote of security holders will be solicited prior to such issuance.

(4) If the securities are to be issued otherwise than in a general public offering for cash, state the reasons for the proposed authorization or issuance and the general effect thereof upon the rights of existing security holders.

L. **Modification or exchange of securities:** If action is to be taken with respect to the modification of any class of securities of the issuer, or the issuance or authorization for issuance of securities of the issuer in exchange for outstanding securities of the issuer, furnish the following information:

(1) If outstanding securities are to be modified, state the title and amount thereof. If securities are to be issued in exchange for outstanding securities, state the

title and amount of securities to be so issued, the title and amount of outstanding securities to be exchanged therefor and the basis of the exchange.

(2) Describe any material differences between the outstanding securities and the modified or new securities.

(3) State the reasons for the proposed modification or exchange and the general effect thereof upon the rights of existing security holders.

(4) Furnish a brief statement as to arrears in dividends or as to defaults in principal or interest in respect to the outstanding securities which are to be modified or exchanged and such other information as may be appropriate in the particular case to disclose adequately the nature and effect of the proposed action.

(5) Outline briefly any other material features of the proposed modification or exchange. If the plan of proposed action is set forth in a written document, file copies thereof with the superintendent at the time the preliminary proxy material is filed.

M. **Mergers, consolidations, acquisitions and similar matters:** Furnish the following information if action is to be taken with respect to any plan for 1) the merger or consolidation of the issuer into or with any other person or of any other person into or with the issuer, 2) the acquisition by the issuer or any of its security holders of securities of another issuer, 3) the acquisition by the issuer of any other going business or of the assets thereof, 4) the sale or other transfer of all or any substantial part of the assets of the issuer, or 5) the liquidation or dissolution of the issuer:

(1) Outline briefly the material features of the plan. State the reasons therefor and the general effect thereof upon the rights of existing security holders. If the plan is set forth in a written document, file three copies thereof with the superintendent at the time preliminary copies of the proxy statement and form of proxy are filed.

(2) Furnish the following information as to the issuer and each person which is to be merged into the issuer or into or with which the issuer is to be merged or consolidated or the business or assets of which are to be acquired or which is the issuer of securities to be acquired by the issuer in exchange for all or a substantial part of its assets or to be acquired by security holders of the issuer. What is required is information essential to an investor's appraisal of the action proposed to be taken.

(a) Describe briefly the business of such person.

(b) State the location and describe the general character of the plants and other important physical properties of such person. The description is to be given from an economic and business standpoint, as distinguished from a legal standpoint. Portfolio or investment assets of an insurer need not be disclosed.

(c) Furnish a brief statement as to dividends in arrears or defaults in principal or interest in respect of any securities of the issuer or of such person, and as to the effect of the plan thereon and such other information as may be appropriate in the particular case to disclose adequately the nature and effect of the proposed action.

(d) Furnish a tabulation in columnar form showing the existing and the pro forma capitalization.

(e) Furnish in columnar form for each of the last five (5) fiscal years an historical summary of earnings and show per share amounts of net earnings, dividends declared for each year and book value per share at the end of the latest period.

(f) Furnish in columnar form for each of the last five (5) fiscal years a combined pro forma summary of earnings, as appropriate in the circumstances, indicating the aggregate and pre-share earnings for each such year and the pro forma book value per share at the end of the latest period. If the transaction establishes a new basis of accounting for assets of any of the persons included therein, the pro forma summary of earnings shall be furnished only for the most recent fiscal year and interim period and shall reflect appropriate pro forma adjustments resulting from such new basis of accounting.

(g) To the extent material for the exercise of prudent judgment in regard to the matter to be acted upon, furnish the historical and pro forma earnings data specified in 13 NMAC 3.4.19.13.2.5 and 13 NMAC 3.4.19.13.2.6 [now Subparagraphs (e) and (f) of Paragraph (2) of Subsection M of 13.3.4.19 NMAC] for interim periods of the current and prior fiscal years, if available.

(3) 13 NMAC 3.4.19.13.2 [now Paragraph (2) of Subsection M of 13.3.4.19 NMAC] shall not apply if the plan described in answer to 13 NMAC 3.4.19.13.1 [now Paragraph (1) of Subsection M of 13.3.4.19 NMAC] involves only the issuer and one or more of its totally-held subsidiaries.

(4) As to each class of securities of the issuer, or of any person specified in 13 NMAC 3.4.19.13.2 [now Paragraph (2) of Subsection M of 13.3.4.19 NMAC], which is admitted to dealing on a national securities exchange or with respect to which a market otherwise exists, and which will be materially affected by the plan, state the high and low sale prices (or, in the absence of trading in a particular period, the range of the bid and asked prices) for each quarterly period within two (2) years. This information may be omitted if the plan involves merely the liquidation or dissolution of the issuer.

N. **Financial statements:**

(1) If action is to be taken with respect to any matter specified in 13 NMAC 3.4.19.11, 13 NMAC 3.4.19.12 or 13 NMAC 3.4.19.13 [now Subsections K, L and M of 13.3.4.19 NMAC], furnish financial statements of the issuer and its subsidiaries complying with the requirements of 13 NMAC 3.4.10.2.1, 13 NMAC 3.4.10.2.2 and 13

NMAC 3.4.10.2.3 [now Paragraphs (1), (2) and (3) of Subsection B of 13.3.4.10 NMAC] including schedules of supplementary profit and loss information. Such statements may be omitted with respect to a plan described in answer to 13 NMAC 3.4.19.3 [now Subsection C of 13.3.4.19 NMAC] if the plan involves only the issuer and one or more of its totally-held subsidiaries.

(2) If action is to be taken with respect to any matter specified in 13 NMAC 3.4.19.13.2 [now Paragraph (2) of Subsection M of 13.3.4.19 NMAC], furnish for each person specified therein, other than the issuer, financial statements complying with the requirements of 13 NMAC 3.4.10.2.1, 13 NMAC 3.4.10.2.2 and 13 NMAC 3.4.10.2.3 [now Paragraphs (1), (2) and (3) of Subsection B of 13.3.4.10 NMAC].

(3) The superintendent may, upon the request of the issuer, permit the omission of any of the statements herein required where such statements are not necessary for the exercise of prudent judgment in regard to any matter to be acted upon, or may permit the filing in substitution therefor of appropriate statements of comparable character. The superintendent may also require the filing of other statements in addition to, or in substitution for, the statements herein required in any case where such statements are necessary or appropriate for an adequate presentation of the financial condition of any person whose financial statements are required, or whose statements are otherwise material for the exercise of prudent judgment in regard to any matter to be acted upon. In the usual case, financial statements are deemed material to the exercise of prudent judgment where the matter to be acted upon is authorization or issuance of a material amount of senior securities, but are not deemed material where the matter to be acted upon is the authorization or issuance of common stock, otherwise than in an exchange, merger or consolidation, acquisition or similar transaction.

(4) The proxy statement may incorporate by reference any financial statements contained in an annual report sent to security holders with respect to the same meeting as that to which the proxy statement relates, provided such financial statements substantially meet the requirements of 13 NMAC 3.4.19.14 [now Subsection N of 13.3.4.19 NMAC].

O. **Acquisition or disposition of property:** If action is to be taken with respect to the acquisition or disposition of any property, furnish the following information:

(1) Describe briefly the general character and location of the property.

(2) State the nature and amount of consideration to be paid or received by the issuer or any subsidiary. To the extent practicable outline briefly the facts bearing upon the question of the fairness of the consideration.

(3) State the name and address of the transferor or transferee, as the case may be, and the nature of any material relationship of such person to the issuer or an affiliate of the issuer.

(4) Outline briefly any other material features of the contract or transaction.

P. **Restatement of accounts:** If action is to be taken with respect to the restatement of any asset, capital or surplus account of the issuer, furnish the following information.

(1) State the nature of the restatement and the date as of which it is to be effective.

(2) Outline briefly the reasons for the restatement and for the selection of the particular effective date.

(3) State the name and amount of each account (including any reserve accounts) affected by the restatement and the effect of the restatement thereon. Tabular presentation of the amounts shall be made when appropriate, particularly in the case of recapitalizations.

(4) To the extent practicable, state whether and the extent, if any, to which the restatement will, as of the date thereof, alter the amount available for distribution to the holders of equity securities.

Q. **Action with respect to reports:** If action is to be taken with respect to any report of the issuer or of its directors, officers or committees or any minutes of meetings of its stockholders, furnish the following information.

(1) State whether or not such action is to constitute approval or disapproval of any of the matters referred to in such reports or minutes.

(2) Identify each of such matters which it is intended will be approved or disapproved and furnish the information required by the appropriate section or sections of this schedule with respect to each such matter.

R. **Matters not required to be submitted:** If action is to be taken with respect to any matter which is not required to be submitted to a vote of security holders, state the nature of such matter, the reasons for submitting it to a vote of security holders and what action is intended to be taken by the management in the event of a negative vote on the matter by the security holders.

S. **Amendment of charter, bylaws or other documents:**

(1) If action is to be taken with respect to any amendment of the issuer's charter, bylaws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment.

(2) Where the matter to be acted upon is the classification of directors, state whether vacancies which occur during the year may be filled by the board of directors to

serve only until the next annual meeting or may be so filled for the remainder of the full term.

T. **Other proposed action:** If action is to be taken with respect to any matter not specifically referred to above describe briefly the substance of each such matter in substantially the same degree of detail as is required by 13 NMAC 3.4.19.5 to 13 NMAC 3.4.19.19 [now Subsection E to Subsection S of 13.3.4.19 NMAC], inclusive.

U. **Vote required for approval:** As to each matter which is to be submitted to a vote of security holders, other than elections to office or the selection or approval of auditors, state the vote required for its approval.

[7/1/97; Recompiled 11/30/01]

13.3.4.20 SCHEDULE B - INFORMATION TO BE INCLUDED IN STATEMENTS FILED BY OR ON BEHALF OF A PARTICIPANT (OTHER THAN THE ISSUER) IN A PROXY SOLICITATION IN AN ELECTION CONTEST:

A. **Issuer:** State the name and address of the issuer.

B. **Identity and background:** State the following:

(1) Your name and business address.

(2) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(3) Your residence address.

(4) Information as to all material occupations, positions, offices or employments during the last ten (10) years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

(5) State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten (10) years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

(6) State whether or not, during the past ten (10) years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this requirement need not be included in the proxy statement or other proxy soliciting material.

C. **Interest in securities of the issuer:**

(1) State the amount of each class of securities of the issuer which you own beneficially, directly or indirectly.

(2) State the amount of each class of securities of the issuer which you own of record but not beneficially.

(3) State with respect to all securities of the issuer purchased or sold within the past two (2) years, the dates on which they were purchased or sold and the amount purchased or sold on each such date.

(4) If any part of the purchase price or market value of any of the securities specified in 13 NMAC 3.4.20.3.3 [now Paragraph (3) of Subsection C of 13.3.4.20 NMAC] is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such securities, so state and indicate the amount of the indebtedness as of the latest practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction, and state the names of the parties.

(5) State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any securities of the issuer including but not limited to joint ventures, loan or option arrangements, puts or calls guarantees against losses or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so, name the persons with whom some contracts, arrangements or understandings exist and give the details thereof.

(6) State the amount of securities of the issuer owned beneficially directly or indirectly, by each of your associates and the name and address of each such associate.

(7) State the amount of each class of securities of any parent, subsidiary or affiliate of the issuer which you own beneficially directly or indirectly.

D. **Further matters:**

(1) Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

(2) Describe briefly, and where practicable state the approximate amount of any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

(3) State whether or not you or any of your associates have any arrangement or understanding with any person:

(a) with respect to any future employment by the issuer or its subsidiaries or affiliates; or

(b) with respect to any future transactions to which the issuer or any of its subsidiaries or affiliates will or may be a party.

(c) If so, describe such arrangement or understanding and state the names of the parties thereto.

E. **Signature:** The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct, to the best of my knowledge and belief.

_____

(Date) (Signature of participant or authorized representative)

[7/1/97; Recompiled 11/30/01]

13.3.4.21 SCHEDULE C - INFORMATION REQUIRED IN INFORMATION STATEMENT:

A. **Note:** Where any section, other than 13 NMAC 3.4.21.6 [now Subsection F of 13.3.4.21 NMAC], calls for information with respect to any matter to be acted upon at the meeting, such section need be answered only with respect to proposals to be made by the issuer.

B. **Information required by schedule A:** Furnish the information called for by all of the sections of schedule A (other than 13 NMAC 3.4.19.1, 13 NMAC 3.4.19.3 and 13 NMAC 3.4.19.4) [now Subsections A, C and D of 13.3.4.19 NMAC] which would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting.

C. **Statement that proxies are not solicited:** The following statement shall be set forth on the first page of the information statement in bold face type: WE ARE NOT ASKING YOU FOR A PROXY AND YOU ARE REQUESTED NOT TO SEND US A PROXY.

D. **Date, time and place of meeting:** State the date, time and place of the meeting of security holders, unless such information is otherwise disclosed in material furnished to security holders with the information statement.

E. **Interest of certain persons in or opposition to matters to be acted upon:**

(1) Describe briefly any substantial interest, direct or indirect, by security holdings or otherwise, of each of the following persons in any matter to be acted upon, other than elections to office:

(a) each person who has been a director or officer of the issuer at any time since the beginning of the last fiscal year;

(b) each nominee for election as a director of the issuer;

(c) each associate of the foregoing persons.

(2) Give the name of any director of the issuer who has informed the management in writing that he intends to oppose any action to be taken by the management at the meeting and indicate the action which he intends to oppose.

F. **Proposals by security holders:** If any security holder entitled to vote at the meeting has, not less than ninety days before the issuer's annual meeting, submitted to the issuer a proposal which is accompanied by notice of his intention to present the proposal and indicate the disposition proposed to be made of the proposal by the management at the meeting.

[7/1/97; Recompiled 11/30/01]

PART 5: REGISTRATION OF INSURANCE SECURITIES

13.3.5.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.3.5.2 SCOPE:

This rule applies to sale or offer in this state of any insurance security issued or proposed to be issued by any corporation or person whether or not organized under the laws of this state or authorized to transact business in this state. This rule does not apply to the extent its provisions are preempted by the Capital Markets Efficiency Act of 1996, P.L. 104-290, Section 101 et seq.

[7/1/97; Recompiled 11/30/01]

13.3.5.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978, and the Sale of Insurance Securities Law, Section 59A-35-1 NMSA 1978 et seq.

[12/1/85; Recompiled 11/30/01]

13.3.5.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.3.5.5 EFFECTIVE DATE:

December 1, 1985, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[12/1/85, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.3.5.6 OBJECTIVE:

The purpose of this rule is to set out requirements and methods for registration of insurance securities.

[7/1/97; Recompiled 11/30/01]

13.3.5.7 DEFINITIONS:

To the extent applicable to securities of insurance companies, all definitions relating to general securities set forth in the New Mexico Securities Act and the New Mexico Blue Sky Regulations promulgated by the New Mexico securities bureau shall apply to the sale of insurance securities in New Mexico.

[12/1/85; Recompiled 11/30/01]

13.3.5.8 REGISTRATION OF INSURANCE SECURITIES:

All insurance securities required to be registered under the Sale of Insurance Securities Law shall be registered with and shall be filed with the superintendent of insurance in the manner provided in these regulations.

[12/1/85; Recompiled 11/30/01]

13.3.5.9 REGISTRATION OF NEWLY-FORMED INSURERS:

All filings for registration of insurance securities of newly-formed proposed insurers or entities shall include the disclosure of the information required pursuant to Section 59A-35-8 NMSA 1978.

[12/1/85; Recompiled 11/30/01]

13.3.5.10 REGISTRATION BY NOTIFICATION:

If an insurance security would qualify for registration by notification pursuant to Section 58-13-5A NMSA 1978 if it were not exempt from that provision pursuant to Section 58-13-29C(3) NMSA 1978, it may be registered by notification with the superintendent.

A. **Information required:** A registration statement for registration by notification shall contain the following information:

(1) a statement demonstrating eligibility form registration by notification;

(2) the issuer's name, address and form of organization, the state of foreign jurisdiction and the date of its organization and the general character and location of its business;

(3) a description of the securities being registered;

(4) the total amount of securities to be offered and amount of securities to be offered in this state;

(5) the price at which the securities are to be offered for sale to the public, any variation therefrom at which any portion of the offering is to be made to any persons other than as underwriting and selling discounts or commissions and finders' fees, including cash, securities or anything else of value;

(6) names and addresses of the managing underwriters and a description of the plan of distribution of any securities which are to be offered other than through an underwriter;

(7) a description of any security options outstanding or to be created in connection with the offering.

B. **Documents Required.** A registration statement for registration by notification shall be accompanied by the following documents, along with a consent to service of process:

(1) any adverse order, judgment or decree previously entered in connection with the offering by any court or by the securities and exchange commission;

(2) a copy of any offering circular or prospectus to be used in connection with the offering;

(3) in the case of security qualifying for registration by notification under Section 58-13-5A(2) NMSA 1978 which does not also satisfy the conditions of Section 58-13-5A(1) NMSA 1978, a balance sheet of the issuer, certified by a certified public accountant as of a date within four months prior to the filing of the registration statement, and a summary of earnings for each of the two fiscal years preceding the date of the balance sheet and for any period between the close of the last fiscal year and the date of the balance sheet, or for the period of the issuer's and any predecessor's existence if less than two years;

(4) any agreements with or among underwriters with respect to the offering;

(5) any instrument governing the insurance of the security to be registered;

(6) and a specimen of the security.

C. If no stop order is in effect and no proceeding is pending, a registration statement filed pursuant to this section automatically becomes effective at 3:00 p.m. eastern standard time in the afternoon of the second full business day after the filing of the registration statement or the last amendment, or at an earlier time as the superintendent determines.

D. A prospectus regarding the securities described in an application for registration by notification shall contain the information required pursuant to Section 58-13-6 NMSA 1978 for securities registered by notification pursuant to the New Mexico Securities Act.

E. The superintendent of insurance may, on the request of the registered dealer or issuer filing the registration statement, waive the furnishing in a prospectus of any item of information or any document which the superintendent of insurance deems to be unnecessary in view of the nature of the securities described in such statement.

F. If the securities described in a registration statement are registered under the Securities Act of 1933, the superintendent shall accept in lieu of the prospectus prescribed in this section the prospectus filed under the Securities Act of 1933 with all amendments to that prospectus as of the date on which the registration statement is filed under this section.

[12/1/85; Recompiled 11/30/01]

13.3.5.11 REGISTRATION BY COORDINATION:

Any insurance security for which a registration statement has been filed under the Securities Act of 1933 in connection with the same offering may be registered by coordination.

A. **Information required:** A registration statement for registration by coordination shall contain the following information:

(1) the amount of securities to be offered in this state;

(2) the states in which a registration statement or similar document in connection with the offering has been or is expected to be filed;

(3) an undertaking to forward promptly all amendments to the federal registration statement other than amendments which merely delay the effective date.

B. **Documents required:** A registration statement for registration by coordination shall be accompanied by the following documents, along with a consent to service of process:

(1) a copy of the prospectus and of all amendments filed under the Securities Act of 1933;

(2) any adverse order, judgment or decree previously entered in connection with the offering by any court or by the securities and exchange commission;

(3) a copy of any agreements with or among underwriters, copy of any indenture or other instrument governing the issuance of the security to be registered and a specimen or copy of the security.

C. A registration statement under this section automatically becomes effective at the moment the federal registration statement becomes effective if all the following conditions are satisfied:

(1) no stop order is in effect and no proceeding is pending;

(2) the registration statement has been on file with the superintendent of insurance for at least thirty days; and

(3) a statement of the maximum and minimum proposed offering prices and the maximum underwriting discounts and commissions has been on file for two full business days or for a shorter period allowed by the superintendent of insurance and the offerings made within these limitations. The registrant shall promptly notify by telephone of the date and time when the federal registration statement became effective and the content of the price amendment, if any, and shall promptly file a post-effective amendment containing the information and documents in the price amendment. As used in this section, "price amendment" means the final federal amendment which includes a statement of the offering price, underwriting and selling discounts or commissions, amount of proceeds, conversion rates, call prices and other matters dependent upon the offering price.

D. Upon failure to receive the required notification and post-effective amendment with respect to the price amendment, the superintendent of insurance may enter a stop order, without notice of hearing, retroactively denying effectiveness to the registration statement or suspending its effectiveness until compliance with this section, if he promptly notifies the registrant of the issuance of the order by telegram or by telephone and promptly confirms his telephone message by letter or telegram. If the registrant proves compliance with the requirements of this section as to notice and post-effective amendment, the stop order is void as of the time of its entry. The superintendent of insurance may waive either or both of the conditions specified in 13 NMAC 3.5.11.3.2 and 3.5.11.3.3 [now Paragraphs (2) and (3) of Subsection C of 13.3.5.11 NMAC]. If the federal registration statement becomes effective before all these conditions are satisfied and they are not waived, the registration statement automatically becomes effective as soon as all the conditions are satisfied. If the registrant advises the superintendent of insurance of the date when the federal registration is expected to become effective, the superintendent of insurance shall promptly advise the registrant by telephone or telegram, at the registrant's expense, whether all the conditions are satisfied and whether he then contemplates denial of the permit under Section 59A-35-10 NMSA 1978.

[12/1/85; Recompiled 11/30/01]

13.3.5.12 REGISTRATION BY QUALIFICATION:

Any insurance security may be registered by qualification.

A. **Information required:** A registration statement filed under this section shall contain the following information:

(1) the issuer's and any significant subsidiary's name, address and form of organization, the state or foreign jurisdiction and the date of organization, the general character and location of its business, a description of its physical properties and equipment and a statement of the general competitive conditions in the industry or business in which it is engaged or will be engaged;

(2) every issuer's, director's, and officer's, or person occupying a similar status or performing similar functions, name, address and principal occupation for the past five years, the amount of securities of the issuer held by him as of a specified date within ninety days of the filing of the registration statement, the aggregate remuneration paid to all such persons during the past twelve months and that estimated to be paid during the next twelve months, directly or indirectly, by the issuer and all predecessors, parents and subsidiaries;

(3) the information required in 13 NMAC 3.5.12.1.2 [now Paragraph (2) of Subsection A of 13.3.5.12 NMAC], other than occupation, for all other persons owning of record, or beneficiary if known, ten percent or more of the outstanding shares of any class of equity security of the issuer;

(4) if the issuer was organized within the past three years, the information required in 13 NMAC 3.5.12.1.2 [now Paragraph (2) of Subsection A of 13.3.5.12 NMAC] for every promoter not specified in 13 NMAC 3.5.12.1.2 or 3.5.12.1.3 [now Paragraphs (2) and (3) of Subsection A of 13.3.5.12 NMAC], along with any amount paid to him by the issuer within that period or intended to be paid to him and the consideration for the payment;

(5) the capitalization and long-term debt, on both a current and a pro forma basis, of the issuer and any significant subsidiary, including a description of each security outstanding or being registered or otherwise offered, and a statement of the amount and kind of consideration, whether in the form of cash, physical assets, services, patents, goodwill or anything else, for which the issuer or subsidiary has issued any of its securities within the past two years or is obligated to issue any of its securities;

(6) the kind and amount of securities to be offered; the amount to be offered in this state; the proposed offering price and any variation therefrom at which any portion of the offering is to be made to any person except as underwriting and selling discounts and commissions; the estimated aggregate underwriting and selling discounts or commissions and finders' fees, including, separately, cash, securities or anything else of value to accrue to the underwriters in connection with the offering; the estimated amounts of other selling expenses and legal, engineering and accounting expenses to be incurred by the issuer in connection with the offering; the name and address of every underwriter and every recipient of a finder's fee; a copy of any underwriting or selling-group agreement pursuant to which the distribution is to be made, or the proposed form of any such agreement whose terms have not yet been determined; and a description of the plan of distribution of any securities which are to be offered other than through an underwriter;

(7) the estimated cash proceeds to be received by the issuer from the offering; the purposes for which the proceeds are to be used by the issuer; the amounts to be used for each purpose; the order or priority in which the proceeds will be used for the purpose stated; the amounts of any funds to be raised from other sources to achieve the purposes stated and the sources of any such funds; and, if any part of the proceeds is to be used to acquire any property, including goodwill, other than in the ordinary course of business, the names and addresses of the vendors and the purchase price;

(8) a description of any stock options or other security options outstanding, or to be created, in connection with the offering, together with the amount of any such options held, or to be held, by every person required to be named in 13 NMAC 3.5.12.1.2, 3.5.12.1.3, 3.5.12.1.4, 3.5.12.1.5 or 3.5.12.1.7 [now Paragraphs (2), (3), (4), (5) or (7) of Subsection A of 13.3.5.12 NMAC], and by any person who holds, or will hold, ten percent or more, in the aggregate, of any such options;

(9) the states in which a registration statement or similar document in connection with the offering has been, or is expected to be, filed.

B. **Documents required:** A registration statement filed under this section shall contain the following information and be accompanied by the following documents, along with a consent to service of process:

(1) any adverse order, judgment or decree previously entered in connection with the offering by any court or by the securities and exchange commission, a description of any pending litigation or proceeding to which the issuer is a party and which materially affects its business or assets, including any litigation or proceedings known to be contemplated by governmental authorities;

(2) a copy of any prospectus or circular intended as of the effective date to be used in connection with the offering;

(3) a specimen or copy of the security being registered, a copy of the issuer's articles of incorporation and bylaws as currently in effect and a copy of any indenture or other instrument covering the security to be registered;

(4) a signed or confirmed copy of an opinion of counsel, if available, as to the legality of the security to be registered; and

(5) a balance sheet of the issuer, certified by public accountant, as of a date within four months prior to the filing of the registration statement; a profit and loss statement and analysis of surplus for each of the three fiscal years preceding the date of the balance sheet and for any period between the close of the last fiscal year and the date of the balance sheet, or for the period of the issuer's and any predecessor's existence if less than three years; and, if any part of the proceeds of the offering is to be applied to the purchase of any business, the same financial statements which would be required if that business were the registrant. In the case of a non-issuer distribution, information may not be required under this section unless it is known to the person filing the registration statement or to the persons on whose behalf the distribution is to be made or can be furnished by them without unreasonable effort or expense.

C. A registration statement under this section becomes effective when the superintendent so orders. The superintendent may require as a condition of registration under this section that a prospectus containing any designated part of the information specified in 13 NMAC 3.5.12.1 and 3.5.12.2 [now Subsections A and B of 13.3.5.12 NMAC] be sent or given to each person to whom an offer is made before, or concurrently with:

(1) the first written offer made to him other than by means of a public advertisement by or for the account of the issuer or any other person on whose behalf the offering is being made, or by any underwriter or broker-dealer who is offering part of an unsold allotment or subscription taken by him as a participant in the distribution;

(2) the confirmation of any sale made by or for the account of any such person;

(3) payment pursuant to any such sale; or

(4) delivery of the security pursuant to any such sale, whichever occurs first, but the superintendent shall accept for use under any such requirement a current prospectus or offering for the same securities filed under the Securities Act of 1933 or regulations thereunder.

[12/1/85; Recompiled 11/30/01]

13.3.5.13 SALE OF INSURANCE SECURITIES WITH NON-LICENSED INSURER:

Any insurer not presently holding a certificate of authority to transact insurance in the state of New Mexico shall not sell or offer to sell in the state its securities unless in addition to the registration requirements it provides to the superintendent of insurance proof that it would be able to qualify for a certificate of authority to transact insurance in the state. Such proof shall consist of the filing of such financial and biographical information as would be required by an insurer seeking to be licensed in this state.

[12/1/85; Recompiled 11/30/01]

13.3.5.14 INCORPORATION OF PREVIOUS FILINGS:

Any document filed with the superintendent of insurance under the Sale of Insurance Securities Law within five (5) years preceding the filing of a registration statement may be incorporated by reference in the new registration statement to the extent that the document is currently accurate.

[12/1/85; Recompiled 11/30/01]

13.3.5.15 REGISTRATION FEE:

Each registration statement submitted for filing with the superintendent shall be accompanied by a check or money order for the proper amount of registration fee pursuant to Section 59A-35-9 NMSA 1978. Failure to include the fee with the registration statement shall render the registration incomplete and ineffective.

[12/1/85; Recompiled 11/30/01]

13.3.5.16 MINIMUM PAR VALUE OF DOMESTIC INSURER:

The par value of each capital stock insurer organized under the laws of the state of New Mexico shall be stated in the articles of incorporation and shall be not less than five dollars ($5.00) per share.

[12/1/85; Recompiled 11/30/01]

PART 6: LICENSING OF INSURANCE SECURITIES SALESPERSONS

13.3.6.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.3.6.2 SCOPE:

This rule applies to any person who solicits subscription to or purchase of any securities covered by a securities permit issued under the Sale of Insurance Securities Law. This rule does not apply to the extent its provisions are preempted by the Capital Markets Efficiency Act of 1996, P.L. 104-290, Section 101 et seq.

[7/1/97; Recompiled 11/30/01]

13.3.6.3 STATUTORY AUTHORITY:

Section 59A-35-1 NMSA 1978 et seq. and Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.3.6.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.3.6.5 EFFECTIVE DATE:

December 1, 1985, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.3.6.6 OBJECTIVE:

The purpose of this rule is to establish requirements for licensure of persons selling securities of newly formed or proposed new domestic insurers.

[7/1/97; Recompiled 11/30/01]

13.3.6.7 DEFINITIONS:

To the extent applicable to securities of insurance companies, all definitions relating to general securities set forth in the New Mexico Securities Act and the New Mexico Blue Sky Regulations promulgated by the New Mexico securities bureau shall apply to the sale of insurance securities in New Mexico.

[7/1/97; Recompiled 11/30/01]

13.3.6.8 REQUIREMENTS FOR LICENSE ISSUED BY SUPERINTENDENT:

A. If a person is a securities broker-dealer registered as such under the Securities Exchange Act of 1934, as amended, the superintendent shall issue to the person an insurance securities salesperson license upon receipt by the superintendent of proof of such registration.

B. If a person intends to solicit subscription to or purchase of securities the sale of which is underwritten (other than on a best efforts basis) by a securities broker-dealer registered as such under the Securities Exchange Act of 1934, as amended, the superintendent shall issue to the person an insurance securities salesperson license upon receipt by the superintendent of proof of such registration and underwriting.

C. If a person desiring an insurance securities salesperson license is not a securities broker-dealer registered as such under the Securities Exchange Act of 1934, as amended, or does not intend to solicit subscription to or purchase of securities, the sale of which is underwritten (other than on a best efforts basis) by a securities broker-dealer registered as such under the Securities Exchange Act of 1934, as amended, the person must comply with Section 59A-35-17A and B NMSA 1978 in order to obtain the license.

[7/1/97; Recompiled 11/30/01]

13.3.6.9 FEES:

All persons seeking an insurance securities salesperson license from the superintendent must forward the appropriate fees pursuant to Section 59A-6-1 NMSA 1978 with their request for the license.

[7/1/97; Recompiled 11/30/01]

CHAPTER 4: LICENSING OF INSURANCE PROFESSIONALS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: RESIDENT PRODUCERS AND OTHER RESIDENT LICENSES

13.4.2.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance, Producer Licensing Bureau (PLB).

[13.4.2.1 NMAC – Rp, 13.4.2.1 NMAC, 4/2/2018]

13.4.2.2 SCOPE:

This rule applies to persons seeking licensure to engage in insurance-related activities as defined in Articles 1 and 7 of Section 59A NMSA 1978 and that shall be licensed pursuant to articles of the Insurance Code.

[13.4.2.2 NMAC – Rp, 13.4.2.2 NMAC, 4/2/2018]

13.4.2.3 STATUTORY AUTHORITY:

Sections 28-2-1 et seq., 40-5A-1 et seq., 59A-1-13, 59A-1-14, 59A-2-8, 59A-2-8.1, 59A-2-9, 59A-6-1, 59A-7-1 et seq., 59A-11-1 et seq., 59A-11A-1 et seq., 59A-12-1 et seq., 59A-12B-1 et seq., 59A-12D-1 et seq., 59A-14-1 et seq., 59A-16-8, 59A-16-12, 59A-30-3, 59A-30-4, 59A-32A-1 et seq., 59A-44-1 et seq., 59A-46-1 et seq., 59A-48-1 et seq., 59A-49-1 et seq., 59A-50-1 et seq., 59A-60-1 et seq., 59A-61-1 et seq. NMSA 1978 and 18 U.S.C. Section 1033.

[13.4.2.3 NMAC – Rp, 13.4.2.3 NMAC, 4/2/2018]

13.4.2.4 DURATION:

Permanent.

[13.4.2.4 NMAC – Rp, 13.4.2.4 NMAC, 4/2/2018]

13.4.2.5 EFFECTIVE DATE:

April 2, 2018, unless a later date is cited at the end of a section.

[13.4.2.5 NMAC – Rp, 13.4.2.5 NMAC, 4/2/2018]

13.4.2.6 OBJECTIVE:

A. Covered by this rule. The purpose of this rule is to implement Chapter 59A, Articles 11 and 12 NMSA 1978, and other articles within the Insurance Code that address licensing of insurance professionals by the superintendent of insurance. This rule establishes requirements for obtaining a license as a resident insurance producer, insurance consultant, producer for prepaid dental plans, producer for sales of membership in a health maintenance organization, producer for a fraternal benefit society, vendor selling portable electronics insurance, salesperson for prearranged funeral plans, title insurance producer, pharmacy benefit manager, reinsurance intermediary, managing general agent, registered motor club representative, rental car insurance producer or endorsee, temporary insurance producer or travel insurance producer. This rule also establishes requirements for qualifying examinations and the issuance, duration, continuation and termination of all such licenses, appointments and registrations, referred to herein as "licenses."

B. Covered under other rules. For licensing of bail bondsmen and their solicitors, refer to 13.20.2 NMAC. For licensing of surplus lines brokers, refer to Section 59A-14-1 et seq. NMSA 1978 and 13.4.4 NMAC. For licensing of resident annuity or securities salespersons, refer to Section 59A-35-1 et seq. NMSA 1978 and 13.3.6 NMAC. For licensing of staff, independent and public adjusters refer to Section 59A-13-1 et seq. NMSA 1978 and 13.4.8 NMAC. For licensing of third-party administrators, refer to 13.4.5 NMAC. For appointment of licensed producers to transact credit life and credit health insurance, refer to Section 59A-25-1 et seq. NMSA 1978 and 13.18.2 NMAC.

[13.4.2.6 NMAC – Rp, 13.4.2.6 NMAC, 4/2/2018]

13.4.2.7 DEFINITIONS:

For the purposes of this rule:

A. "affiliate" means a person that controls, is controlled by or is under common control with an insurance producer;

B. "appointment" means official authorization by an insurer of a licensed producer to transact insurance on the insurer's behalf upon application and the payment of required fees by the insurer to the superintendent;

C. "broker" means a type of insurance producer who, not being an agent of the insurer, but as an independent contractor and on behalf of the insured, solicits, negotiates or procures insurance or annuity contracts or the renewal or continuation thereof for insureds or prospective insureds other than the broker. In any controversy between an insured or an insured's beneficiary and the insurer issuing the insurance through its licensed insurance producer at the request of a broker, the broker shall be held to be the agent of the insured unless under particular circumstances it is found that the broker is representing the insurer or in instances of fraud or attempted fraud by the insured. "Broker" does not include a surplus lines broker as defined in Chapter 59A, Article 14 NMSA 1978;

D. "business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity;

E. "compensation" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes or any other form of valuable consideration, whether or not payable pursuant to a written agreement;

F. "designated home state" means a state in which an insurance producer is licensed and which the producer designates for purposes of compliance with licensing regulations;

G. "designated responsible licensed producer" or **"DRLP"** is as defined in Subsection B of 13.4.2.10 NMAC;

H. "errors and omissions policy" or **"professional indemnity insurance"** means a form of casualty insurance that helps to protect individuals and companies from costs of defending against a negligence claim based on allegations of loss caused by an error or omission in the service sold;

I. "escrow" means a transaction in which funds are delivered or given to a person not otherwise having any right, title or interest in them, to be held by that person for delivery or disbursement to another person upon the occurrence of a specified event or the performance of a specified condition;

J. "home state" means the District of Columbia or any state or territory of the United States which is the principal place of residence or principal place of business for an insurance producer and in which the producer is licensed to transact insurance;

K. "insurance" has the meaning set forth in Section 59A-1-5 NMSA 1978;

L. "insurance consultant" means a person who, under an agreement with an insured or potential insured, provides professional advice regarding a policy, annuity or other instrument of insurance in exchange for a fee, as set forth in Section 59A-11A-1 NMSA 1978.

M. "insurance producer" means a person required to be licensed in this state to sell, solicit or negotiate insurance. A licensed insurance producer appointed by an insurer shall, in any controversy between an insured or an insured's beneficiary and the insurer, be held to be the agent of the insurer that issued the insurance solicited or applied for;

N. "insurer" has the meaning set forth in Section 59A-1-8 NMSA 1978;

O. "license" means a document issued by the superintendent of insurance authorizing a person to act as an insurance producer for the lines of authority specified

in the document or to engage in other insurance transactions based on the type of license;

P. "limited lines insurance" means those lines of insurance as set forth in Sections 59A-12-18, 59A-12-18.1 and 59A-60-1 et seq. NMSA 1978, or any other line of insurance that the superintendent deems necessary;

Q. "limited lines insurance producer" means a licensed insurance producer who is qualified to solicit and sell limited lines insurance;

R. "managing general agent" means a specialized type of licensed insurance producer as defined in Subsection C of Section 59A-12B-2 NMSA 1978;

S. "NAIC" means the national association of insurance commissioners;

T. "negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers;

U. "offer and disseminate" means providing general information, such as a description of coverage and price, processing applications, collecting premiums and performing other insurance-related activities for which a license is not required by this state;

V. "pharmacy benefits manager" means a person or its subsidiary that provides claims administration, benefit design and management, pharmacy network management, negotiation and administration of product discounts, rebates and other benefits or other prescription drug or device services to third parties, as further described in Subsection G of Section 59A-61-2 NMSA 1978;

W. "prearranged funeral plan" means a contract for future delivery of a funeral plan as defined in Subsections A, B and C of Section 59A-49-4 NMSA 1978;

X. "prepaid dental plan" means a contractual arrangement whereby a prepaid dental plan organization undertakes to directly provide or to arrange for the provision of prepaid dental services and to pay or make reimbursement for any remaining portion of such prepaid dental services on a prepaid basis through insurance or otherwise;

Y. "principal" means a person who gives authority to another to act on the person's behalf;

Z. "rental car endorsee" means a rental car agent's employee who offers, sells, binds, effects, solicits or negotiates rental car insurance and who satisfies the requirements of Subsection C of 13.4.2.15 NMAC;

AA. **"rental car insurance"** means insurance sold in connection with and incidental to the rental of a vehicle and that applies only to the vehicle that is the subject of the rental agreement, and as further defined in Subsection E of Section 59A-32A-2 NMSA 1978;

BB. **"rental car producer"** means a person or entity in the business of renting rental cars to the public and that is licensed to offer, sell, bind, effect, solicit or negotiate rental car insurance;

CC. **"resident of the state"** means an individual who maintains a principal home in New Mexico and holds no active resident insurance license in another state;

DD. **"sell"** means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer;

EE. **"service representative"** means an individual regularly employed and salaried by an insurer, group of insurers or managing general agent who assists insurance producers in soliciting, negotiating and effectuating insurance for the insurer, group or managing general agent and who, in the conduct of their business, receives no part of the commission on insurance written. A service representative is not required to be licensed, nor shall the service representative independently solicit or negotiate insurance or annuity contracts;

FF."solicit" means to attempt to sell insurance or ask or urge a person to apply for a particular kind of insurance from a particular insurer;

GG. **"superintendent"** means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization;

HH. **"terminate"** means to cancel the relationship between an insurance producer and the insurer or to terminate a licensed insurance professional's authority to transact insurance;

II. **"title abstract plant"** is as defined in Section 59A-12-13 NMSA 1978;

JJ."title insurance policy" means an insurance contract indemnifying against loss or damages, as set forth in Subsection H of Section 59A-30-3 NMSA 1978;

KK. **"title insurance business"** means the types of business set forth in Subsection C of Section 59A-30-3 NMSA 1978;

LL."title insurance producer" is a person licensed in this state to engage in the business of title insurance and who has been appointed to perform escrow, closing and settlement functions of a real estate transaction by a title insurer;

MM. "travel insurance policy" means insurance coverage for personal risks incident to planned travel as defined in Paragraph (3) of Subsection H of Section 59A-12-18.1 NMSA 1978; and

NN. "travel retailer" means a business entity that makes, arranges or offers travel services.

[13.4.2.7 NMAC – Rp, 13.4.2.7 NMAC, 4/2/2018]

13.4.2.8 TYPES OF INSURANCE LICENSES:

A. License required.

(1) No individual or business entity shall sell, solicit or negotiate insurance in this state unless licensed by the superintendent as an insurance producer for that line of insurance. Any person who is compensated for soliciting or accepting applications for health maintenance organization membership from the public shall be licensed as a health insurance producer in accordance with the provisions of Section 59A-46-17 NMSA 1978.

(2) A business entity that is licensed as an insurance producer shall employ licensed individual insurance producers to transact the types of insurance for which the business entity is licensed. Such an individual insurance producer shall hold a license of the same type as that of the business entity employer.

(3) Persons who engage in other transactions that are subject to the Insurance Code shall be licensed according to requirements set forth under relevant sections.

B. Producer license types based on lines of authority. An insurance producer may be qualified for one or more of the following lines of authority:

(1) casualty insurance, including coverage against legal liability, including for death, injury, disability or damage to real or personal property;

(2) property insurance, including coverage for direct or consequential loss or damage to property of every kind;

(3) accident and health or sickness insurance, including coverage for sickness, bodily injury or accidental death and may include benefits for disability income;

(4) life insurance, including coverage on human lives, benefits of endowment and annuities, and other benefits in the event of death or dismemberment by accident and may include benefits for disability income;

(5) variable life and variable annuity insurance, including contracts deemed to constitute securities that require that the producer also possess a license as a security salesman under other applicable state laws; and

(6) personal lines, including property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

C. Producer licenses for limited lines. An insurance producer may also be licensed for any of the following limited lines:

(1) credit insurance, as sold by individual producers who are employed full time by a vendor of merchandise or other property or by a financial institution that executes consumer loans which require credit life insurance, credit disability insurance, credit property insurance or credit involuntary unemployment insurance as set forth in Section 59A-25-1 et seq. NMSA 1978;

(2) travel insurance, as sold by producers who are qualified to solicit or sell travel insurance as set forth in Section 59A-12-18.1 et seq. NMSA 1978 and 13.4.2.14 NMAC;

(3) portable electronics insurance, as sold by vendors and their employees and representatives in accordance with the provisions of the Portable Electronics Insurance Act found at Section 59A-60-1 et seq. NMSA 1978 and as set forth in 13.4.2.21 NMAC;

(4) rental car insurance, as sold in connection with and incidental to the rental of vehicles by a rental car company and in accordance with the provisions of the Rental Car Insurance Limited Producer License Act found in Section 59A-32A-1 et seq. NMSA 1978 and as set forth in 13.4.2.15 NMAC;

(5) title insurance, as sold by title insurance business entities and the title insurance producers employed by them in accordance with the provisions of the New Mexico Title Insurance Law found in Section 59A-30-1 et seq. NMSA 1978 and as set forth in 13.4.2.13 NMAC; or

(6) motor club services, as sold by a registered representative and provided by a motor club holding a certificate of authority in this state in accordance with the provisions of the Motor Club Law found in Section 59A-50-1 et seq. NMSA 1978 and as set forth in 13.4.2.16 NMAC.

D. Other licenses required. Persons engaging in any of the following types of transaction under the insurance code shall also be licensed:

(1) persons acting as pharmacy benefits managers in accordance with provisions of the Pharmacy Benefits Manager Regulation Act found at Section 59A-61-1 et seq. NMSA 1978 and as set forth in 13.4.2.17 NMAC;

(2) persons offering membership in a prepaid dental plan in accordance with the provisions of the Prepaid Dental Plan Law found in Section 59A-48-1 et seq. NMSA 1978 and as set forth in 13.4.2.18 NMAC;

(3) persons engaged in the sale of prearranged funeral plans in accordance with the provisions of the Prearranged Funeral Plan Regulatory Law found in Section 59A-49-1 et seq. NMSA 1978 and as set forth in 13.4.2.19 NMAC;

(4) persons offering benefits to members through a fraternal benefit society as set forth in Section 59A-44-1 et seq. NMSA 1978 and 13.4.2.20 NMAC;

(5) persons acting as reinsurance intermediaries in accordance with the provisions of the Reinsurance Intermediary Law found at Section 59A-12D-1 et seq. NMSA 1978 and as set forth in 13.4.2.22 NMAC;

(6) persons selling services as insurance consultants in accordance with the provisions of Section 59A-11A-1 et seq. NMSA 1978 and as set forth in 13.4.2.23 NMAC;

(7) third-party administrators performing or providing any service, function, duty or activity in respect to any insurance plan, self-insurance or alternative to insurance in an administrative or management capacity in this state with respect to risks located or partially located in this state or on behalf of persons in this state in accordance with the provisions of Section 59A-12A-1 et seq. NMSA 1978 and as set forth in 13.4.5 NMAC;

(8) persons acting as independent, public and staff adjusters in accordance with the provisions of Section 59A-13-1 et seq. NMSA 1978 and as set forth in 13.4.8 NMAC; and

(9) persons acting as surplus lines brokers in accordance with the provisions of Section 59A-14-1 et seq. NMSA 1978 and as set forth in 13.4.4 NMAC.

[13.4.2.8 NMAC – Rp, 13.4.2.11 NMAC, 4/2/2018]

13.4.2.9 LICENSING REQUIREMENTS FOR INDIVIDUALS:

The superintendent will issue, renew and continue resident licenses for individual insurance producers to transact the kinds of insurance as set forth in 13.4.2.8 NMAC.

A. General requirements.

(1) An applicant shall be at least 18 years of age;

(2) an applicant shall file an application electronically or as otherwise specified by the superintendent;

(3) an applicant shall pay the fees required by Section 59A-6-1 NMSA 1978 as well as providing any additional bond, liability coverage or letter of credit that may be required by the license applied for;

(4) an applicant shall not have committed an act that is a ground for license denial, suspension or revocation under the Insurance Code; and

(5) an applicant shall have passed the examination required for each line of authority for which the license is sought, if examination is required by 13.4.2.11 NMAC.

B. Application form.

(1) The application form may require the following information about the applicant:

(a) proof of the applicant's identity;

(b) name, date of birth, social security number and residence and business address;

(c) personal history;

(d) business experience, including experience, special training or education in the kind of business to be transacted under the license applied for;

(e) previous licensing information, including:

(i) whether the applicant was ever previously licensed to transact insurance in this state or elsewhere;

(ii) whether any license was ever refused, suspended or revoked;

(iii) whether any insurer claims that the applicant is indebted to it, and if so, the details of the claim; and

(iv) whether the applicant has ever had an insurance agency contract or appointment canceled and, if so, the facts of the cancellation;

(f) type of license applied for and kinds of insurance or transactions to be covered thereby;

(g) if the applicant will be adjusting workers' compensation claims, then an in-state physical address for the business entity;

(h) the NAIC number and name of the company holding a New Mexico certificate of authority that is sponsoring the applicant, if applicable;

(i) additional information relating to a particular type of license; and

(j) such other pertinent information and matters as the superintendent may reasonably require.

(2) The superintendent may require any application to be in the applicant's handwriting and under the applicant's oath.

C. Approval. Before approving a license application and issuing a license the superintendent shall confirm that:

(1) all of the applicant's answers to the questions on the application are complete, truthful and satisfactory, including acknowledgment and explanation of any prior criminal charges;

(2) the applicant does not currently hold an active New Mexico resident or nonresident license or an active resident license in another state;

(3) the applicant has provided at least five years of employment history without gaps in the employment record;

(4) the applicant has provided an in-state residential or business address (a post office box does not satisfy this requirement);

(5) the applicant's fingerprints have been submitted for purposes of a state and federal background check, and

(a) pursuant to 18 U.S.C. Section 1033, no individual who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a resident producer, unless the person has the written consent of the superintendent;

(b) pursuant to the Criminal Offender Employment Act found at Section 28-2-1 et seq. NMSA 1978, any prior criminal record shall be considered in connection with application for any license under this article; and

(c) if the results of the background check have not been received or indicate a need for further investigation, the application will not be approved pending further review;

(6) the applicant has satisfied both the general and specific requirements and has provided any additional information necessary for the type of license requested or as required by the superintendent based the initial application answers;

(7) the applicant shall not use or intend to use the license solely to write insurance on the applicant's own life for the purpose of evading in spirit or intent the anti-rebate or anti-discrimination laws relating to insurance;

(8) if the applicant is a citizen of a foreign county, then the application shall include proof that the applicant is eligible to reside and work in the United States; and

(9) the applicant has passed any required examination based on the type of license requested, as set forth in 13.4.2.11 NMAC.

D. Prohibitions. Pursuant to Section 59A-12-11 NMSA 1978, the superintendent shall not license as an insurance producer or permit any such license to continue if the superintendent finds that an applicant for license intends to offer, give or sell stock or other ownership or participating interest in the agency or brokerage as inducement to or in connection with purchase of insurance or that the licensee has previously done so.

E. Contents of license. The contents of the license shall be consistent with the requirements set forth in Section 59A-11-9 NMSA 1978.

F. Special licensing requirements.

(1) Limited line credit insurance license applicants shall include evidence that the insurer will provide a program of instruction to include selling, soliciting and negotiating credit insurance that has been approved by the superintendent.

(2) Variable life and variable annuity or fraternal variable life and variable annuity license applications shall be deferred and reviewed manually by the superintendent. The applicant's FINRA and CRD numbers shall be supplied.

(3) Applicants shall apply for or actively hold a producer license for the life line of authority within the requested license class as follows:

(a) A variable life or a variable annuity producer license requires a life producer license.

(b) A variable life or a variable annuity consultant license requires a life insurance consultant license.

(c) A fraternal variable life or a variable annuity producer licenses requires a fraternal life producer license.

(d) A temporary variable life or a variable annuity producer license requires a temporary producer license.

(e) A viatical variable life or a variable annuity broker license requires a viatical life broker license.

(4) Surplus lines broker applicants shall actively hold both current property and casualty producer licenses prior to applying for a surplus lines broker license.

[13.4.2.9 NMAC – Rp, 13.4.2.8 NMAC, 4/2/2018]

13.4.2.10 LICENSING REQUIREMENTS FOR BUSINESS ENTITIES:

A. General requirements. A business entity acting as an insurance producer is required to obtain an insurance producer license pursuant to Sections 59A-11-3 NMSA 1978 and 59A-12-15 NMSA

(1) When licensing of a business entity is required, the application shall be filed by the business entity.

(2) The application shall be submitted electronically using the uniform business entity application or as otherwise specified by the superintendent.

(3) The business entity shall specify the business type as one of the following legal business types:

(a) partnership;

(b) limited liability company (LLC);

(c) limited liability partnership (LLP); or

(d) corporation.

A sole proprietorship may not apply for a business insurance producer license.

(4) The application shall be accompanied by payment of fees, as follows:

(a) all fees required pursuant to Section 59A-6-1 NMSA 1978;

(b) any bond or letter of credit required for the license applied for; and

(c) an additional license application filing fee for each individual in excess of one who is to exercise the license powers of the business entity, if not a general partner therein.

(5) The application shall be signed on behalf of the applicant by an authorized partner or corporate officer, under oath if required by the superintendent.

(6) If the business is a firm, then each individual who is not a bona fide general partner and who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

(7) If the business is a corporation, then each individual, whether or not an officer, director, stockholder or in other relationship to the corporation, who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

(8) If the business is a partnership, then each individual who is not a general partner and who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

B. Application form. The application form may require information about the business entity as follows:

(1) the name, state of residence, proof of identity, business record, reputation and experience of each partner, officer, member of the board of directors and controlling stockholder of the business entity, and any additional information required of an individual applicant for a producer license as the superintendent deems necessary;

(2) evidence satisfactory to the superintendent that transaction of the business proposed to be transacted under the requested license is within the powers of the business entity as set forth in the entity's articles of incorporation, charter, bylaws, partnership, operating agreement or other governing documents;

(3) at least one individual is specified as the designated responsible licensed producer (DRLP) who is actively licensed in this state as either a resident or nonresident producer for each of the lines of authority applied for by the business entity;

(a) The DRLP(s) designated by the business entity shall cumulatively be licensed for all lines of authority of the business entity; except that

(b) business entities of the following types seeking a producer license are not required to designate a DRLP: portable electronics, pharmacy benefits managers, rental car insurance producers and third party administrators; and

(4) such further information concerning the applicant, appointment of partners, corporate officers, directors and stockholders as may be requested by the superintendent.

C. Approval. The superintendent shall review the application and confirm that:

(1) all answers to the questions on the application are complete, truthful and satisfactory;

(2) the applicant does not already hold an active resident or nonresident license in New Mexico or an active resident license in another state;

(3) the business entity has paid the fees set forth in Section 59A-6-1 NMSA 1978, as well as providing any additional bond, liability coverage or letter of credit that may be required by the type or types of license applied for;

(4) the business entity application lists at least one individual as an owner, officer, partner or director;

(5) the business entity has designated a licensed insurance producer responsible for the business entity's compliance with the insurance laws of this state for every line of authority listed in the application;

(6) the application sets forth the names of all the members, officers and directors of the business entity and the names of each individual who is to exercise the powers conferred by the license upon the business entity;

(7) the business entity license application uses the entity's legal name, unless an assumed name has been previously approved in writing by the superintendent; and

(8) at least one licensed insurance producer who is to exercise license powers is affiliated by submission of an application, and the application for affiliation was submitted with payment as required in Section 59A-6-1 NMSA 1978.

D. Prohibitions, Contents of license, Special licensing requirements. The provisions of Subsections D, E and F of 13.4.2.9 NMAC apply also to business entities seeking a producer license.

[13.4.2.10 NMAC – N, 4/2/2018]

13.4.2.11 EXAMINATION OF APPLICANTS:

A. Applications requiring examination.

(1) Individuals applying for the following types of resident licenses shall take and pass the examination required for issuance of the license by the superintendent:

(a) insurance producer – producer examination;

(b) independent, public or staff adjuster – adjuster examination;

(c) insurance consultant – producer or consultant examination;

(d) viatical broker – producer examination;

(e) surplus lines broker – surplus lines broker examination; and

(f) title insurance producer – title insurance producer examination.

(2) Separate exams may be required for different lines of insurance or license types and may be administered at different times and locations.

B. Examination exemptions.

(1) Pursuant to Section 59A-11-10 NMSA 1978, reexamination is not required for renewal or continuance of current resident licenses unless ordered by the superintendent.

(2) Reexamination is not required for resident applicants who have been licensed in this state within the five years prior to the date of the new application and who seek to be relicensed for the same line or lines of insurance. This exemption does not apply if the previous license was suspended or revoked, if continuation of the license was refused by the superintendent or if the applicant did not previously take and pass an exam in this state.

(3) Examination is not required for:

(a) Applicants seeking a limited lines license in order to transact credit, travel or portable electronics insurance;

(b) Applicants seeking to be licensed as a life and annuity or accident and health insurance producer who hold the Chartered Life Underwriter (C.L.U.) designation by the American College of Life Underwriters;

(c) Applicants seeking to be licensed as a property or casualty insurance producer who hold the designation of Chartered Property and Casualty Underwriter (C.P.C.U.) by the American Institute of Property and Casualty Underwriters;

(d) Applicants seeking a rental car endorsement to transact rental car insurance under the supervision of a rental car producer that has previously provided a training course that has been submitted to and approved by the superintendent pursuant to Subsection D of Section 59A-32A-5 NMSA 1978;

(e) Applicants for a temporary license; or

(f) Applicants for registration as a motor club representative.

(4) Examination is not required for applicant who have taken and passed a similar examination and received a license for the same line or lines of authority in a state in which the reciprocal provisions of Section 59A-5-33 NMSA 1978 apply and:

(a) the license in the other state is current, or

(b) the application is received within 90 days after of cancellation of the previous license. If the license has been canceled, then the following is required:

(i) a certification from the reciprocal state that at the time of cancellation the applicant was in good standing in that state; or

(ii) records maintained by the NAIC indicate that the insurance producer is or was licensed in good standing for the line of authority requested.

(5) Examination is not required for an applicant currently licensed as an insurance producer in another state who moves to this state and applies to become a resident insurance producer within 90 days of establishing legal residence. For such applicants, the examination requirement is waived as to licensure for any line of authority previously held in the prior state, unless otherwise determined by the superintendent.

(6) Examination is not required for an applicant for a license who is a transportation ticket selling agent of a common carrier and who acts under the license only in reference to the issuance of health and accident insurance policies, or insurance on personal effects while being carried as baggage, in connection with the transportation provided by the transportation ticket.

C. Conduct of examinations.

(1) Applicants shall submit a nonrefundable examination fee as set forth in Section 59A-6-1 NMSA 1978.

(2) The superintendent may designate an outside testing service to register applicants and collect examination fees, develop and administer exams, and score and report exam results subject to these requirements:

(a) The activities of the testing service shall be supervised by the superintendent.

(b) Any examination that is developed by the testing service or other outside source shall be reviewed and approved by the superintendent before it is administered. Each examination question and answer shall be verified and approved as to correctness, relevance, content and other factors.

(3) Each examination, as a whole, shall provide a comprehensive test of the applicant's knowledge necessary for the type of license applied for, the duties and responsibilities of the licensee and the insurance laws and regulations of this state.

(4) All examinations shall be conducted in an appropriate setting.

(5) Each examination shall be offered to applicants for a particular license type at least once each month at places within this state designated by the superintendent.

(6) Registration for each offering of the required examinations shall be available online or as otherwise directed by the superintendent.

(7) All examinations shall be available in the Spanish language upon request.

(8) Examination site accommodations shall be available upon request.

D. Examination scoring; pass and fail.

(1) Each examination shall require examinees to answer questions.

(2) The examination shall be scored for all examinees in a fair, impartial and non-discriminatory manner using a consistent scoring process.

(3) An examinee shall achieve a minimum score of seventy percent in order to pass the examination.

(4) An applicant who registers to take an examination but fails to appear as scheduled or fails to pass the examination may reapply and shall resubmit all required fees and forms before being scheduled for another examination.

(5) Any applicant who fails to pass an examination may retake the examination at any subsequent scheduled examination date. However, an applicant who has taken and failed to pass the same examination four times shall not be entitled to take another examination until at least six months after the date of the last examination failed.

E. Examination preparation.

(1) The superintendent may prepare and make available a manual showing the general type and scope of all required examinations.

(2) Information and access to manuals will be provided through the OSI website or as otherwise determined by the superintendent.

[13.4.2.11 NMAC – Rp, 13.4.2.13 NMAC, 4/2/2018]

13.4.2.12 COMMISSIONS AND COMPENSATION:

A. Payment of commissions and compensation.

(1) An insurance company or insurance producer shall not pay to a person nor shall a person accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state unless that person is licensed as required by this state.

(2) Renewal and other deferred commissions may be subsequently paid to a person for selling, soliciting or negotiating insurance in this state if the person was licensed as required at the time of the transaction.

(3) An insurer or insurance producer shall not pay or assign commissions, service fees or other valuable consideration derived from insurance of risks in this state to an individual or business entity who is not licensed to sell, solicit or negotiate insurance in this state.

B. Sharing of commissions and compensation.

(1) Sharing in commissions and compensation between licensees shall be infrequent and shall not be used to avoid appointment of producers by insurers.

(2) A licensee shall not receive a share in commissions or compensation unless the licensee is licensed as to the type of transaction or kind of insurance placed.

(3) An insurance producer shall share commissions or compensation for or on account of the solicitation or negotiation of insurance on individuals, property or risks in this state only with a duly licensed producer appointed by the insurer with which the insurance was placed, or with a duly licensed broker.

(4) The purchase price of a business entity may include ongoing payments or partial payments of accruing commissions to or on behalf of a former owner, whether or not the former owner maintains a current insurance producer license.

(5) Payment of commissions, compensation or other valuable consideration may be made to the personal representative, trust or beneficiary of a deceased insurance producer or broker, or to the deceased producer or broker's heirs or devisees if the estate has been distributed and the decedent would otherwise be entitled to the payment.

C. Disclosure of compensation.

When any insurance producer or any affiliate of the insurance producer receives any compensation from a customer for the placement of insurance or represents the customer with respect to placement of insurance, that producer or affiliate shall comply with the disclosure requirements set forth in Section 59A-12-29 NMSA 1978.

[13.4.2.12 NMAC – N, 4/2/2018]

13.4.2.13 LICENSING OF TITLE INSURANCE PRODUCERS, ESCROW OFFICERS AND TITLE ABSTRACT PLANTS:

A. License required.

(1) Title agents and escrow officers shall be licensed as title insurance producers. In addition to the requirements in this section, they shall also comply with additional requirements set forth in Section 59A-30-1 et seq. NMSA 1978 and in 13.14.1 through 13.14.19 NMAC.

(2) An applicant for a title insurance producer license shall comply with the provisions of 13.4.2.9 NMAC for individual producers or 13.4.2.10 NMAC for business entities.

(3) All applications for a title insurance producer license shall contain a statement that the applicant owns, operates, controls or is affiliated with a licensed title abstract plant or is employed by an individual or entity that does.

(4) Applications shall specify only the county or counties that are supported by the title abstract plant and the title producer license shall permit the licensee to issue policies only on property located in the county or counties for which the licensee has the necessary title abstract plant.

B. Title abstract plant defined. The title abstract plant shall consist of a set of records in which an entry has been made for every document or matter that under the law imparts constructive notice affecting title to, interest in or encumbrances on real property, and that has been filed or recorded in the county for which the title abstract plant is maintained.

(1) The records shall cover a period of 20 years immediately prior to the date of application and shall consist of:

(a) an index or indices in which notations of or references to any documents that describe the property affected are posted, entered or otherwise included, sorted and filed according to the property described; or copies or briefs of all documents that describe the property affected which are sorted and filed according to the property described; and

(b) an index or indices in which all other documents are posted, entered or otherwise included, sorted and filed according to the name or names of the party or parties whose title to real property or any interest or encumbrance is affected.

(2) A title insurance producer license permits the licensee to issue title insurance only on property located in the county or counties for which the licensee has the necessary licensed title abstract plant.

(3) The title insurance producer shall be responsible for maintaining and updating the records of the title abstract plant within 30 days of the courthouse land update schedule.

C. Plant inspections. The title abstract plant shall be subject to inspection by the superintendent. During an inspection, the superintendent may inspect to ascertain that the plant's records are current and that all persons engaged in the business of transacting title insurance are properly licensed and have been appointed by all insurers for whom they transact business.

[13.4.2.13 NMAC – N, 4/2/2018]

13.4.2.14 LICENSING OF LIMITED LINES TRAVEL INSURANCE PRODUCERS:

A. License required.

(1) All applicants for travel insurance producer licenses shall comply with the provisions of 13.4.2.9 NMAC for individual producers or 13.4.2.10 NMAC for business entities.

(2) Upon licensure, the travel insurance producer shall create a register with information about each travel retailer that offers travel insurance on the producer's behalf as set forth in Paragraph (2) of Subsection B of Section 59A-12-18.1 NMSA 1978. The register shall be updated at least annually and made available to the superintendent upon request.

(3) The travel insurance producer shall select a licensed individual insurance producer employee as its designated responsible producer who shall be responsible for the travel insurance producer's compliance with the travel insurance laws and rules of this state.

(4) The designated responsible producer, president, secretary, treasurer and any other officers or persons who direct or control the travel insurance producer's operations shall comply with the fingerprinting and criminal background check requirements of Paragraphs (3) and (4) of Subsection B of Section 59A-12-12 NMSA 1978.

(5) The travel insurance producer shall pay all applicable fees set forth in Section 59A-6-1 NMSA 1978.

(6) The travel insurance producer shall require training of employees and representatives of the retailer as set forth in Paragraph (6) of Subsection B of Section 59A-12-18.1 NMSA 1978.

B. Travel insurance producer and travel retailer responsibilities.

(1) A travel insurance producer shall be responsible for acts of the travel retailer and shall reasonably ensure that the travel retailer complies with the requirements set forth in Section 59A-12-18.1 NMSA 1978.

(2) A travel retailer may offer travel insurance under the license of a travel insurance producer only if:

(a) the travel insurance producer or travel retailer provides to prospective purchasers of travel insurance the items required by Subsection C of Section 59A-12-18.1 NMSA 1978; and

(b) no travel retailer employee or authorized representative who is not licensed as an insurance producer shall provide certain services as set forth in Subsection D of Section 59A-12-18.1 NMSA 1978.

(3) A travel retailer's employees and authorized representatives whose insurance-related activities are limited to the offering and disseminating of travel insurance on behalf and under the direction of a licensed travel insurance producer may receive compensation for those activities.

(4) Travel insurance may be placed as an individual, group or master policy.

C. Travel insurance vending machines.

(1) A licensed insurance producer may solicit for and issue personal travel accident insurance policies of an authorized insurer by means of mechanical vending machines supervised by the insurance producer and placed at airports and other places of convenience to the traveling public if the superintendent finds that:

(a) the travel insurance policy provides reasonable coverage and benefits and is suitable for sale and issuance by vending machine and that use of such a machine in a proposed location would be of material convenience to the public;

(b) the type of machine proposed to be used is reasonably suitable for the purpose;

(c) reasonable means are provided for informing prospective purchasers of policy coverages and restrictions;

(d) reasonable means are provided for the refund of money inserted in defective machines and which insurance so paid for is not received; and

(e) the cost of maintaining such a machine at a particular location is reasonable.

(2) For each travel insurance vending machine the superintendent shall issue a special vending machine license.

(a) The license shall state the name and address of the insurer and insurance producer, the name of the policy to be sold and the serial number, type and operating location of the machine.

(b) The license shall be subject to biennial continuation and to expiration, suspension or revocation coincidental with the license of the insurance producer.

(c) The superintendent shall revoke the license for any vending machine if the superintendent finds that license qualifications no longer exist.

(d) Proof of existence of a vending machine license shall be displayed on or about each machine in use in the manner that the superintendent reasonably requires.

[13.4.2.14 NMAC – N, 4/2/2018]

13.4.2.15 LICENSING OF LIMITED LINES RENTAL CAR INSURANCE PRODUCERS AND ENDORSEES:

A. License required.

(1) No rental car company nor its officers, director, employees or agents shall offer, sell, bind, effect, solicit or negotiate the purchase of rental car insurance unless that company is licensed as an insurance producer pursuant to Section 59A-32A-1 et seq. NMSA 1978.

(2) A rental car company may only act on behalf of an insurer that is authorized to write such insurance in this state.

(3) Rental car insurance may not be offered, except in connection with and incidental to a rental agreement.

(4) Neither a rental car insurance producer nor an endorsee shall represent itself as qualified or licensed as an insurance producer beyond the scope of the limitations set forth in Subsection B of Section 59A-32A-7 NMSA 1978.

(5) A rental car company may not compensate any person, including any of its employees, based solely on placement of rental car insurance.

B. Rental car insurance producer license requirements.

(1) All applicants for rental car insurance producer licenses shall comply with the provisions of 13.4.2.10 NMAC for business entities.

(2) The application shall include a list of all the locations within the state where the rental car insurance producer intends to offer, sell, bind, effect, solicit or negotiate rental car insurance.

(3) The rental car insurance producer license application shall include:

(a) a certificate filed by an insurer indicating that the insurer has reviewed the applicant's training program and believes that it satisfies the requirements of Subsection D of 59A-32A-5 NMSA 1978; and

(b) the insurer intends to appoint the applicant to act as its rental car insurance producer if a license is granted to the applicant by the superintendent.

(4) A rental car insurance producer shall be responsible for establishing a training program for its employees that satisfies the requirements of Subsection D of Section 59A-32A-5 NMSA 1978. The program shall be submitted to and approved by the superintendent prior to its use.

(5) At the time of application, a rental car insurance producer license applicant shall establish, in a format prescribed by the superintendent, a list of its endorsees that also identifies a manager or supervisor for each of the applicant's locations. The list shall be updated quarterly and retained for three years by the applicant. The list shall be provided to the superintendent for inspection upon request.

(6) A rental car insurance producer shall ensure that the actions of its endorsees are properly supervised at all of its locations and shall be held responsible for the actions of its endorsees.

C. Rental car insurance endorsee requirements.

(1) An endorsee shall be at least 18 years of age and an employee of a rental car insurance producer.

(2) An endorsee shall complete the rental car insurance producer's approved training program prior to transacting any rental car insurance.

(3) An endorsee shall act on behalf of the rental car insurance producer under the direct supervision of the manager or supervisor at the location where employed.

(4) An endorsee's authorization expires upon termination of employment with the rental car insurance producer.

(5) The rental car insurance endorsee may offer, sell, bind, effect, solicit or negotiate rental car insurance on behalf of the rental car insurance producer subject to the above provisions and additional provisions set forth in Section 59A-32A-1 et seq. NMSA 1978.

[13.4.2.15 NMAC – N, 4/2/2018]

13.4.2.16 REGISTRATION OF MOTOR CLUB REPRESENTATIVES:

A. Registration required. No individual shall represent a motor club in this state unless that person is registered with the superintendent by a motor club holding a current certificate of authority issued pursuant to Section 59A-5-1 NMSA 1978.

B. Qualifications for registration. An applicant for registration as a motor club representative shall, at a minimum:

(1) be at least 18 years of age;

(2) be of good personal and business reputation;

(3) not previously have had registration refused or revoked;

(4) be suitable and competent to act as such a representative; and

(5) intend in good faith to act and hold him- or herself out as such a representative.

C. Procedures for registration.

(1) Applications for motor club representative registrations are handled in the same manner as applications for casualty insurance producer licenses, except that no examination is required.

(2) Continuations, terminations, denials, suspensions and cancellations of motor club representative registrations are handled in the same manner as those for insurance producer licenses as set forth in 13.4.2.27 and 13.4.2.28 NMAC.

(3) Fees for motor club representative registrations and continuations are as set forth in Section 59A-6-1 et seq. NMSA 1978.

[13.4.2.16 NMAC – N, 4/2/2018]

13.4.2.17 LICENSING OF PHARMACY BENEFITS MANAGERS:

A. License required. No person shall operate as a pharmacy benefits manager in this state unless licensed by the superintendent in accordance with Section 59A-61-1 et seq. NMSA 1978, nor shall a licensed pharmacy benefits manager transact insurance on behalf of an insurer that is not authorized in this state.

B. License requirements. The superintendent will consider an applicant for licensure as a pharmacy benefits manager upon receipt of the following:

(1) payment, in advance, of the fees prescribed in section 59A-6-1 NMSA 1978; and

(2) a completed application in the format required by the superintendent containing:

(a) the name of the pharmacy benefits manager;

(b) the name and business address of the contact person for the pharmacy benefits manager; and

(c) the federal employer identification number for the pharmacy benefits manager, if applicable.

C. Denial, suspension or revocation of license.

(1) The superintendent shall enforce the provisions of the Pharmacy Benefits Manager Regulation Act set forth in Section 59A-61-1 et seq. NMSA 1978 and may suspend, revoke or deny an application for or renewal of a pharmacy benefits manager's license for failure to comply with the requirements of the Pharmacy Benefits Manager Regulation Act.

(2) If the license of a pharmacy benefits manager is revoked:

(a) the pharmacy benefits manager shall proceed immediately following the effective date of the order of revocation to wind up its affairs and conduct no further business except as may be essential to the orderly conclusion of its affairs; except that

(b) the superintendent may permit further operation of the pharmacy benefits manager if the superintendent finds it is in the best interest of patients to do so.

(3) A person whose pharmacy benefits manager license has been denied, suspended or revoked may seek review pursuant to the provisions of Section 59A-4-1 et seq. NMSA 1978.

D. Renewal of license. A pharmacy benefits manager applying for license renewal shall submit the required annual report and fees, including the annual continuation fee, as set forth in Section 59A-6-1 NMSA 1978. Failure to comply with these requirements shall result in cancellation of the license. Instructions for completing the annual report, which is due on or before March 1, are available on the OSI website.

[13.4.2.17 NMAC – N, 4/2/2018]

13.4.2.18 LICENSING OF PREPAID DENTAL PLAN MEMBERSHIP PRODUCERS:

A. License and appointment required. No person shall solicit membership in a prepaid dental plan unless that person has been licensed by the superintendent as a health insurance producer and appointed by the prepaid dental plan organization to act

in this state on the plan's behalf, pursuant to Section 59A-48-14 NMSA 1978. These persons shall comply with insurance producer licensing requirements.

B. Qualifications for licensing. Individuals shall be licensed as producers as described in 13.4.2.9 NMAC and business entities shall be licensed as producers as described in 13.4.2.10 NMAC. Individual licensees shall comply with the examination and continuing education requirements for health insurance producers.

C. Fees and renewals. Both individual producers and business entities that are licensed as producers and acting on behalf of a prepaid dental plan shall comply with the fee and renewal schedules set forth in Section 59A-6-1 NMSA 1978.

[13.4.2.18 NMAC – N, 4/2/2018]

13.4.2.19 LICENSING OF PREARRANGED FUNERAL PLAN PRODUCERS:

A. License required. Any person engaged in the sale of prearranged funeral plans shall be licensed by the superintendent as a life insurance producer. Individuals shall be licensed as producers as described in 13.4.2.9 NMAC and business entities shall be licensed as producers as described in 13.4.2.10 NMAC. The licensee may have no association with the funeral service provider pursuant to Section 59A-49-5 NMSA 1978.

B. Handling of funds. Funds received in connection with sale of a prearranged funeral plan shall be deposited and withdrawn from a trustee subject to the fiduciary duties set forth in Subsection B of 13.4.2.23 NMAC. Strict controls shall be placed over sale of funeral plans and management of collected funds due to the longer anticipated time between the sale of a plan and delivery of the services. The trustee's records and accounting of funds shall be subject to review by the superintendent upon reasonable request.

[13.4.2.19 NMAC – N, 4/2/2018]

13.4.2.20 LICENSING OF FRATERNAL BENEFIT SOCIETY PRODUCERS:

A. License required. Individuals shall be licensed as producers as described in 13.4.2.9 NMAC and business entities shall be licensed as producers as described in 13.4.2.10 NMAC, except as follows:

(1) Fraternal benefit society producers are not required to fulfill the continuing education requirements set forth in 13.4.7 NMAC.

(2) Fraternal benefit society producers may be exempt from the qualifying examination requirements of 13.4.7.11 NMAC if they do not receive commissions or compensation based on sales as set forth in Subsection B of Section 59A-44-33 NMSA 1978.

B. Continuation, suspension, revocation and termination of licenses. General provisions pertaining to the continuation, suspension, revocation and termination of producer licenses shall also apply to licenses issued to fraternal benefit society producers as set forth in 13.4.2.27 and 13.4.2.28 NMAC.

[13.4.2.20 NMAC – N, 4/2/2018]

13.4.2.21 LICENSING OF PORTABLE ELECTRONICS INSURANCE VENDORS:

A. License required. A vendor of portable electronics shall not sell or offer insurance covering portable electronics unless licensed as a limited lines producer in accordance with Subsection B of Section 59A-12-18 NMSA.

(1) A vendor's application shall identify an individual employee or officer of the vendor's organization as the compliance officer with respect to requirements of the Portable Electronics Insurance Act, as set forth in Section 59A-60-1 et seq. NMSA 1978. The application shall also provide the address of the vendor's home office.

(2) Any employee or authorized representative of a licensed vendor may offer and sell insurance covering portable electronics to eligible customers at any location at which the vendor sells portable electronics without obtaining a separate license from the superintendent. These employees and representatives may not represent themselves as personally licensed as a limited lines producer.

(3) The insurer issuing the insurance or its designee shall be responsible for supervising the activities of the vendor's employees and administration of the insurance program.

(a) The insurer shall develop and deliver a training program for the vendor's employees or authorized representatives who offer or sell insurance covering portable electronics.

(b) The training program shall comply with all of the requirements set forth in Paragraph (2) of Subsection D of Section 59A-60-4 NMSA 1978.

(4) A vendor shall maintain a list of its locations that are authorized to sell portable electronics insurance in this state. The list shall be made available to the superintendent upon reasonable notice and request.

(5) Compensation of employees who offer or sell portable electronics insurance on behalf of the vendor shall be in accordance with Section C of Section 59A-60-4 NMSA 1978.

B. Offer and sale of insurance. A licensed vendor shall sell or offer portable electronics insurance only as incidental to the purchase or lease of portable electronics or related services sold or offered by the vendor. A licensed vendor shall provide all

required insurance-related information to customers and prospective customers as set forth in Subsection A of Section 59A-60-4 NMSA 1978.

C. Handling of payments and funds. Payments for portable electronics insurance and handling of funds shall be consistence with the requirements of Subsection C of Section 59A-60-4 NMSA 1978. Funds received by a vendor for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer as set forth in Subsection B of 13.4.2.23 NMAC.

D. Penalties, fines and actions against the license. The superintendent may impose fines or suspend or revoke a vendor's right to transact portable electronics insurance at specific locations where a violation has occurred or may suspend the rights of an individual employee or representative for violation of the Portable Electronics Insurance Act.

[13.4.2.21 NMAC – N, 4/2/2018]

13.4.2.22 LICENSING OF REINSURANCE INTERMEDIARIES:

A. License required.

(1) With respect to the Reinsurance Intermediary Law set forth at Section 59A-12D-1 et seq. NMSA 1978 and this section, "producer" means a licensed producer, broker or reinsurance intermediary. A reinsurance intermediary is as defined in Subsection E of Section 59A-12D-2 NMSA 1978.

(2) Any person acting as either a reinsurance intermediary-broker or as a reinsurance intermediary-manager in this state and either domiciled or with an office located directly or indirectly in this state shall be licensed as a producer in this state.

(a) Typically, an intermediary-broker represents the insurer who is seeking to cede risk to a reinsurer and solicits offers on behalf of the ceding insurer.

(b) Typically, an intermediary-manager acts on behalf of and with authority to bind the reinsurer.

(c) The intermediary's knowledge is imputed to the principal, which may result in adverse consequences to the principal in resolving a dispute.

(3) Any person acting as either a reinsurance intermediary-broker or intermediary-manager in this state and with an office located in another state may be licensed as a producer in that state, if that state's licensing law is substantially similar to the Reinsurance Intermediary Law set forth at Subsection D of Section 59A-12D-1 et seq. NMSA 1978. Otherwise, that person shall be licensed as a producer in this state.

B. Licensing requirements.

(1) A reinsurance intermediary must file and maintain either a fidelity bond or an errors and omissions policy for the protection of the reinsurer. The fidelity bond or the errors and omissions policy must be issued by an admitted insurer or an eligible surplus lines insurer, be in an amount or at an aggregate limit equal to at least $1,000,000 for the benefit of each reinsurer with whom the reinsurance intermediary contracts, and must provide that the superintendent be notified prior to its cancellation or nonrenewal.

(2) The superintendent may issue a reinsurance producer license to an individual or a business entity as follows:

(a) to an individual who has complied with the producer licensing requirements described in 13.4.2.9 NMAC or to a business entity that has complied with the producer licensing requirements described in 13.4.2.10 NMAC;

(b) that has complied with the requirements of the Reinsurance Intermediary Law set forth in Section 59A-12D-1 et seq. NMSA 1978; and

(c) if a business entity, that has named in its application its members, officers, and designated employees who shall act on behalf of the reinsurance intermediary in this state.

C. Denial, suspension or revocation of license. The superintendent may refuse to issue, suspend or revoke a reinsurance intermediary's license in accordance with 13.4.2.27 and 13.4.2.28 NMAC. Furthermore, the superintendent may refuse, suspend or revoke a reinsurer's right to transact business in this state based on the acts of its reinsurance intermediaries done within the scope of their actual or apparent authority.

D. Exception from licensing. Attorneys holding a current license to practice law in this state are not required to be licensed as reinsurance producers when acting in their professional capacity.

E. Duties of a reinsurance intermediary.

(1) Required contract provisions between insurers or reinsurers and reinsurance intermediaries. A reinsurance intermediary may not transact reinsurance in this state except pursuant to a written contract detailing the responsibilities and agreement between the reinsurance intermediary and the principal.

(a) The contract shall be as set forth in Section 59A-23D-7 NMSA 1978 and shall be filed with the superintendent for approval at least thirty days in advance of its effective date.

(b) Duty of care and loyalty. The contract shall clearly set forth the reinsurance intermediary's duty to clearly communicate the terms of a proposed reinsurance agreement, to disclose facts and circumstances including material

information pertaining to underlying risks that may reasonably be expected to impact the obligations of the insurer or reinsurer, to negotiate terms and conditions of a contract for reinsurance, to assist in memorializing the agreement and to maintain records.

(c) Program of reinsurance. Depending on the terms of the written contract, a reinsurance intermediary's duties may extend to developing a program of reinsurance on behalf of the insurer that includes modeling to estimate probabilities of potential loss outcomes, estimating costs of alternate programs, identifying a pool of potential reinsurers, presenting an information packet to reinsurers on behalf of the insurer, negotiating terms of a contract and assisting in drafting and execution of a contract for reinsurance.

(2) Fiduciary duty. A reinsurance intermediary may act as a conduit between the insurer and reinsurer, including for collection and transmission of premiums, communication of loss and claim information, and collection of funds from a reinsurer on behalf of the insurer. A reinsurance intermediary has a fiduciary duty with respect to any funds held in trust by or transmitted through the reinsurance intermediary by either the insurer or reinsurer.

(3) Record-keeping requirements. A reinsurance intermediary shall annually file with the reinsurer a statement of its financial condition as set forth in Subsection K of Section 59A-12D-7 NMSA 1978. The reinsurance intermediary shall be subject to semi-annual review and inspection of its operations by the reinsurer. A reinsurance intermediary shall maintain complete records of all contracts and transactions for a minimum of ten years following the expiration of each contract for reinsurance.

[13.4.2.22 NMAC – N, 4/2/2018]

13.4.2.23 LICENSING OF INSURANCE CONSULTANTS:

A. License required. No person shall examine or offer to examine in exchange for a fee an insurance policy, annuity, endowment contract or other insurance document in order to offer advice, counsel, a recommendation or other information as described in Subsection A of Section 59A-11A-1 unless licensed as an insurance consultant. Neither may a person offer such services through advertisements or any other means that indicate the person is in business for that purpose, unless licensed as an insurance consultant.

B. Qualifications.

(1) Individual applicants for an insurance consultant license shall apply as though for an individual producer's license as set forth in 13.4.2.9 NMAC.

(2) An applicant shall pay the examination application fee as set forth in Section 59A-6-1 NMSA 1978 and shall pass either the insurance producer license examination or the insurance consultant examination required by 13.4.2.11 NMAC.

(3) The applicant shall demonstrate competence and knowledge of insurance contracts and practices of the insurance industry in the lines of insurance for which the license is applied.

C. Limitations, exemptions and conflicts.

(1) A licensed insurance producer may offer customary advice without holding an insurance consultant license.

(2) A licensee shall not receive compensation as either a producer or as a broker if the licensee receives a fee as a consultant for the same transaction as the subject of the consulting service provided.

(3) An attorney or a public accountant licensed to practice in this state is exempt from the insurance consultant licensing requirement when acting within the scope of their practice.

D. Renewal of license. The insurance consultant license is subject to biennial renewal according to the schedule set forth in 13.4.2.26 NMAC, and to suspension or revocation as set forth in 13.4.2.27 NMAC.

E. Contracts and agreements; collection of consulting fees.

(1) An insurance consultant shall not enforce an agreement to provide advice, counsel or a recommendation in exchange for a fee unless a written agreement has been executed between the insurance consultant and the advisee.

(2) At a minimum, the written agreement shall:

(a) be signed by the advisee;

(b) be executed in duplicate, with one copy retained by the advisee;

(c) state the amount paid by the advisee for the service if payment is made in advance, or the amount to be paid if payment is due following delivery of the service;

(d) state the terms of payment agreed upon by the parties if payment is not due immediately upon delivery of the service;

(e) specify the documents to be reviewed by the insurance consultant, and a copy of those documents shall be attached to the agreement, if available;

(f) specify the services to be delivered by the insurance consultant and the format in which delivery shall be made to the advisee;

(g) state the date and method by which the services shall be delivered; and

(h) provide any other information required by the superintendent.

(3) At a minimum, the insurance consultant shall provide the following upon delivery of the agreed services:

(a) a signed statement specifying the advice, counsel, recommendation or information provided to the advisee;

(b) a receipt for the fee paid or a statement indicating the fee to be paid to the consultant.

F. Recordkeeping requirements.

(1) An insurance consultant shall maintain records consistent with good business practices and shall furnish records of business methods, policies and transactions of the licensee within ten days of a request by the superintendent.

(2) An insurance consultant shall, upon a request by the superintendent, furnish both the standard written agreement form used to document an agreement between the insurance consultant and an advisee and examples of executed agreements that confirm the insurance consultant's business practices.

[13.4.2.23 NMAC – N, 4/2/2018]

13.4.2.24 LICENSING OF MANAGING GENERAL AGENTS:

A. License required.

(1) No person shall act as a managing general agent on behalf of any insurer with respect to risks located in this state unless licensed as a producer in this state.

(2) No person shall act as a managing general agent on behalf of an insurer domiciled in this state with respect to risks located outside this state unless licensed as a producer in this state.

(3) The superintendent may issue a producer license to an individual managing general agent or a business entity acting as a managing general agent as follows:

(a) to an individual who has complied with the producer licensing requirements described in 13.4.2.9 NMAC or to a business entity that has complied with the producer licensing requirements described in 13.4.2.10 NMAC; and

(b) that has complied with the requirements of the Managing General Agents Law as set forth at Section 59A-12B-1 et seq. NMSA 1978.

B. Examination and penalties.

(1) The superintendent may refuse to issue, suspend or revoke a managing general agent's license in accordance with 13.4.2.27 and 13.4.2.28 NMAC.

(2) Actions of a managing general agent are considered to be those of the insurer on whose behalf the managing general agent is acting.

(3) The superintendent may examine a managing general agent as if examining the insurer on whose behalf the managing general agent is acting.

(4) If the superintendent determines that a managing general agent, an insurer or another person has failed to comply with the requirements of the Managing General Agents Law as set forth at Section 59A-12B-1 et seq. NMSA 1978, the superintendent may impose any of the penalties set forth in Subsection A of Section 59A-12B-7 NMSA 1978 or any other penalties permitted under the Insurance Code.

C. Required contract provisions. A managing general agent shall not act on behalf of an insurer except as pursuant to a written contract detailing the responsibilities and agreement between the managing general agent and the insurer as set forth in Section 59A-23B-4 NMSA 1978. The contract between a managing general agent and an insurer shall not be assigned by a managing general agent.

D. Record-keeping requirements. A managing general agent shall maintain complete records of all contracts and transactions for a minimum of seven years following the expiration of each written agreement. The superintendent shall have access to the records for the purpose of examination, audit and inspection.

The insurer shall have access sufficient to permit the insurer to fulfill its contractual obligations to insured persons.

E. Duties of insurers. An insurer that has contracted with one or more managing general agents shall comply with the requirements as set forth in Section 59A-12B-5 NMSA 1978, including but not limited to those pertaining to inspection and oversight of the managing general agent's processes and records and those requiring specific notifications to the superintendent.

[13.4.2.24 NMAC – N, 4/2/2018]

13.4.2.25 OBTAINING A TEMPORARY INSURANCE PRODUCER LICENSE:

A. Necessity and duration of license. The superintendent may issue a temporary insurance producer license to an individual for a period not to exceed 180 days without requiring an examination if the superintendent determines that the temporary license is necessary for the servicing of an insurance business in the following situations:

(1) to the surviving spouse or court-appointed personal representative of a licensed individual insurance producer who dies or becomes mentally or physically disabled, in order to allow adequate time for the sale of the producer's insurance business, for the producer's recovery and return to the business or to provide for the training and licensing of new personnel to operate the insurance producer's business;

(2) to an individual who is a member or employee of a business entity upon the death or disability of an individual who is a DRLP with respect to the business entity;

(3) to the designee of a licensed insurance producer entering active service in the armed forces of the United States; or

(4) in any other circumstance in which the superintendent determines that the public interest will best be served by issuance of the license.

B. Limitations.

(1) An applicant will not be issued a temporary license unless supervised by a suitable sponsor who is a licensed insurance producer or by an insurer who assumes responsibility for all acts of the temporary licensee.

(2) The superintendent may impose other limitations on the authority of any temporary licensee to protect insureds and the public.

(3) The superintendent may revoke a temporary insurance producer license if the interest of insureds or the public are endangered.

(4) A temporary license shall not continue after the owner or personal representative disposes of the business.

C. Application granted. Upon application for a temporary insurance producer license, the insurer and the applicant may assume that the license will be issued in due course, effective as of the date the application was filed with the superintendent, unless the superintendent notifies the insurer to the contrary within 15 days after the date of application.

[13.4.2.25 NMAC – N, 4/2/2018]

13.4.2.26 OTHER DUTIES OF LICENSEES:

A. Place of business.

(1) A resident licensed insurance producer shall have and maintain a place of business within this state that is accessible to the public and where the licensee transacts business under the license.

(2) With the exception of title insurance producers, a licensee's place of business may be in the licensee's residence.

(3) A licensee shall inform the superintendent in the format prescribed by the superintendent of a change in the licensee's legal name or address within 20 days of the change. Failure to timely inform the superintendent of a change in legal name or address shall result in a penalty of $50 pursuant to Subsection G of Section 59A-12-17 NMSA 1978.

B. Fiduciary duties.

(1) All funds of others received by a licensee shall be held in a fiduciary capacity. A licensee who diverts or appropriates such funds for personal use or takes or secrets such funds with intent to embezzle without the consent of the person entitled to the funds is guilty of larceny by embezzlement.

(2) Subject to the terms of any agreement between a licensee and the licensee's principal or obligee, each licensee who does not make immediate remittance of funds to the insurer or other person entitled to them shall elect and follow one of the following methods:

(a) remit insurance charges or premiums collected (less applicable commissions, if any) and return premiums to the insurer or person entitled thereto within 15 days after receipt; or

(b) establish and maintain one or more fiduciary bank accounts separate from accounts holding personal, firm or corporate funds, and promptly deposit and retain therein all funds of others pending transmittal to the insurer or person thereto entitled.

(i) Funds belonging to more than one principal may be as deposited and held in the same account so long as the amount held for each principal is readily ascertainable from the records of the licensee.

(ii) The licensee may commingle with such fiduciary funds in a particular account such additional funds as the licensee deems prudent for advancing premiums, reserves for the payment of return commissions or for other contingencies arising in the business of receiving and transmitting premiums or return premiums.

(3) The licensee may commingle with the licensee's own funds those funds of a particular principal who has expressly waived the segregation requirement in writing and in advance.

(4) Permitted commingling of the funds of others with funds of the licensee shall not alter the fiduciary duties of the licensee as to the others' funds.

(5) When requirements for handling of funds contained in other sections are in conflict with the requirements contained in this section, then those other requirements shall prevail as follows:

(a) Third-party administrators shall handle funds and pay, adjust and settle claims pursuant to the requirements of Sections 59A-12A-9 through 59A-12A-11 NMSA 1978.

(b) Title insurance producers shall manage escrow and other funds held in trust pursuant to the requirements of Section 59A-12-22 NMSA 1978 and 13.14.4 NMAC.

(c) Payments received in connection with the sale of prearranged funeral plans shall be subject to additional controls and shall be handled as set forth in 13.4.2.19 NMAC.

(d) Funds received by rental car insurance producers for the purchase of rental car insurance are not required to be treated as fiduciary funds or held in separate accounts.

C. Recordkeeping requirements.

(1) The requirements contained in this section apply generally to all licensees. However, where these rules differ from the recordkeeping requirements that are applicable to specific types of insurance producers the insurance producer shall also comply with the duties imposed by other rules, where applicable.

(2) An insurance producer shall keep complete records of transactions made under the license in the insurance producer's place of business. For each insurance policy placed by or through the licensee, the record shall include:

(a) the names of the insurer and insured;

(b) the number and expiration date;

(c) the premium payable;

(d) the names of all other persons from whom business is accepted or to whom commissions are promised or paid;

(e) all premiums collected; and

(f) additional information as the superintendent may require.

(3) The records shall be available for the superintendent's examination, and the superintendent may at any reasonable time require the licensee to furnish any information kept or required to be kept in such records.

(4) Records shall be maintained for the statutory duration.

(a) Records of each insurance policy shall be retained for a minimum of three years after the policy's expiration, unless a longer period is required.

(b) Records pertaining to title insurance policies shall be retained for a minimum of 15 years after the issuance of the title insurance policy pursuant to Section 59A-30-11 NMSA 1978.

(c) Complete records of reinsurance transactions shall be retained by reinsurance intermediaries for at least ten years after the expiration of each contract, pursuant to Section 59A-12D-5 NMSA 1978.

(d) A third-party administrator shall keep adequate books and records of all transactions between it, insurers and insured persons in its administrative office for the duration of its contractual duties and for five years thereafter, pursuant to Section 59A-12A-6 NMSA 1978.

(e) Licensees may be required to manage and retain additional records for a differing stated duration based on the provisions of the Insurance Code.

(5) Books and records shall be maintained in accordance with prudent standards of insurance record keeping.

D. Duty to report any administrative actions, and civil and criminal prosecution.

(1) A licensee shall report to the superintendent any administrative action taken against the licensee in any jurisdiction or by another governmental agency in this state within 30 days of the final disposition of the matter. The report shall include a copy of the order, consent to order or other relevant legal documents.

(2) A licensee shall report to the superintendent any criminal prosecution of the licensee taken in any jurisdiction within 30 days after the initial pretrial hearing date. The report shall include a copy of the initial complaint filed, any order resulting from the hearing and other relevant legal documents.

(3) A licensee shall report to the superintendent the filing and progress of any civil complaint filed against the licensee in any jurisdiction. The initial report shall include a copy of the complaint. Subsequent reports shall be filed as the case progresses, and the final report shall include the final order, if any, and any other relevant legal documents.

(4) Title insurance producers shall report to the superintendent in compliance with the requirements set forth in 13.14.4.12 NMAC.

E. Duty to report license cancellation. A licensee whose out-of-state resident or non-resident license is canceled through either the action or inaction of the licensee shall report the cancellation to the superintendent within 30 days.

F. Duty to report fraud.

(1) A licensed insurance professional that has a reasonable belief that an act of insurance fraud will be, is being or has been committed shall report to the superintendent pursuant to Section 59A-16C-6 NMSA 1978 and shall cooperate fully with any investigation conducted by the superintendent,

(2) Failure to comply with this duty to report actual of suspected fraud shall constitute grounds for the superintendent to impose an administrative penalty pursuant to Section 59A-1-18 NMSA 1978 in addition to any applicable suspension, revocation or denial of a license.

[13.4.2.26 NMAC – N, 4/2/2018]

13.4.2.27 CONTINUATION, TERMINATION AND REINSTATEMENT OF LICENSES:

A. Continuation of producer licenses. An insurance producer license is continuous, subject to payment of renewal fees as set forth in Section 59A-6-1 NMSA 1978 and completion and submission on or before the due date of the continuing education requirements described in 13.4.7 NMAC, unless the license is canceled, revoked, suspended or otherwise terminated.

(1) A licensed insurance producer who is unable to comply with license renewal requirements due to military service or other extenuating circumstance may request a waiver using forms available on the OSI website or as otherwise directed by the superintendent. An insurance producer in such circumstances may also request a waiver of an examination requirement or of a fine or sanction imposed for failure to comply with renewal procedures.

(2) For licenses issued to individuals:

(a) For licenses issued on or after July 1, 2017, biennial renewal fees shall be paid on or before the last day of the second occurrence of the individual's birth month following issuance of the license.

(b) For licenses issued before July 1, 2017, details pertaining to biennial continuation and renewal of licenses are available on the OSI website for renewals due on March 1, 2018. Thereafter, the license shall be renewed according to the biennial schedule implemented on July 1, 2017.

(c) Continuing education requirements shall be satisfied during the 24 months immediately preceding the renewal date of the license. Additional information pertaining to continuing education requirements may be found in Section 13.4.7 NMAC.

(d) If the superintendent has reason to believe that the competence of any licensee or individual designated to exercise license powers is in question, the superintendent may require as a condition of continuation of the license or license powers that the licensee or individual take and pass the written examination that is required for new applicants for the same license.

(3) For licenses issued to business entities:

(a) Business entity licenses shall renew and continue on a biennial basis on March 1 of the biennial year except for those types of business entity licenses that renew and continue annually pursuant to Section 59A-6-1 NMSA 1978, which shall renew and continue on March 1 of every year.

(b) Business entity affiliations shall renew and continue on an annual basis on March 1 of every year, subject to payment of fees pursuant to Section 59A-6-1 NMSA 1978.

B. Termination of licenses.

(1) A license that is not continued by the licensee shall be deemed terminated at midnight on the last day of the licensee's birth month in the renewal year if an individual license and at midnight of March 1 in the renewal year if a business entity license. However, at the superintendent's discretion, a licensee's request for continuation received within 30 days after the due date may be granted if accompanied by a continuation fee equal to one-hundred-and-fifty percent of the fee otherwise required.

(2) Authorization to transact business in this state shall automatically terminate without notice as of the date and time of termination of a license.

(3) Any license issued to an individual shall terminate upon the death of the person.

(4) If a corporation ceases to exist, its business entity license shall be tendered to the superintendent with notice of the dissolution.

(5) If a change occurs only in the officers or in the name of a corporation, it may continue to transact insurance under the license until action is taken by the superintendent upon a new application, if:

(a) within 30 days of the change, the surviving officers of the corporation file an application on a form prescribed by the superintendent for registration of a change in the officers or the name of the corporation and pay the required fees; and

(b) the application for registration of the change in officers is signed by the secretary or corresponding officer of the corporation.

(6) If the membership of a partnership changes, the surviving or continuing partner or partners may continue to transact insurance business under the license issued to the predecessor partnership until action is taken by the superintendent upon a new application, if:

(a) within 30 days, the surviving partner or partners file an application on a form prescribed by the superintendent for registration of a change in membership and pay the required fee;

(b) at least one person who exercises the producer powers of the predecessor entity continues to exercise those powers of the surviving or continuing partnership; and

(c) the application for registration of the change in membership is signed by a general partner.

C. Reinstatement of licenses.

(1) An individual licensee who allows the license to lapse may, within 12 months following the due date of the required renewal fee and completion of continuing education credits, reinstate the license without the necessity of passing a written examination.

(2) A penalty of double the unpaid renewal fee shall be required for a renewal received after the due date.

(3) If the producer has failed to comply with continuing education requirements during a lapse, the producer shall complete all continuing education hours that would have been necessary to keep the license in compliance.

[13.4.2.27 NMAC – N, 4/2/2018]

13.4.2.28 DENIAL, SUSPENSION, REVOCATION OR CANCELLATION OF LICENSES:

A. Effects of suspension. While a license is suspended, the licensee shall not engage in any transaction for which the license is required, other than receipt and remittance of premiums paid for insurance or other business that was transacted by the licensee while the license was active.

B. Reasons for probation, suspension, revocation or refusal to continue license.

(1) The superintendent may take necessary action based on information obtained via the NAIC attachment warehouse personal information capture system alerts or other appropriate mechanisms used to monitor actions against existing licensees.

(2) It shall be the duty of the superintendent to cancel a license if the superintendent is satisfied that:

(a) a licensee obtained the license by willful misrepresentation or fraud;

(b) a licensee obtained the license chiefly for the purpose of writing insurance on the licensee's own life, property or liability, or on the lives, property or liability of the licensee's associates;

(c) a licensee is not complying with all state and federal laws and regulations relating to insurance; or

(d) the interests of the insured or the public are not being properly served under the license.

(3) The superintendent may place on probation, suspend, revoke or refuse to issue or renew a license for any of the reasons set forth in in Section 59A-11-14 NMSA 1978.

(4) A business entity's license may be suspended, revoked or refused if the superintendent finds after hearing that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation, the violation was not reported to the superintendent and no corrective action was taken.

(5) A rental car insurance producer's license may be revoked or suspended following a hearing by the superintendent for a violation by the producer or the producer's endorsees of the Rental Car Insurance Limited Producer License Act set forth at Section 59A-32A-8 NMSA 1978. The superintendent may also impose penalties

or suspend a transaction of insurance at specific rental locations where such a violation has occurred.

C. Suspension or revocation of or refusal to continue a license.

(1) If the superintendent suspends, revokes or refuses to continue a license, the superintendent shall notify the applicant in writing. The notice shall advise the applicant of the reason for the decision.

(2) Within 30 days of the date of issuance of the notice, the applicant may request a hearing in writing pursuant to Section 59A-4-15 NMSA 1978. The hearing shall be held within 90 days.

(3) The superintendent retains the authority to enforce the provisions of and impose any penalty or remedy authorized by the Insurance Code against any person who is under investigation for or charged with a violation of the Insurance Code even if the person's license has been surrendered or has lapsed by operation of law.

D. Administrative fines.

(1) In addition to, or in lieu of, any applicable suspension, revocation or denial of a license the superintendent may impose fees or administrative fines pursuant to Section 59A-1-18 NMSA 1978 or a specific section of the Insurance Code.

(2) The amount of the administrative fine shall be not less than $100 nor more than $500 unless a small or larger fine is set by a specific section of the Insurance Code.

(3) In the order imposing the fine, the superintendent shall specify the grounds therefor and the period, not to exceed 60 days, within which the licensee shall pay the fine.

(4) If at the end of the allowed payment period the licensee has not paid the fine in full, the license immediately shall be suspended or revoked, or its renewal denied, as the case may be, without further order.

E. Duration of and reinstatement following suspension or revocation of license.

(1) In the order suspending a license, the superintendent shall state the period of suspension, which shall not exceed one year.

(a) The period of suspension may be modified by the superintendent's further order.

(b) At the end of the suspension period the license shall be reinstated upon request of the licensee unless the superintendent finds that the cause or causes of the suspension still exist or are likely to recur. If the superintendent so finds, he shall forthwith revoke the license by further order.

(2) An applicant whose license has been administratively revoked or suspended shall contact the superintendent in order to request reinstatement of the license.

(3) A licensee whose license has been revoked or suspended for noncompliance with the Parental Responsibility Act shall become compliant and provide evidence of compliance to the superintendent before the license may be reinstated.

(4) The superintendent shall not relicense a former licensee whose license has been revoked or its continuation refused without evidence that the former licensee is otherwise qualified for the license and that the cause or causes of the prior revocation or refusal to continue no longer exists and will not recur.

[13.4.2.28 NMAC – N, 4/2/2018]

13.4.2.29 APPOINTMENTS AND CANCELLATION OF PRODUCER CONTRACTS:

A license itself does not create any authority, actual, apparent, or inherent in the licensee to represent or commit an insurer.

A. Appointment of insurance producers.

(1) An insurance producer shall not act as an insurance producer on behalf of an insurer unless the insurance producer becomes an appointed insurance producer of that insurer. An insurance producer who is not acting on behalf of an insurer is not required to become appointed.

(2) An insurer shall appoint a producer using the online electronic application or as otherwise directed by the superintendent.

(a) The appointment shall be filed within 15 days from the date that the agency agreement is executed or when the first insurance application is submitted by the insurance producer on behalf of the insurer.

(b) An insurer may appoint an insurance producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment.

(c) An insurer shall pay the filing appointment fee set forth in Paragraph (3) of Subsection E of Section 59A-6-1 NMSA 1978 for each insurance producer the insurer

appoints, but may contract for reimbursement of the fee by agreement with the producer.

(3) In the event of a merger between two or more insurers, appointments of producers by any of the insurers absorbed by the merger will continue with the resulting insurer.

B. Continuation of appointment.

(1) Appointments of insurance producers shall be continuous subject to the insurer's payment of continuation fees as required by Section 59A-6-1 NMSA 1978 and filing of notice of continuation with the superintendent.

(2) Notice of continuation and payment of continuation fees shall be filed annually with the superintendent on or before March 1 of each year. The annual filing shall include the name, address and license number of each insurance producer appointed by the insurer to solicit or transact business in this state on the insurer's behalf.

C. Termination of appointment.

(1) Insurance producer appointments terminate automatically on April 30 of the year after issuance or continuation of appointment if the appointing insurer does not file a continuation of appointment.

(2) No insurer authorized to transact property or casualty insurance business in this state shall terminate a contract appointing an independent insurance producer without giving the insurance producer written notice of the termination, including the specific reason for such action, at least 180 days prior to the termination except as provided in Subsection C of Section 59A-11-13 NMSA 1978.

(3) No insurer shall terminate an appointment with a property or casualty insurance producer based on an adverse loss-ratio, as set forth in Subsection B of Section 59A-11-13 NMSA 1978.

(4) Notice of termination of appointment by an insurer shall be provided to the superintendent using the online form, or as otherwise directed by the superintendent, within 30 days following the effective date of the termination.

(a) If the reason for termination is one of the reasons for which the superintendent may cancel, suspend, revoke or refuse to issue a license as set forth in 13.4.2.27 and 13.4.2.28 NMAC, Subsection C of Section 59A-11-13 NMSA 1978 and Section 59A-11-14 NMSA 1978, or if the insurer has knowledge that the producer has been found by a court or regulatory agency to have engaged in any of the activities prohibited by 13.4.2.27 NMAC, the notice shall disclose it.

(b) The insurer has a continuing obligation to report to the superintendent should additional information become available following the initial notification.

(c) The insurer shall provide additional information about the reason for termination upon the superintendent's request.

(5) If the reason for the termination is one or more of the activities listed in 13.4.2.27 NMAC, the insurer shall provide a copy of the notice via certified mail to the insurance producer's last known address within 15 days following submission of the notice to the superintendent.

(6) The insurance producer may provide to the superintendent additional information in response to the notice filed by the insurer within 30 days; both the insurer's notice and the insurance producer's response shall be made a permanent part of the file retained by the superintendent.

(7) Any documents and materials related to termination or cancellation of an insurance producer's appointment that are provided to the superintendent shall be handled in a manner that is consistent with the confidentiality provisions set forth in Subsection K of Section 59A-11-13 NMSA 1978.

(8) An insurer may terminate its relationship with an insurance producer for any of the reasons set forth in Subsection C of Section 59A-11-13 NMSA 1978. The provisions of Paragraphs (2) and (3) of Subsection C of 13.4.2.19 NMAC shall not apply for such terminations.

(9) When an insurer ceases operation in this state, all producers and other principals that have been appointed by the insurer shall cease to be authorized to transact business in this state on behalf of the insurer as of the date of such cessation and shall immediately cease all activity on behalf of the insurer.

[13.4.2.29 NMAC – N, 4/2/2018]

13.4.2.30 SUPERINTENDENT'S LICENSING RECORDS:

A. The superintendent shall keep a record of:

(1) each licensee's name, address, date of license, kind of business transacted and qualifications;

(2) the name of the principal or insurer represented; and

(3) all cancellations, suspensions or revocations of a license and notifications submitted by an insurer to the superintendent that pertain to a licensee.

B. Except for confidential information and other matters withheld by the superintendent pursuant to Sections 59A-2-12, 59A-4-11 and 59A-11-13 NMSA 1978, these records shall be made available for public inspection upon request.

[13.4.2.30 NMAC – N, 4/2/2018]

PART 3: NONRESIDENT AGENTS AND BROKERS

13.4.3.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.4.3.2 SCOPE:

This rule applies to all persons seeking licensure as a nonresident agent or nonresident broker.

[7/1/97; Recompiled 11/30/01]

13.4.3.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.4.3.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.4.3.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.4.3.6 OBJECTIVE:

The purpose of this rule is to implement Chapter 59A Article 12, NMSA 1978, by establishing requirements for obtaining a license as a nonresident agent or nonresident broker.

[7/1/97; Recompiled 11/30/01]

13.4.3.7 DEFINITIONS:

For the purpose of this rule:

A. **"Nonresident agent"** has the meaning given in Section 59A-12-2 NMSA 1978.

B. **"Nonresident broker"** has the meaning given in Section 59A-12-3 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.4.3.8 LICENSING REQUIREMENTS:

The superintendent may issue a license as a nonresident broker, or as a nonresident agent for life and health insurance only, to a person who maintains a bona fide continuous residence and a chief place of business within the continental limits of the United States, but not within the state of New Mexico, and who is licensed to engage in the business of insurance outside of New Mexico, under the following conditions:

A. Applicants shall pay in advance to the superintendent the fees prescribed in Section 59A-6-1 NMSA 1978.

B. Applicants shall file with the superintendent the stipulation required by 13 NMAC 4.3.9 [now 13.4.3.9 NMAC].

C. Notwithstanding the conditions required under this rule, a nonresident broker shall be subject to retaliatory or reciprocal requirements, or both, with respect to any taxes, fines, penalties, licenses or fees in addition to or in excess of that imposed by the laws of this state upon nonresident brokers in New Mexico doing business in another state, or whenever any conditions precedent to the right to do business in another state are imposed by its laws beyond those imposed upon nonresident brokers by the laws of New Mexico, the same taxes, fines, penalties, licenses or fees and conditions precedent shall be imposed upon every similar nonresident broker in another state doing or applying to do business in New Mexico so long as the governing laws remain in force; and upon the failure of a nonresident broker to comply, the superintendent shall revoke the license in New Mexico, or shall refuse to grant a license or certificate in the first instance.

D. Pursuant to 18 U.S.C. Section 1033, no person who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a nonresident agent

or a nonresident broker, unless the person has the written consent of the superintendent.

[7/1/97; Recompiled 11/30/01]

13.4.3.9 REQUIRED STIPULATION:

A. Applicants for a nonresident broker's license shall file with the superintendent a stipulation which shall recite the name of the applicant, the nonresident broker's license applied for, and shall agree:

(1) "That in any action or special proceedings brought against (me) or (us) in the state of New Mexico for and on account of any action lawfully permitted to be done or performed by (me) or (us) solely by reasons of the existence of the nonresident broker's license, any documents or process may be served on the superintendent of insurance with the same effect as those served upon (me) or (us) and this service will give jurisdiction of either (me) or (us) to the same extent as if (I) or (we) were a resident of the state of New Mexico."

(2) "That any action or special proceedings brought by (me) or (us) against the superintendent of insurance of the state of New Mexico will be brought in the county of Santa Fe."

(3) "That (I) or (we) will appear at the office of the superintendent of insurance in the city of Santa Fe, New Mexico at any time, pursuant to notice of hearing, order to show cause or subpoena issued by the superintendent of insurance, or these documents deposited in the United States mail, certified and postage prepaid, in a cover addressed to (me) or (us) at the last address filed by (me) or (us) with the superintendent of insurance; this deposit in the mail being thirty or more days before the date specified in the documents for appearance and that in the event of failure so to appear (I) or (we) hereby consent to any subsequent suspension, revocation, refusal to renew or denial of the nonresident broker's license by the superintendent of insurance."

B. This stipulation and the agreement shall give jurisdiction over and shall be binding pursuant to its terms upon the person executing it.

C. Whenever any documents are served on the superintendent pursuant to the terms of this stipulation and agreement, the superintendent shall transmit a copy to the respective nonresident broker licensee or former nonresident broker licensee by depositing it in the United States mail, certified and postage prepaid, in a cover addressed to the person on behalf of whom the superintendent was served. This deposit shall be made within ten days of service on the superintendent and service will be complete as to the person at the end of sixty days after service of the superintendent.

[7/1/97; Recompiled 11/30/01]

PART 4: SURPLUS LINES BROKERS

13.4.4.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.4.4.2 SCOPE:

This rule applies to all persons seeking licensure as a surplus lines broker.

[7/1/97; Recompiled 11/30/01]

13.4.4.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.4.4.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.4.4.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.4.4.6 OBJECTIVE:

The purpose of this rule is to implement Chapter 59A Article 14 NMSA 1978 by establishing requirements for obtaining a license as a surplus lines broker.

[7/1/97; Recompiled 11/30/01]

13.4.4.7 DEFINITIONS:

For the purpose of this rule, **surplus lines broker** has the meaning given in Section 59A-14-2 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.4.4.8 LICENSING REQUIREMENTS:

A. An applicant requesting a license as a surplus lines broker shall file, as part of the application, a bond as required by this rule. The application for a surplus lines broker will be considered for issuance by the superintendent upon the following conditions:

(1) the payment in advance to the superintendent of the fees prescribed in section 59A-6-1 NMSA 1978; and

(2) delivery to the superintendent of a bond to the state of New Mexico in the amount specified in Section 59A-14-8 NMSA 1978 issued by a licensed surety insurer, conditioned that the licensee will fully and faithfully comply with the requirements of this rule.

B. On or before the first day of March of each year, the department of insurance shall mail a billing statement for renewal of the surplus lines broker license to each surplus lines broker licensed in New Mexico.

C. On or before the first day of April of each year, the surplus lines broker shall return the billing statement together with the license renewal fee specified in Section 59A-6-1 NMSA 1978.

D. Pursuant to 18 U.S.C. Section 1033, no person who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a surplus lines broker, unless the person has the written consent of the superintendent.

[7/1/97; Recompiled 11/30/01]

13.4.4.9 REQUIRED EXPERIENCE, TRAINING AND EDUCATION:

To meet the requirements of Section 59A-14-7 NMSA 1978, an applicant for a surplus lines broker license shall file, as part of the application, documentation showing a combination of the following factors totaling at least five years:

A. experience as a licensed agent in the kind of insurance for which the surplus lines broker license is sought;

B. continuing education units of a type and quantity sufficient to satisfy the requirements for renewal of an agent's license; and

C. any other special experience, education or training that the applicant offers to demonstrate that the applicant is reasonably competent to conduct surplus lines business in New Mexico.

[7/1/97; Recompiled 11/30/01]

PART 5: INSURANCE ADMINISTRATORS

13.4.5.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.4.5.2 SCOPE:

This rule applies to all administrators who provide administrative services in connection with insurance or alternatives to insurance or who, in a fiduciary capacity or otherwise, manage or handle funds, money, premiums, fees or other forms of consideration in connection with insurance or alternatives to insurance. This rule also applies to the claims practices of insurers or alternatives to insurance, whether or not they are administered by a third party.

[2/1/92; Recompiled 11/30/01]

13.4.5.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-12A-1 through 59A-12A-17 NMSA 1978.

[2/1/92; Recompiled 11/30/01]

13.4.5.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.4.5.5 EFFECTIVE DATE:

February 1, 1992, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[2/1/92, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.

13.4.5.6 OBJECTIVE:

The purpose of this rule is to provide criteria and procedures applicable to the licensure and conduct of insurance administrators and to govern the practice of insurance administration.

[2/1/92; Recompiled 11/30/01]

13.4.5.7 DEFINITIONS:

As used in this rule, all terms defined in Section 59A-12A-2 NMSA 1978 shall have the meanings ascribed therein.

[2/1/92; Recompiled 11/30/01]

13.4.5.8 LICENSING REQUIREMENTS:

A. The superintendent will issue, renew and permit to exist any license of an insurance administrator to a person qualified as follows:

(1) an applicant shall be at least 18 years of age;

(2) a resident applicant shall have been a resident of the state of New Mexico for at least thirty (30) days immediately preceding the filing of the application;

(3) a nonresident applicant may apply for a license while maintaining its bona fide continuous residence and chief place of business within the continental limits of the United States, but not within the state of New Mexico, and may engage in the business of insurance administration outside of New Mexico; and

(4) the applicant shall complete and file an application and shall successfully pass a personal written examination to determine that the applicant has sufficient knowledge and reasonable familiarity with the insurance laws of New Mexico and with the provisions, terms and conditions of the insurance business to be transacted under the license sought, and that the applicant has a general and fair understanding of the obligations and duties of an insurance administrator.

B. No license shall be issued to or renewed for any administrator acting on behalf of an unauthorized insurer transacting the business of insurance in violation of the Insurance Code or federal law.

C. Pursuant to 18 U.S.C. Section 1033, no person who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as an insurance administrator, unless the person has the written consent of the superintendent.

[7/1/97; Recompiled 11/30/01]

13.4.5.9 INDIVIDUAL APPLICATIONS:

A. Application by an individual for an insurance administrator's license shall be filed with the superintendent on forms prescribed and furnished by the superintendent and accompanied by applicable fees as set out in this regulation. The application shall be signed by the applicant under oath if required by the form. The application form may require information about applicant as to:

(1) name, date of birth, social security number, residence, business address if applicable, and length of time a resident of New Mexico, if applicable;

(2) personal history and business experience in general for at least the five-year period immediately preceding the date of the application;

(3) experience or special training or education in the kind of business to be transacted under the license applied for;

(4) previous licensing;

(5) type of license applied for and kinds of insurance or transactions to be covered thereby;

(6) proof of applicant's identity; and

(7) such other pertinent information and matters as the superintendent may reasonably require.

B. In addition to the written application, individual applicants are required to file therewith the following documents:

(1) Nonresident applicants who are licensed to transact any kind of insurance or insurance administration in another state shall provide a letter of certification or equivalent document from their state of domicile.

(2) Resident applicants who are or have been licensed to transact any kind of insurance or insurance administration in another state shall provide a letter of clearance or equivalent document from such other states where they are or have been licensed.

[2/1/92; Recompiled 11/30/01]

13.4.5.10 CORPORATE APPLICATIONS:

Corporate and partnership applicants shall submit an application for a license in the name of the legal entity and shall submit applications in the name of every officer and manager of a corporation and of every partner in a partnership who is to exercise license powers of the administrator as required by Section 59A-12A-3C NMSA 1978. (Manager as used herein shall mean the highest ranking administrator at a single location.) Such applications shall be filed with the superintendent by the partnership or corporation on form prescribed and furnished by the superintendent, accompanied by an application fee as set out in this rule. The application shall be signed on behalf of the legal entity (partnership or corporation) by a partner or corporate officer thereunto duly authorized, and under oath if so required by the superintendent. The application form may require information about applicant as follows:

A. if a partnership, the name, residence, proof of identity, business record and business experience of each partner and so much additional information concerning such individuals as required of applicants for license as individuals as the superintendent deems advisable;

B. if a corporation, the name, residence, proof of identity, business record and reputation, business experience of each officer, member of the board of directors, controlling stockholder(s), and such additional information concerning such individuals as required of applicants for license as individuals as the superintendent deems advisable;

C. evidence satisfactory to the superintendent that transaction of business proposed to be transacted under the license applied for is within the partnership agreement, if a partnership, or within the corporate powers, if a corporation; and

D. such further information concerning applicant, partners, corporate officers, directors, and stockholders, as the superintendent deems advisable.

E. If a partnership, each individual in addition to a general partner who is to exercise license powers, and if a corporation, each individual, in addition to an officer and manager who is to exercise the license powers, shall file application as though for an individual license for the same kind of business as that applied for by the partnership or corporation.

F. Each application shall be accompanied by payment of the fee for filing an application and the fee for any examination required under the Insurance Code to be taken and passed prior to licensing. An additional license application filing fee is required as to each individual in excess of one who is to exercise the license powers of a corporation, or license powers of a partnership if not a general partner therein.

G. An administrator shall notify the superintendent within thirty (30) days of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a certificate of authority in this state.

[2/1/92; Recompiled 11/30/01]

13.4.5.11 EXCEPTIONS TO LICENSURE REQUIREMENTS:

A. An administrator is not required to hold a certificate of authority as an administrator in this state if all of the following conditions are met:

(1) the administrator has its principal place of business in another state;

(2) the administrator is not soliciting business as an administrator in this state; and

(3) in the case of any group policy or plan of insurance serviced by the administrator, the lesser of five percent (5%) or one hundred (100) certificate holders reside in this state.

B. A person is not required to hold a certificate of authority as an administrator in this state if the person exclusively provides services to one or more bona fide employee benefit plans each of which is established by an employer or an employee organization, or both, and for which the insurance laws of this state are fully preempted pursuant to ERISA. Such persons shall register with the superintendent annually, verifying their status as herein described.

[2/1/92; Recompiled 11/30/01]

13.4.5.12 EXAMINATION OF APPLICANTS:

A. Examinations for insurance administrator licenses shall be arranged through the agents licensing division of the new mexico department of insurance and conducted according to the provisions of Section 59A-11-6 NMSA 1978 as amended.

B. Individual applicants, corporate officers, managers and employees who will exercise license powers and general partners and partnership employees who will exercise license powers shall be required to complete and successfully pass a written examination as herein provided.

[2/1/92; Recompiled 11/30/01]

13.4.5.13 EXEMPTIONS FROM EXAMINATION REQUIREMENTS:

A. No such examination will be required of an applicant for continuation or renewal of an existing insurance administrator's license.

B. In his discretion, the superintendent may waive the examination requirement for insurance administrators who were operating in New Mexico prior to June 16, 1989, the effective date of Chapter 59A, Article 12A NMSA 1978 pursuant to Section 59A-12A-3B NMSA 1978.

C. Upon request from an applicant, the superintendent may waive the examination requirement if the applicant holds a valid certificate of authority as an administrator issued in a state which the superintendent has determined has standards for administrators that are at least as stringent as those contained in the model statute for third party administrators of the national association of insurance commissioners.

[2/1/92; Recompiled 11/30/01]

13.4.5.14 FEES:

Every insurance administrator transacting business in the state of New Mexico shall pay to the superintendent of insurance the following nonrefundable fees:

A. filing application for original insurance administrator license issued to a person as defined in this regulation, $50.00;

B. filing application for original insurance administrator license issued to each officer and each manager exercising license powers of a licensed corporation and each partner exercising license powers in a licensed partnership, $50.00;

C. continuation or renewal of license, each year, $23.00;

D. examination for license conducted directly by superintendent, and payable as to each instance of examination, $50.00;

E. for each request for a duplicate license and for each name change, $30.00;

F. for each annual report filed, $50.00; and

G. for each seal and signature affixed to any instrument, $10.00.

[2/1/92, 7/1/97; Recompiled 11/30/01]

13.4.5.15 ANNUAL CONTINUATION OF LICENSE:

A. Licenses issued shall continue until the first day of March of the following year unless previously canceled by the licensee on a form prescribed by and filed with the superintendent.

B. Each insurance administrator licensed to transact business in the state of New Mexico shall continue the license previously issued by paying a continuation or renewal fee therefor on or before March 1 of each calendar year.

[2/1/92; Recompiled 11/30/01]

13.4.5.16 SCOPE OF LICENSE:

A. The license issued by the superintendent under these regulations shall state the name of the licensee and residence address if an individual, or business address if a partnership or corporation or a place of business is otherwise required of the licensee, the capacity in which the licensee is to act and the kind of business covered, date of issuance of license, and such other information as the superintendent deems pertinent and consistent with law.

B. Any license issued under this regulation entitles the licensee to act for one or more authorized insurers, eligible surplus lines insurers, plans or persons that self insure without being required to obtain a separate license with respect to each insurer, surplus lines insurer, plan or person that self insures.

C. The license of a partnership or corporation shall also state, or record by endorsement attached thereto, the name of each individual authorized to exercise the license powers. At the superintendent's discretion the name of such an individual may be registered with the insurance department in lieu of being shown or endorsed on the license.

[2/1/92; Recompiled 11/30/01]

13.4.5.17 CANCELLATION AND SURRENDER OF LICENSES:

A. Whenever a partnership or corporation licensed as an insurance administrator shall discharge any licensed insurance administrator from its employ, the discharging licensee shall immediately notify the superintendent on a form prescribed by him and request cancellation of the license existing in the name of the discharged licensee. In order to perform services as an administrator, the discharged licensee shall be required to reapply for an administrator's license, and may be reinstated under a new administrator within six months of termination without re-examination by payment of a new initial fee.

B. All licenses issued to natural persons terminate upon the death of such persons.

C. All licenses issued to legal entities terminate upon legal dissolution of such entities.

[2/1/92; Recompiled 11/30/01]

13.4.5.18 REVOCATION OF LICENSE:

A. **Grounds:** In the event that the superintendent is satisfied that any insurance administrator obtained a license by willful misrepresentation or fraud, or that the licensee has not complied with the insurance laws of the state of New Mexico, or that the interests of the insureds or the public are not being properly served under the license, it shall be the duty of the superintendent to revoke the administrator's license.

B. **Hearing:** Any person aggrieved by any action, threatened action, or failure to act of the superintendent shall have the same right to a hearing before the superintendent with respect thereto as provided for in general under Section 59A-4-15 NMSA 1978. Notice of hearing shall be given, the hearing conducted, rights and powers exercised, and the superintendent's order on hearing made and given as provided as to hearings in general under the applicable provisions of Chapter 59A, Article 4 NMSA 1978.

C. **Review:** Any person aggrieved by the superintendent's order on such hearing, or by the superintendent's refusal to hold the hearing, may request a review thereof under the applicable provision of Chapter 59A, Article 4 NMSA 1978.

[2/1/92; Recompiled 11/30/01]

13.4.5.19 ANNUAL REPORTS:

A. Each administrator shall file an annual report for the preceding calendar year with the superintendent on or before March 1 of each year, or within such extension of time therefor as the superintendent for good cause may grant. The report shall be in the form and contain such matters as the superintendent prescribes and shall be verified by at least two (2) officers or two (2) partners of the administrator, if applicable.

B. The annual report shall include the complete names and addresses of all insurers with which the administrator had an agreement during the preceding fiscal year. If requested in writing by the administrator, the names and addresses of the insureds may be kept confidential by the superintendent.

C. At the time of filing its annual report, the administrator shall pay a filing fee as required by this regulation.

[2/1/92; Recompiled 11/30/01]

13.4.5.20 WRITTEN AGREEMENTS:

A. The written agreement between the administrator and insurer required by Section 59A-12A NMSA 1978 -4 shall include a statement of duties which the administrator is expected to perform on behalf of the insurer and the lines, classes or types of insurance for which the administrator is to be authorized to administer. The agreement shall make

provisions with respect to underwriting or other standards pertaining to the business underwritten by such insurer.

B. The insurer or administrator may upon written notice, terminate the written agreement for cause as provided in the agreement. The insurer may suspend the underwriting authority of the administrator during the pendency of any dispute regarding the cause for termination of the written agreement. The insurer must fulfill any lawful obligations with respect to policies or claims affected by the written agreement, regardless of any dispute between the insurer and the administrator.

[2/1/92; Recompiled 11/30/01]

13.4.5.21 COMPENSATION:

A. An insurance carrier, plan, person that self insures, or third-party administrator doing business in this state shall not pay, directly or indirectly, any compensation or fee or any further consideration of value to any insurance administrator for service as an administrator within this state, unless the administrator is duly licensed to transact such business in the state of New Mexico.

B. The prohibition contained in the preceding paragraph does not prevent the payment or receipt of vested renewal or other deferred commissions or fees to or by any person solely because that administrator has ceased to hold a valid license.

[2/1/92; Recompiled 11/30/01]

13.4.5.22 RESPONSIBILITIES OF THE INSURER:

A. If an insurer utilizes the services of an administrator, the insurer shall be responsible for determining the benefits, premium rates, underwriting criteria and claims payment procedures applicable to such coverage and for securing reinsurance, if any. The rules pertaining to these matters must be provided, in writing, by the insurer to the administrator. The responsibilities of the administrator as to any of these matters shall be set forth in the written agreement between the administrator and the insurer.

B. It is the ultimate responsibility of the insurer to provide for competent administration of its programs.

C. In cases where an administrator administers benefits for more than one hundred (100) certificate holders on behalf of an insurer, the insurer shall maintain for a minimum of at least three years any reviews conducted of the operations of the administrator, and shall produce the records pertaining to the review at the request of the superintendent.

[2/1/92; Recompiled 11/30/01]

PART 6: PARENTAL RESPONSIBILITY

13.4.6.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[11/23/95; Recompiled 11/30/01]

13.4.6.2 SCOPE:

This rule applies to all persons who are required to have a license issued by the superintendent before engaging in the business of insurance.

[11/23/95, 7/1/97; Recompiled 11/30/01]

13.4.6.3 STATUTORY AUTHORITY:

Section 40-5A-9 NMSA 1978.

[11/23/95; Recompiled 11/30/01]

13.4.6.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.4.6.5 EFFECTIVE DATE:

November 23, 1995, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[11/23/95, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.4.6.6 OBJECTIVE:

The purpose of this rule is to implement the requirements of the Parental Responsibility Act, Sections 40-5A-1 to 40-5A-13 NMSA 1978, as they apply to the issuance, renewal, suspension or revocation of any license issued by the superintendent of insurance.

[11/23/95, 7/1/97; Recompiled 11/30/01]

13.4.6.7 DEFINITIONS:

All terms defined in the Parental Responsibility Act shall have the same meanings in this rule.

A. **"HSD"** means the New Mexico human services department.

B. **"Judgment and order for support"** means the judgment entered against an obligor by the district court or a tribal court in a case brought by the HSD pursuant to Title IV-D of the Social Security Act.

C. **"License"** means a license, certificate, registration or permit issued by the superintendent or department that a person is required to have to engage in the business of insurance in New Mexico.

D. **"Statement of compliance"** means a certified statement from HSD stating that an applicant or licensee is in compliance with a judgment and order for support.

E. **"Statement of non-compliance"** means a certified statement from HSD stating that an applicant or licensee is not in compliance with a judgment and order for support.

[11/23/95, Recompiled 11/30/01]

13.4.6.8 SANCTIONS:

If an applicant or licensee is not in compliance with a judgment and order for support, the superintendent shall:

A. deny an application for a license as provided in 13 NMAC 4.6.10 [now 13.4.6.10 NMAC] of this rule; or

B. deny license renewal by disapproving the continuation of agent appointments as provided in 13 NMAC 4.6.10 [now 13.4.6.10 NMAC] of this rule; or

C. commence revocation of a license as provided in 13 NMAC 4.6.10 and 4.6.11 [now 13.4.6.10 NMAC and 13.4.6.11 NMAC] of this rule.

[11/23/95; Recompiled 11/30/01]

13.4.6.9 CERTIFIED LIST:

A. **Receipt of certified list from HSD:** Upon receipt of HSD's certified list of obligors not in compliance with a judgment and order for support, the superintendent shall match the certified list of obligors against the current list of licensees and applicants. By the end of the month in which the certified list of obligors is received, the superintendent shall report to HSD the names of the applicants and licensees who are on the certified list of obligors and the action the superintendent has taken in connection with such applicants and licensees.

B. **Receipt of application:** Upon the later receipt of an application for license or renewal, the superintendent shall match the applicant against the current certified list.

[11/23/95; Recompiled 11/30/01]

13.4.6.10 INITIAL ACTION:

A. Upon determination that an applicant or licensee appears on HSD's certified list, the superintendent shall notify the applicant or licensee by letter that the applicant or licensee must provide the superintendent with a subsequent statement of compliance within 30 days of mailing the notification.

B. The notice letter to applicants shall advise that failure to timely provide the statement of compliance shall automatically, without any further notice to the applicant, necessitate the superintendent's rejection of the application and that such rejection constitutes grounds for applicants to request a hearing before the superintendent pursuant to Section 59A-4-15 NMSA 1978.

C. The notice letter to licensees shall advise that failure to timely provide the statement of compliance shall result in commencement of a formal proceeding for license revocation under 13 NMAC 4.6.11 [now 13.4.6.11 NMAC] of this rule.

[11/23/95; Recompiled 11/30/01]

13.4.6.11 PROCEEDING TO REVOKE LICENSE:

The superintendent shall file and serve upon the licensee a notice and order of license revocation, in accordance with the procedures listed in 13 NMAC 4.6.14 [now 13.4.6.14 NMAC] of this rule. If the revocation is due solely to the licensee's failure to comply with a judgment and order for support, and there are no additional grounds due to violations of the Insurance Code, the notice and order of revocation shall state:

A. the grounds for the superintendent's proposed action; and

B. that the superintendent's action to revoke will become final and not subject to review or appeal ninety days after mailing the notice and order unless, on or before the ninety day deadline, the respondent licensee:

(1) files a request for hearing in the docket briefly stating the respects in which the applicant is so aggrieved, the relief to be sought and the grounds to be relied upon as a basis for relief; or

(2) provides the superintendent with a statement of compliance.

[11/23/95; Recompiled 11/30/01]

13.4.6.12 EVIDENCE AND PROOF:

In any hearing under 13 NMAC 4.6.11 [now 13.4.6.11 NMAC] of this rule, relevant evidence is limited to the accuracy or veracity of the statement of non-compliance. The statement of non-compliance is conclusive evidence requiring the superintendent to take the revocation action under 13 NMAC 4.6.11 [now 13.4.6.11 NMAC] of this rule.

[11/23/95; Recompiled 11/30/01]

13.4.6.13 ORDER:

When an action to revoke a license is taken by the superintendent solely because the licensee is not in compliance with a judgment and order for support, the final order shall state that the respondent may reapply for licensure at any time upon presentation of a subsequent statement of compliance filed with and verified by the superintendent.

[11/23/95; Recompiled 11/30/01]

13.4.6.14 PROCEDURES:

Proceedings under this rule shall be governed by Sections 59A-4-15 through 59A-4-18 NMSA 1978, as amended; provided, however, that all denial actions for license applications and renewals and all license revocations for bail bondsmen and bail bondsmen solicitors are governed by the Uniform Licensing Act, Sections 61-1-1 through 61-1-31 NMSA 1978, as amended.

[11/23/95; Recompiled 11/30/01]

PART 7: CONTINUING EDUCATION REQUIREMENTS

13.4.7.1 ISSUING AGENCY:

Office of Superintendent of Insurance (OSI), Producer Licensing Bureau (PLB).

[13.4.7.1 NMAC - Rp, 13.4.7.1 NMAC, 2/27/2018]

13.4.7.2 SCOPE:

A. This rule applies to all licensed adjusters, insurance producers, limited surety agents, bail bond solicitors, property bondsmen, and nonresident insurance producers unless exempted by Subsection B of this section.

B. The continuing education requirements of this rule shall not apply to:

(1) holders of limited licenses issued pursuant to Section 59A-12-18 NMSA 1978;

(2) licensees who have been continuously licensed by the superintendent for 25 years or more, without a lapse of more than 90 days;

(3) persons who maintain a license solely for the purpose of receiving renewal fee residuals and who do not otherwise transact the business of insurance;

(4) agents of fraternal benefit societies licensed pursuant to Section 59A-44-33 NMSA 1978; or

(5) nonresident insurance licensees who are licensed in another state or country that requires completion of continuing education courses.

[13.4.7.2 NMAC - Rp, 13.4.7.2 NMAC, 2/27/2018]

13.4.7.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-6-1, 59A-11-10, 59A-11-23, 59A-12-16, 59A-12-26, 59A-13-12, 59A-44-33, 59A-51-4.1 NMSA 1978.

[13.4.7.3 NMAC - Rp, 13.4.7.3 NMAC, 2/27/2018]

13.4.7.4 DURATION:

Permanent.

[13.4.7.4 NMAC - Rp, 13.4.7.4 NMAC, 2/27/2018]

13.4.7.5 EFFECTIVE DATE:

February 27, 2018, unless a later date is cited at the end of a section.

[13.4.7.5 NMAC - Rp, 13.4.7.5 NMAC, 2/27/2018]

13.4.7.6 OBJECTIVE:

The purpose of this rule is to set forth continuing education requirements for persons who are licensed by the superintendent to transact business in this state and for continuing education providers.

[13.4.7.6 NMAC - Rp, 13.4.7.6 NMAC, 2/27/2018]

13.4.7.7 DEFINITIONS:

As used in this rule:

A. "adjuster" means a resident or non-resident public adjuster, staff adjuster or independent adjuster as defined in Section 59A-13-2 NMSA 1978;

B. "approved course" means a course of instruction approved by the committee as satisfying the continuing education requirements of this rule or that has been previously approved by another state with which New Mexico has reciprocal privileges and that has been submitted by the provider and approved by the committee;

C. "bail bondsman" has the same definition as in Subsection A of Section 59A-51-2 NMSA 1978;

D. "biennially" means every two years or during the 24 months next preceding expiration of the current license;

E. "committee" means OSI's continuing education committee;

F. "compliance period" means the time period between the issue date or last renewal date of the license to the expiration date of the license for purposes of satisfying the continuation requirements;

G. "credit hour" means 50 minutes of actual instruction or self-study time in an approved course;

H. "ethics course" means a course that deals with usage and customs among members of the insurance profession, involving moral and professional conduct and fiduciary obligations and duties toward one another, toward clients, toward insureds, and toward insurers and of responsible insurance agency management;

I. "insurance producer" means a person required to be licensed under the laws of the state of New Mexico to sell, solicit or negotiate insurance;

J. "licensee" means an adjuster, insurance producer, limited surety agent, bail bond solicitor, property bondsman or nonresident insurance producer within the scope of this rule;

K. "limited surety agent" has the same definition as in Subsection C of Section 59A-51-2 NMSA 1978;

L. "nonresident licensee" means a person licensed in this state pursuant to Section 59A-11-23 NMSA 1978;

M. "property bondsman" has the same definition as in Subsection D of Section 59A-51-2 NMSA 1978;

N. "provider" means a person who is authorized by the superintendent to provide approved continuing education courses for licensees and report licensee attendance for credit toward continuing education requirements;

O. "roster" is an official list of licensees who have successfully completed an offering of an approved course;

P. "solicitor" has the same definition as in Subsection E of Section 59A-51-2 NMSA 1978; and

Q. "superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

[13.4.7.7 NMAC - Rp, 13.4.7.7 NMAC, 2/27/2018]

13.4.7.8 INSURANCE CONTINUING EDUCATION COMMITTEE:

A. The superintendent shall appoint an insurance continuing education committee that shall serve at the superintendent's pleasure. The committee shall be a volunteer committee and shall not be entitled to per diem or other reimbursement or remuneration.

B. The committee shall approve individual courses of instruction for continuing education credit, notify the superintendent of approved courses as they are approved, make recommendations regarding continuing education courses and perform other tasks assigned by the superintendent.

C. The committee shall not approve any continuing education course that does not provide a method by which a provider can assure that a licensee has completed the course.

[13.4.7.8 NMAC - Rp, 13.4.7.8 NMAC, 2/27/2018]

13.4.7.9 REQUIREMENTS FOR LICENSEES:

A. Hours required biennially.

(1) All licensees must complete a minimum of three hours of credits in ethics during each compliance period. Ethics credit hours may be included toward the total credit hour requirement for each license type.

(2) Title insurance licensees shall complete ten credit hours of approved courses covering title insurance. At least three credit hours must specifically cover the

proper handling of escrow funds. These three hours can also be used to satisfy the requirement for three credit hours in ethics.

(3) Limited surety agents, property bondsmen, solicitors and bail bond solicitors shall complete 14 hours of approved courses covering the Bail Bondsmen Licensing Law, Sections 59A-51-1 et seq. NMSA 1978 and related regulations during each two-year compliance period.

(4) All other licensees shall complete 24 credit hours of approved courses covering some or all of the kinds of insurance for which they are licensed during each compliance period. Licensees who transact insurance under multiple lines of authority are only required to satisfy a single 24 hour continuing education requirement for each compliance period.

(5) Adjusters who are licensed prior to July 1, 2017 must satisfy continuing education credits prior to renewal of licenses beginning with the first biennial renewal cycle occurring after April 30, 2018.

(6) Non-resident licensees are not required to complete New Mexico's continuing education requirements if the home state requires continuing education and the licensee has complied with the continuing education requirements of the home state, pursuant to the provisions of Section 59A-11-23 NMSA 1978. However, if a non-resident licensee fails to complete the required continuing education courses in the home state, the New Mexico nonresident license shall also be cancelled.

B. No carryover. No licensee may carry over credit hours earned in a compliance period to the next compliance period.

C. No duplicate credit. No additional credit will be granted to a licensee for completion of the same approved course more than once in any compliance period.

D. Course completion date. Course credits are applied to licensing requirements based on the date that the course is taken, rather than on the date that the course credit is reported by the provider.

E. Course approval. Licensees shall receive course credit only for courses that have been approved by the committee prior to enrollment in the course.

F. Extensions. Licensees who meet the criteria of illness, medical disability, military deployment or circumstances beyond the control of the licensee may apply for an extension of time to complete their continuing education requirement or a waiver, in whole or in part, of the continuing education requirement.

(1) The superintendent shall establish the duration of the extension when it is granted.

(2) If the circumstances supporting the extension continue beyond the granted extension period, the licensee may reapply for an extension.

(3) The licensee must request the extension prior to the end of the compliance period for which it applies, using the form available on the OSI website.

(4) Licensees called to active military service in a combat theater, may apply for an exemption from or an extension of time for meeting the continuing education requirements or extending their license renewal. The licensee must request the extension or waiver prior to the end of the compliance period, using the form available on the OSI website.

G. Reinstating a discontinued license. A licensee whose license is discontinued shall complete all required continuing education credits before submitting an application for reinstatement. If the license is discontinued for longer than a single biennial compliance period, the licensee must complete 24 hours of continuing education credits in addition to all credits necessary to renew the license. Instead of completing the required continuing education courses, the licensee may choose to retake the qualifying examination.

[13.4.7.9 NMAC - Rp, 13.4.7.9 NMAC, 2/27/2018]

13.4.7.10 COURSE CONTENT:

A. Course length. Individual courses shall be a minimum of one credit hour in length.

B. Ethics. A single continuing education course may include both ethics and other insurance topics meeting the requirements of Subsection C of this section.

C. Insurance subjects.

(1) General instruction time shall be designed to refresh the licensee's understanding of basic insurance principles and coverages, applicable laws and regulations, and recent and prospective changes to them.

(2) Required hours for specialized training requirements must be completed prior to transacting the type of insurance and may also be counted toward the 24 credit hour general producer licensee requirement.

(a) Producers desiring to transact business relating to stop loss insurance shall complete at least eight credit hours relating specifically to stop loss insurance.

(b) Adjusters and producers desiring to transact business relating to flood insurance shall complete at least four credit hours relating specifically to flood insurance within one year of the effective date of this rule.

(c) Producers shall not transact business relating to long term care until they have completed at least eight hours of continuing education relating specifically to long term care, and shall complete at least four hours of continuing education relating specifically to long term care during each compliance period thereafter. The course must include topics relating to long term care partnership for producers who wish to transact long term care partnership business. Producers who transact long term care insurance as of the effective date of this rule shall have one year following the effective date of this rule to complete the eight-hour initial course requirement.

(3) Required training shall not focus specifically on training that is insurer- or company-product specific and may not include sales or marketing information.

D. Approved learning formats.

(1) A course may utilize any combination of classroom instruction, lectures, seminars, panel discussions, question-and-answer periods, correspondence courses, online web-based courses and recorded presentations, as long as the provider can assure that a licensee has completed the course.

(2) A minimum of three hours of continuing education course hours for each compliance period must be earned through participation in a formal classroom or in another learning format that permits the student to interact with a live instructor. Licensees are responsible for tracking this requirement and are subject to audit by the superintendent.

[13.4.7.10 NMAC - Rp, 13.4.7.10 NMAC, 2/27/2018]

13.4.7.11 PROVIDER AND COURSE REQUIREMENTS:

A. Provider qualifications. Prior to submitting proposed courses to the committee for approval, the provider must submit the following information and be approved as a provider:

(1) the name and contact information for the provider's primary contact person;

(2) the provider's physical and mailing address;

(3) the provider's website address;

(4) a link that will be provided for licensees to review course dates, location, and content;

(5) procedures that will be used to process online enrollment in courses, including payment via credit card; and

(6) experience and qualifications of the course instructors.

B. Course content. To obtain approval of a course, a provider shall assure that:

(1) the curriculum offered relates to insurance subjects, or subjects which relate to the individual licensee's transaction of insurance business;

(2) the course has significant intellectual or practical content and that its primary objective is to increase the participant's professional competence as a licensee; and

(3) pursuant to Subsection B of Section 59A-12-26 NMSA 1978, instruction shall be designed to refresh the licensee's understanding of:

(a) basic principles and coverages involved,

(b) applicable insurance laws and regulations,

(c) proper conduct of the licensee's business,

(d) duties and responsibilities of the licensee, and

(e) to address recent and prospective changes.

C. Course approval.

(1) The provider's course application to the committee shall include, at a minimum, the following information:

(a) a statement identifying the knowledge, skills, or abilities the licensee is expected to obtain through completion of the course;

(b) a detailed course content outline showing the approximate times for major topics;

(c) a detailed description of the course materials, including a course content word count, that demonstrates that the course supports the number of credit hours requested;

(d) the method of evaluation by which the provider measures how effectively the course meets its objectives and provides for student input;

(e) the total number of course hours requested for approval, including the method the applicant is using to determine the number of course hours and the number of hours included in the total number of course hours requested for approval that are ethics topics;

(f) the course application fee as specified in Section 59A-6-1 NMSA 1978; and

(g) for applicants determining self-study course hours by using the average of approved times in other states, a list of all course approved times and the states in which the course is approved;

(2) Prior approval. A provider must submit each course for review and receive approval of the course prior to making that course available for enrollment by licensees. If the committee determines that the course content is incomplete or inadequate, the provider will be notified and required to supplement or modify the course before receiving approval.

(3) Renewals. The original course application fee covers the period until the initial expiration of the course. Courses must be resubmitted for renewal, along with the renewal fee specified in Section 59A-6-1 NMSA 1978. Courses will not automatically be re-approved by the committee.

(4) Electronic course submission. Beginning July 1, 2017 any provider wishing to have a course approved by the committee, must submit each course for approval electronically. Instructions for electronic submission of courses may be found on the OSI website. Providers should allow up to 60 days for the committee to approve a new course.

(5) Course expiration. All continuing education courses already approved by the committee at the time of the adoption of the final version of this regulation by the superintendent, will expire on March 31, 2018. All courses approved by the committee thereafter will expire two years after the date the course is approved.

(6) Voluntary cancellation. Providers shall notify the superintendent when a course is discontinued or no longer active and when there is a change to the provider's information of record.

(7) Non-voluntary course cancellation. Approved courses shall be cancelled and the content updated, as necessary, to reflect changes in the law or regulations. Failure of the provider to update courses in a timely manner may result in cancelation of the course by the superintendent.

D. Statement of approved courses. Providers of approved courses shall include the following written statement in the course materials for each approved course: "This course has been approved by the Insurance Continuing Education Committee as New Mexico Insurance Continuing Education Course Number (insert number) for (insert number) hours of credit."

E. Instructors. A provider of an approved course shall assure that instructors for all courses are qualified by practical or academic experience to teach the subject to be covered. For purposes of this rule, practical or academic experience shall include, but is not limited to, actual experience related to the kind of insurance which is the subject of the course, undergraduate or graduate educational training, or professional insurance industry

designations such as the *Chartered Property Casualty Underwriter* (CPCU), *Chartered Life Underwriter* (CLU), and *Fellow of the Life Management Institute* (FLMI) designations.

F. Enrollment. Providers shall make available a current list of scheduled courses including course content, applicable credits, course dates, instructor information and course location as appropriate. Providers shall collect course fees at the time of registration.

G. Minimum classroom requirements.

(1) Courses must comply with the approved learning formats listed in Subsection D of 13.4.7.10 NMAC.

(2) A disinterested third party attendant, an instructor, or a disinterested third party using visual observation technology must visually monitor attendance either inside or at all exits of the course presentation area at all times during the course presentation.

(3) An instructor must be involved in each classroom presentation of the course, but in circumstances involving remote presentations, all students and the instructor do not need to be in the same location. Students may attend remotely via the internet or other real-time format. While presenting recorded or text materials, the instructor making the live course presentation does not have to be the same instructor included on the recorded presentation or who prepared the text materials.

(4) Question and answer discussion periods must be provided by either an instructor making a live presentation of the course to licensees in the same room, or via real-time live audio or audio-visual connection which shall allow for student inquiries and responses with the presenting instructor, or by an instructor who is present for the entire remote, recorded, or computer-based course presentation with the students in the same room.

(5) The course pace shall be set by the instructor and does not allow for independent completion of the course by students.

(6) Providers may not include time spent by students on the final examination and pre-tests in determining course credit hours.

H. Course completion. A provider shall assure that each licensee completes the course either by:

(1) monitoring the course to witness attendance and participation; or

(2) requiring submission of a test or other written work evidencing understanding of the course material.

I. Reciprocal courses. In order for a licensee to receive credit for a reciprocal course, the reciprocal course must be approved in the provider's home state and have been submitted by the provider in its entirety to the committee for prior approval. The committee may choose to deny approval of any course hours that are related to the home state's laws or regulations or may deny any material, based on the NAIC's guidance.

J. Submission of roster. Within ten business days after the completion of the course of instruction by a licensee, the provider must electronically submit an attendance roster to the superintendent. Instructions for electronic submittal may be found on the OSI website.

K. Records. A provider shall maintain records of attendance and course completion for a minimum of three years and make such records available to the superintendent or the committee at any time upon request.

L. Audits. The OSI staff may conduct audits of any course or provider without prior notice to the provider. OSI staff or a designee may attend courses without identifying themselves as employees or representatives of OSI. If continuing education records are audited or reviewed and the validity or completeness of the records are questioned, the provider shall have 30 days from the date of notice to correct discrepancies or submit new documentation.

[13.4.7.11 NMAC - Rp, 13.4.7.11 NMAC, 2/27/2018]

13.4.7.12 REPORTING REQUIREMENTS:

A. Reporting by providers. Continuing education providers are required to report completion of continuing education courses to the superintendent. However, it is the responsibility of the individual resident licensee to ensure that the superintendent's records reflect the completion of the required number of continuing education courses on or before the continuing education due date. The licensee must correct any discrepancies in the record through the continuing education provider:

B. Transition and reporting after July 1, 2017.

(1) All continuing education courses must be completed and reported prior to renewal of the license. Licensees who fail to complete the required continuing education courses will not be permitted to renew the license, which will result in immediate termination of the license, pursuant to Section 59A-11-10 NMSA 1978.

(2) For individual licensees who were issued or who renewed a one-year agent, broker, or solicitor license prior to July 1, 2017, the license must be renewed for a biennial insurance producer or bail bondsmen's license by April 30, 2018. Prior to that renewal, the individual licensee must have completed 15 hours of continuing education courses, including at least one hour in ethics, as was required at the time the license was issued or renewed.

(3) For all biennial licenses issued after July 1, 2017, the licensee shall renew on the last day of the second birth month following issue of the license, such that the initial compliance period shall be no less than thirteen months and no more than twenty-four months in length. Prior to renewal, licensees shall complete the required number of continuing education courses, as set forth in Subsection A of 13.4.7.9 NMAC. The compliance period for completion of continuing education courses is the period between issue of the license and renewal on or before the last day of the licensees second birth month following issue.

(4) Thereafter, insurance producer licenses must be renewed biennially on or before the last day of the licensee's birth month. Required continuing education courses must be completed and reported during the compliance period, which is the twenty-four-month period immediately preceding renewal of the license. In order to allow time for the provider to report course attendance prior to expiration of the license, students should plan accordingly in order to avoid payment of penalties.

C. Fees. A licensee shall submit all continuing education fees prescribed by Subsection E of Section 59A-12-26 NMSA 1978 to the provider. The provider will then submit the hourly course fee electronically to the superintendent on behalf of the licensee. Registration fees are nonrefundable for licensees who fail to attend or fail to successfully complete a course. Instructions for electronic submittal of fees may be found on each provider's website and on the OSI website.

D. Records.

(1) The licensee is responsible for confirming that all continuing education credits have been correctly recorded by the provider. The licensee may print a copy of the entire educational transcript for reference purposes. Instructions for reviewing and printing the transcript may be found on the OSI website.

(2) It is recommended that all licensees maintain copies of certificates of completion of approved courses and verified statements for a period of three years.

(3) Individual continuing education credit information can be reviewed by the licensee, by the public or by the superintendent. Instructions for viewing continuing education information may be found on the OSI website.

(4) The superintendent shall be notified electronically of any noncompliance with the continuing education requirements by licensees.

[13.4.7.12 NMAC - Rp, 13.4.7.12 NMAC, 2/27/2018]

13.4.7.13 AUDITING PROCEDURES:

A. All continuing education records submitted or maintained pursuant to this rule are subject to audit by the superintendent.

B. If the superintendent finds a licensee or provider has failed to timely report continuing education credits through the online system, the superintendent may impose a penalty.

C. A provider who fails to submit the roster to the superintendent within ten business days may be subject to removal from the list of approved continuing education providers in the state. Instructions for submitting the roster shall be provided to approved course providers.

[13.4.7.13 NMAC - Rp, 13.4.7.14 NMAC, 2/27/2018]

13.4.4.14 [RESERVED]

13.4.4.15 [RESERVED]

PART 8: PUBLIC, STAFF AND INDEPENDENT ADJUSTERS

13.4.8.1 ISSUING AGENCY:

Office of Superintendent of Insurance (OSI), Producer Licensing Bureau (PLB).

[13.4.8.1 NMAC - N, 7/1/2019]

13.4.8.2 SCOPE:

This rule applies to resident and non-resident persons seeking licensure to provide adjusting services in this state, as defined in Article 13 of 59A NMSA 1978.

[13.4.8.2 NMAC - N, 7/1/2019]

13.4.8.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, and 59A-13-1 et seq. NMSA 1978.

[13.4.8.3 NMAC - N, 7/1/2019]

13.4.8.4 DURATION:

Permanent.

[13.4.8.4 NMAC - N, 7/1/2019]

13.4.8.5 EFFECTIVE DATE:

July 1, 2019, unless a later date is cited at the end of a section.

[13.4.8.5 NMAC - N, 7/1/2019]

13.4.8.6 OBJECTIVE:

A. Covered by this rule. The purpose of this rule is to set forth licensing requirements of public, independent and staff adjusters in this state.

B. Exclusions: This rule does not apply to persons who are excluded pursuant to Subsection B of Section 59A-13-2 NMSA 1978.

[13.4.8.6 NMAC - N, 7/1/2019]

13.4.8.7 DEFINITIONS:

As used in this rule:

A. "Adjuster" has the meaning provided in Section 59A-13-2 NMSA 1978.

B. "Advertisement" is as set forth in Subsection 19 of this rule.

C. "Business entity" has the meaning provided in Section 59A-13-2 NMSA 1978.

D. "Catastrophic disaster" means an event that results in large numbers of deaths and injuries; causes extensive damage or destruction of facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long-term effect on general economic activity; or severely affects state, local and private sector capabilities to begin and sustain response activities. For purposes of this rule, a catastrophic disaster shall be declared by the president of the United States, the governor of the state, or the superintendent of insurance.

E. "Designated home state" is used when the adjuster's home state does not license adjusters and means a state in which an adjuster does not maintain his, her, or its principal place of residence or business, but in which the adjuster is licensed in good standing and has designated as the home state for purposes of compliance with licensing regulations.

F. "Home state" means the District of Columbia or any state or territory of the United States which is the principal place of residence or principal place of business for an insurance adjuster and in which the adjuster is licensed to provide services as a resident adjuster.

G. "Independent adjuster" means an adjuster who is not a staff adjuster or a public adjuster and includes a representative or an employee of an independent adjuster. An independent adjuster is a professional who conducts investigations, verifications, negotiations, and settling of claims for or on behalf of an insurance

company, a self-insured firm, or a government agency, without being under the employment of the company, firm, or agency in question.

H. "Insurance" has the meaning set forth in Section 59A-1-5 NMSA 1978.

I. "Negotiate" means the act of conferring directly with or offering advice directly to a person whose real or personal property is covered under a policy of insurance regarding a claim or claims for loss or damage with the objective of arriving at a settlement.

J. "Nonresident adjuster" means an adjuster who has a current resident license in the adjuster's home state or designated home state, and who has applied for and received a nonresident adjuster's license in this state. A nonresident adjuster may be licensed only for the same type or types of adjuster's license for which the adjuster is licensed in the home state or designated home state.

K. "Public adjuster" means an adjuster who, for direct or indirect compensation or any other thing of value on behalf of the insured:

(1) acts or aids, investigates, negotiates, settles, adjusts, advises or otherwise assists an insured with a claim or claims for loss or damage under any policy of insurance covering the insured person's real or personal property, or on behalf of any other public insurance adjuster who is acting on behalf of an insured;

(2) advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as an public adjuster of first-party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(3) directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy, for the insured.

L. "Resident of the state" means an individual who maintains a principal home in New Mexico and holds no active resident insurance license in another state.

M. "Resident adjuster" means an adjuster who resides principally in New Mexico and who conducts business primarily in New Mexico or who has designated New Mexico as the home state for purposes of licensing;

N. "Staff adjuster" a person who is a salaried employee of an insurer or an affiliate of the insurer, and who is engaged in adjusting insured losses solely for that company or other companies under common control or ownership.

O. "Superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

[13.4.8.7 NMAC - N, 7/1/2019]

13.4.8.8 LICENSE REQUIRED:

A. No individual or business entity shall act as or make any representation as being an adjuster unless licensed as such by the superintendent, nor shall such person accept a commission, service fee or other valuable consideration for investigating or settling claims in New Mexico if that person is required to be licensed and is not so licensed.

B. No person, regardless of location, shall act as, or make any representation as being, an adjuster with respect to workers' compensation claims of claimants resident or located in New Mexico unless licensed as such by the superintendent. Pursuant to Section 59A-13-11 NMSA 1978, each workers' compensation insurer shall have at least one claims representative within New Mexico, licensed as an adjuster, to pay workers' compensation claims of claimants resident or located in New Mexico. Such claims shall be paid promptly through such representatives from accounts in financial institutions located within New Mexico.

C. A business entity may not be licensed as an adjuster unless at least one officer, active partner, or other managing individual of the business entity, and each individual performing acts of an insurance adjuster on behalf of the business entity in this state, are individually licensed by the superintendent separately from the business entity. The business entity shall designate a licensed adjuster responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

D. Each license shall contain:

(1) the name of the insurance adjuster;

(2) the date of issuance and the date of expiration of the license; and

(3) if applicable, the name of the firm with which the insurance adjuster is employed at the time the license is issued.

E. An individual may be licensed as both an independent and staff adjuster, but must apply separately for each.

F. Each licensee who is a resident of this state or a business entity organized under the laws of this state shall:

(1) maintain a place of business in this state which shall be easily accessible to the public and is the place where the adjuster principally conducts transactions under the license;

(2) maintain in the place of business the required records; and

(3) notify the superintendent of any change in the address of the licensee's place of business within 20 days or be subject to a penalty of fifty dollars ($50).

G. No later than 30 days after moving within a state or from one state to another state, a nonresident adjuster's licensed in this state shall file with the superintendent:

(1) the licensee's new address, and

(2) proof of authorization to act as an insurance adjuster in any new state of residence if that state requires licensure of insurance adjusters.

[13.4.8.8 NMAC - N, 7/1/2019]

13.4.8.9 LICENSING REQUIREMENTS FOR INDIVIDUAL ADJUSTERS:

The superintendent will issue, renew and continue adjuster's licenses for individual adjusters as follows:

A. Electronic submission. The individual applicant shall submit the application electronically or as otherwise directed by the superintendent.

B. Individual requirements. The superintendent shall issue an individual adjuster's license only to an individual who is otherwise in compliance with Chapter 59A, Articles 11 and 13 NMSA 1978 and who has furnished evidence satisfactory to the superintendent that the applicant for license:

(1) is not less than 18 years of age;

(2) is a bona fide resident of this state, or of a state or country that permits residents of this state to act as adjusters therein, except that under circumstances of necessity the superintendent may waive the requirement of reciprocity;

(3) is trustworthy, reliable and can demonstrate a good business reputation, and intent to engage in a bona fide manner in the business of adjusting insurance claims;

(4) has passed the examination required for licensing;

(5) shall not have committed an act that is a ground for license denial, suspension or revocation under the Insurance Code;

(6) has paid the license fee, as set forth in Section 59A-6-1 NMSA 1978; and

(7) has filed the bond as required 13.4.8.11 NMAC, or otherwise demonstrated financial responsibility, as approved by the superintendent.

C. Exceptions for staff adjuster. Paragraphs (2) and (7) of Subsection B of this section shall not apply as to staff adjusters.

D. Exceptions for prior license holders. Individuals holding licenses as adjusters as of July 1, 2017, shall be deemed to meet the qualifications for the license except as provided in Chapter 59A, Articles 11 and 13 NMSA 1978. The examination requirement is waived provided that the individual's license is not allowed to terminate through lapse, or otherwise.

E. Additional requirement for public adjusters. An applicant for a license to act as a public adjuster must, as part of the application, endorse an authorization for disclosure to the superintendent of all financial records of any funds the public insurance adjuster holds as a fiduciary using the form available on the OSI website. The authorization shall continue in force and effect while the public adjuster continues to be licensed in this state.

F. Application form.

(1) The application form may require the following information about the applicant:

(a) proof of the applicant's identity;

(b) name, date of birth, social security number, residence and business addresses, and email address;

(c) personal history;

(d) business experience, including experience, special training or education pertaining to insurance adjusters;

(e) previous licensing information, including:

(i) whether the applicant was ever previously licensed to transact insurance or adjusting in this state or elsewhere;

(ii) whether any license was ever refused, suspended or revoked;

(iii) whether any insurer or member of the public claims that the applicant is indebted to it, and if so, the details of the claim; and

(iv) whether the applicant has ever had a contract or appointment with an insurer canceled and, if so, the facts of the cancellation;

(f) type or types of adjuster's license applied for;

(g) if the applicant will be adjusting workers' compensation claims, then an in-state physical address for the business entity;

(h) the NAIC number and name of the company holding a New Mexico certificate of authority that is sponsoring the applicant, if applicable;

(i) such other pertinent information and matters as the superintendent may reasonably require.

(2) The superintendent may require any application to be in the applicant's handwriting and under the applicant's oath.

G. Approval. Before approving an application and issuing a license, the superintendent shall confirm that:

(1) all of the applicant's answers to the questions on the application are complete, truthful and satisfactory, including acknowledgment and explanation of any prior criminal charges;

(2) if the applicant is applying for a resident license, the applicant does not currently hold an active New Mexico resident or nonresident license or an active resident license in another state;

(3) if the applicant is applying for a resident license, the applicant has provided an in-state residential or business address (a post office box does not satisfy this requirement), unless the applicant has designated New Mexico as the home state for licensing purposes only;

(4) if the applicant is applying for a nonresident license, the applicant currently holds an active resident license in another state or designated home state that requires an examination;

(5) if applying for a resident license, the applicant has passed the required examination, or if applying for a nonresident license, the applicant has passed the required examination in the applicant's home state or designated home state;

(6) the applicant has provided at least five years of employment history without gaps in the employment record;

(7) the applicant's fingerprints have been submitted for purposes of a state and federal background check, and

(a) pursuant to 18 U.S.C. Section 1033, no individual who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a resident adjuster, unless the person has the written consent of the superintendent;

(b) pursuant to the Criminal Offender Employment Act found at Section 28-2-1 et seq. NMSA 1978, any prior criminal record shall be considered in connection with application for any license; and

(c) if the results of the background check have not been received or indicate a need for further investigation, the application will not be approved pending further review;

(8) the applicant has satisfied both the general and specific requirements and has provided any additional information necessary for the adjuster's license requested or as required by the superintendent based the initial application answers;

(9) the applicant has submitted the application fee as set forth in Section 59A-6-1 NMSA 1978; and

(10) if the applicant is a citizen of a foreign county, then the application shall include proof that the applicant is eligible to reside and work in the United States.

H. Requirements for nonresident applicants and licensees.

(1) A nonresident adjuster's licensee must designate the superintendent for service of process in accordance with the application requirement for nonresident licensees.

(2) Upon submission of the required application and payment of the license fee set forth in Section 59A-6-1 NMSA 1978, the superintendent may issue a nonresident license to an applicant for an adjuster's license who is not a permanent resident of this state, if the applicant is currently licensed as a resident adjuster in the applicant's home state or designated home state and the applicant satisfies all of the following:

(a) currently holds a valid adjuster's license, of the same type as the license applied for, in another state that requires a qualifying examination of sufficient scope as required by the superintendent;

(b) meets the requirements set forth in Subsection B of this section;

(c) is self-employed as an adjuster or associated with or employed by a business entity or other adjuster in the adjuster's home state or designated home state; and

(d) discloses whether the applicant has ever had any license or eligibility to hold any license declined, denied, suspended, or revoked, whether the applicant has ever been placed on probation and whether an administrative fine or penalty has been levied against the applicant and, if so, the reason for the action.

(3) Each individual who holds a nonresident license shall comply with all requirements of this rule and with other rules and laws of this state applicable to adjusters, including the requirements on record maintenance for each license type and for financial responsibility as set forth in 13.4.8.11 NMAC.

(4) As a condition of doing business in this state, a nonresident adjuster shall submit an affidavit certifying that the licensee is familiar with and understands the laws set forth in Article 13 of 59A NMSA 1978, these rules, and the terms and conditions of the types of insurance contracts that provide coverage on real and personal property. The affidavit shall be provided initially and upon renewal, using the form available on the OSI website. Compliance with this filing requirement is necessary for the issuance, continuation, reinstatement, or renewal of a nonresident adjuster's license.

[13.4.8.9 NMAC - N, 7/1/2019]

13.4.8.10 LICENSING REQUIREMENTS FOR BUSINESS ENTITIES:

A. Individual licenses required. A business entity that is licensed as a public or independent adjuster, or as both, shall employ licensed individual adjusters to adjust the types of claims for which the business entity is licensed. Such individuals shall hold an adjuster's license of the same type or types as that of the business entity employer.

B. General adjuster licensing requirements for business entities. Any resident or nonresident business entity that desires a license as a public or independent adjuster, or as both, shall file a completed application or applications with the superintendent, pursuant to Sections 59A-11-3 and 59A-12-15 NMSA 1978.

(1) The business entity shall be:

(a) organized under the laws of this state or any other state or territory of the United States;

(b) admitted to conduct business in this state by the secretary of state, if required; and

(c) authorized by its articles of incorporation or its partnership agreement to act as a public or independent adjuster; and

(2) The business entity's application or applications shall:

(a) be filed by the business entity;

(b) be submitted electronically or as otherwise specified by the superintendent;

(c) specify the business type as one of the following legal business types:

(i) partnership;

(ii) limited liability company (LLC);

(iii) limited liability partnership (LLP); or

(iv) corporation; but not as a

(v) sole proprietorship;

(d) be accompanied by payment of fees, as follows:

(i) all fees required pursuant to Section 59A-6-1 NMSA 1978;

(ii) a bond or evidence of financial responsibility as set forth in 13.4.8.11 NMAC; and

(iii) an additional license application filing fee for each individual in excess of one who is to exercise the license powers of the business entity, if not a general partner therein;

(e) designate an individual licensed adjuster who is responsible for the business entity's compliance with the insurance laws, rules and regulations of this state; and

(f) be signed on behalf of the applicant by an authorized partner or corporate officer, under oath if required by the superintendent.

(3) If the business is a firm, then each individual who is not a bona fide general partner and who is to exercise license powers, shall file an application for the same type of adjuster's license as that applied for by the business entity.

(4) If the business is a corporation, then each individual, whether or not an officer, director, stockholder or in other relationship to the corporation, who is to exercise license powers shall file an application for the type of adjuster's license as that applied for by the business entity.

(5) If the business is a partnership, then each individual who is not a general partner and who is to exercise license powers, shall file an application for the same type of adjuster's license applied for by the business entity.

C. Application form. The application form may require information about the business entity as follows:

(1) the name, state of residence, proof of identity, business record, reputation and experience of each partner, officer, member of the board of directors and controlling stockholder of the business entity, and any additional information required of an individual applicant for an adjuster's license as the superintendent deems necessary;

(2) evidence satisfactory to the superintendent that transaction of the business proposed to be transacted under the requested license is within the powers of the business entity as set forth in the entity's articles of incorporation, charter, bylaws, partnership, operating agreement or other governing documents;

(3) at least one individual is specified as the designated responsible adjuster who is actively licensed in this state as either a resident or nonresident adjuster for each type of adjuster's license applied for by the business entity. The designated responsible licensed adjusters designated by the business entity shall cumulatively be licensed for all types of adjuster's license of the business entity; and

(4) such further information concerning the applicant, appointment of partners, corporate officers, directors and stockholders as may be requested by the superintendent.

D. Approval. The superintendent shall review the application and confirm that:

(1) the applicant meets all of the requirements set forth in Subsections B and C of this section;

(2) all answers to the questions on the application are complete, truthful and satisfactory;

(3) the applicant does not already hold an active resident or nonresident license in New Mexico or, if applying for a resident license, an active resident license in another state;

(4) the business entity has paid the fees set forth in Section 59A-6-1 NMSA 1978;

(5) the business entity application lists at least one individual as an owner, officer, partner or director;

(6) the business entity has designated a licensed adjuster responsible for the business entity's compliance with the laws of this state;

(7) the application sets forth the names of all the members, officers and directors of the business entity and the names of each individual who is to exercise the powers conferred by the license upon the business entity;

(8) the business entity license application uses the entity's legal name, unless an assumed name has been previously approved in writing by the superintendent; and

(9) at least one licensed adjuster who is to exercise license powers is affiliated by submission of an application, and the application for affiliation was submitted with payment as required in Section 59A-6-1 NMSA 1978.

E. Special licensing requirements. The following apply to business entities seeking an adjuster's license:

(1) The business entity intends to be actively engaged in the business of public or independent adjusting.

(2) No officer, director, member, manager, partner, or any other person who has the right or ability to control the license holder has:

(a) had a license suspended or revoked or been the subject of any other disciplinary action by a financial or insurance regulator of this state, another state, or the United States; or

(b) committed an act for which a license may be denied under the Insurance Code.

(3) Nothing contained in this section shall be construed to permit any unlicensed employee or representative of any business entity to perform any act of a public or independent adjuster without obtaining that type of adjuster's license.

(4) Each corporation or partnership shall notify the superintendent not later than the 30th day after the date of:

(a) a felony conviction of a licensed adjuster of the entity or any individual affiliated with the business entity; and

(b) an event that would require notification under the Insurance Code.

(5) If a licensee does not maintain the qualifications necessary to obtain the license, the superintendent shall revoke or suspend the license or deny the renewal of the license.

(6) Each adjuster shall maintain all required records, including all records relating to customer complaints received from customers and the superintendent.

F. Portable electronics. A business entity applying for an independent adjuster's license for the purposes of portable electronics insurance shall comply with the filing requirements set forth in Subsection D of Section 59A-13-4 NMSA 1978.

[13.4.8.10 NMAC - N, 7/1/2019]

13.4.8.11 PROOF OF FINANCIAL RESPONSIBILITY:

A. Prior to issuance of a license as an independent or public adjuster to an individual and for the duration of the license, the applicant shall file with the superintendent a surety bond in favor of the superintendent in aggregate amount of not less than ten thousand dollars, conditioned to pay actual damages resulting to this state or any member of the public in this state from violation of law by the licensee while acting as an adjuster. The bond shall be one executed by an authorized surety insurer and offered by a producer licensed and appointed in this state.

B. A surety bond used to maintain and demonstrate proof of financial responsibility under this section shall:

(1) remain in effect for the duration of the license, or until the surety is released from liability by the superintendent, or until canceled by the surety;

(2) be in the form specified by the superintendent;

(3) be executed by the insurance adjuster as principal and a surety company authorized to do business in this state as surety;

(4) be payable to the superintendent for the use and benefit of an insured, conditioned that the insurance adjuster shall pay any final judgment recovered against it by an insured;

(5) provide that the surety will give no less than 30 days prior written notice of bond termination to the licensee and the superintendent;

(6) be separate from any other financial responsibility obligation; and

(7) not be used to demonstrate financial responsibility for any other license, certification, or person.

C. The applicant or licensee may file with the superintendent a cash bond, a professional liability policy or similar policy or contract of professional liability coverage in like amount acceptable to the superintendent, in lieu of the surety bond.

D. Each public or independent insurance adjuster must obtain separate proof of financial responsibility and may not rely on the bond of any other insurance adjuster to demonstrate proof of financial responsibility.

E. The superintendent may ask for the evidence of financial responsibility at any time that the superintendent deems relevant.

F. The authority to act as a public or independent adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

[13.4.8.11 NMAC - N, 7/1/2019]

13.4.8.12 EXAMINATION OF APPLICANTS:

A. Examinations required. An individual applying for a license as an adjuster shall, prior to issuance of a license, personally take and pass a written examination. The examination required by this section shall be of sufficient scope to reasonably test the applicant's:

(1) knowledge, experience or training relating to the assessment of:

(a) real and personal property values; and

(b) physical loss of or damage to real or personal property that may be the subject of insurance and claims under insurance;

(2) knowledge of the duties and responsibilities of an adjuster holding the type of adjuster's license applied for as set forth by law and regulation in this state, including ethical and fair trade practices;

(**3)** knowledge of basic insurance theory, the essential elements of contracts, and claims, and ethics terms and effects of the types of insurance contracts that provide coverage on real and personal property;

(4) knowledge and experience adequate to enable an adjuster holding the type of adjuster's license applied for to engage in the business as an adjuster fairly and without injury to the public or any member of the public with whom the applicant may have business as an adjuster; and

(5) technical competence in the handling of the types of claims for which the applicant is being tested.

B. Examination exemptions.

(1) Examination is not required for an individual who was licensed in this state as an adjuster prior to July 1, 2017, unless the license is allowed to lapse or is terminated for any reason, as set forth in Subsection D of 13.4.8.9 NMAC.

(2) Examination is not required for applicants who have taken and passed a similar examination and received the same type of adjuster's license in a state in which the reciprocal provisions of Section 59A-5-33 NMSA 1978 apply; and

(a) the license in the other state is current, or

(b) the application is received within 90 days after cancellation of the previous license. If the license has been canceled, then the following is required:

(i) a certification from the reciprocal state that at the time of cancellation the applicant was in good standing in that state; or

(ii) records maintained by the NAIC indicate that the adjuster is or was licensed in good standing for the type of license applied for.

(3) Reexamination is not required for renewal or continuance of resident or designated home state licenses, unless ordered by the superintendent.

(4) Reexamination is not required for resident applicants who have been licensed in this state within the year prior to the date of the new application and who seek to be relicensed for the same types of adjuster's license. This exemption does not apply if the previous license was suspended, revoked or terminated, if continuation of the license was refused by the superintendent or if the applicant did not previously take and pass an exam in this state.

(5) Examination is not required for a nonresident applicant who is licensed by designating a home state other than the state of residence, if the state of licensure requires the passing of a written examination in order to obtain the license and is a reciprocal state.

(6) Examination is not required for an applicant currently licensed as an adjuster in another state who moves to this state and applies to become a resident insurance adjuster within 90 days of establishing legal residence. For such applicants, the examination requirement is waived as to licensure for the type of adjuster's license previously held in the prior state, unless otherwise determined by the superintendent.

C. Examination fee. Each individual applying for an examination shall remit a nonrefundable fee as set forth in Section 59A-6-1 NMSA 1978.

D. Administration of exams. The superintendent may contract with an outside testing service for administering examinations and collecting the nonrefundable fee.

E. Failure to appear. An individual who fails to appear for an examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

[13.4.8.12 NMAC - N, 7/1/2019]

13.4.8.13 CONTINUATION, NONRENEWAL, CANCELLATION, DENIAL, REVOCATION, SUSPENSION, TERMINATION AND REINSTATEMENT OF LICENSE:

A. Continuation and nonrenewal of adjuster's licenses. Unless the license is canceled, revoked, suspended or otherwise terminated, an adjuster's license is continuous, subject to payment by the due date of renewal fees as set forth in Section 59A-6-1 NMSA 1978, and for individual licensees, compliance with the continuing education requirements set forth in 13.4.7 NMAC.

(1) For resident licenses issued to individuals:

(a) Biennial renewal fees shall be paid on or before the last day of the second occurrence of the individual's birth month following issuance of the license.

(b) Continuing education requirements shall be satisfied during the 24 months immediately preceding the renewal date of the license. Additional information pertaining to continuing education requirements is set forth at 13.4.7 NMAC.

(c) An individual who is unable to comply with license renewal requirements due to military service, disability or other extenuating circumstance may request a waiver using forms available on the OSI website or as otherwise directed by the superintendent. An adjuster in such circumstances may also request a waiver of a fine or sanction imposed for failure to comply with renewal procedures.

(d) If the superintendent has reason to believe that the competence of any individual licensee is in question, the superintendent may require as a condition of continuation of the license that the individual licensee take and pass the written examination that is required for new applicants for the same license.

(e) If an adjuster's license has been expired for one year or more, the adjuster applicant must submit to reexamination. Reexamination must be completed within the 12 months preceding the application.

(2) For licenses issued to business entities:

(a) Business entity licenses shall renew and continue on a biennial basis on March 1 of the biennial year, subject to payment of fees as set forth in Section 59A-6-1 NMSA 1978.

(b) Business entity affiliations shall renew and continue on an annual basis on March 1 of every year, subject to payment of fees pursuant to Section 59A-6-1 NMSA 1978.

(3) For nonresident licenses issued to individuals:

(a) As a condition of the continuation of a nonresident adjuster's license, the licensee shall maintain a resident adjuster's license of the same type in the adjuster's home state or designated home state.

(b) The licensee shall pay the biennial renewal fees on or before the last day of the second occurrence of the individual's birth month following issuance of the license.

(c) If the licensee's home state requires continuing education substantially equivalent to that of this state as set forth in 13.4.7 NMAC for renewal of the adjuster's license and the licensee has satisfied the continuing education requirements of the home state, then the licensee may renew the nonresident adjuster's license in this state with evidence that the licensee is compliant with the continuing education requirement of the home state.

(d) If the home state does not require continuing education, the nonresident license cannot be renewed until the licensee:

(i) completes the hours required for renewal of the New Mexico resident license by completing courses offered by a continuing education provider that have been approved by the continuing education committee in this state, or

(ii) completes equivalent continuing education requirements for license renewal for a state that the licensee has designated as the home state; and

(iii) uploads the certificates of completion electronically or as otherwise directed by the superintendent.

B. Reasons for suspension, revocation or refusal to continue license. The superintendent may suspend, revoke, or refuse to issue or renew an adjuster's license or may levy a fine or penalty or any combination of the above actions for any one or more of the following causes:

(1) providing incorrect, misleading, incomplete or materially untrue information in the license application;

(2) violating any insurance laws, regulations, subpoena or order of the superintendent or of another state's insurance commissioner, including engaging in any unfair trade practices or fraud;

(3) obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business;

(5) intentionally misrepresenting the terms of an actual or proposed insurance contract or settlement offer;

(6) committing an illegal act that is a ground for license denial, suspension or revocation under the Insurance Code;

(7) using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility, in the conduct of insurance business in this state or elsewhere;

(8) having an insurance or adjuster's license probated, suspended, revoked or refused in any other state;

(9) forging another's name to any document related to an insurance transaction;

(10) cheating, including improperly using notes or any other reference material, to complete an examination for an adjuster's license;

(11) failing to comply with an administrative or court order imposing a child support obligation; or

(12) termination or cancelation of evidence of financial responsibility, as set forth in 13.4.8.11 NMAC.

C. Termination of licenses.

(1) Adjuster's licenses are subject to termination for any of the reasons set forth in Subsection B of 13.4.2.27 NMAC.

(2) If a nonresident adjuster's license is terminated by the home state or designated home state for any reason, the nonresident adjuster's license shall terminate immediately, unless the termination is due to the adjuster being issued a resident adjuster's license in a new home state. If there is a change in the home state, then the notice of change must include both the previous and current addresses. If the new home state does not have reciprocity with this state, the nonresident adjuster's license shall terminate.

D. Effects of suspension. While a license is suspended, the licensee shall not engage in any transaction for which the license is required, other than transfer of business that was transacted by the licensee while the license was active.

E. Application for license after suspension, denial of application, or revocation of license. Adjuster's licenses are subject to the provisions for reinstatement as set forth in Subsection C of 13.4.2.27 NMAC.

(1) An adjuster whose license is suspended by the superintendent may apply for a new license only after the expiration of the period of suspension.

(2) In the event that the action by the superintendent is to revoke or deny application for licensure or refuse renewal of an existing license, the superintendent shall notify the applicant or licensee in writing, advising of the reason for the refusal. The applicant or licensee may request a hearing to be held within 30 days.

(3) Paragraph (2) of this subsection does not apply to an applicant whose license application was denied for failure by the applicant to:

(a) pass the required written examination; or

(b) submit a properly completed license application.

F. Action against business entities. The license of a business entity may be probated, suspended, revoked, or refused if the superintendent finds, after a hearing, that its designated individual licensee's violation occurred while acting on behalf of or representing the business entity and that the violation was known or should have been known by one or more of the business entity's partners, officers or managers and that the violation was neither reported to the superintendent nor was corrective action taken.

G. Disciplinary proceeding for conduct committed before surrender or forfeiture of license. The superintendent shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by the Insurance Code against any person who is under investigation for or charged with a violation of this regulation even if the person's license has been surrendered or has expired by operation of law.

(1) The superintendent may institute a disciplinary proceeding against a former licensee for conduct that the licensee committed before the effective date of a voluntary surrender or automatic forfeiture of the license.

(2) In a proceeding under this section, the fact that the license holder has surrendered or forfeited the license does not affect the license holder's culpability for the conduct.

[13.4.8.13 NMAC – N, 7/1/2019]

13.4.8.14 CONDUCT OF ADJUSTERS:

A. Standards of conduct. All adjusters shall adhere to the following standards of conduct:

(1) An adjuster shall not permit an unlicensed employee or representative of the adjuster to conduct business for which a license is required pursuant to the Insurance Code.

(2) An adjuster shall be honest and fair in all communications with the insured, the insurer and the public.

(3) An adjuster shall give prompt, knowledgeable service and courteous, fair and objective treatment at all times.

(4) An adjuster shall not give legal advice, and shall not deal directly with any policyholder or claimant who is represented by legal counsel without the consent of the legal counsel involved.

(5) An adjuster shall comply with all local, state and federal privacy and information security laws, if applicable.

(6) An adjuster shall not pay a commission, service fee or other valuable consideration to a person for investigating or settling claims in this state if that person is required to be licensed pursuant to the Insurance Code and is not so licensed.

(7) An adjuster shall not undertake the adjustment of any claim if the adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage or which otherwise exceeds the adjuster's experience. An adjuster shall obtain competent technical assistance, when necessary to help handle claims and losses outside the adjuster's area of expertise.

(8) An adjuster shall disclose to an insured if the adjuster has any interest or will be compensated by any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop or any other business entity that performs any work in conjunction with damages caused by the insured loss.

B. Conduct prohibited.

(1) An adjuster shall not represent an insured on a claim or charge a fee to an insured while representing the insurance carrier against which the claim is made.

(2) An adjuster shall not advance money to any potential client or insured.

(3) An adjuster shall not adjust a loss related to physical damage of a property on which the adjuster also acts as or is employed as any type of contractor or otherwise provides building repairs or products of any type for compensation, or is a

controlling person in a business relating to such contracting, regardless of whether the contractor is a licensed adjuster.

(4) An adjuster shall avoid any direct or indirect financial interest of a claim adjusted by the adjuster other than the salary, fee, commission or other consideration established in a written contract, unless, in the case of a public adjuster, full written disclosure has been made to the insured.

(5) An adjuster shall avoid conflicts of interest, including acquiring any interest in salvaged property or participating in any way, directly or indirectly, in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted, unless, in the case of a public adjuster, full written disclosure has been made to the insured and written permission has been obtained from the insured.

(6) In those instances in which an adjuster who is also a contractor is performing either as an adjuster or as a contractor on behalf of an insured, the adjuster shall provide the insured with a disclaimer, on a form promulgated by the superintendent and signed by the adjuster, indicating in which of these two capacities the adjuster is serving the insured and affirming that the adjuster is not serving the insured in the other capacity. The adjuster shall retain copies of such signed disclaimers and make them available to the superintendent upon the superintendent's request.

[13.4.8.14 NMAC – N, 7/1/2019]

13.4.8.15 STAFF ADJUSTERS:

A. Description of staff adjusters. A staff adjuster is an employee of an insurance company whose work is to investigate, evaluate, and eventually settle a claim. In certain situations, a staff adjuster may award the claim to the insured (by writing a check in behalf of the company). Evidence of financial responsibility as described in 13.4.8.11 NMAC is not required of licensed staff adjusters.

B. Powers of staff adjusters. A staff adjuster shall have only such powers with respect to claims and losses as granted by the staff adjuster's employer or affiliates of the staff adjuster's employer.

C. Appointment required. A staff adjuster must be appointed by an insurance company in order to be licensed in this state.

(1) If the appointment of a licensed staff adjuster is terminated by an insurance company for any reason, notice shall be provided to the superintendent within 10 days.

(2) After a staff adjuster's appointment by the insurance company is terminated, the staff adjuster's license will terminate automatically if the superintendent is not notified that the staff adjuster has been appointed by another insurance company

within 30 days after submission of the initial notice that the appointment has been terminated.

D. Examination requirement.

(1) Although the initial examination requirement is waived for adjusters who were licensed prior to July 1, 2017, the examination waiver is lost if the adjuster's license is terminated for any reason after July 1, 2017, including loss of the staff adjuster's appointment. Once a license is terminated and the waiver is lost, the adjuster must pass the required examination before the license will be reinstated.

(2) The applicant must pass the required examination within one year prior to applying for the license. If a staff adjuster who has passed the required examination is without an appointment or is otherwise unlicensed for more than one year, reexamination will be required before the license can be reinstated.

[13.4.8.15 NMAC - N, 7/1/2019]

13.4.8.16 INDEPENDENT ADJUSTERS:

A. Description of independent adjusters.

(1) An independent adjuster is a professional who conducts investigations, verification, negotiations, and settling of claims for or on behalf of an insurance company, a self-insured firm, or a government agency, without being under the employment of the company, firm, or agency in question.

(2) Independent adjusters either are hired through a third-party firm that specializes in handling claims or are self-employed entities. A licensed independent adjuster may be outsourced by an insurer to handle claims in this state.

(3) Independent adjusters are generally utilized for one of the following reasons:

(a) to assist an insurer following a major catastrophe resulting in a manpower shortage to investigate and negotiate on its behalf;

(b) for statutory reasons or to comply with provisions of an insurance contract;

(c) to meet a need for special expertise; or

(d) to deal with claims in remote areas.

B. Powers and responsibilities of independent adjusters. An independent adjuster shall have the powers granted by its principal to investigate, report upon, adjust

and settle claims on behalf of an insurer or self-insurer and have additional powers as to claims and losses only as may be conferred by the principal.

C. Standards of conduct of independent adjusters. In addition to the general standards of conduct that apply to all adjusters as set forth in 13.4.8.14 NMAC, an independent adjuster shall also self-identify as an independent adjuster and, if applicable, identify the adjuster's employer when dealing with any policyholder or claimant.

D. Records of independent adjusters.

(1) Each independent adjuster shall keep at the business address shown on his license a record of all transactions under the license. The records shall include:

(a) documents relating to all investigations or adjustments undertaken, and

(b) a statement of any fee, commission or other compensation received or to be received by the adjuster on account of such investigation or adjustment.

(2) The adjuster shall make such records available for examination by the superintendent at all reasonable times, and shall retain records as to a particular investigation or adjustment for not less than three years after completion of such investigation or adjustment.

(3) Failure of a licensed independent adjuster, as determined by the superintendent after notice and an opportunity for a hearing, to properly maintain records in accordance with this section and make them available to the superintendent on request constitutes grounds for the suspension of the license.

[13.4.8.16 NMAC - N, 7/1/2019]

13.4.8.17 POWERS AND RESPONSIBILITIES OF PUBLIC ADJUSTERS:

A. General authority. A licensed public adjuster may adjust claims on behalf of insured clients for property claims, both real and personal, including loss of income. Although business entities can be licensed as a both public and independent adjuster, an individual adjuster that is licensed as a public adjuster shall not be licensed additionally as either a staff or independent adjuster.

B. Standards of conduct. In addition to the general standards of conduct that apply to all adjusters as set forth in 13.4.8.14 NMAC, public adjusters shall also adhere to the following legal and ethical requirements:

(1) All contracts for the services of a public adjuster and required disclosures shall be executed in writing and shall comply with the specific requirements set forth in Section 59A-13-15 NMSA 1978. A sample contract and sample disclosure form, which

may be used by a public adjuster, are available on the OSI website. Use of the sample contract and disclosure will be accepted by the superintendent as compliance with this requirement.

(2) A public adjuster shall serve with objectivity and complete loyalty in the interest of the public adjuster's client alone and shall render to the client such information, counsel and service as will best serve the client's insurance claim needs and interest.

(3) A public adjuster shall not solicit, or attempt to solicit, a client during the progress of a loss-producing occurrence, as defined in the client's insurance contract.

(4) Unless disclosed to the client in writing, a public adjuster shall not refer or direct the client to get needed repairs or services in connection with a loss from any person:

(a) with whom the public adjuster has a financial interest; or

(b) from whom the public adjuster may receive direct or indirect compensation for the referral.

(5) Unless disclosed to the client in writing, a public adjuster shall not accept any compensation or anything of value in connection with a client's specific loss in exchange for the referral of a client to any third-party individual or firm, attorney, appraiser, umpire, construction company, contractor, or salvage company. Such disclosure shall include the source and amount of any such compensation.

(6) A public adjuster shall not agree to any settlement without the client's knowledge and consent.

(7) An individual public adjuster, while so licensed by the superintendent, shall not be licensed as a staff adjuster or an independent adjuster.

(8) The contract between the public adjuster and the client shall not be construed to prevent a client from pursuing any civil remedy after the three-business day revocation or cancellation period.

(9) A public adjuster shall not engage in the unauthorized practice of law.

C. Misrepresentation.

(1) A public adjuster shall not misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as a staff adjuster employed by the insurer or acting as an independent adjuster.

(2) A public adjuster shall not make a misrepresentation, in violation of Insurance Code, to an insured or to an insurance company in the conduct of their actions as public adjusters.

D. Public adjuster fees.

(1) The public adjuster's contract shall disclose that the public adjuster is hired by and compensated by the insured to assist in preparation, presentation and settlement of the claim. The contract shall disclose that the public adjuster's fee or commission shall be paid by the insured from the proceeds of the settlement, and shall state whether the compensation is based on a percentage of the settlement.

(2) No public adjuster shall require, demand or accept any fee, retainer, compensation, deposit, or other thing of value prior to settlement of a claim and collection of money due to be paid by an insurance company. The public adjuster shall not collect the entire fee from the first check issued by an insurance company. Rather, the public adjuster's fees shall be paid as a percentage of each check issued by an insurance company.

(3) A public adjuster shall not pay a commission, service fee or other valuable consideration to a person for investigating or settling claims in this state if that person is required to be licensed pursuant to the Insurance Code and is not so licensed.

(4) A person shall not accept a commission, service fee or other valuable consideration for investigating or settling claims in this state if that person is required to be licensed pursuant to the Insurance Code and is not so licensed.

(5) In the event of a catastrophic disaster, there shall be limits on catastrophic fees that a public adjuster shall charge, agree to, or accept as compensation or reimbursement. Any payment, commission, fee, or other thing of value shall not exceed ten percent of any insurance settlement or proceeds.

E. Records of public adjusters. Records of public adjusters shall be maintained in compliance with Section 59A-13-17 NMSA 1978.

F. Fiduciary duties of public adjusters.

(1) Escrow or trust accounts. Public adjusters shall comply with the escrow and trust account requirements set forth in Section 59A-13-16 NMSA 1978.

(2) Handling of funds.

(a) All funds of others received by a public adjuster, including funds received as claim proceeds shall be received and held by the public adjuster in a fiduciary capacity. A public adjuster may not divert or appropriate fiduciary funds received or held. An adjuster who diverts or appropriates such funds for personal use or takes or

secrets such funds with intent to embezzle without the consent of the person entitled to the funds is subject to fines and penalties set forth in the Insurance Code and is guilty of larceny.

(b) Subject to the terms of any agreement between an adjuster and the adjuster's principal or obligee, each adjuster who does not make immediate remittance of funds to the insured or other person entitled to them shall elect and follow one of the following methods:

(i) forward insurance funds received (less applicable compensation, if any) to the insured or person entitled thereto within 15 days after receipt; or

(ii) establish and maintain one or more fiduciary bank accounts separate from accounts holding personal, firm or corporate funds, and promptly deposit and retain therein all funds of others pending transmittal to the insured or person thereto entitled.

(c) The following exceptions to the prohibition against commingling of funds shall apply:

(i) Funds belonging to more than one principal may be deposited and held in the same account so long as the amount held for each principal is readily ascertainable from the records of the licensee.

(ii) A public adjuster may commingle with such fiduciary funds in a particular account such additional funds as the adjuster deems prudent for payment of claims or for other contingencies arising in the adjusting business.

(iii) A public adjuster may commingle with the adjuster own funds those funds of a particular principal who has expressly waived the segregation requirement in writing and in advance.

(iv) Permitted commingling of the funds of others with the adjuster's funds shall not alter the fiduciary duties of the adjuster as to the others' funds.

[13.4.8.17 NMAC - N, 7/1/2019]

13.4.8.18 EMPLOYMENT OF EMERGENCY ADJUSTERS:

In the event of an emergency requiring the immediate expansion of adjuster services in this state, an insurer or a public adjuster licensed in this state may request authority from the superintendent to employ adjusters to assist with the emergency who are not licensed in this state but who have fulfilled all licensing requirements in their home or in a designated home state and are in good standing in the state of licensure.

A. Request to employ emergency adjusters. An insurer or public adjuster requesting authority to employ emergency adjusters shall provide the superintendent with the following information:

(1) the nature of the emergency and the affected region of the state;

(2) a list of the emergency adjusters that the insurer or public adjuster shall use that are not licensed in this state, including the following information for each emergency adjuster:

(a) name,

(b) home address,

(c) last four digits of social security number,

(d) national producer number,

(e) home state where the adjuster is licensed, and

(f) the effective date of the contract between the adjuster and the insurer or public adjuster;

(3) for the individual designated by the insurer or public adjuster who will be responsible for the conduct of these adjusters:

(a) name,

(b) contact information,

(c) national producer number, and

(d) New Mexico license number; and

(4) any other information that the superintendent may require.

B. Limits on use of emergency adjusters.

(1) The adjustment of claims by the adjusters listed in Paragraph (2) of Subsection A of this section shall be limited to claims arising from the emergency. An emergency adjuster shall, as to claims and losses, have the powers of the employer, subject to extension or limitation by contract.

(2) Use of the listed adjusters shall be limited to the 90 days immediately following the emergency, unless an extension of time is requested by the insurer or public adjuster and granted by the superintendent.

C. Approval of emergency adjusters.

(1) A request by an insurer or public adjuster to employ emergency adjusters to assist with an emergency who are not licensed in New Mexico but who are currently licensed and in good standing in their home state shall be deemed approved unless the request is disapproved by the superintendent within three business days of its submission to the superintendent.

(2) An insurer or public adjuster that requests authorization pursuant to this section may commence employing the adjusters listed in Paragraph (2) of Subsection A of this section while awaiting the superintendent's decision on their request.

D. Denial. An insurer or public adjuster may not utilize emergency adjusters who do not have an adjuster's license issued by the home state or designated home state.

[13.4.8.18 NMAC - N, 7/1/2019]

13.4.8.19 ADVERTISEMENTS:

A. Definition. As used in this section, "advertisement" includes:

(1) printed and published material, audio visual material and descriptive literature of an insurance adjuster used in direct mail, newspapers, magazines, radio, telephone and television scripts, internet web sites, billboards, and similar displays;

(2) descriptive literature and promotional aids of all kinds issued by an insurance adjuster for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, form letters, and lead-generating devices of all kinds;

(3) prepared promotional talks, presentations and materials for use by an insurance adjuster, and those representations made on a recurring basis by an insurance adjuster to members of the public;

(4) advertising material used to:

(a) solicit contracts from insureds; or

(b) modify existing contracts;

(5) material included with a contract when the contract is delivered and materials used in the solicitation of contract renewals, extensions or reinstatements, except those extensions or reinstatements provided for in the contract;

(6) lead card solicitations, defined as communications distributed to the public which, regardless of form, content, or stated purpose, are intended to result in the

compilation or qualification of a list containing names or other personal information regarding insureds who have expressed a specific interest in obtaining assistance with having their claims settled, and which are intended to be used to solicit residents of this state for the execution of a contract for an insurance adjuster's services; and

(7) any other communication directly or indirectly related to an insurance adjuster contract, and intended to result in the eventual execution of such a contract.

B. Exclusions: "Advertisement" does not include:

(1) communications or materials used within an insurance adjuster's own organization, not used as promotional aids and not disseminated to the public;

(2) communications with insureds other than materials soliciting insureds to enter, renew, extend or reinstate a contract for an insurance adjuster's services;

(3) correspondence between a prospective insured and an adjuster in the course of negotiating a contract; and

(4) material used solely for the recruitment, training, and education of an insurance adjuster's personnel and subcontractors, provided it is not also used to induce the public to enter, renew, extend or reinstate a contract for an insurance adjuster's services.

C. Use of materials. An adjuster shall not disseminate or use any form of agreement, advertising, or other communication, regardless of format or medium, in this state that is harmful to the profession of insurance adjusting and that does not comply with Insurance Code or this section.

D. Requirements and prohibitions.

(1) Each advertisement by a licensed adjuster soliciting or advertising business must display the adjuster's name, address, and license number as they appear in the records of the superintendent.

(2) A licensed adjuster may not solicit or attempt to solicit a client for employment during the progress of a loss-producing natural disaster occurrence.

(3) A licensed adjuster may not solicit or attempt to solicit business, directly or indirectly, or act in any manner on a bodily injury loss covered by a life, health, or accident insurance policy or on any claim for which the client is not an insured under the insurance policy.

(4) A licensed adjuster may not use any letterhead, advertisement, or other printed material, or use any other means, to represent that the adjuster is an

instrumentality of the federal government, of a state, or of a political subdivision of a state.

[13.4.8.19 NMAC - N, 7/1/2019]

CHAPTER 5: INSURANCE RECEIVERSHIPS AND GUARANTY ASSOCIATIONS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: FILING CLAIMS IN DELINQUENCY PROCEEDINGS

13.5.2.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.5.2.2 SCOPE:

This rule applies to all persons who submit claims in delinquency proceedings pursuant to the Insurers Conservation, Rehabilitation and Liquidation Law, Section 59A-41-1 NMSA 1978 et seq.

[7/1/97; Recompiled 11/30/01]

13.5.2.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.5.2.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.5.2.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.5.2.6 OBJECTIVE:

The purpose of this rule is to specify the requirements for submitting claims to the receiver or ancillary receiver in delinquency proceedings pursuant to the Insurers Conservation, Rehabilitation and Liquidation Law, Section 59A-41-1 NMSA 1978 et seq.

[7/1/97; Recompiled 11/30/01]

13.5.2.7 DEFINITIONS:

[RESERVED]

13.5.2.8 CLAIM FILING PROCEDURE:

If requested, any of the following documents sustaining a claim must be submitted to the receiver or ancillary receiver before the claim will be considered.

A. Original policies, other contracts of insurance or other satisfactory proof of coverage, if the claim is made by the insured.

B. A certified copy of the judgment, if the claim is based upon a judgment.

C. A dismissal with prejudice of any pending legal action, if the claim is in suit, unless the claim is made contingent upon the result of this action. The dismissal will be filed upon approval of the claim by the court.

D. A full or partial release, both as to the insured and the company, if the claim is made by a third party in connection with a matter not in suit. The release will be effective upon approval of the claim by the court.

E. Detailed invoices covering claims for services, advertising, supplies, legal or adjusting services, etc. The original contract must be submitted with all claims based upon contracts other than insurance contracts. If the contract is oral, the claimant must supply the name of the person who acted for the company, the date of the conversation, the identity of all parties to the conversation, and a detailed description of the content of the conversation.

F. Proof of authority satisfactory to the receiver or ancillary receiver must be submitted to support claims filed by receivers, administrators, assignees, attorneys-in-fact, agents and guardians.

G. Any other relevant documentation the receiver or ancillary receiver may request.

H. Name and address of claimant. All notices regarding claims and all dividends, if any, may be sent to the address shown on the proof of claim unless other written instructions are given.

[7/1/97; Recompiled 11/30/01]

13.5.2.9 CLAIM FOR RETURN OF UNEARNED PREMIUM:

If requested, any of the following information sustaining a claim for a return of premium on an individual policy of insurance must be submitted to the receiver or ancillary receiver before the claim will be given consideration:

A. the original policy of insurance or other satisfactory proof of coverage;

B. affidavit of payment of premium and non-recoupment;

C. if return premium has been assigned, an assignment of return premium;

D. any other relevant documentation the receiver or ancillary receiver may request.

[7/1/97; Recompiled 11/30/01]

13.5.2.10 CLAIMS - GENERAL:

If requested, any of the following information sustaining a claim, other than a claim for return of premium on an individual policy of insurance, must be submitted to the receiver or ancillary receiver before the claim will be given consideration:

A. The total amount of the claim.

B. Nature and value of any security held by the claimant for his or her benefit, including other bonds, policies or contracts covering the loss.

C. A concise statement of facts relating to the claim.

D. In the event the claims are for personal injury or damage to property, the name and address of the person injured or the owner of the property must be given. The date, place, time and all circumstances surrounding the accident in question must be set out.

E. Any disbursement made, showing the date, to whom paid, what the payment covered, and the amount paid must be set out in full. Original receipts, vouchers, and releases, where these have been issued, must be attached in the case of each payment. In the event the originals are not available, fully verified copies may be attached. If the claim has not been paid, all bills must be listed and attached. Any and all bills for hospital and surgical care must be itemized and individual items listed. If

more than one person is injured, the itemized list must be supplied for each person injured of any and all payments and charges paid and due to be paid.

F. Any other relevant information the receiver or ancillary receiver may request.

[7/1/97; Recompiled 11/30/01]

CHAPTER 6: LIFE AND HEALTH INSURANCE FORMS AND RATES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: LIFE AND HEALTH MATRIX POLICY FORM FILING

13.6.2.1 ISSUING AGENCY:

NM Office of Superintendent of Insurance, P.O. Box 1689, Santa Fe, NM 87504-1689.

[13.6.2.1 NMAC - N, 04/01/2018]

13.6.2.2 SCOPE:

This rule applies to all life and health insurers issuing individual life or health insurance policies or group life or health insurance policies sitused in New Mexico.

[13.6.2.2 NMAC - N, 04/01/2018]

13.6.2.3 STATUTORY AUTHORITY:

Sections 59A-1-10 through 59A-1-17; 59A-2-7 through 59A-2-9; 59A-5-10; 59A-6-l; 59A-18-12; 59A-18-13.2; 59A-18-16.l; 59A-18-16.2; 59A-21-l et seq.; 59A-22-l et seq. NMSA 1978.

[13.6.2.3 NMAC - N, 04/01/2018]

13.6.2.4 DURATION:

Permanent.

[13.6.2.4 NMAC - N, 04/01/2018]

13.6.2.5 EFFECTIVE DATE:

April 1, 2018 unless a later date is cited at the end of a section.

[13.6.2.5 NMAC - N, 04/01/2018]

13.6.2.6 OBJECTIVE:

The purpose of this rule is to address the use of forms previously filed and approved on a matrix basis for New Mexico-sitused group policyholders or for individual policies issued to New Mexico residents.

[13.6.2.6 NMAC - N, 04/01/2018]

13.6.2.7 DEFINITIONS:

As used in this rule:

A. "Group policy" means a contract for group life or group health insurance made between an insurer and an employer, association, trust or other group that covers individuals based on their relationships to the group policy holder with or without the covered individuals' dependents. Group policy does not include the certificate of insurance delivered to individuals insured under such contracts.

B. "Health insurance" has the meaning as set forth in Section 59A-7-3 NMSA 1978.

C. "Individual" has the meaning set forth in Subsection B of Section 59A-1-10 NMSA 1978.

D. "Insurer" has the meaning set forth in Section 59A-1-8 NMSA 1978.

E. "Life insurance" has the meaning as set forth in Section 59A-7-2 NMSA 1978.

F. "Matrix form" means a policy or certificate consisting of multiple insert pages or paragraphs each with its own unique identifiable form number, allowing for the creation of multiple policies, certificates or applications by using combinations of the insert pages and paragraphs. Matrix forms do not include riders, amendments, endorsements, declaration pages, schedule pages and certificate/policy specification pages and a matrix form is not created by the addition of such forms.

G. "SERFF" means the national association of insurance commissioners (NAIC) system for electronic rate and form filings.

H. "Subscriber" means an individual whose employment or other group status, except family dependency, is the basis for their coverage for group insurance.

[13.6.2.7 NMAC - N, 04/01/2018]

13.6.2.8 ISSUANCE OF MATRIX FORMS PROHIBITED:

No insurance policies or related certificates issued to New Mexico - situsedgroup policyholders or individual insurance policies issued to New Mexico residents with effective dates of July 1, 2019, or later may include matrix-based forms, subject to the exception as described in 13.6.1.9 NMAC.

[13.6.2.8 NMAC - N, 04/01/2018]

13.6.2.9 EXCEPTIONS FOR PREVIOUSLY APPROVED MATRIX FORMS:

Matrix forms previously filed with and approved by the superintendent may continue to be used as follows:

A. Matrix forms previously filed with and approved by the superintendent may continue to be marketed and sold in this state, provided that the individual policy or group policy becomes effective on or before July 1, 2019.

B. Coverage provided under individual policies or group policies and certificates that include matrix-based forms may continue if the individual policy or group policy was issued prior to July 1, 2019. Coverage may also be extended to new subscribers under existing group insurance plans that use matrix-based forms that have been approved and are in use as of July 1, 2019.

C. Changes to policies or certificates using previously filed and approved matrix forms, affiliated forms, and rates subject to Subsections A and B of this section, including but not limited to changes required to maintain compliance with state or federal statutory or regulatory laws or requirements, shall not require an insurer to issue new non-matrix forms and will be permitted, provided the following requirements are met:

(1) Any changes that fall outside the scope of approved variability of previously approved matrix-based forms shall require a form filing of a rider, endorsement, or amendment and must be submitted to the superintendent for approval;

(2) A sample issue specimen of the applicable matrix-based policy or certificate forms including every insert page and form to be included in the policy or certificate as it will be issued to the policyholder or certificate holder and that is the subject of the filing must be provided with the SERFF filing in the supporting document tab;

(3) any modification in a matrix-based form that also requires a change to the previously approved rates must include a corresponding rate filing; and

(4) A rate filing subject to Subsections A and B of this section affecting an entire class or block of coverage under this section, will be subject to the superintendent's review and approval.

[13.6.2.9 NMAC - N, 04/01/2018]

CHAPTER 7: INSURANCE TRADE PRACTICES AND FRAUDS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: FREEDOM TO CHOOSE INSURANCE COMPANY AND INSURANCE PROFESSIONAL

13.7.2.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, P.O. Box 1269, Santa Fe, New Mexico 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.7.2.2 SCOPE:

This rule applies to any person engaged in selling real or personal property, or in the business of financing the purchase of real or personal property, or of lending money on the security of real or personal property.

[7/1/97; Recompiled 11/30/01]

13.7.2.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-16-14 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.7.2.4 DURATION:

Permanent

[7/1/97; Recompiled 11/30/01]

13.7.2.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.7.2.6 OBJECTIVE:

The purpose of this rule is to protect borrowers and purchasers from being required to purchase insurance from a particular insurance company or insurance professional as a condition to receiving a loan or mortgage by promulgating the form of notice required by Section 59A-16-14 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.7.2.7 DEFINITIONS:

[RESERVED]

13.7.2.8 NOTICE REQUIRED:

The following form shall be used to give the notice of rights required by Section 59A-16-14 NMSA 1978:

FREEDOM TO CHOOSE

INSURANCE COMPANY AND INSURANCE PROFESSIONAL

The undersigned person hereby acknowledges that I have been informed by (individual's name) on behalf of (name of lender) that, although I may be required by the seller or lender to purchase insurance to cover the property that is being used as security for the loan, I may purchase that insurance from the insurance company or agent of my choice, and cannot be required by the seller or lender, as a condition of the sale or loan, to purchase or renew any policy of insurance covering the property through any particular insurance company, agent, solicitor, or broker. I hereby acknowledge receipt of a true copy of this notice on the _____day of_____, _____.

_____

(Signature of Purchaser or Borrower)

[7/1/97; Recompiled 11/30/01]

13.7.2.9 AUTHORIZATION FOR LENDER TO OBTAIN INSURANCE:

The following form shall be used when the borrower or purchaser, after signing the form required by 13 NMAC 7.2.8 [now 13.7.2.8 NMAC], nevertheless chooses to authorize the lender to purchase the required coverages:

AUTHORIZATION FOR LENDER TO OBTAIN INSURANCE

Although (name of lender) will accept suitable insurance policies to protect our respective interests in the property used as security for the loan through my choice of any agent of any insurance company licensed in New Mexico, I have elected to authorize (name of lender) to purchase insurance coverage for our joint protection, and I hereby authorize (name of lender) to obtain from any insurance company licensed in New Mexico or any of its agents the following insurance polices, until such time as I rescind this authorization or supply a substitute or replacement policy:

DECLARATIONS FOR POLICIES OF INSURANCE

Name of Purchaser or Borrower:_____

Address:_____

Name of Mortgagee/Lienholder:_____

Address:_____

Name of Contingent Beneficiary, if any:_____

Address:_____

Name of Insurance Company:_____

COVERAGES	PREMIUMS
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

TOTAL $_____

[7/1/97; Recompiled 11/30/01]

PART 3: MAINTENANCE OF COMPLAINT RECORDS

13.7.3.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.7.3.2 SCOPE:

This rule applies to all insurers subject to the New Mexico Unfair Insurance Practices Act, Section 59A-16-1 et seq NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.7.3.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.7.3.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.7.3.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.7.3.6 OBJECTIVE:

The purpose of this rule is to prescribe the minimum information to be maintained in the record of complaints required of all insurers under Section 59A-16-22 NMSA 1978 and to provide a suggested format for this record.

[7/1/97; Recompiled 11/30/01]

13.7.3.7 DEFINITIONS:

As used in this rule:

A. **"Complaint"** means a written communication primarily expressing a grievance.

B. **"Insurance department complaint"** means a written communication regarding a complaint transmitted by the department of insurance.

[7/1/97; Recompiled 11/30/01]

13.7.3.8 CONTENT OF COMPLAINT RECORD:

13 NMAC 7.3.11 [now 13.7.3.11 NMAC] sets forth the minimum information required to be contained in an insurer's complaint record in order to comply with the statute. Refinements and additions to the information specified may, of course, be maintained in the complaint record. 13 NMAC 7.3.12 [now 13.7.3.12 NMAC] contains an explanation of the various headings, codes and other notations contained in 13 NMAC 7.3.11 [now 13.7.3.11 NMAC]. The codes are used in order to simplify both the classification of the action underlying the complaint and the keeping of the records.

[7/1/97; Recompiled 11/30/01]

13.7.3.9 FORMAT OF COMPLAINT RECORD:

13 NMAC 7.3.11 [now 13.7.3.11 NMAC] is the suggested format for the complaint record required to be maintained by the statutes and this rule. Refinements, deviations from or additions to this suggested format are permitted so long as the minimum information contemplated by such format can be obtained for department of insurance review within a reasonable time following a request therefor by an authorized representative of the department of insurance.

[7/1/97; Recompiled 11/30/01]

13.7.3.10 MAINTENANCE OF THE RECORD:

The complaint record shall be kept on a calendar year basis and the number of complaints by line of insurance, function, reason, disposition, and state of origin shall be compiled not less frequently than annually. The maintenance of this complaint record shall be required for complaints received on and after October 1, 1973.

[7/1/97; Recompiled 11/30/01]

13.7.3.11 COMPLAINT RECORD - FORM:

NAME OF COMPANY: _____

A	B		C	D	E	F	G	H
	Function Code	Reason Code	Line Type	Company Disposition After Complaint Receipt	Date Received	Date Closed	Insurance Department Complaint	State of Origin
Company Identification Number								
Agents Number Staff								
Adjusters Number								
Independent Adjuster								

[7/1/97; Recompiled 11/30/01]

13.7.3.12 COMPLAINT RECORD - EXPLANATION:

A. **A - Company identification number:** As noted, this refers to the company's identification number of the complaint or other means or identifying the complaint, and shall also include the license number or other means of identifying any licensee of the department of insurance (such as agent, adjuster or independent adjuster) whose conduct or records are involved in the complaint.

B. **B - Function code:** Complaints are to be classified by function(s) of the company involved. Separate classifications are to be maintained for underwriting, marketing and sales, claims, policyholder service and miscellaneous.

C. **B - Reason code:** Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above:

(1) **Underwriting:**

(a) company underwriting;

(b) individual's application underwriting (this refers to any complaint where misrepresentations or declarations in an application for insurance resulted in company action involved in the complaint);

(c) cancellation;

(d) rescission;

(e) non-renewal;

(f) premiums and rating;

(g) delays;

(h) refusal to insure;

(i) miscellaneous (not covered by above).

(2) **Marketing and sales:**

(a) general advertising;

(b) mass marketing advertising (advertising which is essentially directed to reach more people than in a one to one relationship);

(c) agent handling;

(d) replacement;

(e) dividend illustration;

(f) delays;

(g) alleged misleading statement or misrepresentation;

(h) miscellaneous (not covered by above).

(3) **Claims:**

(a) claims procedure;

(b) delays;

(c) unsatisfactory settlements;

(d) natural disaster adjusting (hurricane or flood situations which produce a large number of claims);

(e) unsatisfactory settlement offer;

(f) denial of claim;

(g) miscellaneous (not covered by above).

(4) **Policyholder service:**

(a) failure to respond;

(b) delays;

(c) miscellaneous (not covered by above).

(5) **Miscellaneous:** Not covered in 13 NMAC 7.3.12.3.1 through 13 NMAC 7.3.12.3.4 [now Paragraphs (1) through (4) of Subsection C of 13.7.3.12 NMAC].

D. **C - Line type:** Complaints are to be classified according to the line of insurance involved, as follows:

(1) automobile;

(2) fire;

(3) homeowners - farmowners;

(4) crop;

(5) inland marine;

(6) individual life;

(7) group life;

(8) annuities;

(9) individual accident and health;

(10) group accident and health;

(11) workers' compensation;

(12) liability insurance other than automobile;

(13) mobile homeowners;

(14) miscellaneous (not covered by above).

E. **D - Company disposition after receipt:** The complaint record shall note the disposition of the complaint. The following examples illustrate the type of information called for, but are not intended to be required language nor to exhaust the possibilities: corrective action was taken; no action was deemed necessary; or a satisfactory explanation was given to the complainant. If the company wishes it may use a code for entries in this column.

F. **E - Date received:** This refers to the date the complaint was received.

G. **F - Date closed:** This refers to the date on which the complaint was disposed of, whether by one action or a series of actions as may be present in connection with some complaints.

H. **G - Insurance department complaint:** If the origin of the complaint was from an insurance department, it should be so identified.

I. **H - State of origin:** The complaint record should note the state from which the complaint originated. Ordinarily this will be the state of residence of the complainant.

[7/1/97; Recompiled 11/30/01]

PART 4: CATASTROPHIC CLAIMS

13.7.4.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance ("OSI").

[13.7.4.1 NMAC – Rp, 13.7.4.1 NMAC, 3/1/2023]

13.7.4.2 SCOPE:

This rule applies to catastrophic claims settlement practices of insurers and other persons subject to Section 59A-16-20 NMSA 1978.

[13.7.4.2 NMAC – Rp, 13.7.4.2 NMAC, 3/1/2023]

13.7.4.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-16-20 and 59A-16-20.1 NMSA 1978. [13.7.4.3 NMAC – Rp, 13.7.4.3 NMAC, 3/1/2023]

13.7.4.4 DURATION:

Permanent.

[13.7.4.4 NMAC - Rp, 13.7.4.4 NMAC, 3/1/2023]

13.7.4.5 EFFECTIVE DATE:

March 1, 2023, unless a later date is cited at the end of a section.

[13.7.4.5 NMAC - Rp, 13.7.4.5 NMAC, 3/1/2023]

13.7.4.6 OBJECTIVE:

This rule establishes definitions and procedures for implementing Subsection F of Section 59A-16-20 NMSA 1978 requiring all catastrophic claims to be settled within a 90-day period after the assignment of a catastrophic claim number when a catastrophic loss has been declared and subjecting insurers who fail to settle catastrophic claims within this time period to the enforcement and penalty provisions of the Insurance Code, specifically those pertaining to the Unfair Claims Practices Act.

[13.7.4.6 NMAC - Rp, 13.7.4.6 NMAC, 3/1/2023]

13.7.4.7 DEFINITIONS:

A. "Catastrophe" means a disaster, natural disaster or accident or series of disasters, natural disasters or accidents arising out of a single event that results in the submittal of claims against insurers by at least three percent of the population of the geographic area directly impacted by the event, results in:

(1) the submittal of claims against insurers by at least three percent of the population of the geographic area directly impacted by the event, results in total insured losses in New Mexico of more than $2,500,000 and takes place within a period of seven consecutive days; or

(2) the declaration of an emergency by the Governor of New Mexico under the governor’s statutory powers including, but not necessarily limited to, those enumerated under the All Hazard Emergency Management Act or the Public Health Emergency Response Act, followed by the Superintendent’s independent determination that a catastrophe has occurred.

B. "Catastrophic claim" means a property insurance claim or a vehicle physical damage insurance claim directly resulting from a catastrophe. A catastrophic claim does not include a claim for injury or death to a human, liability for loss or damage to another, loss of use of property or a vehicle, loss of earnings or other loss or damage consequential to a catastrophe.

C. "Catastrophic claim number" means a unique numerical designation assigned to a given catastrophe for the purpose of referencing information relating to the catastrophe. A catastrophic claim number may be a combination of numerals and letters.

D. "Catastrophic claims bureau" means:

(1) a group of agency staff designated by the superintendent at the time of the catastrophe to gather information relating to catastrophic claims, to recommend the declaration of catastrophes, and to recommend assignment of catastrophic claim numbers;

(2) an independent organization appointed by the superintendent to gather information relating to catastrophic claims, to recommend the declaration of catastrophes, and to recommend assignment of catastrophic claim numbers; or

(3) a combination of the arrangements described in Paragraphs (1) and (2) of this subsection.

E. "Claims settlement" means an agreement between an insurer and claimant as to the amount of money owed to the claimant on a particular claim.

F. "Disaster" means a fire, flood, explosion, or technological accident that causes severe property damage or loss.

G. "Geographic area" means the area adversely affecting a significant portion of the population within the catastrophe region identified as a town, city, county or region or combination thereof as determined by the superintendent.

H. "Natural disaster" means a natural event, including a tornado, storm, high water, wind-driven water, earthquake, volcanic eruption, landslide, mudslide, snowstorm, wildfire or drought, that causes severe damage or loss to property located in New Mexico.

I. "Payment" means loss payment, excluding adjustment expenses and net of actual salvage and subrogation recoveries. For an applicable line of business, payment shall include losses associated with loss of use, additional living expense, fair rental value, and other losses pertinent to that line of business.

J. "Post-declaration claim" means a catastrophic claim reported to an insurer after a catastrophe has been declared.

K. "Potentially qualifying event" means a disaster, natural disaster or accident or series of disasters, natural disasters or accidents that the superintendent, a catastrophic claims bureau or an insurer reasonably anticipates could result in a catastrophe declaration.

[13.7.4.7 NMAC - Rp, 13.7.4.7 NMAC, 3/1/2023]

13.7.4.8 CATASTROPHIC CLAIMS BUREAU:

The superintendent will designate a catastrophic claims bureau to make recommendations to the superintendent concerning the declaration of a catastrophe and assignment of a catastrophic claim number. The superintendent may choose to make such designation using any of the arrangements described in Subsection D of Section 7 of this rule. The superintendent may require an insurer to report information concerning each catastrophic claim to the catastrophic claims bureau.

[13.7.4.8 NMAC - N, 3/1/2023]

13.7.4.9 PRE-DECLARATION INSURER REPORTING REQUIREMENTS:

Upon the existence of a potentially qualifying event, the superintendent will issue a bulletin describing data required to be submitted by insurers. An insurer shall report the information described in the bulletin to the catastrophic claims bureau within seven days of the issuance of the bulletin. If an insurer reasonably believes additional information will aid the superintendent in deciding whether to declare a catastrophe, the insurer shall also submit that information. Nothing in this rule diminishes the superintendent's authority to require additional reporting.

[13.7.4.9 NMAC - N, 3/1/2023]

13.7.4.10 DECLARATION OF CATASTROPHE:

Upon the occurrence of an event that reasonably appears to be a catastrophe, and after receipt of the pre-declaration insurer reports required pursuant to Section 9 of this rule, the superintendent will consult with the catastrophic claims bureau as soon as practicable and will decide whether or not to declare a catastrophic loss. If the superintendent declares a catastrophic loss, then the superintendent will immediately assign a catastrophic claim number to that loss.

[13.7.4.10 NMAC - N, 3/1/2023]

13.7.4.11 CATASTROPHIC CLAIMS SETTLEMENT PRACTICES:

A. An insurer shall settle each catastrophic claim within a 90-day period after the superintendent has declared a catastrophic loss and has assigned a catastrophic claim number.

B. If the governor has declared an emergency, then the event giving rise to the governor's emergency declaration may, at the superintendent's discretion, be treated as a catastrophe consistent with the provisions of Section 10 of this rule, without the need for the pre-declaration insurer reports. Under such circumstances, an insurer shall settle each catastrophic claim within a 90-day period after the superintendent has exercised this discretion and declared a catastrophe. However, nothing in this rule shall be construed to reduce any of the superintendent's powers or alter any of the superintendent's duties as provided by Section 59A- 2-7 NMSA 1978, the All Hazard

Emergency Management Act, the Public Health Emergency Response Act or any rule implementing those laws.

[13.7.4.11 NMAC – Rp, 13.7.4.8 NMAC, 3/1/2023]

13.7.4.12 EXCEPTION FOR POST-DECLARATION CLAIMS:

If a claim is a post-declaration claim, an insurer shall settle such post-declaration claim within a 90-day period after such claim is reported to the insurer.

[13.7.4.12 NMAC - N, 3/1/2023]

13.7.4.13 TOLLING:

An insurer may toll the 90-day period described in Section 10, 11, or 12 of this Rule by one of the following mechanisms:

A. If, prior to the expiration of the 90-day period described in Section 10, 11, or 12 of this Rule, whichever is applicable, an insurer presents sufficient evidence to the superintendent to demonstrate a reasonable belief or probable cause that one or more claims subject to this Rule was fraudulent, the applicable 90 day period shall be tolled during the pendency of the investigation into such fraud. However, if the superintendent determines that the evidence is insufficient, the 90 day time period shall not be tolled, and, if this determination is made after the expiration of the 90-day period, the insurer will be deemed to be in violation of this Rule.

B. If, prior to the expiration of the 90-day period described in Section 10, 11, or 12 of this Rule, whichever is applicable, an insurer demonstrates to the superintendent that a claimant has not submitted all required documentation for the claim, the applicable 90-day period shall be tolled until the claimant produces sufficient documentation.

[13.7.4.13 NMAC - N, 3/1/2023]

PART 5: CONFIDENTIAL ABUSE INFORMATION

13.7.5.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[1/1/99; Recompiled 11/30/01]

13.7.5.2 SCOPE:

A. This rule applies to those insurers and insurance support organizations which receive or maintain confidential abuse information in connection with insurance actions

which pertain to persons who are residents of this state or involve policies delivered, issued for delivery, or renewed in this state.

B. This rule does not apply to the following lines of insurance:

(1) fidelity or surety bonds, or any other bonding obligations;

(2) warranties or service contracts;

(3) title insurance;

(4) marine and transportation insurance;

(5) boiler and machinery insurance.

[1/1/99; Recompiled 11/30/01]

13.7.5.3 STATUTORY AUTHORITY:

Sections 59A-16B-6 and 59A-16B-7, NMSA 1978.

[1/1/99; Recompiled 11/30/01]

13.7.5.4 DURATION:

Permanent.

[1/1/99; Recompiled 11/30/01]

13.7.5.5 EFFECTIVE DATE:

January 1, 1999, unless a later date is cited at the end of a section or paragraph.

[1/1/99; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.7.5.6 OBJECTIVE:

The purpose of this rule is to implement the Domestic Abuse Insurance Protection Act, Sections 59A-16B-1 et seq., NMSA 1978 by establishing requirements for the protection of, and procedures for the transfer and disclosure of, confidential abuse information received by insurers or insurance support organizations in connection with insurance actions.

[1/1/99; Recompiled 11/30/01]

13.7.5.7 DEFINITIONS:

In addition to the definitions provided in Section 59A-16B-3, NMSA 1978, as used in this rule:

A. **"Applicant"** means a person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

B. **"Insurance support organization"** means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about protected persons for the primary purpose of providing the information to an insurer for insurance actions.

C. **"Insurance action"** means any action involving insurance which entails:

(1) the determination of a protected person's eligibility for an insurance coverage, benefit or payment;

(2) the renewal, reinstatement, change of location information endorsement, or change in insurance benefits of a policy.

(3) a claim for benefits.

D. **"Location information"** means the address and telephone number of the residence, place of employment, school or other location of a protected person.

E. **"Protected person"** means:

(1) a victim of domestic abuse who has notified an insurer that he or she is or has been a victim of domestic abuse and who:

(a) in the case of property or casualty insurance, is a present or proposed named insured or certificate-holder;

(b) in the case of life, health, or disability insurance, is a present or proposed principal insured or certificate-holder;

(c) is a present or proposed policy-owner;

(d) is a present applicant;

(e) is a present claimant;

(f) derives or is proposed to derive insurance coverage under an insurance policy subject to this rule; or

(2) an individual or entity that provides shelter, advocacy, counseling, or protection to victims of domestic abuse.

[1/1/99; Recompiled 11/30/01]

13.7.5.8 NOTICE OF CONFIDENTIAL ABUSE INFORMATION PRACTICES:

An insurer shall provide a separate notice of confidential abuse information practices in connection with the insurance actions set forth in 13 NMAC 7.5.11 [now 13.7.5.11 NMAC]. The notice shall be written in plain language and shall:

A. state that confidential abuse information may be received in the course of collecting information from persons other than the protected person;

B. state the types of confidential abuse information that may be received and the types of sources and investigative techniques that may be used to collect information;

C. state that the insurer is prohibited by law from using confidential abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy;

D. state the types of disclosures identified in Section 59A-16B-4 NMSA 1978 and the circumstances under which such disclosures may be made without prior authorization;

E. state that confidential abuse information used by an insurance support organization to prepare its report to the insurer may be retained by the insurance support organization but may not be disclosed to other persons without the written consent of the protected person except as otherwise permitted by Section 59A-16B-4 NMSA 1978]

F. describe the rights established in 13 NMAC 7.5.14 , 7.5.15 and 7.5.17 [now 13.7.5.14 NMAC, 13.7.5.15 NMAC and 13.5.7.17 NMAC] and the manner in which such rights may be exercised;

G. describe the insurer's location information confidentiality program and instructions for applying to participate in the program;

H. provide a convenient means of notifying the insurer that the person wishes to be a protected person.

[1/1/99; Recompiled 11/30/01]

13.7.5.9 ABBREVIATED NOTICE PERMITTED:

In lieu of the notice prescribed in 13 NMAC 7.5.8 [now 13.7.5.8 NMAC], the insurer may provide an abbreviated notice which shall:

A. state that confidential abuse information may be received from persons other than the protected person;

B. state that the insurer is prohibited by law from using confidential abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy;

C. state that a right of access and correction exists with respect to all confidential abuse information received;

D. state that the full notice prescribed in 13 NMAC 7.5.8 [now 13.7.5.8 NMAC] will be furnished upon request;

E. provide a convenient means of notifying the insurer that the person wishes to be a protected person.

[1/1/99; Recompiled 11/30/01]

13.7.5.10 ALTERNATIVE NOTICE PERMITTED:

In lieu of the notices prescribed in 13 NMAC 7.5.8 and 7.5.9 [now 13.7.5.8 NMAC and 13.7.5.9 NMAC], an insurer may provide the notice required by Section 4 of the NAIC Insurance Information and Privacy Protection Model Act (1980 proceedings of the NAIC, as amended) if the notice is modified to make specific reference to confidential abuse information and to provide a convenient means of notifying the insurer that the person wishes to be a protected person.

[1/1/99; Recompiled 11/30/01]

13.7.5.11 WHEN NOTICE TO BE GIVEN:

The notice of confidential abuse information practices shall be provided to:

A. all persons who submit applications for insurance or claims for benefits on or after the effective date of this rule as follows:

(1) in the case of an application for insurance, a notice shall be provided at the time the applicant is asked to execute a record release authorization form;

(2) in the case of a claim for benefits, if a claimant is asked to execute a record release authorization form before the claim can be processed, a notice shall be provided at the same time.

B. all protected persons within one year of the effective date of this rule as follows:

(1) in the case of a policy renewal, a notice shall be provided no later than the policy renewal date if:

(a) confidential abuse information has been received from a source other than the protected person or from public records; or

(b) a notice meeting the requirements of this section has not been given within the previous twenty-four (24) months;

(2) in the case of a policy reinstatement, change in location information endorsement, or change in insurance benefits, a notice shall be provided when the insurer sends a notice or confirmation of a policy reinstatement, change in location information endorsement, or change in insurance benefits if:

(a) confidential abuse information has been received from a source other than the protected person or from public records; or

(b) a notice meeting the requirements of this section has not been given within the previous twenty-four (24) months.

[1/1/99; Recompiled 11/30/01]

13.7.5.12 CONTENT OF RECORD RELEASE AUTHORIZATION FORMS:

Whenever a record release authorization form is used by an insurer or insurance support organization to obtain a protected person's authorization for the types of persons specified in the form to release records which may contain confidential abuse information about the protected person to the insurer or insurance support organization, the record release authorization form must:

A. be written in plain language;

B. be dated;

C. specify the types of persons authorized to release records which may contain confidential abuse information about the protected person;

D. name the insurer and identify by generic reference representatives of the insurer to whom the protected person is authorizing information to be released;

E. specify the purposes for which the released information is being collected;

F. specify the length of time such authorization shall remain valid, which shall be no longer than:

(1) in the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for change in policy benefits:

(a) thirty (30) months from the date the authorization is signed if the application or request involves life, health or disability insurance;

(b) one (1) year from the date the authorization is signed if the application or request involves property or casualty insurance;

(2) in the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy:

(a) the term of coverage of the policy if the claim is for a health insurance benefit;

(b) the duration of the claim if the claim is not for a health insurance benefit.

G. advise the protected person that he or she is entitled to:

(1) receive a copy of the record release authorization form; [and]

(2) revoke the record release authorization in writing, r5effective ten days after receipt by the insurer, but that doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

[1/1/99; Recompiled 11/30/01]

13.7.5.13 CONFIDENTIAL ABUSE INFORMATION POLICIES AND PROCEDURES:

A. **Employees:** An insurer shall, by the effective date of this rule, develop, make available for inspection by the superintendent, and implement written policies and procedures to protect against any collection, use, disclosure or transfer of confidential abuse information by the insurer which would violate the Domestic Abuse Insurance Protection Act or this rule. These policies and procedures shall include:

(1) limiting access to confidential abuse information to only those persons who reasonably need access to the information in order to perform their jobs;

(2) appropriate training for all employees with access to confidential abuse information who work in New Mexico or serve New Mexico applicants, insureds, or claimants;

(3) disciplinary measures for violations of the confidential abuse information policies and procedures;

(4) methods for handling, disclosing, storing and disposing of confidential abuse information; [and]

(5) periodic monitoring of employees who have access to confidential abuse information to ensure they are complying with the insurer's confidential abuse information policies and procedures.

B. **Contractual arrangements:** With respect to contractual arrangements between an insurer and a person in which the disclosure or transfer of confidential abuse information may occur, an insurer shall include a provision in the contract by which the recipient of confidential abuse information agrees to be bound by the provisions of the Domestic Abuse Insurance Protection Act in all respects and to be subject to enforcement of that act in the courts of this state.

[1/1/99; Recompiled 11/30/01]

13.7.5.14 ACCESS TO CONFIDENTIAL ABUSE INFORMATION:

A. If any protected person, after proper identification, submits a written request to an insurer or insurance support organization for access to confidential abuse information about the protected person which is reasonably described by the protected person and reasonably locatable and retrievable by the insurer or insurance support organization, the insurer or insurance support organization shall within thirty (30) business days from the date such request is received:

(1) inform the protected person of the nature and substance of such confidential abuse information in writing, by telephone or by other oral communication, whichever the insurer or insurance support organization prefers;

(2) permit the protected person to see and copy, in person, such confidential abuse information pertaining to him or her or to obtain a copy of such confidential abuse information by mail, whichever the protected person prefers, unless such confidential abuse information is in coded form, in which case an accurate translation in plain language shall be provided in writing;

(3) disclose to the protected person the identity, if recorded, of those persons to whom the insurer or insurance support organization has disclosed such confidential abuse information within two (2) years prior to such request, and if the identity is not

recorded, the names of those insurers and insurance support organizations or other persons to whom such information is normally disclosed; and

(4) provide the protected person with a summary of the procedures by which he or she may request correction, amendment or deletion of confidential abuse information.

B. Any confidential abuse information provided pursuant to 13 NMAC 7.5.14.1 [now Subsection A of 13.7.5.14 NMAC] shall identify the person or governmental entity that provided it unless the person who provided it is an agent; the protected person who is the subject of the information; or a natural person acting in a personal capacity rather than in a business or professional capacity.

C. An insurer or insurance support organization may charge a reasonable fee to cover the costs incurred in providing a copy of confidential abuse information to persons.

D. The obligations imposed by this section upon an insurer may be satisfied by another insurer authorized to act on its behalf. With respect to the copying and disclosure of confidential abuse information pursuant to a request under 13 NMAC 7.5.14.1 [now Subsection A of 13.7.5.14 NMAC], an insurer or insurance support organization may make arrangements with an insurance support organization to copy and disclose confidential abuse information on its behalf.

E. The rights granted to protected persons in this section shall extend to all persons to the extent confidential abuse information about them is received and maintained by an insurer or insurance support organization in connection with an insurance action. The rights granted to all persons by this subsection shall not extend to information about them that relates to and is received in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

[1/1/99; Recompiled 11/30/01]

13.7.5.15 CORRECTION, AMENDMENT OR DELETION OF CONFIDENTIAL ABUSE INFORMATION:

A. Within thirty (30) business days from the date of receipt of a written request from a protected person to correct, amend or delete any confidential abuse information about the protected person within its possession, an insurer or insurance support organization shall either:

(1) correct, amend or delete the portion of the confidential abuse information in dispute; or

(2) notify the protected person of:

(a) its refusal to make such correction, amendment or deletion;

(b) the reasons for the refusal; and

(c) the protected person's right to file a statement as provided in 13 NMAC 7.5.15.3 [now Subsection C of 13.7.5.15 NMAC].

B. If the insurer or insurance support organization corrects, amends or deletes confidential abuse information in accordance with 13 NMAC 7.5.15.1.1 [now Paragraph (1) of Subsection A of 13.7.5.15 NMAC], the insurer or insurance support organization shall so notify the protected person in writing and furnish the correction, amendment or fact of deletion to:

(1) any person specifically designated by the protected person who may have, within the preceding two (2) years, received such confidential abuse information;

(2) any insurance support organization whose primary source of confidential abuse information is insurers if the insurance support organization has systematically received such confidential abuse information from the insurer within the preceding three (3) years; provided, however, that the correction, amendment or fact of deletion need not be furnished if the insurance support organization no longer maintains confidential abuse information about the protected person; and

(3) any insurance support organization that furnished the confidential abuse information that has been corrected, amended or deleted.

C. Whenever a protected person disagrees with an insurer's or insurance support organization's refusal to correct, amend or delete confidential abuse information, the protected person shall be permitted to file with the insurer or insurance support organization:

(1) a concise statement setting forth what the protected person thinks is the correct, relevant or fair confidential abuse information; and

(2) a concise statement of the reasons why the protected person disagrees with the insurance institution's, agent's or insurance support organization's refusal to correct, amend or delete confidential abuse information.

D. In the event a protected person files either of the statements described in 13 NMAC 7.5.15.3 [now Subsection C of 13.7.5.15 NMAC], the insurer or insurance support organizations shall:

(1) file the statement with the disputed confidential abuse information and provide a means by which anyone reviewing the disputed confidential abuse information will be made aware of the protected person's statement and have access to it; and

(2) in any subsequent disclosure by the insurer or insurance support organization of the confidential abuse information that is the subject of disagreement, clearly identify the matter in dispute and provide the protected person's statement along with the confidential abuse information being disclosed; and

(3) furnish the statement to the persons and in the manner specified in 13 NMAC 7.5.15.2 [now Subsection B of 13.7.5.15 NMAC].

E. The rights granted to protected persons in this section shall extend to all persons to the extent confidential abuse information about them is collected and maintained by an insurer or insurance support organization in connection with an insurance action. The rights granted to all persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

[1/1/99; Recompiled 11/30/01]

13.7.5.16 RECORD OF CONFIDENTIAL ABUSE INFORMATION DISCLOSED BY INSURER:

An insurer shall maintain a record of all disclosures of confidential abuse information, except those disclosures permitted by paragraph 4A(3) of the Domestic Abuse Insurance Protection Act, made to any person who is not an employee or agent of the insurer. The record shall include:

A. the name and address or location of the person to whom the information is disclosed; if the information is disclosed to an institution, a contact person shall be named;

B. the date and purpose of the disclosure;

C. a description of the information disclosed;

D. the authorization or release form allowing the disclosure of the information, if required.

[1/1/99; Recompiled 11/30/01]

13.7.5.17 MAINTAINING CONFIDENTIALITY OF LOCATION INFORMATION:

A. **Insurer program required:** Each insurer shall develop by the effective date of this rule a location information confidentiality program to be followed by all persons who have access to the location information of protected persons. The program shall include:

(1) a reasonable procedure by which a protected person can request participation in the insurer's location information confidentiality program;

(2) a system of internal control procedures for maintaining the confidentiality of the location information of a protected person, including provisions for regular internal review; and

(3) procedures to be followed when any action is taken with respect to an application, policy, claim, or other material involving a protected person, including procedures for the designation of a mailing address to be used by the insurer.

B. **Notice to protected person of disclosure of location information:**

(1) If the insurer is required, pursuant to an order of the superintendent or a court of competent jurisdiction or as otherwise required by law, to disclose the location information of a protected person, the insurer shall:

(a) give the protected person notice of receipt of the order within ten (10) days of receipt of the order;

(b) advise the person issuing the order that the protected person's location information is confidential and protected by the Domestic Abuse Insurance Protection Act, Chapter 59A, Article 16B NMSA 1978, and by the Confidential Abuse Information rule, 13 NMAC 7.5 [now 13.7.5 NMAC];

(c) continue to otherwise maintain the confidentiality of the location information.

(2) If the insurer elects to file suit against the person who committed domestic abuse against a protected person, the insurer shall:

(a) give the protected person notice of intent to file suit at least thirty (30) days prior to the date suit is filed;

(b) advise the court in which suit is filed that the protected person's location information is confidential and protected by the Domestic Abuse Insurance Protection Act, Chapter 59A, Article 16B NMSA 1978, and by the Confidential Abuse Information Rule, 13 NMAC 7.5 [now 13.7.5 NMAC];

(c) continue to otherwise maintain the confidentiality of the location information.

C. **Prohibition against disclosure:**

(1) No insurer or insurance support organization may sell or otherwise disclose the location information of a protected person, except as permitted by

paragraph 4A(3) of the Domestic Abuse Insurance Protection Act, without having first obtained the written consent of the protected person.

(2) Written consent is not required if the use or disclosure of the location information of the protected person is internal or to an affiliate of the insurer and the only use of the location information will be in connection with the marketing of insurance products, provided the affiliate agrees not to disclose the location information of the protected person for any other purpose or to unaffiliated persons. With respect to the marketing of insurance products, the protected person must be given an opportunity to indicate that he or she does not want his or her location information used for such marketing purposes and has given no indication that he or she does not want his or her location information used for such purposes.

(3) This prohibition shall not apply to location information disclosed to or utilized by insurance support organizations, including, but not limited to, index, fraud, and medical information bureaus, which assist insurers or insurance support organizations with underwriting, claims settlement, detection or prevention of fraud, or detection or prevention of material misrepresentation or material nondisclosure.

[1/1/99; Recompiled 11/30/01]

CHAPTER 8: INSURANCE POLICIES AND RATES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: RATE FILINGS BY INSURERS AND RATE SERVICE ORGANIZATIONS

13.8.2.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[7-1-97; 13.8.2.1 NMAC - Rn & A, 13 NMAC 8.2.1, 1-15-02; A, 3-1-06]

13.8.2.2 SCOPE:

This rule applies to all rate and rate-related rules filings made on or after the effective date of this rule pursuant to Chapter 59A, Article 17 NMSA 1978, including but not limited to rate filings applicable to risks covered through assigned risk pools and similar residual market plans.

[7-1-97; 13.8.2.2 NMAC - Rn & A, 13 NMAC 8.2.2, 1-15-02; A, 3-1-06]

13.8.2.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-17-2, 59A-17-3, 59A-17-4, 59A-17-5, 59A-17-6.1, 59A-17-6.2, 59A-17-16, 59A-17-17, 59A-17-28, 59A-17-29 and 59A-32-13 NMSA 1978.

[7-1-97; 13.8.2.3 NMAC - Rn & A, 13 NMAC 8.2.3, 1-15-02; A, 3-1-06; A, 10-1-07]

13.8.2.4 DURATION:

Sections 1 through 27 and 29 of 13.8.2 NMAC are permanent. 13.8.2.28 NMAC shall expire on October 1, 2010.

[7-1-97; 13.8.2.4 NMAC - Rn, 13 NMAC 8.2.4, 1-15-02; A, 10-1-07]

13.8.2.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section.

[7-1-97; 13.8.2.5 NMAC - Rn, 13 NMAC 8.2.5, 1-15-02; A, 3-1-06]

13.8.2.6 OBJECTIVE:

The purpose of this rule is to provide standards, procedures, and methods which fairly and appropriately meet the statutory mandates.

[7-1-97; 13.8.2.6 NMAC - Rn, 13 NMAC 8.2.6, 1-15-02]

13.8.2.7 DEFINITIONS:

A. Advisory filing means any filing by a licensed advisory organization within the scope of its license, solely for informational purposes and such limited uses as provided in 13.8.2.20 NMAC. The term includes a rate filing limited to pure premium rates, supplementary rates, and supporting data developed and trended as appropriate.

B. Advisory organization has the meaning given in Section 59A-17-4 NMSA 1978.

C. Credible or **credibility** in connection with statistical data is used in conformance with generally-accepted actuarial standards.

D. Commercial insurance has the meaning given in Section 59A-17-4 NMSA 1978.

E. Expenses include acquisition expenses, field supervision and collection expenses, general expenses, taxes, licenses and fees.

F. Filing means any submission to the superintendent to establish or revise rates.

G. Line of business means a line of business as shown in the annual statement to the superintendent.

H. Pure premium rate means that portion of a rate which represents the loss cost per unit of exposure, and may include loss adjustment expense.

I. Regular business day means every day except Saturday, Sunday and official state government holidays.

J. Regular business hours are 8:00 a.m. to 5:00 p.m., mountain standard or mountain daylight time, whichever is applicable, on regular business days; provided that regular business hours may be shortened on certain days without notice by official action of the governor or the public regulation commission.

K. Supplementary rate information has the meaning given in Section 59A-17-4 NMSA 1978.

L. Supporting data means data and information which justifies, supports, interprets, describes, explains or underlies any rate or supplementary rate information, including but not limited to data the superintendent requires or may require pursuant to this rule.

M. Reference filing as used in 13.8.2 NMAC and in Paragraph C of Section 59A-17-9 NMSA 1978 means a filing by an insurer to adopt a legally effective filing by an advisory organization to which the insurer is a member, a subscriber or an affiliate.

[7-1-97; 13.8.2.7 NMAC - Rn & A, 13 NMAC 8.2.7, 1-15-02; A, 3-1-06; A, 10-1-07]

[See Section 59A-17-4 NMSA 1978 for additional definitions]

13.8.2.8 FILING PROCEDURES:

A. Every filing shall be made by submitting it to the superintendent in accordance with 13.8.2.8 NMAC.

B. Filings shall be made separately from policy form filings.

C. Filings may be made by mail, courier, the national association of insurance commissioners' system for electronic rate and forms filing (SERFF) or in person and shall be addressed to the superintendent.

D. Paper filings shall be submitted in an original and one copy, along with a self-addressed stamped envelope.

E. All filings shall be submitted with the appropriate current completed transmittal documents in substantially the format of the national association of insurance commissioners' uniform transmittal documents, which are available online at www.naic.org.

(1) The *property and casualty transmittal* document shall include:

(a) group name and "NAIC" number;

(b) company name, domicile, "NAIC" number and "FEIN" number;

(c) company tracking number;

(d) contact information of filer or corporate officer, including: name and address; title; telephone numbers; fax numbers and e-mail address;

(e) signature and printed name of authorized filer;

(f) type and sub-type of insurance;

(g) state specific product code, if applicable;

(h) company program title;

(i) filing type;

(j) effective date requested, including: new or renewal;

(k) a statement indicating whether the filing is a reference filing, including the reference organization name and reference organization number and title, if applicable;

(l) company's date of filing;

(m) status of filing in domicile;

(n) company tracking number;

(o) filing description; and

(p) the appropriate filing fees, including check number and fee amount, if applicable.

(2) The *rate/rule filing schedule* document shall include:

(a) company tracking number;

(b) corresponding company tracking number of form filing, if applicable;

(c) a statement indicating whether the filing is for a rate increase or rate decrease or is rate neutral;

(d) a description of the filing method;

(e) a description of the rate change proposed by the company, including: company name, overall indicated change, when applicable, overall percentage rate impact; written premium change for the program; number of policyholders affected for the program; written premium for the program; maximum percentage change and minimum percentage change;

(f) overall percentage of last rate revision;

(g) effective date of last rate revision;

(h) a description of the filing method of the company's last filing; and

(i) a statement of the rule number or page number submitted for review, including whether the filing is new, a replacement or a withdrawal and the previous state filing number.

F. If the filing includes a loss cost multiplier, the filer shall also submit the appropriate current completed national association of insurance commissioners' loss cost transmittal documents which are available online at www.naic.org.

(1) The *lost cost data entry* document shall include:

(a) company tracking number;

(b) name of advisory organization and reference or item filing number if the filing is an adoption of an advisory organization loss cost filing;

(c) company name and "NAIC" number;

(d) product coding matrix for line of business (type of insurance) and line of insurance (sub-type of insurance);

(e) a statement describing coverage, indicated percentage rate level change, requested percentage rate level change, and for loss costs only: expected loss ratio; loss cost modification factor; selected loss cost multiplier; expense constant, if applicable; and company current loss cost multiplier;

(f) a five year rate change history, including: year; policy count; percentage of change; effective date; state earned premium; incurred losses, state loss ratio and countrywide loss ratio;

(g) a statement of selected provisions for expense constants, including: total production expense; general expense; taxes, license and fees; underwriting profit and contingencies; other expenses; and the total of all figures listed;

(h) a statement of whether the company will apply lost cost factors to future filings; and

(i) a statement of the estimated maximum rate increase for any insured.

(2) The *expense constant supplement* document shall include:

(a) company tracking number;

(b) corresponding company tracking number of form filing, if applicable;

(c) a description of development of expected loss ratio;

(d) a statement of selected overall, variable, and fixed provisions for total production expense; general expense; taxes, license and fees; underwriting profit and contingencies; other expenses; and the total of all figures listed;

(e) a statement of the expected loss ratio and the variable expected loss ratio;

(f) a statement of the formula expense constant and the formula variable loss cost multiplier;

(g) a statement of the selected expense constant and the selected variable loss cost multiplier;

(h) an explanation of any differences between Subparagraphs (f) and (g) of Paragraph (2) of Subsection F of 13.8.2.8 NMAC; and

(i) a statement of the rate level change for the coverage to which the *expense constant supplement* document applies.

(3) The *loss cost filing for other than workers' compensation* document shall include:

(a) company tracking number;

(b) corresponding company tracking number of form filing, if applicable;

(c) loss cost reference filing number or a statement that the filing is an independent rate filing;

(d) a statement that:

(i) the insurer files to have its loss cost multipliers and, if utilized, expense constants be applicable to future revisions of the advisory organization's prospective loss costs for this line of insurance; the insurer's rates will be the

combination of the advisory organization's prospective loss costs and the insurer's loss cost multipliers and if utilized, expense constants specified in the attachments; the rates will apply to policies written on or after the effective date of the advisory organization's prospective loss costs; this authorization is effective until disapproved by the commissioner, or until amended or withdrawn by the insurer; or

(ii) the insurer files to have its loss cost multipliers and, if utilized, expense constants be applicable only to the identified advisory organization reference filing;

(e) a statement of the line, sub line, coverage, territory, class or combination thereof to which the *loss cost filing* document applies;

(f) a description of loss cost modification;

(g) if expense constants are utilized, the filer shall attach *expense constant supplement* or other supporting information and shall not include the items listed in Subparagraphs (h) through (l) of Paragraph (3) of Subsection F of 13.8.2.8 NMAC;

(h) a description of development of expected loss ratio, including selected provisions for:

(i) total production expense;

(ii) general expense;

(iii) taxes, licenses and fees;

(iv) underwriting profit and contingencies;

(v) other expense, and

(vi) total of all figures listed;

(i) a statement of expected loss ratio;

(j) a statement of the company formula loss cost multiplier;

(k) a statement of the company selected loss cost multiplier; and

(l) a statement of the rate level change for the coverage(s) to which the *loss cost filing* document applies.

(4) The *loss cost filing for workers' compensation* document shall include:

(a) company tracking number;

(b) corresponding form filing number;

(c) loss cost reference filing number or a statement that the filing is an independent rate filing;

(d) a statement that:

(i) the insurer files to have its loss cost multipliers and, if utilized, expense constants be applicable to future revisions of the advisory organization's prospective loss costs for this line of insurance; the insurer's rates will be the combination of the advisory organization's prospective loss costs and the insurer's loss cost multipliers and if utilized, expense constants specified in the attachments; the rates will apply to policies written on or after the effective date of the advisory organization's prospective loss costs; this authorization is effective until disapproved by the commissioner, or until amended or withdrawn by the insurer; or

(ii) the insurer files to have its loss cost multipliers and, if utilized, expense constants be applicable only to the identified advisory organization reference filing;

(e) applicable class codes;

(f) description of loss cost modification;

(g) if expense constants are utilized, the filer shall attach *expense constant supplement* or other supporting information and shall not include the items listed in Subparagraphs (h) through (o) of Paragraph (4) of Subsection F of 13.8.2.8 NMAC;

(h) a description of development of expected loss and loss adjustment expense ratio, including selected provisions for:

(i) total production expense;

(ii) general expense;

(iii) taxes, licenses and fees;

(iv) underwriting profit and contingencies;

(v) other expenses, and

(vi) total of all figures listed;

(i) a statement of expected loss ratio;

(j) a statement of the overall impact of expense constant and minimum premiums;

(k) a statement of the overall impact of size-of-risk discounts plus expense graduation recognition in retrospective rating;

(l) a statement of the company formula loss cost multiplier;

(m) a statement of the company selected loss cost multiplier;

(n) a statement disclosing whether the filer is amending its minimum premium formula; and

(o) a statement disclosing whether the filer is changing its premium discount schedules.

(5) If a filer desires acknowledgment of receipt, a suitable receipt shall be submitted together with a second self-addressed, stamped envelope. Such receipts are returned as a courtesy and accommodation to the filer. Failure to return a receipt, even though requested in accordance with Paragraph (5) of Subsection A of 13.8.2.8 NMAC, shall not stay, toll, extend or otherwise affect any time period, or limit or otherwise affect any action the superintendent may take.

(6) Filings shall be date stamped as of the date received. Each filing shall be reviewed upon receipt for compliance with procedural requirements. If found to comply, the filing shall be accepted as of the date received. If found not to comply, the filing shall be returned to the filer or the filer shall be otherwise notified.

(7) Filings not received during regular business hours on a regular business day shall be deemed received on the next regular business day.

G. In computing periods of time, the last day shall be counted and the first day shall not be counted. Saturdays, Sundays and holidays shall be counted. If the last day of a time period falls on a day which is not a regular business day, the time period shall be extended to the close of business on the next regular business day.

H. Every filing shall be open to public inspection during regular business hours. A copy of any filing or a designated portion thereof may be obtained by making request to the superintendent and paying the charge he shall prescribe.

I. Any filing may be withdrawn at any time prior to the time it becomes effective. In the interest of efficiency, filers should notify the superintendent of withdrawals at the earliest possible date.

J. Filings subject to prior approval may contain a request to become effective on any specified date on or after their date of filing.

[7-1-97; 13.8.2.8 NMAC - Rn, 13 NMAC 8.2.8, 1-15-02; A, 3-1-06; A, 10-1-07]

13.8.2.9 AMENDING FILINGS:

Any pending filing may be amended, provided that the entire filing, including the amendment, shall be deemed made as of the date the amendment was filed, unless waived by the superintendent.

[7-1-97; 13.8.2.9 NMAC - Rn, 13 NMAC 8.2.9, 1-15-02; A, 3-1-06]

13.8.2.10 FILINGS OF CONFIDENTIAL MATERIAL:

Materials that are required by statute to be kept confidential or that are considered by the filer to be trade secrets shall be filed separately from materials that are required to be open to public inspection.

A. Filings of underwriting guidelines pursuant to Section 59A-17-5.1 NMSA 1978 shall be submitted with the following words in bold uppercase type on the heading of the cover letter: **CONFIDENTIAL UNDERWRITING GUIDELINES.**

B. Filings of materials other than underwriting guidelines or insurance scoring models that the filer considers to be a trade secret shall be submitted with the following words in bold uppercase type on the heading of the cover letter: **REQUESTED CONFIDENTIAL MATERIALS.** The superintendent shall advise the filer within 30 days whether such material shall be open to public inspection. The superintendent shall keep such materials closed from public inspection prior to his determination on their confidentiality.

[7-1-97; 13.8.2.10 NMAC - Rn, 13 NMAC 8.2.10, 1-15-02; A, 3-1-06; A, 10-1-07]

13.8.2.11 NOTIFICATION:

The superintendent shall notify by mail or electronic media the filer and each other party of his approval or disapproval of each filing. Where a filing is disapproved, the superintendent shall state the reasons for disapproval.

[7-1-97; 13.8.2.11 NMAC - Rn, 13 NMAC 8.2.11, 1-15-02; A, 3-1-06]

13.8.2.12 RIGHT TO HEARING:

Any person aggrieved by any action, threatened action or failure to act of the superintendent in connection with a filing has the right to request a hearing pursuant to Section 59A-17-34A NMSA 1978. The superintendent may grant or deny the request.

[7-1-97; 13.8.2.12 NMAC - Rn, 13 NMAC 8.2.12, 1-15-02]

13.8.2.13 REVIEW OF FINAL ORDER:

A. Reconsideration. The filer or any other party aggrieved by the superintendent's final order deciding the issues following a hearing, or refusing to grant a hearing, pursuant to13.8.2.12 NMAC, may, in addition to other remedies provided by law, move for reconsideration, stating in detail the basis therefor. Any motion for reconsideration shall be filed within fifteen days of the superintendent's final order, and is barred thereafter. A motion for reconsideration is an optional remedy, and need not be exhausted as a condition of further administrative appeal.

B. Appeal. The filer or any party aggrieved by the superintendent's final order deciding the issues following hearing, or refusing to grant a hearing, pursuant to 13.8.2.12 NMAC, may request a review by the public regulation commission pursuant to this section.

(1) Following exhaustion of any right to hearing before the superintendent, the filer or any other aggrieved party may request the public regulation commission to review any final order of the superintendent made pursuant to13.8.2.12 NMAC.

(2) Every such request for review shall be made within thirty days after the superintendent's final order, and is barred thereafter; provided, that if a motion for reconsideration is timely filed with the superintendent, a request for review shall be made within thirty days after the date the motion is filed.

(3) The public regulation commission's review shall be on the record before the superintendent, unless the public regulation commission in its discretion deems it necessary or appropriate to supplement the evidence through public hearing or otherwise; provided, that the scope of review shall be limited to the issues raised before the superintendent; and further provided, that the public regulation commission may summarily affirm or reverse the superintendent without hearing.

(4) Every request for review shall state with particularity the grounds upon which review is sought, and shall itemize each alleged error with citations to the applicable portions of the official record. If the transcript of record is not available despite appellant's prompt request therefor, citations shall be filed within ten days after the transcript first becomes available in substantially complete form. In any event, the request for review, with or without record citations must be timely filed within the time period specified in Paragraph (2) of Subsection B of 13.8.2.13 NMAC.

(5) The costs of transcribing the record shall be borne by the appellant.

[7-1-97; 13.8.2.13 NMAC - Rn & A, 13 NMAC 8.2.13, 1-15-02]

13.8.2.14 COMPANY FILINGS:

A. Any insurer may make rates and rate filings on its own behalf in accordance with this section and other applicable portions of this rule.

B. Any insurer may file at any time any rate or supplementary rate information applicable to any line or part of a line of property and casualty insurance business for which the insurer is certificated.

C. Every company filing shall be accompanied by the exhibits required under 13.8.2.17 NMAC.

D. Every company filing, except filings pursuant to 13.8.2.16 NMAC, shall comply with 13.8.2.18 NMAC.

E. The review period for a company filing begins when the filing is received by the superintendent, unless delayed for amendment or lack of sufficient information pursuant to Chapter 59A, Article 17 NMSA 1978 and 13.8.2 NMAC.

F. Except as provided in 13.8.2.25 NMAC, company filings based on an advisory organization advisory loss cost filing may not be used until either the superintendent has notified the advisory organization that the advisory filing is acceptable or the statutory review period has expired with no action, whichever is sooner.

[7-1-97; 13.8.2.14 NMAC - Rn & A, 13 NMAC 8.2.14, 1-15-02; A, 3-1-06; A, 10-1-07]

13.8.2.15 PERMISSIBLE BASES FOR COMPANY FILINGS:

Company filings shall meet all statutory rate standards and take into consideration all applicable rate factors. Subject to the foregoing sentence, an insurer may base a company rate filing on:

A. the insurer's own experience in the particular line of business, including but not limited to premiums, investment income, loss experience and actual expenses;

B. average pure premium rates and supporting data, such as loss experience, developed and trended as appropriate, from an advisory organization advisory filing, together with the insurer's own experience in the particular line of business, including but not limited to premiums, investment income and actual expenses, as provided in 13.8.2.20 NMAC;

C. other company ratemaking methods, for limited markets, as provided in 13.8.2.16 NMAC; or

D. any other method meeting statutory standards which has been submitted to and approved by the superintendent prior to the rate filing.

[7-1-97; 13.8.2.15 NMAC - Rn, 13 NMAC 8.2.15, 1-15-02; A, 10-1-07]

13.8.2.16 OTHER COMPANY FILING METHODS FOR LIMITED MARKETS:

The superintendent may authorize an insurer to make a company rate filing on any basis meeting statutory rate standards, including but not limited to ratemaking by reference to an approved New Mexico filing of another company, or any other appropriate method, where the insurer demonstrates to the superintendent's satisfaction that:

A. the predicted New Mexico premium volume for the line or part of a line of business is so minimal that development of a rate is economically unfeasible; and

B. there is a need or demand for such coverage in New Mexico which will be inadequately or uneconomically served if the filer does not file a rate and make a market in the line or part of a line of business.

[7-1-97; 13.8.2.16 NMAC - Rn, 13 NMAC 8.2.16, 1-15-02]

13.8.2.17 REQUIRED EXHIBITS:

A. Rate filings that require supporting information shall include the following exhibits for each line of business, showing by individual insurer for the three most recently-completed consecutive calendar or calendar-accident years:

(1) actual direct written premiums;

(2) actual direct earned premiums;

(3) actual direct paid losses;

(4) the change in direct loss reserves during the year, including:

(a) reported reserves, based on actual reserves; and

(b) incurred but not reported reserves, based on separate calculations or equivalent to the change in reported reserves;

(5) incurred losses, derived from the foregoing;

(6) underlying data used to calculate any loss development factors and trend factors included in the filing, including but not limited to a description of the basis for and methods used to establish such factors;

(7) actual expenses for each of the following categories:

(a) commissions;

(b) other acquisition expenses;

(c) general expenses; and

(d) taxes, licenses and fees;

(8) investment income from each of the following sources, including method of calculation, allocated to the specific line of business:

(a) unearned premium reserves;

(b) loss reserves, including but not limited to IBNR;

(c) loss adjustment expense reserves;

(d) any contingency reserves; and

(e) surplus held in conjunction with the line of business; and

(9) average credit or debit written in conjunction with any schedule rating plan or similar plan.

B. If not shown in the transmittal documents, the filing shall contain an exhibit which displays the maximum percentage of rate increase that any policyholder may experience as a result of the filing.

[7-1-97; 13.8.2.17 NMAC - Rn, 13 NMAC 8.2.17, 1-15-02; A, 3-1-06; A, 10-1-07]

13.8.2.18 RATEMAKING REQUIREMENTS:

Rate filings are subject to the following ratemaking requirements, in addition to all other requirements prescribed by law.

A. Rate filings may be based on any reasonable base period of at least three recent consecutive calendar, calendar-accident or policy years, or any combination of these, developed and trended as appropriate, unless the Superintendent finds such base to be inadequate or unreliable, in which case he shall specify the base to be used.

B. Expense data shall be derived from insurers' actual New Mexico expenses where available by line. Expenses and expense trending shall reflect actual expenses adjusted for anticipated increases or decreases on a company-by-company or other basis which accurately reflects differences in insurers' modes of operation and expense levels.

C. Rate filings shall reflect investment income allocated to the line or part of a line of New Mexico business. Investment income shall track each insurer's overall investment rate of return, including but not limited to realized capital gains. Investment income shall

include income from each and every source specified in Subsection H of 13.8.2.17 NMAC.

D. Premiums, investment income, loss experience, actual expenses and all other applicable rate factors shall be adjusted to the level anticipated during the period to which the rates will apply.

[7-1-97; 13.8.2.18 NMAC - Rn, 13 NMAC 8.2.18, 1-15-02; A, 3-1-06]

13.8.2.19 RATE MODIFICATION:

A. Filings made to modify rates shall be made pursuant to 13.8.5 NMAC, Rate Modification Plans.

B. If requested by an insured, experience modifiers shall be developed and applied separately and individually to each insured legal entity in New Mexico; provided, that if past experience is unavailable for individual legal entities, and cannot be developed at reasonable cost, such request shall apply on a prospective basis only. Such request shall be made not less than 120 days prior to the proposed effective date of the individual entity rating, and shall remain in effect for at least two full rating periods.

[7-1-97; 13.8.2.19 NMAC - Rn, 13 NMAC 8.2.19, 1-15-02]

13.8.2.20 ADVISORY ORGANIZATION FILINGS:

A. Any licensed advisory organization may make advisory filings within the scope of its license as provided in 13.8.2 NMAC.

B. Advisory filings shall be made for informational purposes and such uses as permitted in 13.8.2 NMAC. Advisory rate filings are limited to pure premium rates, supplementary rate information and supporting data, including loss experience, developed and trended as appropriate. Advisory rate filings shall not contain data on premiums, investment income, expenses, profit factor, dividend allowance permissible loss ratio or other factors or supporting data which could be used to develop a full rate, other than loss experience.

C. The superintendent shall review all advisory filings. The superintendent shall determine if the filing is made by a properly licensed advisory organization within the scope of its license, and if the scope of such filing is limited in accordance with 13.8.2 NMAC, and if not, shall reject the filing. The superintendent shall also consider the rate standards contained in Section 59A-17-6 NMSA 1978 in determining whether advisory filings are acceptable.

D. An insurer may seek the superintendent's permission to base its own independent filing, or portions thereof, on information, data, statistics or pure premium

rates contained in an advisory filing upon making a showing satisfactory to the superintendent that:

(1) the insurer lacks credible loss data of its own on which to base rates;

(2) the insurer's use of a uniform system of statistics, classifications, rating schedules, rating rules, underwriting rules or other similar information makes use of such supplementary rate information from an advisory filing both necessary and appropriate; provided, that Paragraph (2) of Subsection D of 13.8.2.20 NMAC applies only to statistical supplementary rate information, and does not apply to nor permit adoption of any rate, rate manual, minimum premium or policy fee; and

(3) with regard to Paragraph (1) of Subsection D of 13.8.2.20 NMAC, that such use of the advisory filing or portions thereof is appropriate because the loss experience contained in the advisory filing reasonably and accurately applies to the insurer, and will not result in rates which are excessive, inadequate or unfairly discriminatory.

[7-1-97; 13.8.2.20 NMAC - Rn, 13 NMAC 8.2.20, 1-15-02; A, 3-1-06; A, 10-1-07]

13.8.2.21 ASSIGNED RISK POOL FILINGS:

A. For purposes of rate filings, assigned risk plans and similar residual market plans applicable to risks not insurable through the voluntary market shall be considered and treated as if the plan were a single insurer.

B. Rates for assigned risk plans and other residual market plans may be based on:

(1) the plan's own premiums, investment income, loss and expense data, and other statutory factors;

(2) premiums, investment income, loss and expense data, and other statutory factors for all New Mexico risks in the line of business as a whole; provided, that if this option is used, a reasonable, actuarially-justified surcharge may be provided to reflect any demonstrated difference between projected loss and expense experience for the plan and for the line of business as a whole. Such surcharge shall be justified on the basis of comparative loss and expense experience for at least two recent consecutive years; or

(3) any other reasonable method meeting statutory standards and approved by the superintendent.

[7-1-97; 13.8.2.21 NMAC - Rn, 13 NMAC 8.2.21, 1-15-02; A, 3-1-06]

13.8.2.22 RATES FOR GOVERNMENTAL ENTITIES:

Rate filings need not be followed in connection with policies bid or to be issued to state or local governmental entities in New Mexico; provided, that no rate to any such governmental entity shall exceed the filed rate or rates which would be applicable to the entity but for the provisions of 13.8.2 NMAC. 13.8.2 NMAC does not authorize bidding or issuance to governmental entities of lines or types of insurance for which an insurer has not otherwise filed and obtained approval of a rate, nor does it relieve any insurer of any duty to comply with the Insurance Code or laws related to bidding, sale or issuance of insurance to governmental entities.

[7-1-97; 13.8.2.22 NMAC - Rn, 13 NMAC 8.2.22, 1-15-02; A, 3-1-06]

13.8.2.23 ADVISORY ORGANIZATION MEMBERS' RIGHT OF NONADHESION TO FILINGS:

No advisory organization shall require any member or subscriber insurer to adhere to the organization's New Mexico filings, whether made on behalf of the insurer or otherwise. No advisory organization shall in any manner limit or refuse to grant any insurer any right or privilege, including but not limited to full membership rights granted other insurers, or otherwise discriminate against any insurer, on the basis that the insurer has not adhered to or does not adhere to the organization's filings.

[7-1-97; 13.8.2.23 NMAC - Rn, 13 NMAC 8.2.23, 1-15-02; A, 10-1-07]

13.8.2.24 STATISTICAL SERVICES; INFORMATION:

The superintendent may require insurers to provide statistical information in a standard format. The superintendent may designate an advisory organization to receive such information and tabulate it. The superintendent may act pursuant to this section by notifying affected insurers in writing.

[7-1-97; 13.8.2.24 NMAC - Rn, 13 NMAC 8.2.24, 1-15-02; A, 10-1-07]

13.8.2.25 WORKERS COMPENSATION REFERENCE FILINGS:

An insurer that wishes to adopt an approved advisory workers compensation filing that has been filed on its behalf by the workers compensation advisory organization designated by the superintendent, with no deviation other than effective date, shall do so in accordance with Paragraph C of Section 59A-17-9 NMSA 1978.

[7-1-97; 13.8.2.25 NMAC, Rn, 13 NMAC 8.2.25, 1-15-02; Repealed, 3-1-06 - Rn, 13.8.2.26 NMAC & A, 3-1-06; A, 10-1-07]

13.8.2.26 AUTOMATIC ADOPTION OF ADVISORY LOSS COST FILINGS:

An insurer may satisfy its obligation to make a rate filing by authorizing the superintendent of insurance to have its loss cost multipliers and, if utilized, expense

constants be applicable to future revisions of the advisory organization's advisory prospective loss costs. However, an insurer that proposes to revise its loss cost multipliers, or deviate from the effective date or any other component of the advisory organization loss cost filing, or which fails to file with the superintendent of insurance to accept future advisory prospective loss cost filings of the specified advisory organization, must submit a filing in accordance with the provisions of 13.8.2 NMAC.

[13.8.2.26 NMAC - N, 10-1-07]

13.8.2.27 MAINTENANCE OF RATE INFORMATION:

Regardless of whether an insurer is required to file its rates with the superintendent, an insurer shall maintain a copy of its rates and supplementary rate information currently in effect in sufficient detail to produce the premium charged on a policy. This information shall be available for immediate inspection by the superintendent.

[13.8.2.27 NMAC - N, 10-1-07]

13.8.2.28 NONCOMPETITIVE MARKETS:

A. The following markets lack a reasonable degree of competition and are therefore subject to the filing and prior approval requirements of Paragraph B of Section 59A-17-9 NMSA 1978:

(1) farmowners multiple peril, due to the concentration of market share within a relatively small number of competitors as well as the increasing dominance of its largest writer;

(2) medical professional liability, due to its concentration of market share among relatively few competitors as well as the increasing dominance in recent years of its largest writer;

(3) credit, due to its concentration of market share among relatively few competitors; or

(4) mortgage guaranty, due to the dominance of market share maintained by two competitors, the infrequent entry and exit of competitors, and the relatively low number of competitors for the market's premium volume.

B. The determination of noncompetitive markets in Subsection A of 13.8.2.28 NMAC shall expire on October 1, 2010.

[13.8.2.28 NMAC - N, 10-1-07]

13.8.2.29 REVERSE COMPETITIVE MARKETS:

The following factors are likely indicators of a reverse competitive market:

A. insurance products sold or solicited in point-of-sale conjunction with purchases of consumer goods;

B. insurance products sold or solicited by individuals other than professional insurance agents;

C. products that insurers market primarily to parties other than prospective policyholders or to the parties that will pay the premium;

D. low loss ratios; or

E. high commission ratios.

[13.8.2.29 NMAC - N, 10-1-07]

PART 3: CASUALTY, PROPERTY, TITLE AND VEHICLE INSURANCE POLICY FORMS

13.8.3.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[7-1-97; 13.8.3.1 NMAC - Rn & A, 13 NMAC 8.3.1, 3-1-06]

13.8.3.2 SCOPE:

This rule applies to policies of all property, casualty, vehicle, marine and transportation, surety and title insurance coverages that are within the scope of Chapter 59A, Article 18 NMSA 1978.

[6-3-70; 13.8.3.2 NMAC - Rn & A, 13 NMAC 8.3.2, 3-1-06]

[See Section 59A-18-2 NMSA 1978 for the definition of policy and Chapter 59A, Article 7 NMSA 1978 for definitions of kinds of insurance.]

13.8.3.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-17-6.1, 59A-17-6.2, 59A-18-12 and 59A-18-14 NMSA 1978.

[7-1-97; 13.8.3.3 NMAC - Rn & A, 13 NMAC 8.3.3, 3-1-06; A, 10-1-07]

13.8.3.4 DURATION:

Permanent.

[7-1-97; 13.8.3.4 NMAC - Rn, 13 NMAC 8.3.4, 3-1-06]

13.8.3.5 EFFECTIVE DATE:

June 3, 1970, unless a later date is cited at the end of a section.

[7-1-97; 13.8.3.5 NMAC - Rn & A, 13 NMAC 8.3.5, 3-1-06]

13.8.3.6 OBJECTIVE:

The purpose of this rule is to implement Sections 59A-18-12 and 59A-18-14 NMSA 1978 by specifying the requirements for property, casualty, vehicle, marine and transportation, surety and title insurance policy forms.

[7-1-97; 13.8.3.6 NMAC - Rn & A, 13 NMAC 8.3.6, 3-1-06]

13.8.3.7 DEFINITIONS:

A. "Commercial insurance has the meaning given in Section 59A-17-4 NMSA 1978; and

B. "Reference filing" means a filing by an insurer to adopt a legally effective filing by an adivsory organization to which the insurer is amember, a subscriber or an affiliate.

[7-1-97; 13.8.3.7 NMAC - Rn & A, 13 NMAC 8.3.7, 3-1-06; A, 10-1-07]

13.8.3.8 GENERAL FILINGS:

A. Every insurer, advisory organization, FAIR plan, pool, or joint underwriting and joint reinsurance group, association or other organization of insurers must file with the superintendent of insurance every form of policy, endorsement, rider involving the granting or exclusion of coverage, or application which becomes a part of the policy, of casualty, fire, marine and transportation, wet marine, title and vehicle insurance.

B. An insurer may satisfy its obligation to make a policy form filing by becoming a member of or subscriber to, a licensed advisory organization which makes policy form, endorsement, rider or application filings and by authorizing the superintendent of insurance to accept these filings on its behalf.

C. Filings not subject to the limited exemption from prior approval in 13.8.3.9 NMAC may contain a request to become effective on any specified date on or after their date of filing.

[6-3-70; 7-1-97; 13.8.3.8 NMAC - Rn, 13 NMAC 8.3.8, 3-1-06; A, 10-1-07]

13.8.3.9 LIMITED EXEMPTION FROM PRIOR APPROVAL:

A. A commercial insurance filing shall become effective and may be used upon filing and shall be exempt from the requirement that the filing shall be made at least sixty days before its proposed effective date and from the prior approval requirements of Section 59A-18-12 NMSA 1978 if the filing is not:

(1) for workers compensation insurance, an advisory organization filing or a company filing that deviates, in any manner other than effective date, from an approved workers compensation advisory organization filing;

(2) for medical professional liability insurance;

(3) for a market that is noncompetitive pursuant to 13.8.2.28 NMAC;

(4) a market that is reverse competitive;

(5) an assigned risk filing;

(6) for title insurance;

(7) for farm owner's insurance; or

(8) for ranch owner's insurance.

B. Filings that qualify for the limited exemption provided by Subsection A of 13.8.3.9 NMAC shall be subject to all other requirements of 13.8.3 NMAC and Chapter 59A, Article 18 NMSA 1978.

C. The filing and use of forms that do not comply with or that violate provisions of the Insurance Code or administrative rules shall be subject to the administrative penalties stated in the Insurance Code, including Section 59A-1-18 NMSA 1978.

[7-1-97; 13.8.3.9 NMAC - Rn & A, 13 NMAC 8.3.9, 3-1-06; A, 10-1-07]

13.8.3.10 FILING REQUIREMENTS:

A. Separate filing: Form filings shall be made separately from rate or rate-related rule filings. Filings may be made by mail, courier, the national association of insurance commissioner's system for electronic rate and forms filing (SERFF) or in person and shall be addressed to the superintendent.

B. Transmittal documents: All form filings shall be submitted with completed transmittal documents in substantially the format of the appropriate current national association of insurance commissioners' uniform transmittal documents which are available online at www.naic.org.

(1) The *property and casualty transmittal* document shall include:

(a) group name and "NAIC" number;

(b) company name, domicile, "NAIC" number and "FEIN" number;

(c) company tracking number;

(d) contact information of filer or corporate officer, including: name and address; title; telephone numbers; fax numbers and e-mail address;

(e) signature and printed name of authorized filer;

(f) type and sub-type of insurance;

(g) state specific product code, if applicable;

(h) company program title;

(i) filing type;

(j) effective date requested, including: new or renewal;

(k) a statement indicating whether the filing is a reference filing, including the reference organization name and reference organization number and title, if applicable;

(l) company's date of filing;

(m) status of filing in domicile;

(n) company tracking number;

(o) filing description; and

(p) the appropriate filing fees, including check number and fee amount, if applicable.

(2) The *form filing schedule* document shall include:

(a) company tracking number;

(b) corresponding company tracking number of rate or rule filing, if applicable; and

(c) a description of the filing, including:

(i) form name, description and synopsis;

(ii) form number, including edition date;

(iii) a statement whether the filing is new, a replacement or a withdrawal;

(iv) if the filing is a replacement, the form number it replaces; and

(v) the previous state filing number.

C. Number of copies: The filer shall prepare the letter for transmission in duplicate. A stamped, self-addressed envelope must be included. The insurance division shall retain one copy and return the other to the filer with indication of the action taken by the division.

D. Name and address: The name and address of the insurer making the filing shall be clearly indicated. If group insurer stationery is used, the filer must identify the insurer or insurers for whom the filing is intended to be made.

E. Description: The filer shall give a description of the policy forms, endorsements, riders or applications being filed, identifying specifically the policy form affected and indicating whether it is a new policy form or supersedes current policy form filings, specifically describing the changes, including whether any of the changes include limitations, reductions or restrictions in coverages. This description may be given generally by reference to the title of the policy form, if any, enclosed with the filing.

F. Effective date: The filer shall state in the letter the date that the insurer proposes the form to become effective.

[6-3-70; 7-1-97; 13.8.3.10 NMAC - Rn & A, 13 NMAC 8.3.10, 3-1-06]

13.8.3.11 REQUIRED CONTENTS OF POLICIES:

No policy forms shall be filed, delivered or issued for delivery in this state unless:

A. a statement of the premium or if the insurance is of a character where the exact premium is not determinable at inception of the contract, a statement of the basis and rates upon which the premium is to be determined and paid, is expressed therein;

B. the time the insurance takes effect and terminates, if determinable, is expressed therein;

C. it purports to express therein the person or persons insured;

D. every printed portion of the text matter and any endorsement or attached paper is printed in readable and legible type;

E. the exclusions, conditions and limitations of indemnities are adequately captioned or clearly set forth in the policy or contract; and

F. every form, including riders and endorsements, is identified by a form designation, provided however, that in order that policy forms, endorsements, riders or applications which follow the standard provisions filed by a rating organization will be readily recognized as standard forms, all these forms printed for use in New Mexico shall bear a recognition designation given the standard form by the rating organization. Insurers are not precluded from also adding their own designation.

[6-3-70; 7-1-97; 13.8.3.11 NMAC - Rn, 13 NMAC 8.3.11, 3-1-06]

13.8.3.12 POLICY FORM RESTRICTION:

Insurers shall not require their New Mexico insureds or applicants for insurance to make a "warranty" either expressed or implied, of any fact or allegation in the application for an insurance policy. This does not prohibit the use of the word "representations" or words of similar import and does not prohibit the use of the word "warranty" if the application contains a definition of "warranty" in which the language used is clear, understandable and accurate.

[6-3-70; 7-1-97; 13.8.3.12 NMAC - Rn, 13 NMAC 8.3.12, 3-1-06]

13.8.3.13 INSURERS AFFILIATED WITH ADVISORY ORGANIZATIONS:

All insurers affiliated with advisory organizations shall adhere to the following procedures.

A. An insurer newly affiliated with an advisory organization will be presumed to be using the forms filed by the advisory organization from the effective date of membership or subscribership or affiliation.

B. An insurer retiring from membership or subscribership or affiliation with an advisory organization will immediately upon retirement be presumed to meet the filing requirements of policy forms as provided in 13.8.3.8 NMAC.

[6-3-70; 7-1-97; 13.8.3.13 NMAC - Rn, 13 NMAC 8.3.13, 3-1-06; A, 10-1-07]

13.8.3.14 AMENDING FILINGS:

Any pending filing may be amended, provided that the entire filing, including the amendment, shall be deemed made as of the date the amendment was filed, unless waived by the superintendent.

[13.8.3.14 NMAC - N, 10-1-07]

13.8.3.15 AUTOMATIC ADOPTION OF ADVISORY ORGANIZATION FORM FILINGS:

An insurer may satisfy its obligation to make a form filing by authorizing the superintendent of insurance to adopt on its behalf all form filings legally in effect that have been filed by an advisory organization to which the insurer is a member or a subscriber or an affiliate. However, an insurer that proposes to use a form or to deviate from the effective date or any other componenet of the advisory organization from filing, or which fails to file with the superintendent of insurance to accept future form filings of the specified advisory organization, must submit a filing in accordance with the provisions of 13.8.3 NMAC.

[13.8.3.15 NMAC - N, 10-1-07]

PART 4: CANCELLATION, NONRENEWAL OR CHANGE IN COVERAGES OF PROPERTY AND CASUALTY INSURANCE POLICIES

13.8.4.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[7/1/97; 13.8.4.1 NMAC - Rn & A, 13 NMAC 8.4.1, 12/31/07]

13.8.4.2 SCOPE:

This rule applies to all insurers who cancel, change, or fail to renew, coverage in any policy of property and casualty insurance.

[7/1/97; 13.8.4.2 NMAC - Rn, 13 NMAC 8.4.2, 12/31/07]

13.8.4.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-18-29 NMSA 1978.

[7/1/97; 13.8.4.3 NMAC - Rn, 13 NMAC 8.4.3, 12/31/07]

13.8.4.4 DURATION:

Permanent.

[7/1/97; 13.8.4.4 NMAC - Rn, 13 NMAC 8.4.4, 12/31/07]

13.8.4.5 EFFECTIVE DATE:

February 1, 1980, unless a later date is cited at the end of a section.

[7/1/97; 13.8.4.5 NMAC - Rn & A, 13 NMAC 8.4.5, 12/31/07]

13.8.4.6 OBJECTIVE:

The purpose of this rule is to implement Section 59A-18-29 NMSA 1978 by establishing minimum requirements for the cancellation, non-renewal or changes in coverage on all policies of property or casualty insurance issued by an insurer to an insured.

[2/1/80, 7/1/97; 13.8.4.6 NMAC - Rn, 13 NMAC 8.4.6, 12/31/07]

13.8.4.7 DEFINITIONS:

The following words and terms shall have the following meanings unless the context otherwise requires:

A. "agent" means any person licensed by the superintendent to transact the insurer's business in this state;

B. "casualty insurance" has the meaning given in Section 59A-7-6 NMSA 1978;

C. "insurance binder" means any undertaking by an insurer, or its agent, to issue a policy of insurance to the insured;

D. "insured" means any person who has been issued a policy of insurance or insurance binder by an insurer;

E. "insurer" means any insurance company authorized to transact property and casualty insurance in this state, and any non-admitted insurance company providing property and casualty policies of insurance through a surplus line broker in this state;

F. "mail or mailing" means the deposit of a written notice to the insured in the U.S. mails, first-class postage prepaid, addressed to the insured at his last known address;

G. "marine and transporation insurance" has the meaning given in Section 59A-7-5 NMSA 1978;

H. "personal insurance" has the meaning given in Section 59A-17A-3 NMSA 1978;

I. "policy or policy of insurance" has the meaning given in Section 59A-18-2 NMSA 1978;

J. "policy term" means the stated time during which a policy is effective;

K. "property and casualty insurance", as used in this rule, includes property, casualty, vehicle, marine and transportation, wet marine and surety insurance;

L. "property insurance" has the meaning given in Section 59A-7-4 NMSA 1978;

M. "surety insurance" has the meaning given in Section 59A-7-8 NMSA 1978;

N. "vehicle insurance" has the meaning given in Section 59A-7-7 NMSA 1978; and

O. "wet marine insurance" has the meaning given in Section 59A-7-5 NMSA 1978;

[2/1/80, 7/1/97; 13.8.4.7 NMAC - Rn & A, 13 NMAC 8.4.7, 12/31/07]

13.8.4.8 CANCELLATION DURING POLICY TERM - MORE THAN SIXTY (60) DAYS AFTER EFFECTIVE DATE OF POLICY:

A. If a policy of insurance has been in effect for sixty (60) days or more, an insurer may cancel the policy if there has been a substantial change in the risk assumed by the insurer since the policy was issued. An insurer, to affect such cancellation, shall mail or deliver to the insured a written notice stating the reason for such cancellation and stating when, not less than thirty (30) days after mailing or delivery, the cancellation shall be effective.

B. If a policy of insurance has been in effect for sixty (60) days or more, an insurer may cancel the policy only for one or more of the following reasons:

(1) the policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the insurer;

(2) willful and negligent acts or omission by the insured have substantially increased the hazards insured against;

(3) revocation or suspension of driver's license of the named insured or other operator who either resides in the same household or customarily operates the vehicle; or

(4) the named insured presented a claim based on fraud or material misrepresentation.

C. An insurer, to affect such cancellation, shall mail or deliver to the insured a written notice stating the reason for such cancellation and stating when, not less than fifteen (15) days after the mailing or delivery, the cancellation shall be effective. Provided, however, an insurer may eliminate the reason for such cancellation from any notice mailed to an additional insured or lienholder under the policy.

[2/1/80, 7/1/97; 13.8.4.8 NMAC - Rn, 13 NMAC 8.4.8, 12/31/07]

13.8.4.9 NON-RENEWAL OF POLICIES:

If an insurer or an agent elects not to renew a policy of insurance, the insurer or agent making such election shall mail to the insured, not less than thirty (30) days prior to the expiration date of the policy, a written notice of non-renewal. This section shall not apply to the transfer of a policy upon its expiration to an affiliated insurer.

[2/1/80, 7/1/97; 13.8.4.9 NMAC - Rn & A, 13 NMAC 8.4.9, 12/31/07]

13.8.4.10 NOTICE OF CHANGE IN LIMITS:

Written notice of any change in the required limits of underlying coverage for an "umbrella" or "excess liability" policy shall be mailed or delivered to the insured not less than thirty (30) days prior to the expiration date of the affected policy.

[2/1/80, 7/1/97; 13.8.4.10 NMAC - Rn, 13 NMAC 8.4.10, 12/31/07]

13.8.4.11 CHANGE IN POLICY FORM:

An insurer shall provide written notice to its agents or its insureds of any change in policy form not less than thirty (30) days prior to the effective date of the change. Change in policy form means any change of limitation, restriction in coverage, or change in deductible.

[2/1/80, 7/1/97; 13.8.4.11 NMAC - Rn, 13 NMAC 8.4.11, 12/31/07]

13.8.4.12 NOTICE OF CHANGE IN INSURER:

If an insurer, upon expiration of a policy of insurance, transfers the policy to an affiliated insurer, the following notification requirements shall apply.

A. For personal insurance policies, the transferring insurer shall send the insured a written notice of change of insurer. Such notice shall be mailed to the insured not less than thirty (30) days prior to the expiration date of the policy and shall include the name and contact information of the insurer accepting the transferred policy, the reason for the transfer, the dollar amount of any increase or decrease in premium resulting from the transfer and any restrictions or changes in coverage terms or provisions resulting from the transfer.

B. For other than personal insurance policies, the transferring insurer shall provide written notice of change of insurer to the agent or the insured prior to the expiration date of the policy and shall include the name and contact information of the insurer accepting the transferred policy and the reason for the transfer.

[13.8.4.12 NMAC - N, 12/31/07]

PART 5: RATE MODIFICATION PLANS

13.8.5.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, P.O. Box 1269, Santa Fe, New Mexico, 87504-1269.

[2/1/95; Recompiled 11/30/01]

13.8.5.2 SCOPE:

A. This rule applies to authorized property and casualty insurers and rate service organizations that file rates, loss costs or supplementary information with the department.

B. This rule applies only to those classes of insurance (monoline or packaged) commonly known as commercial vehicle, commercial general liability, professional liability, commercial property, worker's compensation and contract surety bonds.

C. This rule does not apply to boiler and machinery insurance.

[4/1/97; Recompiled 11/30/01]

13.8.5.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-3-6, 59A-17-5, 59A-17-16, 59A-17-17, 59A-17-28, 59A-17-29 and 59A-32-13 NMSA 1978.

[2/1/95; Recompiled 11/30/01]

13.8.5.4 DURATION:

Permanent.

[4/1/97; Recompiled 11/30/01]

13.8.5.5 EFFECTIVE DATE:

February 1, 1995, unless a later date is cited at the end of a section or paragraph. Reformatted in NMAC format effective April 1, 1997.

[2/1/95, 4/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.8.5.6 OBJECTIVE:

The purpose of this rule is to establish criteria for the modification of manual rates through the application of insurer rate modification plans and experience rating plans and the reporting of pertinent information concerning the utilization of such plans in order to determine whether rates developed thereunder meet the standards of the rating law. Such information may also be utilized to assist in monitoring competition in accordance with Section 59A-17-3(A)(2) NMSA 1978.

[2/1/95; Recompiled 11/30/01]

13.8.5.7 DEFINITIONS:

A. **"Consent to rate"** means a deviation from the manual rate agreed to by both the insured and insurer.

B. **"Experience rating plan"** means any rating plan or system whereby a manual rate for insurance is adjusted or modified based on the past loss experience of the insured.

C. **"Manual rate"** means a rate, whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit and variations based on loss or expense considerations, designed to apply on a generic basis to similar risks within the same market, filed by an insurer or rate service organization with the department, approved by the superintendent, and made part of the rating manual used by an insurer or rate service organization.

D. **"Rate modification plan"** means a rating plan or procedure, exclusive of experience rating, which provides a listing of various risk characteristics or conditions and a range of modification factors which may be applied for those characteristics or conditions to the manual rate of a particular insurance risk. The effect of the modification factor is to increase (debit) or decrease (credit) the manual rate. Rate modification plans include, but are not limited to, plans commonly referred to as schedule rating plans and individual risk premium modification plans.

[2/1/95; Recompiled 11/30/01]

13.8.5.8 STANDARDS FOR RATE MODIFICATION PLANS:

Rate modification plans shall comply with the following standards:

A. Rate modification plans may only be used to acknowledge variance in risk or expense characteristics.

B. Rate modification plans may be based only on rating characteristics not already reflected in the manual rates or experience rating plan. Rate modification plans must clearly indicate the objective criteria to be used.

C. Individual underwriting files must contain specific criteria and document particular circumstances of the risk in support of each debit or credit. Such documentation must be maintained in the file to enable the superintendent to verify compliance with this rule. Documentation may include, but is not limited to inspection reports, photographs, agent observations and findings, insured formal safety plans, premises evaluations and narrative reports covering other aspects of the risk. Expenses such as reduced commissions may be considered but must be documented in the underwriting file.

D. Any rate modification plan designed to be applied simultaneously to property, liability, or vehicle coverage shall contain reasonable factors that give appropriate recognition to the distinct exposures involved in such coverage.

E. Once a rate modification plan has been filed and approved, its use by the insurer is mandatory. The rate modification plan must be applied uniformly in a non-discriminatory manner for all eligible classes of risk even if the application of the rate modification plan results in a "1.0" modification or no change in a previous modification applied.

F. The application of any rate modification plan shall not result in debits or credits that exceed 25 percent for the commercial vehicle, commercial general liability and commercial property lines of business. The application of any rate modification plan shall not result in debits or credits that exceed 15 percent for the workers' compensation line of business. Modifications generated by loss experience or company expense experience are not subject to this limitation. Professional liability, contract surety bonds, and directors and officers liability are not subject to this limitation.

G. Once a rate modification plan has been applied to a risk and a credit or debit established, no changes in the credit or debit can be made without appropriate justification and documentation.

H. Any rate modification plan must provide that an applicant will be notified in writing by the insurer at the issuance of a new policy of the factors and resulting amounts which resulted in the rating modification, whether a debit or credit, so that, among other things, the applicant will be fairly apprised of any corrective action that might be appropriate with respect to the insurance risk. The insured must also be notified in writing by the insurer at the issuance of a renewal policy of either the removal of credits or the addition of debits in the rating modification and the reasons therefor.

[2/1/95, 4/1/97; Recompiled 11/30/01]

13.8.5.9 CONSENT TO RATE:

A. Upon written application of an insured stating the reasons therefor, filed with the superintendent on a form to be prescribed by the superintendent, and upon approval of the application by the superintendent, an insurer may charge a rate in excess of that otherwise applicable to a specific risk.

B. The insurer shall pay the filing fees specified in Section 59A-6-1 NMSA 1978.

[2/1/95; Recompiled 11/30/01]

13.8.5.10 EXPERIENCE RATING PLANS:

Experience rating plans shall comply with the following standards:

A. Premium and loss figures used in the calculation of experience rating plan rates must be verifiable and justifiable. Loss figures shall fairly reflect the expected value of salvage, subrogation, subsequent injury fund recoveries and other recoveries, whether paid or unpaid.

B. Underwriting files must document the basis of the experience rating in sufficient detail so that the superintendent can verify compliance with this rule.

C. Once an insurer or rate service organization has filed an experience rating plan, its use is mandatory. The experience rating plan must be applied uniformly in a non-discriminatory manner for all eligible classes of risk even if the application of the experience rating plan results in a "1.0" experience modification or no change in a previously applied experience modification.

D. An experience rating plan must provide that an applicant will be notified in writing by the insurer at the issuance of a new policy of the experience rating modification, whether a debit or credit. The insured must also be notified in writing by the insurer at the issuance of a renewal policy of any changes in the experience rating modification. In the case of contingent, temporary, or provisional experience rating modifications, notice should be provided within 30 days of modification to premium.

[2/1/95, 4/1/97; Recompiled 11/30/01]

13.8.5.11 REPORTING PERTINENT INFORMATION:

A. At the request of the superintendent, an insurer authorized to write any insurance in this state to which this rule applies shall submit data to the superintendent establishing the relationship of aggregated premiums actually charged to policyholders by the insurer for each line of commercial insurance to the aggregate premium that would have been produced by the insurers' filed unmodified rates for that line of commercial insurance. A rate service organization may file the data on behalf of the insurer.

B. The rate modification plan filed by the national council of compensation insurance shall be for workers' compensation insurance. The national council of compensation insurance shall perform an independent audit of insurer records to verify accurate recording at the policy level and tabulation of total debits and credits. The national council of compensation insurance shall annually submit data to the superintendent establishing the relationship of aggregated premiums actually charged to policyholders by insurers for workers' compensation insurance to the aggregate premium that would have been produced by the insurers' filed unmodified rates.

[2/1/95; Recompiled 11/30/01]

13.8.5.12 RATE COMPLIANCE EXAMINATIONS:

To determine compliance with this rule, the superintendent may order a rate compliance examination be made of any insurer to which this rule applies.

[2/1/95; Recompiled 11/30/01]

13.8.5.13 PENALTIES:

Any insurer that fails to comply with the provisions of this rule shall be subject to the penalties or sanctions provided in the Insurance Code.

[2/1/95; Recompiled 11/30/01]

13.8.5.14 TRANSITION:

A. Any new insurance program to which this rule is applicable, instituted on or after the effective date of this rule, must meet all requirements of this rule.

B. Insurers must use only filed and approved programs. Insurers currently offering insurance programs to which this rule is applicable shall file revised rate modification plans, experience rating plans, and revised base rates to minimize the impact on policyholders, if necessary, to meet the requirements of this rule. Workers' compensation filings should be made at least 90 days in advance of the effective date of this rule. All other applicable insurance programs should be filed at least 60 days in advance of the effective date of this rule.

[2/1/95, 4/1/97; Recompiled 11/30/01]

PART 6: PERSONAL INSURANCE CREDIT INFORMATION

13.8.6.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[13.8.6.1 NMAC - N, 1/1/06]

13.8.6.2 SCOPE:

This rule applies to personal insurance written by an insurer or a group of affiliated insurers authorized to do business in New Mexico or written pursuant to the FAIR Plan Act, but does not apply to commercial insurance or any other types of insurance.

[13.8.6.2 NMAC - N, 1/1/06]

13.8.6.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978 and the Personal Insurance Credit Information Act, Chapter 59A, Article 17A NMSA 1978 (being Laws 2005, Chapter 275).

[13.8.6.3 NMAC - N, 1/1/06]

13.8.6.4 DURATION:

Permanent.

[13.8.6.4 NMAC - N, 1/1/06]

13.8.6.5 EFFECTIVE DATE:

January 1, 2006, unless a later date is cited at the end of a section.

[13.8.6.5 NMAC - N, 1/1/06]

13.8.6.6 OBJECTIVE:

The purpose of this rule is to implement portions of the Personal Insurance Credit Information Act, Chapter 59A, Article 17A NMSA 1978 (being Laws 2005, Chapter 275).

[13.8.6.6 NMAC - N, 1/1/06]

13.8.6.7 DEFINITIONS:

[RESERVED]

13.8.6.8 ADVERSE ACTION NOTIFICATION:

A. The notification to consumers required by 59A-17A-8 NMSA 1978 and 13.8.6 NMAC shall be in one document, shall address the consumer by name and shall, in addition to the information described in Subsections A and B of 59A-17A-8 NMSA 1978, provide the consumer with the following information:

(1) the name, address, and telephone number of the consumer reporting agency or third party vendor that provided the information and how the consumer can obtain a free copy of his credit report from that entity;

(2) the insurer, and not the consumer reporting agency or third party vendor, made the decision regarding insurance and the consumer reporting agency or third party vendor cannot provide the consumer with the reasons for the adverse action;

(3) if the consumer finds inaccurate or incomplete information in his credit report and so notifies the consumer reporting agency or third party vendor, the consumer reporting agency is required to investigate and correct any information that it determines is inaccurate or incomplete, or concerning which the accuracy can no longer be verified;

(4) if the consumer reporting agency corrects any information in the credit report, the consumer must instruct the consumer reporting agency to notify the insurer in order for the insurer to know of this correction;

(5) how the consumer can obtain an annual free copy of his credit report from each of the major national consumer reporting agencies, under federal law; and

(6) the life circumstances considered by the insurer in its extraordinary life circumstances exception policy are those that have occurred within three years of the date of application for or renewal of personal insurance coverage and include the following:

(a) an acute or chronic medical condition, illness, injury or disease;

(b) divorce;

(c) death of a spouse, child or parent;

(d) involuntary loss of employment for more than three consecutive months;

(e) identity theft; or

(f) total or other loss that makes a home uninhabitable.

B. An insurer may provide the following language in the notice to comply with the requirements of Subsection A of 13.8.6.8 NMAC. A sample form of notice is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance", then "property and casualty".

(1) Dear (*name of consumer*):

(2) We have (*describe the specific adverse action taken by using one of the following:*

(a) *"given you less than our best rates",*

(b) *"declined to renew your policy",*

(c) *"declined to offer you a policy",*

(d) *"canceled your policy", or*

(e) *"restricted the coverage that we will provide you"*) due in part to your credit information.

(3) The most important (insert the words "credit-related" if applicable) factors that negatively affected your insurance score are:

(a) (*list the most important factor*);

(b) (*list the second most important factor, if applicable*);

(c) (*list the third most important factor, if applicable*); and

(d) (*list the fourth most important factor, if applicable*).

(4) Your credit information was obtained from (*name the consumer reporting agency*) consumer credit reporting agency. You have a right to a free copy of your consumer credit report by contacting them at (*list their toll-free number*) or at (*list their mail address*) within 60 days. Please note that (*name the consumer reporting agency*) cannot provide you with the reasons for our decision regarding insurance with us.

(5) If you dispute information in your report, contact (*name the consumer reporting agency*). (*Name the consumer reporting agency*) is required to investigate your dispute and get back to you in less than 60 days. If they find that the information is inaccurate, incomplete or can't be verified, they are required to promptly correct your report.

(6) While some errors may have a noticeable impact on our decision regarding your insurance or on your premium, other errors may not. (*Name the consumer reporting agency*) might not alert us to the error correction unless you tell them to do so. You should also notify us once your report has been corrected.

(7) If you correct errors with one reporting agency it may not fix those errors with other reporting agencies. Therefore you may wish to check your consumer credit report from each of the major national reporting agencies.

(8) Once a year you can get a free copy of your report from each of the major reporting agencies by calling (*list toll-free phone number*), by visiting (*list website*), or by writing to (*list mailing address*).

(9) If your credit information has been adversely impacted by an extraordinary life circumstance that has occurred within the last 3 years, you may request in writing that we consider this when using your credit information. These extraordinary life circumstances include:

(a) an acute or chronic medical condition, illness, injury or disease;

(b) divorce;

(c) death of a spouse, child or parent;

(d) involuntary loss of employment for more than three consecutive months;

(e) identity theft; or

(f) total or other loss that makes your home uninhabitable.

(10) If you believe any of these applies to you and has impacted your credit, please contact (*use one of the following: "us", "your insurance agent", "us or your insurance agent"*). We may require you to provide reasonable documentation of this circumstance and explain how it has negatively affected your credit.

[13.8.6.8 NMAC - N, 1/1/06]

13.8.6.9 INSURANCE SCORING FILINGS:

Insurers shall include in the heading of the cover letter for filings made pursuant to 59A-17A-9 NMSA 1978 the following words in bold uppercase type: **CONFIDENTIAL INSURANCE SCORING FILING**.

[13.8.6.9 NMAC - N, 1/1/06]

PART 7: NOTIFICATION REQUIREMENT OF DISCONTINUATION OF INSURANCE PRODUCT

13.8.7.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance.

[13.8.7.1 NMAC – N/E, 2/1/2024

13.8.7.2 SCOPE:

This emergency rule applies to all property and casualty insurers who discontinue an insurance product.

[13.8.7.2 NMAC – N/E, 2/1/2024]

13.8.7.3 STATUTORY AUTHORITY:

Sections 59A-2-9 NMSA 1978.

[13.8.7.3 NMAC – N/E, 2/1/2024]

13.8.7.4 DURATION:

This Emergency rule expires 180 days from the effective date unless a permanent rule is adopted before that time.

[13.8.7.4 NMAC – N/E, 2/1/2024]

13.8.7.5 EFFECTIVE DATE:

February 1, 2024, unless a later date is cited at the end of a section.

[13.8.7.5 NMAC – N/E, 2/1/2024]

13.8.7.6 OBJECTIVE:

The purpose of this rule is to alert existing and prospective insureds of a property and casualty insurer's deletion of an insurance product.

[13.8.7.6 NMAC – N/E, 2/1/2024]

13.8.7.7 DEFINITIONS:

[RESERVED]

13.8.7.8 NOTIFICATION REQUIREMENT:

All property or casualty insurance carriers that discontinue any product shall provide at least 30 days notice to the property and casualty bureau of the office of superintendent of insurance prior to the effective date of the discontinuation.

[13.8.7.8 NMAC – N/E, 2/1/2024]

CHAPTER 9: LIFE INSURANCE AND ANNUITIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: SALES OF LIFE INSURANCE, ENDOWMENTS OR ANNUITY CONTRACTS CONCURRENT WITH SALES OF MUTUAL FUNDS OR OTHER SECURITIES

13.9.2.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.9.2.2 SCOPE:

This rule shall apply, but is not limited, as follows:

A. to acts and practices in the advertising, promotion, offering, solicitation, negotiation of or effecting the sale of:

(1) life insurance policies, endowments and annuity contracts being offered for sale or purchase concurrently with the sale of shares of a mutual fund or other security;

(2) contracts which contemplate the offering or the purchase of a life insurance policy, endowment or annuity contract concurrent with the sale of shares of a mutual fund or other security;

B. to any acts and practices, whether they involve the use of language disseminated by means of sales kits, policy jackets or covers, letters, personal presentations, visual aids and other sales media in connection with the solicitation, sale, servicing or collection of premiums for a life insurance policy, an endowment or an annuity contract involved concurrently with an integrated plan or an investment program of a mutual fund or other security engaged in by any insurer as defined by Section 59A-1-8 NMSA 1978;

C. to sales of life insurance policies, endowments or annuity contracts and mutual fund shares or other securities as part of an integrated plan;

D. to sales in which both life insurance policies, endowments and annuity contracts and mutual fund shares or other securities are offered as part of the same investment program;

E. to sales programs in which both life insurance policies, endowments and annuity contracts and mutual fund shares or other securities are discussed and their purchase solicited during the same interview.

[7/1/97; Recompiled 11/30/01]

13.9.2.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.9.2.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.9.2.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.2.6 OBJECTIVE:

The purpose of this rule is to establish the minimum standards for disclosure of information in the sales of life insurance policies, endowments or annuity contracts, concurrently with the sale of mutual fund shares or other securities.

[7/1/97; Recompiled 11/30/01]

13.9.2.7 DEFINITIONS:

[RESERVED]

13.9.2.8 RESPONSIBILITY OF INSURANCE COMPANY AND AGENT:

No insurance company, agent, or person to whom this rule applies shall make, concurrent with the sales of life insurance policies, endowments and annuity contracts and mutual fund shares or other securities, a proposal or billing other than in accordance with the requirements of this rule.

[7/1/97; Recompiled 11/30/01]

13.9.2.9 TIE-IN SALES:

The insurance agent or solicitor at the commencement of and throughout the sales presentation, must fully disclose to the purchaser that he has the right to purchase a life

insurance policy, an endowment or an annuity contract only; mutual fund shares or other securities only, or together a life insurance policy or an endowment or an annuity and mutual fund shares or other securities.

[7/1/97; Recompiled 11/30/01]

13.9.2.10 WRITTEN PROPOSAL:

In any solicitation of an offer to buy, or in any sale of a life insurance policy, an endowment or an annuity contract, concurrently with the sale of shares of a mutual fund or other security, the prospect or policyholder must be furnished a copy of a clear and unambiguous written proposal not later than at the time the solicitation or proposal is made. A copy of such written proposal shall be kept on file by the insurance agent, or by the insurance company if no agent is involved.

[7/1/97; Recompiled 11/30/01]

13.9.2.11 CONTENTS OF PROPOSAL:

Any proposal referred to in this rule must:

A. be dated and signed by the insurance agent;

B. state the name of the company in which the life insurance policy, or endowment or annuity contract is to be written;

C. state that the purchaser has the right to purchase a life insurance policy, or an endowment or an annuity contract only, mutual fund shares or other securities only, or together a life insurance policy, an endowment and an annuity contract and mutual fund shares or other securities;

D. be accurate and complete and state all facts without which the proposal would have the capacity or tendency to mislead or deceive;

E. show the premium charge for life insurance policy, or endowment or annuity contract separately from any other charge;

F. show the value of the life insurance policy, or endowment or annuity contract, if any, separately from any other value;

G. show the amount of the death benefit for the life insurance policy, if it is involved in the presentation, separately from any other benefit which may accrue upon the death of the insured;

H. set forth separately all matters pertaining to the life insurance policy, endowment or annuity contract, if any are involved;

I. set forth policy numbers, name of company, face value and cash values of all existing policies which are to be surrendered if the proposal is accepted.

[7/1/97; Recompiled 11/30/01]

13.9.2.12 STATEMENT TO BE SEPARATE:

Any bill, statement, draft, or representation sent or delivered to any policyholder must show the premium charge for the life insurance policy, an endowment or an annuity contract separate from any other charges or values shown in the same billing, but nothing in this section shall prevent the disclosure of the total premium charge for the life insurance policy or the endowment or the annuity contract stated with any other charges or values shown in the same billing to arrive at the total billing charge.

[7/1/97; Recompiled 11/30/01]

13.9.2.13 MAINTENANCE OF FILE BY INSURANCE COMPANY:

A. **File of advertising and other sales material:** Each insurance company to whom this rule applies, shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement, advertising material, sales literature and sales aid of any other kind used in connection with the concurrent sale of life insurance policies, endowments or annuity contracts and mutual fund shares or other securities as may hereafter be prepared or disseminated in this state, with a notation attached to each such piece of material which shall indicate the manner and extent of distribution, the nature of use and the form number of any policy or contract issued in connection with the offering. Such file shall be subject to regular and periodical inspection by the superintendent of insurance or his authorized representatives. All such material shall be maintained in said file for a period of not less than three years.

B. **Certificate of compliance:** Each insurance company required to file an annual statement which is now or which hereafter becomes subject to the provisions of this rule must file with the department of insurance, together with its annual statement, a certificate executed by an authorized officer of the insurance company wherein it is stated that to the best of his knowledge, information and belief the advertisements, advertising material, sales literature and sales aids which were disseminated by the insurance company during the preceding statement year comply or were made to comply in all respects with the provisions of the insurance laws of this state as implemented and interpreted by this rule.

[7/1/97; Recompiled 11/30/01]

13.9.2.14 EXCLUSION:

The provisions of this rule shall not apply to any arrangement for the concurrent purchase of a life insurance policy, an endowment or an annuity contract and mutual

fund shares or other securities which arrangement would be deemed a "security" as defined by the Sale of Insurance Securities Law, Section 59A-35-1 et seq NMSA 1978. However, any sales literature and contract to purchase a life insurance policy, an endowment or an annuity contract in connection with such arrangement shall be furnished to the department of insurance prior to the offering of any sale of life insurance policies, endowments or annuity contracts under such an arrangement.

[7/1/97; Recompiled 11/30/01]

13.9.2.15 DUAL LICENSE REQUIRED:

No person shall solicit an offer to buy or solicit the sale of life insurance, endowments or annuity contracts concurrent with a sale of shares of a mutual fund or other security unless the person is licensed as a life insurance agent in accordance with the provisions of Section 59A-11-1 et seq. and Section 59A-12-1 et seq NMSA 1978. and is also licensed to sell securities by the chief of the securities bureau of the financial institutions division of the regulation and licensing department.

[7/1/97; Recompiled 11/30/01]

13.9.2.16 VIOLATIONS:

A. Any insurance company or agent who willfully violates any of the provisions of this rule shall, after a hearing, be subject to have its insurance suspended or revoked by the superintendent of insurance.

B. Nothing in this section shall be construed as limiting the power of the state to punish any person for any conduct which constitutes a crime by statute or at common-law, or to limit any statutory or common-law right of any person in any court for any act involved in the sale of life insurance, endowments or annuity contracts concurrently with the sale of shares of a mutual fund or other securities.

[7/1/97; Recompiled 11/30/01]

PART 3: VARIABLE ANNUITY CONTRACTS

13.9.3.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.9.3.2 SCOPE:

This rule applies to insurance companies delivering or issuing for delivery in this state variable annuities.

[7/1/97; Recompiled 11/30/01]

13.9.3.3 STATUTORY AUTHORITY:

Sections 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.9.3.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.9.3.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.3.6 OBJECTIVE:

The purpose of this rule is to establish the requirements for issuance or delivery of variable annuities.

[7/1/97; Recompiled 11/30/01]

13.9.3.7 DEFINITIONS:

For the purpose of this rule:

A. **"Agent"** means a person, corporation, partnership or other legal entity that under the laws of this state is licensed as a life insurance agent, solicitor, general agent or life insurance broker.

B. **"Net investment return"** means that the rate of investment return to be credited to the variable annuity contract in accordance with the terms of the contract after deductions for tax charges, if any, and for asset charges either at a rate not in excess of that stated in the contract, or in the case of a contract issued by a nonprofit corporation under which the contractholder participates fully in the investment, mortality and

expense experience of the account, in an amount not in excess of the actual expense not offset by other deductions. The net investment return to be credited to a contract shall be determined at least monthly.

C. **"Variable annuity"** means a policy or contract that provides for annuity benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer as to the policy or contract, as provided for in Section 59A-20-30 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.9.3.8 QUALIFICATION OF INSURANCE COMPANIES TO ISSUE VARIABLE ANNUITIES:

A. A company shall not deliver or issue for delivery variable annuities within this state unless it is licensed or organized to do a life insurance or annuity business in this state and the superintendent is satisfied that its condition or method of operation in connection with the issuance of these contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the superintendent shall consider among other things:

(1) the history and financial condition of the company;

(2) the character, responsibility and fitness of the officers and directors of the company; and

(3) the law and rule under which the company is authorized in the state of domicile to issue variable annuities.

B. If the company is a subsidiary of an admitted life insurance company, or affiliated with a company by common management or ownership, it may be deemed by the superintendent to have satisfied the provisions of 13 NMAC 9.3.8.1.2 [now Paragraph (2) of Subsection A of 13.9.3.8 NMAC] if either it or the admitted life company satisfies the provisions of 13 NMAC 9.3.8.1.2 [now Paragraph (2) of Subsection A of 13.9.3.8 NMAC]. Companies licensed and having a satisfactory record of doing business in this state for a period of at least three (3) years may be deemed to have satisfied the superintendent with respect to 13 NMAC 9.3.8.1.2 above [now Paragraph (2) of Subsection A of 13.9.3.8 NMAC].

C. Before any company shall deliver or issue for delivery variable annuities within this state it shall submit to the superintendent:

(1) a general description of the kinds of variable annuities it intends to issue;

(2) if requested by the superintendent, a copy of the statutes and rules of its state of domicile under which it is authorized to issue variable annuities; and

(3) if requested by the superintendent, biographical data with respect to officers and directors of the company on the NAIC uniform biographical data forms.

[7/1/97; Recompiled 11/30/01]

13.9.3.9 SEPARATE ACCOUNT:

A domestic company issuing variable annuities shall establish one or more separate accounts pursuant to Section 59A-20-30 NMSA 1978 and subject to the provisions in this section and in 13 NMAC 9.3.10, 13 NMAC 9.3.11 and 13 NMAC 9.3.12 [now 13.9.3.10 NMAC, 13.9.3.11 NMAC and 13.9.3.12 NMAC].

A. Unless otherwise approved by the superintendent, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to the separate account. Unless otherwise approved by the superintendent, the portion, if any, of the assets of the separate account equal to the company's reserve liability with regard to the benefits and funds referred to in 13 NMAC 9.3.10.2 [now Subsection B of 13.9.3.10 NMAC] shall be valued in accordance with the rules otherwise applicable to the company's assets.

B. To the extent provided under the applicable contracts, that portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct.

C. The company shall maintain in each such separate account assets with a value at least equal to the reserves and other contract liabilities with respect to the account, except as may otherwise be approved by the superintendent.

D. Rules under any provision of the insurance laws of this state or any rule applicable to the officers and directors of insurance companies with respect to conflict of interest shall also apply to members of a separate accounts committee, board or other similar body. No officer or director of the company nor a member of the committee, board or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of the separate account.

[7/1/97; Recompiled 11/30/01]

13.9.3.10 INVESTMENTS:

A. Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in 13 NMAC 9.3.10.2 [now Subsection B of 13.9.3.10 NMAC]:

(1) amounts allocated to a separate account and its accumulations may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies; and

(2) the investments in the separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

B. Reserves for benefits guaranteed as to dollar amount and duration and funds guaranteed as to principal amount or stated rate of interest may be maintained in a separate account if a portion of the assets of the separate account at least equal to the reserve liability is invested in accordance with the laws and rules of this state governing the investments of life insurance companies. That portion of the assets also shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

C. With respect to seventy-five percent (75%) of the market value of the total assets in a separate account a company shall not purchase or otherwise acquire the securities of an issuer, other than securities issued or guaranteed as to principal or interest by the United States, if immediately after the purchase or acquisition the market value of the investment, together with prior investments of the separate account in the security taken at market, would exceed ten percent (10%) of the market value of the assets of the separate account. The superintendent, may waive this limitation if, in the opinion of the superintendent, the waiver will not render the operation of the separate account hazardous to the public or policyholders in this state.

D. Unless otherwise permitted by law or approved by the superintendent, a company shall not purchase or otherwise acquire for its separate accounts the voting securities of an issuer if, as a result of the acquisition, the insurance company and its separate accounts, in the aggregate, will own more than ten percent (10%) of the total issued and outstanding voting securities of the issuer. This shall not apply with respect to securities held in separate accounts where the voting rights are exercisable only in accordance with instructions from persons having interest in the accounts.

E. The limitations provided in 13 NMAC 9.3.10.3 and 9.3.10.4 [now Subsections C and D of 13.9.3.10 NMAC] of this subsection shall not apply to investments with respect to a separate account in the securities of an investment company registered under the Investment Company Act of 1940, if the investments of the investment company comply in substance with 13 NMAC 9.3.10.3 and 9.3.10.4 [now Subsections C and D of 13.9.3.10 NMAC].

[7/1/97; Recompiled 11/30/01]

13.9.3.11 REGISTERED ACCOUNTS:

A. Notwithstanding any other provisions of law, a company may:

(1) with respect to a separate account registered with the securities and exchange commission as a unit investment trust, exercise voting rights in connection with securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interests in such accounts ratably as determined by the company; or

(2) with respect to a separate account registered with the securities and exchange commission as a management investment company, establish for the account a committee, board or other body, whose members may or may not be otherwise affiliated with the company and may be elected to membership by the vote of persons having interests in the account ratably as determined by the company. The committee, board or other body may have the power, exercisable alone or in conjunction with others, to manage the separate account and the investment of its assets.

B. A company, committee, board or other body may make other provisions in respect to a separate account as may be deemed appropriate to facilitate compliance with requirements of any federal or state law now or hereafter in effect if the superintendent approves the provisions as not hazardous to the public or the company's policyholders in this state.

[7/1/97; Recompiled 11/30/01]

13.9.3.12 TRANSFER OF ASSETS:

A. No sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in the case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless the transfer, whether into or from a separate account, is made:

(1) by a transfer of cash; or

(2) by a transfer of securities having a valuation which could be readily determined in the marketplace, if that transfer of securities is approved by the superintendent.

B. The superintendent may authorize other transfers among such accounts, if, in his opinion, such transfers would not be inequitable.

[7/1/97; Recompiled 11/30/01]

13.9.3.13 FILING OF CONTRACTS:

The filing requirements applicable to variable annuities shall be those filing requirements otherwise applicable under existing statutes and rules of this state with respect to individual and group life insurance and annuity contract form filings, to the extent appropriate.

[7/1/97; Recompiled 11/30/01]

13.9.3.14 CONTRACT REQUIREMENTS:

A. A variable annuity providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of variable benefits. A contract, including a group contract and a certificate in evidence of variable benefits issued under the contract, shall state that the dollar amount will vary to reflect investment experience and shall contain on its first page a clear statement to the effect that the benefits of the contract are on a variable basis.

B. Illustrations of benefits payable under any variable annuity shall not include projections of past investment experience into the future or attempted predictions of future investment experience. Nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of benefits.

C. No individual variable annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or provisions which in the opinion of the superintendent are more favorable to the holders of contracts:

(1) a provision that there shall be a grace period of thirty (30) days or of one month, within which any stipulated payment to the insurer falling due after the first may be made, during which grace period the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which a payment received during the grace period shall be applied to produce the values arising under the contract; and

(2) a provision that, at any time within [insert number of years] from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of overdue payments as required by contract, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover overdue payments and indebtedness shall be applied to produce the values arising under the contract.

[7/1/97; Recompiled 11/30/01]

13.9.3.15 VARIABLE FACTORS:

A. A variable annuity contact delivered or issued for delivery in this state shall stipulate the investment increment factors to be used in computing the dollar amount of variable benefits or other variable contractual payments or values thereunder, and may guarantee that expense and mortality results shall not adversely affect the dollar amounts. In the case of an individual variable annuity contract under which the expense and mortality results may adversely affect the dollar amount of benefits, the expense and mortality factors shall be stipulated in the contract.

B. In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

(1) The annual net investment increment assumption shall not exceed five percent (5%) except with the approval of the superintendent.

(2) To the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a lower life expectancy at any age, or, if approved by the superintendent, from another table.

C. Expense, as used in this section, may exclude some or all taxes, as stipulated in the contract.

[7/1/97; Recompiled 11/30/01]

13.9.3.16 RESERVES:

The reserve liability for variable annuities shall be established pursuant to the requirements of Section 59A-8-5 NMSA 1978 in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

[7/1/97; Recompiled 11/30/01]

13.9.3.17 NONFORFEITURE BENEFITS:

A. To the extent that a variable annuity contract provides benefits that do not vary in accordance with the investment performance of a separate account before the annuity commencement date, the contract shall contain provisions that satisfy the requirements of Section 59A-20-33 NMSA 1978 and shall not otherwise be subject to this section.

B. In the case of a contract issued on or after January 1, 1999, no variable annuity contract, except as stated in 13 NMAC 9.3.18 and 9.3.17.1 [now 13.9.3.18 NMAC and Subsection A of 13.9.3.17 NMAC], shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or provisions which in the opinion of the superintendent are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan described in the contract that complies with 13 NMAC 9.3.22.1 [now Subsection A of 13.9.3.22 NMAC]. The description will include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(2) If a contract provides for a lump sum settlement at maturity or at any other time, that upon surrender of the contract at or prior to the commencement of annuity payments, the company will pay in lieu of a paid-up annuity benefit a cash surrender benefit described in the contract that complies with 13 NMAC 9.3.22.2 [now Subsection B of 13.9.3.22 NMAC]. The contract may provide that the company reserves the right, at its option, to defer the determination and payment of a cash surrender benefit for any period during which the New York stock exchange is closed for trading (except for normal holiday closing) or when the securities and exchange commission has determined that a state of emergency exists that may make determination and payment impractical.

(3) A statement that a paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

[7/1/97; Recompiled 11/30/01]

13.9.3.18 EXEMPTIONS FROM NONFORFEITURE BENEFITS:

13 NMAC 9.3.17 [now 13.9.3.17 NMAC] shall not apply to any:

A. reinsurance;

B. group annuity contract purchases in connection with one or more retirement plans or plans of deferred compensation established or maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combination thereof, or other than plans providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code;

C. premium deposit fund;

D. investment annuity;

E. immediate annuity;

F. deferred annuity contract after annuity payments have commenced;

G. reversionary annuity; or

H. to any contract which is to be delivered outside this state through an agent or other representative of the company issuing the contract.

[7/1/97; Recompiled 11/30/01]

13.9.3.19 MINIMUM NONFORFEITURE VALUES:

A. The minimum values as specified in this section of paid-up annuity, cash surrender or death benefits available under a variable annuity contract shall be based upon nonforfeiture amounts meeting the requirements of this subsection.

B. The minimum nonforfeiture amount on any date prior to the annuity commencement date shall be an amount equal to the percentages of net considerations (as specified in 13 NMAC 9.3.20) [now 13.9.3.20 NMAC] increased (or decreased) by the net investment return allocated to the percentages of net considerations, reduced to reflect the effect of:

(1) any partial withdrawals from or partial surrenders of the contract;

(2) the amount of any indebtedness on the contract, including interest due and accrued;

(3) an annual contract charge not less than zero and equal to:

(a) the lesser of $30 or two percent (2%) of the end of year contract value; less

(b) the amount of any annual contract charge deducted from any gross considerations credited to the contract during such contract year; and

(4) a transaction charge of $10 for each transfer to another separate account or to another investment division within the same separate account.

C. The annual contract charge of $30 and the transaction charge of $10 referred to in 13 NMAC 9.3.19.2.3.1 and 9.3.19.2.4 [now Subparagraph (a) of Paragraph (3) and Paragraph (4) of Subsection B of 13.9.3.19 NMAC] will be adjusted to reflect changes in the consumer price index in accordance with 13 NMAC 9.3.21 [now 13.9.3.21 NMAC].

[7/1/97; Recompiled 11/30/01]

13.9.3.20 NET CONSIDERATION PERCENTAGES:

The percentages of net considerations used to define the minimum nonforfeiture amount in 13 NMAC 9.3.19 [now 13.9.3.19 NMAC] shall meet the requirements of this section.

A. With respect to contracts providing for periodic considerations, the net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of $30 and less a collection charge of $1.25 per consideration credited to the contract during that contract year less any charges for premium taxes. The percentages of net considerations shall be sixty-five percent (65%) for the first contract year and eighty-seven and one-half percent (87.5%) for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent (65%) of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent (65%).

B. With respect to contracts providing for a single consideration, the net consideration used to define the minimum nonforfeiture amount shall be the gross consideration less a contract charge of $75 and less any charge for premium taxes. The percentage of the net consideration shall be ninety percent (90%).

C. The annual contract charge of $30, the collection charge of $1.25 per collection, and the single consideration contract charge of $75 referred to in 13 NMAC 9.3.20.1 and 9.3.20.2 [now Subsections A and B of 13.9.3.20 NMAC], will be adjusted to reflect changes in the consumer price index in accordance with 13 NMAC 9.3.21 [now 13.9.3.21 NMAC].

[7/1/97; Recompiled 11/30/01]

13.9.3.21 DEMONSTRATION OF COMPLIANCE:

Demonstration that a contract's nonforfeiture amounts comply with this section shall be based on the following assumptions:

A. values should be tested at the end of each of the first twenty (20) contract years;

B. a net investment return of seven percent (7%) per year should be used;

C. if the contract provides for transfers to another separate account or to another investment division within the same separate account, one transfer per contract year should be assumed;

D. in determining the state premium tax applicable to the contract, the state of residence should be assumed to equal the state of delivery;

E. with respect to contracts providing for periodic considerations, monthly considerations of $100 should be assumed for each of the first 240 months;

F. with respect to contracts providing for a single consideration, a $10,000 single consideration should be assumed; and

G. the following contract charges should be used:

(1) for contracts filed in 1980 or earlier, the annual contract charge of $30 referred to in 13 NMAC 9.3.19 and 9.3.20 [now 13.9.3.19 NMAC and 13.9.3.20 NMAC], the charge of $10 per transfer referred to in 13 NMAC 9.3.19 [now 13.9.3.19 NMAC], the collection charge of $1.25 per consideration referred to in 13 NMAC 9.3.20 [now 13.9.3.20 NMAC], and the contract charge of $75 referred to in 13 NMAC 9.3.20.2 [now Subsection B of 13.9.3.20 NMAC].

(2) for contracts filed in 1981 or later, the contract charges in 13 NMAC 9.3.21.7.1 [now Paragraph (1) of Subsection G of 13.9.3.21 NMAC] multiplied by the ratio of the consumer price index for June of the calendar year preceding the date of filing, to the consumer price index for June 1979.

H. If the contract provides for allocation of considerations to both fixed and variable accounts, one hundred percent (100%) of the considerations should be assumed to be allocated to the variable account.

I. As used herein, the consumer price index means the index for all urban consumers for all items published by the bureau of labor statistics of the United States department of labor or its successor. If publication of the consumer price index ceases, or if the index otherwise becomes unavailable or is altered in such a way as to be unusable, the superintendent will substitute an index deemed suitable by the superintendent.

[7/1/97; Recompiled 11/30/01]

13.9.3.22 OTHER NONFORFEITURE RULES:

A. Any paid-up annuity benefit available under a variable annuity contract shall be such that its present value on the annuity commencement date is at least equal to the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

B. For variable annuity contracts that provide cash surrender benefits, the cash surrender benefit at any time prior to the annuity commencement date shall not be less than the minimum nonforfeiture amount computed after the request for surrender is received by the company. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

C. A variable annuity contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the annuity commencement date shall include a statement in a prominent place in the contract that these benefits are not provided.

D. Notwithstanding the requirements of this section, a variable annuity contract may provide under the situations specified in 13 NMAC 9.3.22.4.1 or 9.3.22.4.2 [now Paragraphs (1) or (2) of Subsection D of 13.9.3.22 NMAC] of this subsection that the company, at its option, may cancel the annuity and pay the contractholder its accumulated value and by such payment be released of any further obligation under the contract:

(1) If, at the time the annuity becomes payable, the accumulated value is less than $2,000, or would provide an initial income of less than $20 per month; or

(2) If, prior to the time the annuity becomes payable under a periodic payment variable annuity contract, no considerations have been received under the contract for a period of two (2) full years and the total considerations paid prior to such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract, and the accumulated value amount to less than $2,000.

E. For a variable annuity contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of 13 NMAC 9.3.19 [now 13.9.3.19 NMAC], additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of additional benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

[7/1/97; Recompiled 11/30/01]

13.9.3.23 REQUIRED REPORTS:

A. A company issuing individual variable annuities shall mail to the contractholder at least once in each contract year after the first at his or her last address known to the company, a statement or statements reporting the investments held in the separate account. The company shall submit annually to the insurance superintendent a

statement of business of its separate account or accounts in such form as may be prescribed by the national association of insurance commissioners.

B. A company issuing individual variable annuities shall mail to the contractholder at least once in each contract year after the first at his or her last address known to the company a statement reporting as of a date not more than four (4) months previous to the date of mailing. In the case of an annuity contract under which payments have not yet commenced, the statement shall contain:

(1) the number of accumulation units credited to the contract and the dollar value of a unit; or

(2) the value of the contractholder's account.

[7/1/97; Recompiled 11/30/01]

13.9.3.24 FOREIGN COMPANIES:

If the law or rules in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public substantially equal to that provided by this rule, the superintendent, to the extent deemed appropriate by the superintendent, may consider compliance with that law or rules as compliance with this rule.

[7/1/97; Recompiled 11/30/01]

13.9.3.25 QUALIFICATIONS OF AGENTS FOR THE SALE OF VARIABLE ANNUITIES:

A. **Required licensing:**

(1) A person may not sell or offer for sale in this state any variable annuity contract unless the person is an agent and has filed with the superintendent, in a form satisfactory to the superintendent, evidence that the person holds any license or authorization that may be required by any federal or state securities law for the solicitation or sale of variable annuity contracts.

(2) Any examination administered by the department for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this rule, include such questions concerning the history, purpose, regulation and sale of variable annuity contracts as the superintendent deems appropriate.

B. **Required reporting:** A person qualified in this state under this section to sell or offer to sell variable annuity contracts shall immediately report to the superintendent:

(1) any suspension or revocation of his or her agent's license in any other state or territory of the United States;

(2) the imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension, or revocation of or denial of registration, imposed upon him or her by any national securities exchange, or national securities association, or any federal, state or territorial agency with jurisdiction over securities or variable annuity contracts;

(3) any judgment or injunction entered against him or her on the basis of conduct deemed to have involved fraud, deceit, misrepresentation or violation of any insurance or securities law or rule.

C. **Licensing actions:** The superintendent may reject an application or suspend or revoke or refuse to renew an agent's qualification under this section to sell or offer to sell variable annuity contracts upon any ground that would bar the applicant or agent from being licensed to sell other life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's license shall also govern any proceeding for suspension or revocation of an agent's qualification to sell or offer to sell variable annuity contracts. [7/1/97; Recompiled 11/30/01]

PART 4: CORPORATE AND PARTNERSHIP LIFE INSURANCE

13.9.4.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.9.4.2 SCOPE:

This rule applies to corporations and partnerships that insure the life of any director, partner, officer, agent or employee where the corporation or partnership is named as a beneficiary in or assignee of the life insurance policy.

[7/1/97; Recompiled 11/30/01]

13.9.4.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.9.4.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.9.4.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.4.6 OBJECTIVE:

The purpose of this rule is to establish requirements for evidence of authority when a corporation or partnership insures the life of any director, partner, officer, agent or employee and the corporation or partnership is named as a beneficiary in or assignee of the life insurance policy.

[7/1/97; Recompiled 11/30/01]

13.9.4.7 DEFINITIONS:

[RESERVED]

13.9.4.8 LIFE INSURANCE ON DIRECTORS, OFFICERS, AGENTS AND EMPLOYEES OF CORPORATIONS:

A. **Evidence of authority:** Whenever 1) a corporation organized under the laws of this state causes to be insured the life of any director, officer, agent or employee; and 2) the corporation is named as a beneficiary in or assignee of the life insurance policy, the corporation's authority to effect, assign, release, relinquish, convert, surrender, change the beneficiary, or to take any other or different action with reference to the insurance shall be demonstrated by a written statement to that effect that is signed by the president and the secretary or other corresponding officer of the corporation. The statement shall be binding upon the corporation and shall serve as sufficient evidence of corporate authority for purposes of the insurance company. The statement shall protect the insurance company in any act done or suffered by it in good faith reliance on the statement without the need for further inquiry into the validity of the corporate authority or the regularity of the corporate proceedings.

B. **Actions of directors:** No person shall be disqualified, by reason of interest in the subject matter, from acting as a director or as a member of the executive committee of a corporation on any corporate act relating to this type of insurance.

[7/1/97; Recompiled 11/30/01]

13.9.4.9 LIFE INSURANCE ON A PARTNER OR PARTNERS, OFFICERS, AGENTS AND EMPLOYEES OF PARTNERSHIPS:

A. **Evidence of authority:** Whenever 1) a partnership organized under the laws of this state causes to be insured the life of one or all of the partners or a partnership officer, agent, or employee; and 2) the partnership is named as a beneficiary in or assignee of the life insurance policy, the partnership's authority to effect, assign, release, relinquish, convert, surrender, change the beneficiary, or to take any other or different action with reference to the insurance shall be demonstrated by a written statement to that effect that is signed by any partner. The statement shall be binding upon the partnership and shall serve as sufficient evidence of partnership authority for purposes of the insurance company. The statement shall protect the insurance company in any action done or suffered by it in good faith reliance on the statement without the need for further inquiry into the validity of the partnership authority or the regularity of the partnership proceedings.

B. **Actions of partners:** No person shall be disqualified, by reason of interest in the subject matter, from acting as a partner of the partnership on any partnership action relating to this type of insurance.

[7/1/97; Recompiled 11/30/01]

PART 5: LIFE INSURANCE DISCLOSURE

13.9.5.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[13.9.5.1 NMAC - Rp 13 NMAC 9.5.1, 12-31-03]

13.9.5.2 SCOPE:

A. This rule applies to:

(1) any solicitation, negotiation or procurement of life insurance occurring within this state;

(2) any issuer of life insurance contracts including fraternal benefit societies.

B. Unless specifically included, this rule shall not apply to:

(1) annuities;

(2) credit life insurance;

(3) group life insurance (except for disclosures relating to preneed funeral contracts or prearrangements as provided in this rule; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy);

(4) life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001 et seq. as amended; or

(5) variable life insurance under which the amount or duration of the life insurance varies according to the investment experience of a separate account.

[13.9.5.2 NMAC - Rp 13 NMAC 9.5.2, 1-1-04]

13.9.5.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-16-4, and 59A-16-5 NMSA 1978.

[13.9.5.3 NMAC - Rp 13 NMAC 9.5.3, 1-1-04]

13.9.5.4 DURATION:

Permanent.

[13.9.5.4 NMAC - Rp 13 NMAC 9.5.4, 1-1-04]

13.9.5.5 EFFECTIVE DATE:

1-1-04, unless a later date is cited at the end of a section.

[13.9.5.5 NMAC - Rp 13 NMAC 9.5.5, 1-1-04]

13.9.5.6 OBJECTIVE:

The objective of this rule is to require insurers to deliver to purchasers of life insurance information which will improve the buyer's ability to select the most appropriate plan of life insurance for the buyer's needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of similar plans of insurance. This rule does not prohibit the use of additional material which is not a violation of this rule or any other statute or rule.

[13.9.5.6 NMAC - Rp 13 NMAC 9.5.6, 1-1-04]

13.9.5.7 DEFINITIONS:

For the purposes of this rule, the following definitions apply:

A. "**buyer's guide"** means the Life Insurance Buyer's Guide contained in 13.9.5.14 NMAC or other language approved by the superintendent;

B. "current scale of nonguaranteed elements" means a formula or other mechanism that produces values for an illustration as if there is no change in the basis of those values after the time of illustration;

C. "generic name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider;

D. "nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation;

E. "policy data" means a display or schedule of numerical values, both guaranteed and nonguaranteed, for each policy year or a series of designated policy years of the following information: illustrated annual, other periodic, and terminal dividends; premiums; death benefits; cash surrender values and endowment benefits;

F. "policy summary" means a written statement describing the elements of the policy and meeting the requirements of 13.9.5.8 NMAC; and

G. "preneed funeral contract or prearrangement" means an agreement by or for an individual before that individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

[13.9.5.7 NMAC - Rp 13 NMAC 9.5.7, 1-1-04]

13.9.5.8 CONTENTS OF POLICY SUMMARY:

Every policy summary shall include at least the following information:

A. The prominently placed title "Statement Of Policy Cost And Benefit Information."

B. The name and address of the insurance agent or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary.

C. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

D. The generic name of the basic policy and each rider.

E. The following amounts, where applicable, for the first five (5) policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns; including, but not necessarily limited to, the years for which cost

comparison indexes are displayed and the earlier of at least one age from sixty (60) through sixty-five (65) and policy maturity:

(1) the annual premium for the basic policy;

(2) the annual premium for each optional rider;

(3) the amount payable upon death at the beginning of the policy year regardless of the cause of death, other than suicide or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider; with benefits provided under the basic policy and each rider shown separately;

(4) the total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider; and

(5) any endowment amounts payable under the policy which are not included under cash surrender values above.

F. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the policy summary shall also indicate that the annual percentage rate will be determined by the company in accordance with the provisions of the policy and the applicable law.

G. The date on which the policy summary is prepared.

[13.9.5.8 NMAC - Rp 13 NMAC 9.5.13, 1-1-04]

13.9.5.9 DUTIES OF INSURERS:

A. The insurer shall provide a buyer's guide to all prospective purchasers, prior to accepting the applicant's initial premium or premium deposit. However, if the policy for which the application is made contains an unconditional refund provision for at least ten (10) days, the buyer's guide may be delivered with the policy or prior to delivery of the policy.

B. The insurer shall provide a policy summary to prospective purchasers where the insurer has identified the policy form as one that will not be marketed with an illustration. The policy summary shall show guarantees only. It shall consist of a separate document with all the required infoormation set out in a manner that does not minimize or reender any portion of the summary obscure. Any amounts that remain level for two (20 or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in Subsection E of 13.9.5.8 NMAC shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, death benefits shall be displayed seperately for each insured or for each class of insured if death benefits do not differ

within class. Zero amounts shall be displayed as a blank space. Delivery of the policy summary shall be consistent with the time for delivery of the buyer's guide as specified in Subsection A of this section.

[13.9.5.9 NMAC - Rp 13 NMAC 9.5.15, 1-1-04]

13.9.5.10 REQUIREMENTS APPLICABLE TO EXISTING POLICIES:

A. Upon request of the policyowner, the insurer shall furnish either policy data or an in force illustration as follows:

(1) For policies issued prior to the effective date of 13.9.14 NMAC, the insurer shall furnish policy data, or, at its option, an in force illustrations meeting the requirements of 13.9.14 NMAC.

(2) For policies issued after the effective date of the illustration rule that were declared not to be used with an illustration, the insurer shall furnish policy data, limited to guaranteed values, if it has chosen not to furnish an in force illustration meeting the requirements of the rule.

(3) If the policy was issued after the effective date of the illustration rule and declared to be used with an illustration, an in force illustration shall be provided.

(4) Unless otherwise requested, the policy data shall be provided for twenty consecutive years beginning with the previous policy anniversary. The statement of policy data shall include nonguaranteed elements according to the current scale, the amount of outstanding policy loans, and the current policy loan interest rate. Policy values shown shall be based on the current application of nonguaranteed elements in effect at the time of the request. The insurer may charge a reasonable fee, not to exceed $20.00, for the preparation of the statement.

B. If a life insurance company, changes its method of determining scales of nonguaranteed elements on existing policies; it shall, no later than when the first payment is made on the new basis, advise each affected policy owner residing in this state of this change and of its implication on affected policies. This requirement shall not apply to policies for which the amount payable upon death under the basic policy as of the date when advice would otherwise be required does not exceed $5,000.

C. If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor; it shall, no later than the first policy anniversary following the revision, advise accordingly each affected policy owner residing in this state.

[13.9.5.10 NMAC - Rp 13 NMAC 9.5.17, 1-1-04]

13.9.5.11 PRENEED FUNERAL CONTRACTS OR PREARRANGEMENTS:

The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant's initial premium or deposit, for a preneed funeral contract or prearrangement that is funded or to be funded by a life insurance policy:

A. the fact that a life insurance policy is involved or being used to fund a prearrangement;

B. the nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person;

C. the relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

D. the impact on the prearrangement:

(1) of any changes in the life insurance policy including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

(2) of any penalties to be incurred by the policyholder as a result of failure to make premium payments;

(3) of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;

E. a list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

F. all relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement;

G. any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

H. the fact that a sales commission or other form of compensation is being paid and if so, the identity of such individuals or entities to whom it is paid.

[13.9.5.11 NMAC - Rp 13. NMAC 9.5.23, 1-1-04]

13.9.5.12 GENERAL RULES:

A. Each insurer shall maintain, at its home office or principal office, a complete file containing one copy of each document authorized and used by the insurer pursuant to this rule. Such file shall contain one copy of each authorized form for a period of three (3) years following the date of its last authorized use unless otherwise provided by this rule.

B. An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

C. An insurance agent, broker or producer shall not use terms such as "financial planner", "investment advisor", "financial consultant", or "financial counseling" in such a way as to imply that he or she is primarily engaged in an advisory business in which compensation is unrelated to sales unless such is actually the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that aperson citing membership, if authorized only to sell insurance products discloses that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with solicitation, negotiation or sevicing of policies.

D. Any reference to nonguaranteed elements shall include a statement that such item is not guaranteed and is based on the company's current scale of nonguaranteed elements (use appropriate term such as 'current dividend" or "current rate" scale). If a nonguaranteed element would be reduced by the existence of a policy loan, a statement to this effect must be included in any reference to nonguaranteed elements. A presentation or depiction of a policy issued after the effective date of 13.9.14 NMAC that includes nonguaranteed elements over a period of years shall be governed by that rule.

[13.9.5.12 NMAC - Rp 13 NMAC 9.5.24, 1-1-04]

13.9.5.13 FAILURE TO COMPLY:

Failure of an insurer to provide or deliver a buyer's guide, a policy summary or policy data as provided in 13.9.5.9 through 13.9.5.10 NMAC shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an insurance policy.

[13.9.5.13 NMAC - Rp 13 NMAC 9.5.25, 1-1-04]

13.9.5.14 LIFE INSURANCE BUYER'S GUIDE:

[The face page of the buyer's guide shall read as follows:]

Life Insurance Buyer's Guide

This guide can help you when you shop for life insurance. It discusses how to:

* Find a Policy That Meets Your Needs and Fits Your Budget

* Decide How Much Insurance You Need

* Make Informed Decisions When You Buy a Policy

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

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IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.

2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?

3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.

4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.

5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly**.

6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.

7.	Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need and for how long and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

* If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.

* It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.

* Ask your tax advisor if dropping your policy could affect your income taxes.

* If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.

* You may have valuable rights and benefits in the policy you now have that are not in the new one.

* If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.

* At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

* How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?

* Do I have children for whom I'd like to set aside money to finish their education in the event of my death?

* How will my family pay final expenses and repay debts after my death?

* Do I have family members or organizations to whom I would like to leave money?

* Will there be estate taxes to pay after my death?

* How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What Is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some

policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able trade many term insurance policies for a cash value policy during a conversion period - even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

* Do premiums or benefits vary from year to year?

* How much do the benefits build up in the policy?

* What part of the premiums or benefits is not guaranteed?

* What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

* How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)

* Are there special policy features that particularly suit your needs?

* How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

[13.9.5.14 NMAC - Rp 13 NMAC 9.5.26, 1-1-04]

PART 6: REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

13.9.6.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[13.9.6.1 NMAC - Rp 13 NMAC 9.6.1, 1-1-04]

13.9.6.2 SCOPE:

This rule applies to the replacement of life insurance and annuities as defined in this rule.

A. Unless otherwise specifically included, this rule shall not apply to transactions involving:

(1) credit life insurance;

(2) group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of 13.9.6.12 NMAC;

(3) group life insurance and annuities used to fund prearranged funeral contracts;

(4) an application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the superintendent;

(5) proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

(6) the following:

(a) policies or contracts used to fund (i) an employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA); (ii) a plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer; (iii) a governmental or church plan defined in Section 414, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or (iv) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(b) notwithstanding Subparagraph (a) of this paragraph, this rule shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurer has been notified that plan participants may choose from among two (2) or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this subsection, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee;

(7) where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

(8) existing life insurance that is a non-convertible term life insurance policy that will expire in five (5) years or less and cannot be renewed;

(9) immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this rule; or

(10) structured settlements.

B. Registered contracts shall be exempt from the requirements of Paragraph (2) of Subsection A of 13.9.6.10 NMAC and Subsection B of 13.9.6.11 NMAC with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

[13.9.6.2 NMAC - Rp 13 NMAC 9.6.2, 1-1-04]

13.9.6.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, and 59A-16-7 NMSA 1978.

[13.9.6.3 NMAC- Rp 13 NMAC 9.6.3, 1-1-04]

13.9.6.4 DURATION:

Permanent.

[13.9.6.4 NMAC - Rp 13 NMAC 9.6.4, 1-1-04]

13.9.6.5 EFFECTIVE DATE:

1-1-04, unless a later date is cited at the end of a section.

[13.9.6.5 NMAC - Rp 13 NMAC 9.6.5, 1-1-04]

13.9.6.6 OBJECTIVE:

The purpose of this rule is:

A. to regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities;

B. to protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions, it will;

(1) assure that purchasers receive information with which a decision can be made in his or her own best interest;

(2) reduce the opportunity for misrepresentation and incomplete disclosure; and

(3) establish penalties for failure to comply with requirements of this rule.

[13.9.6.6 NMAC - Rp 13 NMAC 9.6.6, 1-1-04]

13.9.6.7 DEFINITIONS:

A. "Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity or individually solely through mails, telephone, the Internet or other mass communication media.

B. "Existing insurer" means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of "replacement."

C. "Existing policy or contract" means an individual life insurance policy (policy) or annuity contract (contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.

D. "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four (4) months before or thirteen (13) months after the effective date of the new policy, it will be deemed *prima facie* evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This *prima facie* standard is not intended to increase or decrease the monitoring obligations contained in Paragraph (5) of Subsection A of 13.9.6.9 NMAC.

E. "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in 13.9.14 NMAC.

F. "Policy summary," for the purposes of this rule;

(1) for policies or contracts other than universal life policies, means a written statement regarding a policy or contract which shall contain to the extent applicable, but need not be limited to, the following information: current death benefit; annual contract premium; current cash surrender value; current dividend; application of current dividend; and amount of outstanding loan;

(2) for universal life policies, means a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders); the current death benefit at the end of the current report period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current report period; and the amount of outstanding loans, if any, as of the end of the current report period.

G. "Producer," for the purpose of this rule, shall be defined to include agents, brokers and producers.

H. "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

I. "Registered contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

J. "Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) reissued with any reduction in cash value; or

(5) used in a financed purchase.

K. "Sales material" means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.

[13.9.6.7 NMAC - Rp 13 NMAC 9.6.7, 1-1-04]

13.9.6.8 DUTIES OF PRODUCERS:

A. A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. If the answer is "no," the producer's duties with respect to replacement are complete.

B. If the applicant answered "yes" to the question regarding existing coverage referred to in Subsection A of this section, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in 13.9.6.14 NMAC or other substantially similar form approved by the superintendent. However, no approval shall be required when amendments to the notice are limited to the omission of references not applicable to the product being sold or replaced. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and left with the applicant.

C. The notice shall list all life insurance policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

D. In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.

E. Except as provided in Subsection C of 13.9.6.10 NMAC, in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this section, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

[13.9.6.8 NMAC - Rp 13 NMAC 9.6.8, 1-1-04]

13.9.6.9 DUTIES OF INSURERS THAT USE PRODUCERS:

Each insurer that use producers shall:

A. maintain a system of supervision and control to insure compliance with the requirements of this rule that shall include at least the following:

(1) inform its producers of the requirements of this rule and incorporate the requirements of this rule into all relevant producer training manuals prepared by the insurer;

(2) provide to each producer a written statement of the company's position with respect to the acceptability of replacements providing guidance to its producer as to the appropriateness of these transactions;

(3) a system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with Paragraph (2) above;

(4) procedures to confirm that the requirements of this rule have been met; and

(5) procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or producer. Compliance with this rule may include, but shall not be limited to, systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring;

B. have the capacity to monitor each producer's life insurance policy and annuity contract replacements for that insurer, and shall produce, upon request, and make such records available to the Insurance Department. The capacity to monitor shall include the ability to produce records for each producer's:

(1) life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;

(2) number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;

(3) annuity contract replacements as a percentage of the producer's total annual annuity contract sales;

(4) number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by Paragraph (5) of Subsection A of this section; and

(5) replacements, indexed by replacing producer and existing insurer;

C. require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

D. require with each application for life insurance or an annuity that indicates an existing policy or contract a completed notice regarding replacements as contained in 13.9.6.14 NMAC;

E. when the applicant has existing policies or contracts, each insurer shall be able to produce copies of any sales material required by Subsection E of 13.9.6.8 NMAC, the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the producer's and applicant's signed statements with respect to financing and replacement for at least five (5) years after the termination or expiration of the proposed policy or contract;

F. ascertain that the sales material and illustrations required by Subsection E of 13.9.6.8 NMAC meet the requirements of this rule and are complete and accurate for the proposed policy or contract;

G. if an application does not meet the requirements of this rule, notify the producer and applicant and fulfill the outstanding requirements; and

H. maintains records in paper, photograph, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

[13.9.6.9 NMAC - Rp 13 NMAC 9.6.9, 1-1-04]

13.9.6.10 DUTIES OF REPLACING INSURERS THAT USE PRODUCERS:

A. Where a replacement is involved in the transaction, the replacing insurer shall:

(1) verify that the required forms are received and are in compliance with this rule;

(2) notify any other existing insurer that may be affected by the proposed replacement within five (5) business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five (5) business days of a request from an existing insurer;

(3) be able to produce copies of the notification regarding replacement required in Subsection B of 13.9.6.8 NMAC, indexed by producer, for at least five (5) years or until the next regular examination by the insurance department of a company's state of domicile, whichever is later; and

(4) provide to the policy or contract owner notice of the right to return the policy or contract within thirty (30) days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or

contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract; such notice may be included in 13.9.6.14 or 13.9.6.16 NMAC.

B. In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract. With regard to financed purchases the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

C. If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements made of an insurer pursuant to Subsection E of 13.9.6.8 NMAC, the insurer may:

(1) require with each application a statement signed by the producer that:

(a) represents that the producer used only company-approved sales material; and

(b) states that copies of all sales material were left with the applicant in accordance with Subsection D of 13.9.6.8 NMAC; and

(2) within ten (10) days of the issuance of the policy or contract:

(a) notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the producer has represented that copies of all sales material have been left with the applicant in accordance with Subsection D of 13.9.6.8 NMAC;

(b) provide the applicant with a toll free number to contact company personnel involved in the compliance function if such is not the case; and

(c) stress the importance of retaining copies of the sales material for future reference; and

(3) be able to produce a copy of the letter or other verification in the policy file for at least five (5) years after the termination or expiration of the policy or contract.

[13.9.6.10 NMAC - Rp 13 NMAC 9.6.10, 1-1-04]

13.9.6.11 DUTIES OF EXISTING INSURERS:

Where a replacement is involved in the transaction, the existing insurer shall:

A. retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five (5) years or until the conclusion of the next regular examination conducted by the Insurance Department of its state of domicile, whichever is later.

B. send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced within five (5) business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within five (5) business days of receipt of the request from the policy or contract owner.

C. upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice, advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy owner. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan.

[13.9.6.11 NMAC - Rp 13 NMAC 9.6.12, 1-1-04]

13.9.6.12 DUTIES OF INSURERS WITH RESPECT TO DIRECT RESPONSE SOLICITATION:

A. In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice regarding replacement in 13.9.6.15 NMAC, or other substantially similar form approved by the superintendent.

B. If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(1) provide to applicants or prospective applicants with the policy or contract a notice, as described in 13.9.6.16 NMAC, or other substantially similar form approved by the superintendent. In these instances the insurer may delete the references to the producer, including the producer's signature, and references not applicable to the product being sold or replaced, without having to obtain approval of the form from the superintendent. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this paragraph. The requirement to make a diligent effort shall

be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this section; and

(2) comply with the requirements of Paragraph (2) of Subsection A of 13.9.6.10 NMAC, if the applicant furnishes the names of the existing insurers, and the requirements of Paragraphs (3) and (4) of Subsection A and Subsection B of 13.9.6.10 NMAC.

[13.9.6.12 NMAC - Rp 13 NMAC 9.6.11, 1-1-04]

13.9.6.13 VIOLATIONS AND PENALTIES:

A. Any failure to comply with this rule shall be considered a violation of Section 59A-16-6 NMSA 1978. Examples of violations include:

(1) any deceptive or misleading information set forth in sales material;

(2) failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(3) the intentional incorrect recording of an answer;

(4) advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(5) advising a policy or contract owner to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company.

B. Policy and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract owners of the same producer shall be deemed prima facie evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed *prima facie* evidence of the producer's intent to violate this rule.

C. Where it is determined that the requirements of this rule have not been met the replacing insurer shall provide to the policy owner an in force illustration if available or policy summary for the replacement policy or available disclosure document for the replacement contract and the appropriate notice regarding replacements in 13.9.6.14 or 13.9.6.16 NMAC.

[13.9.6.13 NMAC - Rp 13 NMAC 9.6.13, 1-1-04]

13.9.6.14 APPENDIX A: IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

IMPORTANT NOTICE:

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one,

and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured

or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____

Applicant's Signature and Printed Name Date

_____ _____

Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. __(Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid, you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate

statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

[13.9.6.14 NMAC - N, 1-1-04]

13.9.6.15 APPENDIX B: NOTICE REGARDING REPLACEMENT NOTICE REGARDING REPLACEMENT REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

[13.9.6.15 NMAC - Rp 13 NMAC 9.6.14, 1-1-04]

13.9.6.16 APPENDIX C: IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES.

IMPORTANT NOTICE:

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____

Applicant's Signature and Printed Name Date

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid, you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

[13.9.6.16 NMAC - N, 1-1-04]

PART 7: UNIVERSAL LIFE INSURANCE

13.9.7.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7-1-97; Recompiled 11/30/01]

13.9.7.2 SCOPE:

This rule applies to all individual universal life insurance policies except variable life insurance policies covered by 13 NMAC 9.8 [now 13.9.8 NMAC].

[12-1-85; Recompiled 11/30/01]

13.9.7.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[12-1-85; Recompiled 11/30/01]

13.9.7.4 DURATION:

Permanent.

[7-1-97; Recompiled 11/30/01]

13.9.7.5 EFFECTIVE DATE:

December 1, 1985, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[12-1-85, 7-1-97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.7.6 OBJECTIVE:

The purpose of this rule is to supplement other rules on life insurance policies in order to accommodate the development and issuance of universal life insurance plans.

[12-1-85; Recompiled 11/30/01]

13.9.7.7 DEFINITIONS:

A. **"Cash surrender value"** means the net cash surrender value plus any amounts outstanding as policy loans.

B. **"Fixed premium universal life insurance policy"** means a universal life insurance policy other than a flexible premium universal life insurance policy.

C. **"Flexible premium universal life insurance policy"** means a universal life insurance policy which permits the policyowner to vary, independently of each other, the amount or timing of one or more premium payments or the amount of insurance.

D. **"Interest-indexed universal life insurance policy"** means any universal life insurance policy where the interest credits are linked to an external referent.

E. **"Net cash surrender value"** means the maximum amount payable to the policyowner upon surrender.

F. **"Policy value"** means the amount to which separately identified interest credits and mortality, expense, or other charges are made under a universal life insurance policy.

G. **"Universal life insurance policy"** means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality and expense charges are made to the policy. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

[12-1-85; Recompiled 11/30/01]

13.9.7.8 RESERVE VALUATION:

The minimum valuation standard for universal life insurance policies shall be the commissioners reserve valuation methods and the tables and interest rates specified in this section.

A. **Terminal reserve:** The terminal reserve for the basic policy and any benefits and/or riders for which premiums are not paid separately as of any policy anniversary shall be equal to the net level premium reserves less C and less D, where:

(1) net level premium reserves shall be equal to r(A-B) where:

(a) r is equal to one, unless the policy is a flexible premium policy and the policy value is less than the guaranteed maturity fund, in which case r is the ratio of the policy value to the guaranteed maturity fund.

(b) *A* is the present value of all future guaranteed benefits at the date of valuation.

(c) *B* is the quantity PVFB. a_{x+t} divided by a_x where:

(i) PVFB is the present value of all benefits guaranteed at issue assuming future guaranteed maturity premiums are paid by the policyowner and taking into account all guarantees contained in the policy or declared by the insurer;

(ii) a_x and a_{x+t} are present values of an annuity of one per year payable on policy anniversaries beginning at ages x and x+t, respectively, and continuing until the highest attained age at which a premium may be paid under the policy;

(iii) x is the issue age; and

(iv) t is the duration of the policy.

(2) *C* is the quantity (a-b). a_{x+t} r divided by a_x where:

(a) (a-b) is as described in Section 59A-8-5E(1) NMSA 1978 for the plan of insurance defined at issue by the guaranteed maturity premiums and all guarantees contained in the policy or declared by the insurer.

(b) a_{x+t} and a_x are defined in 13 NMAC 9.7.8.1.1.3.2 [now Item (ii) of Subparagraph (c) of Paragraph (1) of Subsection A of 13.9.7.8 NMAC].

(3) *D* is the sum of any additional quantities analogous to *C* which arise because of structural changes in the policy, with each such quantity being determined on a basis consistent with that of *C* using the maturity date in effect at the time of the change.

B. **Guaranteed maturity premium:** The guaranteed maturity premium for flexible premium universal life insurance policies shall be that level gross premium, paid at issue and periodically thereafter over the period during which premiums are allowed to be paid, which will mature the policy on the latest maturity date, if any, permitted under the policy (otherwise at the highest age in the valuation mortality table), for an amount which is in accordance with the policy structure. The guaranteed maturity premium is calculated at issue based on all policy guarantees at issue (excluding guarantees linked to an external referent). The guaranteed maturity premium for fixed premium universal life insurance policies shall be the premium defined in the policy which at issue provides the minimum policy guarantees.

C. **Guaranteed maturity fund:** The guaranteed maturity fund at any duration is that amount which, together with future guaranteed maturity premiums, will mature the policy based on all policy guarantees at issue.

D. **Recalculation for structural changes:** The guaranteed maturity premium, the guaranteed maturity fund and the quantity *B* in 13 NMAC 9.7.8.1.1.3 [now Subparagraph (c) of Paragraph (1) of Subsection A of 13.9.7.8 NMAC] shall be recalculated to reflect any structural changes in the policy. This recalculation shall be done in a manner consistent with the descriptions above.

E. **Futured guaranteed benefits:** Future guaranteed benefits are determined by:

(1) projecting the greater of the guaranteed maturity fund and the policy value, taking into account future guaranteed maturity premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc., contained in the policy or declared by the insurer; and

(2) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

F. **Present value:** All present values shall be determined using:

(1) an interest rate (or rates) specified by Section 59A-8-5 NMSA 1978 for policies issued in the same year;

(2) the mortality rates specified by Section 59A-8-5 NMSA 1978 for policies issued in the same year or contained in such other table as may be approved by the superintendent for this purpose; and

(3) any other tables needed to value supplementary benefits provided by a rider which is being valued together with the policy.

[12-1-85; Recompiled 11/30/01]

13.9.7.9 ALTERNATIVE MINIMUM RESERVES:

A. If, in any policy year, the guaranteed maturity premium on any universal life insurance policy is less than the valuation net premium for such policy, calculated by the valuation method actually used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such contract shall be the greater of 13 NMAC 9.7.9.1.1 or 9.7.9.1.2 [now Paragraphs (1) or (2) of Subsection A of 13.9.7.9 NMAC].

(1) The reserve calculated according to the method, the mortality table, and the rate of interest actually used.

(2) The reserve calculated according to the method actually used but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the guaranteed maturity premium in each policy year for which the valuation net premium exceeds the guaranteed maturity premium.

B. For universal life insurance reserves on a net level premium basis, the valuation net premium is PVFB divided by a_x and for reserves on a commissioners reserve valuation method, the valuation net premium is PVFB divided by a_x + (a-b) divided by a_x.

[12-1-85; Recompiled 11/30/01]

13.9.7.10 MINIMUM CASH SURRENDER VALUES FOR FLEXIBLE PREMIUM POLICIES:

Minimum cash surrender values for flexible premium universal life insurance policies shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

A. The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to the accumulation to that date of the premiums paid minus the accumulations to that date of:

(1) the benefit charges;

(2) the averaged administrative expense charges for the first policy year and any insurance-increase years;

(3) actual administrative expense charges for other years;

(4) initial and additional acquisition expense charges not exceeding the initial or additional expense allowances, respectively;

(5) any service charges actually made (excluding charges for cash surrender or election of a paid-up nonforfeiture benefit); and

(6) any deductions made for partial withdrawals; all accumulations being at the actual rate or rates of interest at which interest credits have been made unconditionally to the policy (or have been made conditionally, but for which the conditions have since been met), and minus any unamortized unused initial and additional expense allowances.

B. Interest on the premiums and on all charges referred to in 13 NMAC 9.7.10.1.1 - 9.7.10.1.6 [now Paragraphs (1) - (6) of Subsection A of 13.9.7.10 NMAC] shall be accumulated from and to such dates as are consistent with the manner in which interest is credited in determining the policy value.

C. The benefit charges shall include the charges made for mortality and any charges made for riders of supplementary benefit for which premiums are not paid separately. If benefit charges are substantially level by duration and develop low or no cash values, then the superintendent shall have the right to require higher cash values unless the insurer provides adequate justification that the cash values are appropriate in relation to the policy's other characteristics.

D. The administrative expense charges shall include charges per premium payment, charges per dollar of premium paid, periodic charges per thousand dollars of insurance, periodic per policy charges, and any other charges permitted by the policy to be imposed without regard to the policyowner's request for services.

E. The averaged administrative expense charges for any year shall be those which would have been imposed in that year if the charge rate or rates for each transaction or period within the year had been equal to the arithmetic average of the corresponding charge rates which the policy states will be imposed in policy years two through twenty in determining the policy value.

F. The initial acquisition expense charges shall be the excess of the expense charges, other than service charges, actually made in the first policy year over the averaged administrative expense charges for that year. Additional acquisition expense charges shall be the excess of the expense charges, other than service charges, actually made in an insurance-increase year over the averaged administrative expense charges for that year. An insurance-increase year shall be the year beginning on the date of increase in the amount of insurance by policyowner request (or by the terms or the policy).

G. Service charges shall include charges permitted by the policy to be imposed as the result of a policyowner's request for a service by the insurer (such as the furnishing of future benefit illustrations) or of special transactions.

H. The initial expense allowance shall be the allowance provided by Section 59A-20-31D items (b), (c), and (d) NMSA 1978, or by Section 59A-20-31F NMSA 1978, as applicable for a fixed premium, fixed benefit endowment policy with a face amount equal to the initial face amount of the flexible premium universal life insurance policy, with level premiums paid annually until the highest attained age at which a premium may be paid under the flexible premium universal life insurance policy, and maturing on the latest maturity date permitted under the policy, if any, otherwise at the highest age in the valuation mortality table. The unused initial expense allowance shall be the excess, if any, of the initial expense allowance over the initial acquisition expense charges as defined above.

I. If the amount of insurance is subsequently increased upon request of the policyowner (or by the terms of the policy), an additional expense allowance and an unused additional expense allowance shall be determined on a basis consistent with the above and with Section 59A-20-31F(5) NMSA 1978, using the face amount and the latest maturity date permitted at that time under the policy.

J. The unamortized unused initial expense allowance during the policy year beginning on the policy anniversary at age x+t (where x is the issue age) shall be the unused initial expense allowance multiplied by a_{x+t} divided by a_x where a_{x+t} and a_x are present values of an annuity of one per year payable on policy anniversaries beginning at ages x+t and x, respectively and continuing until the highest attained age at which a premium may be paid under the policy, both on the mortality and interest bases guaranteed in the policy. An unamortized unused additional expense allowance shall be the unused additional expense allowance multiplied by a similar ratio of annuities, with a_x replaced by an annuity beginning on the date as of which the additional expense allowance was determined.

[12-1-85; Recompiled 11/30/01]

13.9.7.11 MINIMUM CASH SURRENDER VALUES FOR FIXED PREMIUM POLICIES:

For fixed premium universal life insurance policies, the minimum cash surrender values shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

A. The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to *A* minus *B* minus *C* minus *D*, where:

(1) *A* is the present value of all future guaranteed benefits.

(2) *B* is the present value of future adjusted premiums. The adjusted premiums are calculated as described in Section 59A-2-31D and 59A-20-31F NMSA 1978, as applicable. If Section 59A-20-31F NMSA 1978 is applicable, the nonforfeiture net level premium is equal to the quantity PVFB divided by a_x, where PVFB is the present value of all benefits guaranteed at issue assuming future premiums are paid by the policyowner and all guarantees contained in the policy or declared by the insurer and a_x is the present value of an annuity of one per year payable on policy anniversaries beginning at age x and continuing until the highest attained age at which a premium may be paid under the policy.

(3) *C* is the present value of any quantities analogous to the nonforfeiture net level premium which arise because of guarantees declared by the insurer after the issue date of the policy. a_x shall be replaced by an annuity beginning on the date as of which the declaration became effective and payable until the end of the period covered by the declaration.

(4) *D* is the sum of any quantities analogous to *B* which arise because of structural changes in the policy.

B. Future guaranteed benefits are determined by:

(1) projecting the policy value, taking into account future premiums, if any, and using all guarantees of interest mortality, expense deductions etc., contained in the policy or declared by the insurer; and

(2) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

C. All present values shall be determined using:

(1) an interest rate (or rates) specified by Section 59A-20-31 NMSA 1978 for policies issued in the same year; and

(2) the mortality rates specified by Section 59A-20-31 NMSA 1978 for policies issued in the same year or contained in such other table as may be approved by the superintendent for this purpose.

[12-1-85; Recompiled 11/30/01]

13.9.7.12 MINIMUM PAID-UP NONFORFEITURE BENEFITS:

If a universal life insurance policy provides for the optional election of a paid-up nonforfeiture benefit, it shall be such that its present value shall be at least equal to the cash surrender value provided for by the policy on the effective date of the election. The present value shall be based on mortality and interest standards at least as favorable to the policyowner as:

A. in the case of a flexible premium universal life insurance policy, the mortality and interest basis guaranteed in the policy for determining the policy value; or

B. in the case of a fixed premium policy the mortality and interest standards permitted for paid-up nonforfeiture benefits by Section 59A-20-31 NMSA 1978. In lieu of the paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount of longer period of death benefits, or, if applicable, a greater amount or earlier payment of endowment benefits.

[12-1-85; Recompiled 11/30/01]

13.9.7.13 MANDATORY POLICY PROVISIONS:

A. The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised as to the status of the policy. The end of the current report period must be not more than three months previous to the date of the mailing of the report. Specific requirements of this report are detailed in 13 NMAC 9.7.15 [now 13.9.7.15 NMAC].

B. The policy shall provide for an illustrative report which will be sent to the policyowner upon request. Minimum requirements of such report are the same as those set forth in 13 NMAC 9.7.14 [now 13.9.7.14 NMAC]. The insurer may charge the policyowner a reasonable fee for providing the report.

C. The policy shall provide guarantees of minimum interest credits and maximum mortality and expense charges. All values and data shown in the policy shall be based on guarantees. No figures based on nonguarantees shall be included in the policy.

D. The policy shall contain at least a general description of the calculation of cash surrender values including the following information:

(1) the guaranteed maximum expense charges and loads;

(2) any limitation on the crediting of additional interest; interest credits shall not remain conditional for a period longer than twelve months;

(3) the guaranteed minimum rate or rates of interest;

(4) the guaranteed maximum mortality charges;

(5) any other guaranteed charges;

(6) any surrender or partial withdrawal charges.

E. If the policyowner has the right to change the basic coverage, any limitation on the amount of timing of such change shall be stated in the policy. If the policyowner has the right to increase the basic coverage, the policy shall state whether a new period of contestability and/or suicide is applicable to the additional coverage.

F. The policy shall provide for written notice to be sent to the policyowner's last known address at least thirty days prior to termination of coverage. A flexible premium policy shall provide for a grace period of at least thirty days after lapse. Unless otherwise defined in the policy, lapse shall occur on that date on which the net cash surrender value first equals zero.

G. If there is a misstatement of age or sex in the policy, the amount of the death benefit shall be that which would be purchased by the most recent mortality charge at the correct age or sex. The superintendent of insurance may approve other methods which are deemed satisfactory.

H. If a policy provides for a "maturity date," "end date," or similar date, then the policy shall also contain a statement, in close proximity to that date, that it is possible that coverage may not continue to the maturity date even if scheduled premiums are paid in a timely manner, if such is the case.

[12-1-85; Recompiled 11/30/01]

13.9.7.14 DISCLOSURE REQUIREMENTS:

In connection with any advertising solicitation, negotiation, or procurement of a universal life insurance policy:

A. Any statement of policy cost factors or benefits shall contain:

(1) the corresponding guaranteed policy cost factors or benefits, clearly identified;

(2) a statement explaining the nonguaranteed nature of any current interest rates, charges, or other fees applied to the policy, including the insurer's rights to alter any of these factors; and

(3) any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited.

B. Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value.

C. Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined.

D. If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy.

E. Any illustrated benefits based upon non-guaranteed interest, mortality, or expense factors shall be accompanied by the statement indicating that these benefits are not guaranteed.

F. If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy's maturity date, such facts shall be disclosed, including notice that coverage will terminate under such circumstances.

[12-1-85; Recompiled 11/30/01]

13.9.7.15 PERIODIC DISCLOSURE TO POLICYOWNER:

The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised of the status of the policy. The end of the current report period shall be not more than three months previous to the date of the mailing of the report. Such reports shall include the following:

A. the beginning and end of the current report period;

B. the policy value at the end of the previous report period and at the end of the current report period;

C. the total amounts which have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

D. the current death benefit at the end of the current report period on each life covered by the policy;

E. the net cash surrender value of the policy as of the end of the current report period;

F. the amount of outstanding loans, if any, as of the end of the current report period;

G. if fixed premium policies assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; and

H. if flexible premium policies, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

[12-1-85; Recompiled 11/30/01]

13.9.7.16 INTEREST-INDEXED UNIVERSAL LIFE INSURANCE POLICIES:

The following information shall be submitted in connection with any filing of interest-indexed universal life insurance policies (interest-indexed policies). All such information received shall be treated confidentially to the extent permitted by law.

A. A description of how the interest credits are determined, including:

(1) a description of the index;

(2) the relationship between the value of the index and the actual interest rate to be credited;

(3) the frequency and timing of determining the interest rate; and

(4) the allocation of interest credits, if more than one rate of interest applies to different portions of the policy value.

B. The insurer's investment policy, which includes a description of the following:

(1) how the insurer addressed the reinvestment risks;

(2) how the insurer plans to address the risk of capital loss on cash outflows;

(3) how the insurer plans to address the risk that appropriate investments may not be available or not available in sufficient quantities;

(4) how the insurer plans to address the risk that the indexed interest rate may fall below the minimum contractual interest rate guaranteed in the policy;

(5) the amount and type of assets currently held for interest indexed policies; and

(6) the amount and type of assets expected to be acquired in the future.

C. If policies are linked to an index for a specified period less than to the maturity date of the policy, a description of the method used (or currently contemplated) to determine interest credits upon the expiration of such period.

D. A description of any interest guarantee in addition to or in lieu of the index.

E. A description of any maximum premium limitations and the conditions under which they apply.

[12-1-85; Recompiled 11/30/01]

13.9.7.17 ADDITIONAL FILING REQUIREMENTS FOR INTEREST-INDEXED UNIVERSAL LIFE INSURANCE POLICIES:

A. Annually, every insurer shall submit a statement of actuarial opinion by the insurer's actuary similar to the example contained in 13 NMAC 9.7.17.4 [now Subsection D of 13.9.7.17 NMAC].

B. Annually, every insurer shall submit a description of the amount and type of assets currently held by the insurer with respect to its interest-indexed policies.

C. Prior to implementation, every domestic insurer shall submit a description of any material change in the insurer's investment strategy or method of determining the interest credits. A change is considered to be material if it would affect the form of definition of the index (i.e. any change in the information supplied pursuant to 13 NMAC 9.7.16 [now 13.9.7.16 NMAC] or if it would significantly change the amount or type of assets held for interest-indexed policies).

D. The following is a sample of the statement required by 13 NMAC 9.7.17.1 [now Subsection A of 13.9.7.17 NMAC].

I,_____, am _____

(name) (position of relationship to insurer)

_____ for the XYZ life insurance company

(the insurer) in the state of _____

(state of domicile of insurer)

I am a member of the American academy of actuaries (or if not, state other qualifications to sign annual statement actuarial opinions).

I have examined the interest-indexed universal life insurance policies of the insurer in force as of December 31, 19__, encompassing _____ number of policies and $ _____ of insurance in force.

I have considered the provisions of the policies, I have considered any reinsurance agreements pertaining to such policies, the characteristics of the identified assets and the investment policy adopted by the insurer as they affect future insurance and investment cash flows under such policies and related assets. My examination included such tests and calculations as I considered necessary to form an opinion concerning the insurance and investment cash flows arising from the policies and related assets.

I relied on the investment policy of the insurer and on projected investment cash flows as provided by _____, chief investment officer of the insurer.

The tests were conducted under various assumptions as to future interest rates, and particular attention was given to those provisions and characteristics that might cause future insurance and investment cash flows to vary with changes in the level of prevailing interest rates.

In my opinion, the anticipated insurance and investment cash flows referred to above make good and sufficient provision for the contractual obligations of the insurer under these insurance policies.

_____

signature of actuary

[12-1-85; Recompiled 11/30/01]

PART 8: VARIABLE LIFE INSURANCE

13.9.8.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.9.8.2 SCOPE:

This rule applies to variable life insurance policies issued for delivery in this state.

[7/1/97; Recompiled 11/30/01]

13.9.8.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[12/1/85; Recompiled 11/30/01]

13.9.8.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.9.8.5 EFFECTIVE DATE:

December 1, 1985, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[12/1/85, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.8.6 OBJECTIVE:

The purpose of this rule is to supplement other rules on life insurance policies in order to accommodate the development and issuance of universal life insurance policies.

[7/1/97; Recompiled 11/30/01]

13.9.8.7 DEFINITIONS:

A. **"Affiliate"** of an insurer means any person, directly or indirectly, controlling, controlled by, or under common control with such insurer; any person who regularly furnishes investment advice to such insurer with respect to its separate accounts for which a specific fee or commission is charged; or any director, officer, partner, or employee of any such insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

B. **"Agent"** means any person, corporation, partnership, or other legal entity which is licensed by this state as a life insurance agent and is authorized to sell variable life policies.

C. **"Assumed investment rate"** means the rate of investment return which would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses, and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than

incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

D. **"Benefit base"** means the amount to which the net investment return is applied.

E. **"Control"** (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing more than ten (10) percent of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the superintendent that control does not exist in fact. The superintendent may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

F. **"Flexible premium policy"** means any variable life insurance policy other than a scheduled premium policy.

G. **"General account"** means all assets of the insurer other than assets in separate accounts established pursuant to Section 59A-5-16 NMSA 1978 or pursuant to the corresponding insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

H. **"Incidental insurance benefit"** means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income, or term rider.

I. **"Minimum death benefit"** means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

J. **"Net investment return"** means the rate of investment return in a separate account to be applied to the benefit base.

K. **"Policy processing day"** means the day on which charges authorized in the policy are deducted from the policy's cash value.

L. **"Scheduled premium policy"** means any variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.

M. **"Separate account"** means a separate account established pursuant to 59A-20-30 NMSA 1978 Section or pursuant to the corresponding insurance laws of the state of domicile of a foreign or alien insurer.

N. **"Variable death benefit"** means the amount of the death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

O. **"Variable life insurance policy"** means any individual policy which provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, pursuant to Section 59A-20-30 NMSA 1978 of the nsurance laws of this state or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

[12/1/85; Recompiled 11/30/01]

13.9.8.8 LICENSING AND APPROVAL TO DO BUSINESS IN THIS STATE:

An insurer shall not deliver or issue for delivery in this state any variable life insurance policy unless:

A. The insurer is licensed or organized to do a life insurance business in this state.

B. The insurer has obtained the written approval of the superintendent for the issuance of variable life insurance policies in this state. The superintendent shall grant such written approval only after he has found that:

(1) the plan of operation for the issuance of variable life insurance policies is not unsound;

(2) the general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to assure reasonably competent operation of the variable life insurance business of the insurer in this state; and

(3) the present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this state. The superintendent shall consider, among other things:

(a) the history of operation and financial condition of the insurer;

(b) the qualifications, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the insurer and those

persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(c) the applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life insurance policies; the state of entry of an alien insurer shall be deemed its state of domicile for this purpose; and

(d) if the insurer is a subsidiary of, or is affiliated by common management or ownership with another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meet these standards.

[12/1/85; Recompiled 11/30/01]

13.9.8.9 FILING FOR PERMANENT APPROVAL TO DO BUSINESS IN THIS STATE:

The superintendent may, at his discretion, require that an insurer, before it delivers or issues for delivery any variable life insurance policy in this state, file with this department the following information for the consideration of the superintendent in making the determination required by 13 NMAC 9.8.8.2 [now Subsection B of 13.9.8.8 NMAC]:

A. copies of and a general description of the variable life insurance policies it intends to issue;

B. a general description of the methods of operation of the variable life insurance business of the insurer, including methods of distribution of policies and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial or distribution services to the insurer;

C. with respect to any separate account maintained by an insurer for any variable life insurance policy, a statement of the investment policy the issuer intends to follow for the investment of the assets held in such separate account, and a statement of procedures for changing such investment policy; the statement of investment policy shall include a description of the investment objectives intended for the separate account;

D. a description of any investment advisory services contemplated;

E. a copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies;

F. biographical data with respect to officers and directors of the insurer on the national association of insurance commissioners uniform biographical data form; and

G. a statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the policy.

[12/1/85; Recompiled 11/30/01]

13.9.8.10 STANDARDS OF SUITABILITY:

Every insurer seeking approval to enter into the variable life insurance business in this state shall establish and maintain a written statement specifying the standards of suitability to be used by the insurer. Such standards of suitability shall specify that no recommendations shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of such policy is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or to the agent making the recommendation.

[12/1/85; Recompiled 11/30/01]

13.9.8.11 USE OF SALES MATERIALS:

An insurer authorized to transact variable life insurance business in this state shall not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its variable life insurance business in this state which is false, misleading, deceptive, or inaccurate.

[12/1/85; Recompiled 11/30/01]

13.9.8.12 REQUIREMENTS APPLICABLE TO CONTRACTUAL SERVICES:

Any material contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial, or other services with respect to variable life insurance operations shall be in writing and provide that the supplier of such services shall furnish the superintendent with any information or reports in connection with such services which the superintendent may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with these regulations and any other applicable law or regulations.

[12/1/85; Recompiled 11/30/01]

13.9.8.13 REQUIRED REPORTS:

A. Any insurer authorized to transact the business of variable life insurance in this state shall submit to the superintendent, in addition to any other materials which may be required by this rule or any other applicable laws or regulations:

(1) an annual statement of the business of its separate account or accounts in such form as may be prescribed by the national association of insurance commissioners;

(2) prior to the use in this state any information furnished to applicants as provided for in 13 NMAC 9.8.34 [now 13.9.8.34 NMAC];

(3) prior to the use in this state the form of any of the reports to policyholders as provided for in 13 NMAC 9.8.36 [now 13.9.8.36 NMAC]; and

(4) such additional information concerning its variable life insurance operations or its separate accounts as the superintendent shall deem necessary.

B. Any material submitted to the superintendent under this section shall be disapproved if it is found to be false, misleading, deceptive, or inaccurate in any material respect and, if previously distributed, the superintendent shall require the distribution of amended material.

[12/1/85; Recompiled 11/30/01]

13.9.8.14 AUTHORITY OF SUPERINTENDENT TO DISAPPROVE:

Any material required to be filed with and approved by the superintendent shall be subject to disapproval at any time it is found by him not to comply with the standards established by this rule.

[12/1/85; Recompiled 11/30/01]

13.9.8.15 POLICY QUALIFICATION:

The superintendent shall not approve any variable life insurance form filed unless it conforms to the requirements of 13 NMAC 9.8.15, 9.8.16, 9.8.17, 9.8.18, 9.8.19 and 9.8.20 [now Sections 15, 16, 17, 18, 19 and 20 of 13.9.8 NMAC].

[12/1/85; Recompiled 11/30/01]

13.9.8.16 FILING OF VARIABLE LIFE INSURANCE POLICIES:

All variable life insurance policies, and all riders, endorsements, applications and other documents which are to be attached to and made a part of the policy and which relate to the variable nature of the policy, shall be filed with the superintendent and approved by him prior to delivery or issuance for delivery in this state.

A. The procedures and requirements for such filing and approval shall be, to the extent appropriate and not inconsistent with this article, the same as those otherwise applicable to other life insurance policies.

B. The superintendent may approve variable life insurance policies and related forms with provisions the superintendent deems to be not less favorable to the policyholder and the beneficiary than those required by 13 NMAC 9.8.15, 9.8.16, 9.8.17, 9.8.18, 9.8.19 and 9.8.20 [now Sections 15, 16, 17, 18, 19 and 20 of 13.9.8 NMAC].

[12/1/85; Recompiled 11/30/01]

13.9.8.17 MANDATORY POLICY BENEFIT AND DESIGN REQUIREMENTS:

Variable life insurance policies delivered or issued for delivery in this state shall comply with the following minimum requirements:

A. Mortality and expense risks shall be borne by the insurer. The mortality and expense charges shall be subject to the maximums stated in the contract.

B. For scheduled premium policies, a minimum death benefit shall be provided in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid (subject to the provisions of 13 NMAC 9.8.18.2.2) [now Paragraph (2) of Subsection B of 13.9.8.18 NMAC].

C. The policy shall reflect the investment experience of one or more separate accounts established and maintained by the insurer. The insurer must demonstrate that the reflection of investment expense in the variable life insurance policy is actuarially sound.

D. Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

E. Any changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

F. The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other non-forfeiture benefits, as described either in the policy or in a statement filed with the superintendent of the state in which the policy is delivered, or issued for delivery, shall be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values and other non-forfeiture benefits must be at least equal to the minimum values required by the Standard Non-Forfeiture Law of New Mexico for a general account policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under the Standard Non-Forfeiture Law of New Mexico. If the policy does not contain an assumed investment rate this demonstration shall be based on the maximum interest rate permitted under the Standard Non-Forfeiture Law. The method of computation may disregard incidental

minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not to be limited to, a guarantee that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

G. The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the superintendent.

[12/1/85; Recompiled 11/30/01]

13.9.8.18 MANDATORY POLICY PROVISIONS:

Every variable life insurance policy filed for approval in this state shall contain at least the following:

A. The cover page or pages corresponding to the cover pages of each such policy shall contain:

(1) a prominent statement in either contrasting color or in boldface type that the amount or duration of death benefit may be variable or fixed under specified conditions;

(2) a prominent statement in either contrasting color or in boldface type that cash values may increase or decrease in accordance with the experience of the separate account subject to any specified minimum guarantees;

(3) a statement describing any minimum death benefit required;

(4) the method, or a reference to the policy provision which describes the method, for determining the amount of insurance payable at death;

(5) to the extent permitted by state law, a captioned provision that the policy holder may return the variable life insurance policy within 10 days of receipt of the policy by the policyholder, and receive a refund equal to the sum of: 1) the difference between the premiums paid including any policy fees or other charges and the amounts allocated to any separate accounts under the policy; and 2) the value of the amounts allocated to any separate accounts under the policy, on the date the returned policy is received by the insurer or its agent. Until such time as state law authorizes the return of payments as calculated in the preceding sentence, the amount of the refund shall be the total of all premium payments for such policy; and

(6) such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with this regulation.

B. **Grace period:**

(1) For scheduled premium policies, a provision for a grace period of not less than thirty-one days from the premium due date which shall provide that where the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date.

(2) For flexible premium policies, a provision for a grace period beginning on the policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges in accordance with the terms of the policy. Such grace period shall end on a date not less than 61 days after the mailing date of the required report to policyholders.

(3) The death benefit payable during the grace period will equal the death benefit in effect immediately prior to such period less any overdue charges. If the policy processing days occur monthly, the insurer may require the payment of not more than 3 times the charge which were due on the policy processing day on which the amounts available under the policy were insufficient to pay all charges authorized by the policy that are necessary to keep such policy in force until the next policy processing day.

C. For scheduled premium policies, a provision that the policy will be reinstated at any time within two years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(1) all overdue premiums with interest at a rate not exceeding six percent per annum compounded annually and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding six percent per annum compounded annually; or

(2) 110 percent of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding six percent per annum compounded annually.

D. A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy.

E. A provision designating the separate account to be used and stating that:

(1) the assets of such separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account; and

(2) the assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly.

F. A provision specifying what documents constitute the entire insurance contract under state law.

G. A designation of the officers who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on his behalf, shall be considered as representations and not warranties.

H. An identification of the owner of the insurance contract.

I. A provision setting forth conditions or requirements as to the designation, or change of designation, or a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation.

J. A statement of any conditions or requirements concerning the assignment of the policy.

K. A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured.

L. A provision that the policy shall be incontestable by the insurer after it has been in force for two years during the lifetime of the insured, provided, however, that any increase in the amount of the policy's death benefits subsequent to the policy issue date, which increase occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's insurability, shall be incontestable after any such increase has been in force, during the life-time of the insured, for two years from the date of issue of such increase.

M. A provision stating that the investment policy of the separate account shall not be changed without the approval of the insurance commissioner of the state of domicile of the insurer, and that the approval process is on file with the superintendent of this state.

N. A provision that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans, or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(1) for up to six months from the date of request, if such payments are based on policy values which do not depend on the investment performance of the separate account; or

(2) otherwise, for any period during which the New York stock exchange is closed for trading (except for normal holiday closing) or when the securities and exchange commission has determined that a state of emergency exists which may make such payment impractical.

O. If settlement options are provided, at least one such option shall be provided on a fixed basis only.

P. A description of the basis for computing the cash value and the surrender value under the policy shall be included.

Q. Premiums or charges for incidental insurance benefits shall be stated separately.

R. Any other policy provision required by this rule.

S. Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this rule.

T. A provision for non-forfeiture insurance benefits. The insurer may establish a reasonable minimum cash value below which any non-forfeiture insurance options will not be available.

[12/1/85; Recompiled 11/30/01]

13.9.8.19 POLICY LOAN PROVISIONS:

Every variable life insurance policy, other than term insurance policies and pure endowment policies, delivered or issued for delivery in this state shall contain provisions which are not less favorable to the policyholder than a provision for policy loans after the policy has been in force for three (3) full years which provides the following:

A. at least 75% of the policy's cash surrender value may be borrowed at the end of the current policy year;

B. the amount borrowed shall bear interest at a rate not to exceed that permitted by state insurance law;

C. any indebtedness shall be deducted from the proceeds payable on death;

D. any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any non-forfeiture benefit;

E. for scheduled premium policies, whenever the indebtedness exceeds the cash surrender value, the insurer shall give notice of any intent to cancel the policy if the excess indebtedness is not repaid within thirty-one days after the date of mailing of such notice; for flexible premium policies, whenever the total charges authorized by the policy

that are necessary to keep the policy in force until the next following processing day exceed the amounts available under the policy to pay such charges, a report must be sent to the policy holder containing the information specified by 13 NMAC 9.8.18 or 13 NMAC 9.8.36 [now 13.9.8.18 NMAC or 13.9.8.36 NMAC];

F. the policy may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the policyholder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110% of the corresponding increase in cash value and by furnishing such evidence of insurability as the insurer may request;

G. the policy may specify a reasonable minimum amount which may be borrowed at any time but such minimum shall not apply to any automatic premium loan provision;

H. no policy loan provision is required if the policy is under extended insurance non-forfeiture option;

I. the policy loan provisions shall be constructed so that variable life insurance policyholders who have not exercised such provisions are not disadvantaged by the exercise thereof; and

J. amounts paid to the policyholders upon the exercise of any policy loan provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the amounts for policy loans from the general account.

[12/1/85; Recompiled 11/30/01]

13.9.8.20 OTHER POLICY PROVISIONS:

The following provision may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this state:

A. an exclusion for suicide within two years of the issue date of the policy; provided, however, that to the extent of the increased death benefits only, the policy may provide an exclusion for suicide within two years of any increase in death benefits which results from an application of the owner subsequent to the policy issue date;

B. incidental insurance benefits may be offered on a fixed or variable basis;

C. policies issued on a participating basis shall offer to pay dividend amounts in cash; in addition, such policies may offer the following dividend options:

(1) the amount of the dividend may be credited against premium payments;

(2) the amount of the dividend may be applied to provide amounts of additional fixed or variable benefit life insurance;

(3) the amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(4) the amount of the dividend may be applied to provide paid-up amounts of fixed benefit one-year term insurance; and

(5) the amount of the dividend may be deposited as a variable deposit in a separate account.

D. A provision allowing the policyholder to elect in writing in the application for the policy or thereafter in automatic premium loan on a basis not less favorable than that required of policy loans under 13 NMAC 9.8.19 [now 13.9.8.19 NMAC], except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed.

E. A provision allowing the policyholder to make partial withdrawals.

F. Any other policy provision approved by the superintendent.

[12/1/85; Recompiled 11/30/01]

13.9.8.21 RESERVE LIABILITIES UNDER STANDARD VALUATION LAW:

Reserve liabilities for variable life insurance policies shall be established under the Standard Valuation Law in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

[12/1/85; Recompiled 11/30/01]

13.9.8.22 RESERVE LIABILITIES FOR THE GUARANTEED MINIMUM DEATH BENEFIT:

For scheduled premium policies, reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in the general account of the insurer and shall be not less than the greater of the following minimum reserves:

A. the aggregate total of the term cost, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life insurance contract, assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the assumed investment rate; or

B. the aggregate total of the "attained age level" reserves on each variable life insurance contract; the "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall equal the "residue," as described in 13 NMAC 9.8.21 [now 13.9.8.21 NMAC] of the prior year's "attained age level" reserve on the contract, with any such "residue," increased or decreased by a payment computed on an attained age basis as described in 13 NMAC 9.8.22.2.2 [now Paragraph (2) of Subsection B of 13.9.8.22 NMAC].

(1) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall be determined by adding interest at the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the "excess," if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

(2) The payment referred to in 13 NMAC 9.8.22.2 of this rule [now Subsection B of 13.9.8.22 NMAC] shall be computed so that the present value of a level payment of that amount each year over the future premium paying period of the contract is equal to (A) minus (B) minus (C), where (A) is the present value of the future guaranteed minimum death benefits, (B) is the present value of the future death benefits that would be payable in the absence of such guarantee, and (C) is any "residue," as described in 13 NMAC 9.8.22.2 [now Subsection B of 13.9.8.22 NMAC], of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid-up, the payment shall equal (A) minus (B) minus (C). The amounts of future death benefits referred to in (B) shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate and/or the valuation interest rate but in no event may exceed the maximum interest rate permitted for the valuation of life contracts.

C. The valuation interest rate and mortality table used in computing the two minimum reserves described in 13 NMAC 9.8.22 [now 13.9.8.22 NMAC] above shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

[12/1/85; Recompiled 11/30/01]

13.9.8.23 RESERVE LIABILITIES FOR GUARANTEED MINIMUM DEATH BENEFIT FOR FLEXIBLE PREMIUM POLICIES:

For flexible premium policies, reserve liabilities for any guaranteed minimum death benefit shall be maintained in the general account of the insurer and shall be not less

than the aggregate total of the term costs, if any, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the valuation interest rate. The valuation interest rate and mortality table used in computing this additional reserve, if any, shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

[12/1/85; Recompiled 11/30/01]

13.9.8.24 INCIDENTAL INSURANCE BENEFIT:

Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits shall be maintained in the general account and reserve liabilities for all variable aspects of the variable incidental insurance benefits shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

[12/1/85; Recompiled 11/30/01]

13.9.8.25 ESTABLISHMENT AND ADMINISTRATION OF SEPARATE ACCOUNTS:

Any domestic insurer issuing variable life insurance shall establish one or more separate accounts pursuant to Section 59A-20-30 NMSA 1978 of the New Mexico Insurance Code.

A. If no law or other regulation provides for the custody of separate account assets and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets shall be in writing and the superintendent shall have authority to review and approve of both the terms of any such contract and the proposed custodian prior to the transfer of custody.

B. Such insurer shall not without the prior written approval of the superintendent employ in any material connection with the handling of separate account assets any person who:

(1) within the last ten years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of Sections 1341, 1342, or 1343 of Title 18, United States Code; or

(2) within the last ten years has been found by any state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit, or knowing misrepresentation; or

(3) within the last ten years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit, or knowing misrepresentation.

C. All persons with access to the cash securities, or other assets of the separate account shall be under bond in the amount of not less than $10,000.

D. The assets of such separate accounts shall be valued at least as often as variable benefits are determined but in any event at least monthly.

[12/1/85; Recompiled 11/30/01]

13.9.8.26 AMOUNTS IN THE SEPARATE ACCOUNT:

The insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies on the benefit base for such policies.

[12/1/85; Recompiled 11/30/01]

13.9.8.27 LIMITATIONS ON INVESTMENTS BY THE SEPARATE ACCOUNT:

A. No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(1) in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made; and

(2) such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the superintendent in advance.

B. The separate account shall have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under policies funded by the account.

[12/1/85; Recompiled 11/30/01]

13.9.8.28 LIMITATIONS ON OWNERSHIP:

A. A separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such account in such security valued as

required by these regulations, would exceed 10% of the value of the assets of the separate account. The superintendent may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state.

B. No separate account shall purchase or otherwise acquire the voting securities of any issuer if as a result of such acquisition the insurer and its separate accounts, in the aggregate, will own more than 10% of the total issued and outstanding voting securities of such issuer. The superintendent may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state or jeopardize the independent operation of the issuer of such securities.

C. The percentage limitation specified in 13 NMAC 9.8.28.1 [now Subsection A of 13.9.2.28 NMAC] shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the Investment Company Act of 1940 or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of 13 NMAC 9.8.27 [now 13.9.8.27 NMAC] and other applicable portions of this rule.

[12/1/85; Recompiled 11/30/01]

13.9.8.29 SEPARATE ACCOUNT INVESTMENT POLICY:

The investment policy of a separate account operated by a domestic insurer filed under 13 NMAC 9.8.27 [now 13.9.8.27 NMAC] shall not be changed without first filing such change with the superintendent of insurance.

A. Any change filed pursuant to this section shall be effective sixty days after the date it was filed with the superintendent, unless the superintendent notifies the insurer before the end of such sixty-day period of his disapproval of the proposed change. At any time the superintendent may, after notice and public hearing, disapprove any change that has become effective pursuant to this section.

B. The superintendent may disapprove the change if he determines that the change would be detrimental to the interests of the policyholders participating in such separate account.

[12/1/85; Recompiled 11/30/01]

13.9.8.30 CHARGES AGAINST SEPARATE ACCOUNT:

The insurer must disclose in writing, prior to or contemporaneously with delivery of the policy, all charges that may be made against the separate account, including, but not limited to, the following:

A. taxes or reserves for taxes attributable to investment gains and income of the separate account;

B. actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

C. actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities;

D. charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

E. a charge, at a rate specified in the policy, for mortality and expense guarantees;

F. any amounts in excess of those required to be held in the separate accounts; and

G. charges for incidental insurance benefits.

[12/1/85; Recompiled 11/30/01]

13.9.8.31 STANDARDS OF CONDUCT:

Every insurer seeking approval to enter into the variable life insurance business in this state shall adopt by formal action of its board of directors a written statement specifying the standards of conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such standards of conduct shall be binding on the insurer and those to whom it refers. A code or codes of ethics meeting the requirements of Section 17j under the Investment Company Act of 1940 and applicable rules and regulations thereunder shall satisfy the provisions of this section.

[12/1/85; Recompiled 11/30/01]

13.9.8.32 CONFLICTS OF INTEREST:

Rules under any provision of the Insurance Code of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body.

[12/1/85; Recompiled 11/30/01]

13.9.8.33 INVESTMENT ADVISORY SERVICES TO A SEPARATE ACCOUNT:

A. An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless:

(1) the person providing such advice is registered as an investment adviser under the Investment Advisers Act of 1940; or

(2) the person providing such advice is an investment manager under the Employee Retirement Income Security Act of 1974 with respect to the assets of each employee benefit plan allocated to the separate account; or

(3) the insurer has filed with the superintendent and continues to file annually the following information and statements concerning the proposed adviser:

(a) the name and form of organization, state of organization, and its principal place of business;

(b) the names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment advisor be an individual, of such individual;

(c) a written standard of conduct complying in substance with the requirements of 13 NMAC 9.8.31 [now 13.9.8.31 NMAC] of this rule which has been adopted by the investment adviser and is applicable to the investment adviser, its officers, directors, and affiliates;

(d) a statement provided by the proposed adviser as to whether the adviser or any person associated therewith:

(i) has been convicted within ten years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director or an insurance company, a banker, an insurance agent, a securities broker, or an investment adviser involving embezzlement, fraudulent conversion, or misappropriation of funds of securities, or involving the violation of Sections 1341, 1342, or 1343 of Title 18 of United States Code;

(ii) has been permanently or temporarily enjoined by order, judgment, or decree of any court of competent jurisdiction from acting as an investment adviser, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(iii) has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under any such laws; or

(iv) has been censured, denied an investment adviser registration, had a registration as an investment adviser revoked or suspended, or been barred or suspended from being associated with an investment adviser by order of federal or state regulatory authorities; and

(v) such investment advisory contract shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than sixty days' written notice to the investment adviser.

B. The superintendent may after notice and opportunity for a hearing by order require such investment advisory contract to be terminated if he deems continued operation thereunder to be hazardous to the public or the insurer's policyholders.

[12/1/85; Recompiled 11/30/01]

13.9.8.34 INFORMATION FURNISHED TO APPLICANTS:

An insurer delivering or issuing for delivery in this state any variable life insurance policies shall deliver to the applicant for the policy, and obtain a written acknowledgment of receipt from such applicant coincident with or prior to the execution of the application, the following information. The requirements of this section shall be deemed to have been satisfied to the extent that a disclosure containing information required by this section is delivered, either in the form of: 1) a prospectus included in the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission; or 2) all information and reports required by the Employee Retirement Income Security Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933 pursuant to Section 3(a)(2) thereof.

A. A summary explanation, in non-technical terms, or the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the separate account and the factors which affect such variation. Such explanation must include notices of the provisions required by 13 NMAC 9.8.18.1.5 and 13 NMAC 9.8.18.6 [now Paragraph (5) of Subsection A of 13.9.8.18 NMAC and Subsection F of 13.9.8.18 NMAC];

B. A statement of the investment policy of the separate account, including:

(1) a description for the investment objectives intended for the separate account and the principal types of investments intended to be made; and

(2) any restriction or limitations on the manner in which the operations of the separate account are intended to be conducted.

C. A statement of the net investment return of the separate account for each of the last ten years of such lesser period as the separate account has been in existence.

D. A statement of the charges levied against the separate account during the previous year.

E. A summary of the method to be used in valuing assets held by the separate account.

F. A summary of the federal income tax aspects of the policy applicable to the insured, the policyholder and the beneficiary.

G. Illustrations of benefits payable under the variable life insurance contract. Such illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investment experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only.

[12/1/85; Recompiled 11/30/01]

13.9.8.35 APPLICATIONS:

The application for a variable life insurance policy shall contain:

A. a prominent statement that the death benefit may be variable or fixed under specified conditions;

B. a prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees); and

C. questions designed to elicit information which enables the insurer to determine the suitability of variable life insurance for the applicant.

[12/1/85; Recompiled 11/30/01]

13.9.8.36 REPORTS TO POLICYHOLDERS:

Any insurer delivering or issuing for delivery in this state any variable life insurance policies shall mail to each variable life insurance policyholder at his or her last known address the following reports:

A. **Anniversary reports:**

(1) Within thirty days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, any optional payments allowed pursuant to 13 NMAC 9.8.15, 9.8.16, 9.8.17, 9.8.18, 9.8.19 and 9.8.20 [now Sections 15, 16, 17, 18, 19 and and 20 of

13.9.8 NMAC] under the policy computed as of the policy anniversary date; provided, however, that such statement may be furnished within thirty days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than sixty days prior to the mailing of such notice.

(2) This statement shall state that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this rule.

(3) If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate. For flexible premium policies, the report must contain a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made against the cash value.

(4) In addition, the report must show the projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report assuming that: 1) planned periodic premiums, if any, are paid as scheduled; 2) guaranteed costs of insurance are deducted; and 3) the net investment return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

B. **Separate account and summary information:** Annually, a statement or statements including:

(1) a summary of the financial statement of the separate account based on the annual statement last filed with the superintendent;

(2) the net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five years when available;

(3) a list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the superintendent;

(4) any charges levied against the separate account during the previous year; and

(5) a statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment adviser of the separate account.

C. **Additional report for flexible premium policies:** For flexible premium policies, a report must be sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day. The report must indicate the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of such amount.

[12/1/85; Recompiled 11/30/01]

13.9.8.37 FOREIGN COMPANIES:

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially similar to that provided by these rules, the superintendent to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these rules.

[12/1/85; Recompiled 11/30/01]

13.9.8.38 QUALIFICATIONS TO SELL VARIABLE LIFE INSURANCE:

A. No person may sell or offer for sale in this state any variable life insurance policy unless such person is an agent and has filed with the superintendent, in a form satisfactory to the superintendent, evidence that such person holds any license or authorization which may be required for the solicitation or sale of variable life insurance.

B. Any examination administered by the department for the purpose of determining the eligibility for any person for licensing as an agent shall, after the effective date of these rules, include such questions concerning the history, purpose, regulation, and sale of variable life insurance as the superintendent deems appropriate.

[12/1/85; Recompiled 11/30/01]

13.9.8.39 REPORTS OF DISCIPLINARY ACTIONS:

Any person qualified in this state under these rules to sell or offer to sell variable life insurance shall immediately report to the superintendent:

A. any suspension or revocation of his agent's license in any other state or territory of the United States;

B. the imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension, or revocation of or denial of registration, imposed upon him by any national securities exchange, or national securities association, or any federal, state, or territorial agency with jurisdiction over securities or variable life insurance; and

C. any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

[12/1/85; Recompiled 11/30/01]

13.9.8.40 REFUSAL TO QUALIFY AGENT TO SELL VARIABLE LIFE INSURANCE:

The superintendent may reject any application or suspend or revoke or refuse to renew any agent's qualification under these regulations to sell or offer to sell variable life insurance upon any ground that would bar such applicant or such agent from being licensed to sell other life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's license shall also govern any proceeding for suspension or revocation of an agent's qualification of sell or offer to sell variable life insurance.

[12/1/85; Recompiled 11/30/01]

PART 9: UNISEX NONFORFEITURE STANDARDS

13.9.9.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.9.9.2 SCOPE:

This rule applies to all life insurers providing non-forfeiture benefits on a sex-neutral basis.

[7/1/97; Recompiled 11/30/01]

13.9.9.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978.

[12/1/85; Recompiled 11/30/01]

13.9.9.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.9.9.5 EFFECTIVE DATE:

December 1, 1985, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[12/1/85, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.9.6 OBJECTIVE:

The purpose of these rules is to permit individual life insurance policies to provide the same cash surrender values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is implied by this rule.

[12/1/85; Recompiled 11/30/01]

13.9.9.7 DEFINITIONS:

A. **"1980 CSO table, with or without ten year select mortality factors"** means that mortality table, consisting of separate rates of mortality for male and female lives developed by the society of actuaries committee to recommend new mortality tables for valuation of standard individual ordinary life insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the commissioners 1980 standard ordinary mortality table, with or without ten-year select mortality factors.

B. **"1980 CSO table (M), with or without ten-year select mortality factors"** means that mortality table consisting of the rates of mortality for males lives from the 1980 CSO tables, with or without ten-year select mortality factors.

C. **"1980 CSO table (F), with or without ten-year select mortality factors"** means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO table, with or without ten-years select mortality factors.

D. **"1980 CET table"** means that mortality table consisting of separate rates of mortality for male and female lives, developed by the society of actuaries committee to recommend new mortality tables for valuation of standard individual ordinary life insurance, incorporated in the 1980 NAIC Amendments to the Model Standard

Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the commissioners 1980 extended term insurance table.

E. **"1980 CET table (M)"** means that mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

F. **"1980 CET table (F)"** means that mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

[12/1/85; Recompiled 11/30/01]

13.9.9.8 MORTALITY TABLES:

For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this state after the operative date of Section 59-16-8F(10) (now codified at Section 59A-20-31K) NMSA 1978 for that policy form:

A. a mortality table which is a blend of the 1980 CSO table (M) and the 1980 CSO table (F) with or without ten-year select mortality factors may at the option of the company be substituted for the 1980 CSO table, with or without ten-year select mortality factors; and

B. a mortality table which is of the same blend as used in (I) but applied to form a blend of the 1980 CET Table (M) and the 1980 CET table (F) may at the option of the company be substituted for the 1980 CET table for use in determining minimum cash surrender values and amount of paid-up nonforfeiture benefits.

C. The following table will be considered as the basis for acceptable tables:

(1) 100% male 0% female for tables to be designated as the 1980 CSO-A and 1980 CET-A tables;

(2) 80% male 20% female for tables to be designated as the 1980 CSO-B and 1980 CET-B tables;

(3) 60% male 40% female for tables to be designated as the 1980 CSO-C and 1980 CET-C tables;

(4) 50% male 50% female for tables to be designated as the 1980 CSO-D and 1980 CET-D tables;

(5) 40% male 60% female for tables to be designated as the 1980 CSO-E and 1980 CET-E tables;

(6) 20% male 80% female for tables to be designated as the 1980 CSO-F and 1980 CET-F tables; and

(7) 0% male 100% female for tables to be designated as the 1980 CSO-G and 1980 CET-G tables.

D. Tables A and G are not to be used with respect to policies issued on or after January 1, 1985, except where the proportion of persons insured is anticipated to be 90% or more of one sex or the other or except for certain policies converted from group insurance. Such group conversion issued on or after January 1, 1986 must use mortality tables based on the blend of lives by sex expected for such policies if such group conversions are considered as extensions of the Norris decision. This consideration has not been clearly defined by court or legislative action in all jurisdictions.

[12/1/85, 2/2/89, 7/1/97; Recompiled 11/30/01]

13.9.9.9 ALTERNATE RULE:

A. In determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits for any policy of insurance on the life of either a male or female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this state after the operative date of Section 59-16-8F(10) NMSA 1978 (now codified at Section 59A-20-31K NMSA 1978) for that policy form, in addition to the mortality tables that may be used according to13 NMAC 9.9.8 [now 13.9.9.7 NMAC]:

(1) a mortality table which is a blend of the male and female rates of mortality according to the 1980 CSO smoker mortality table, in the case of lives classified as smokers, or the 1980 CSO nonsmokers mortality table, in the case of lives classified as nonsmokers, with or without ten-year select mortality factors, may at the option of the company be substituted for the 1980 CSO table, with or without ten-year select mortality factors; and

(2) a mortality table which is of the same blend as used in (i) [*sic*] but applied to form a blend of the male and female rates or mortality according to the corresponding 1980 CET smoker mortality table or 1980 CET nonsmoker mortality table may at the option of the company be substituted for the 1980 CET table.

B. The following blended mortality tables for smokers will be considered acceptable:

(1) **Table SA:** 100% male 0% female smoker tables designated as 1980 CSO-SA and 1980 CET-SA tables.

(2) **Table SB:** 80% male 20% female smoker tables designated as 1980 CSO-SB and 1980 CET-SB tables.

(3) **Table SC:** 60% male 40% female smoker tables designated as 1980 CSO-SC and 1980 CET-SC tables.

(4) **Table SD:** 50% male 50% female smoker tables designated as 1980 CSO-SD and 1980 CET-SD tables.

(5) **Table SE:** 40% male 60% female smoker tables designated as 1980 CSO-SE and 1980 CET-SE tables.

(6) **Table SF:** 20% male 80% female smoker tables designated as 1980 CSO-SF and 1980 CET-SF tables.

(7) **Table SG:** 0% male 100% female smoker tables designated as 1980 CSO-SG and 1980 CET-SG tables.

C. The following blended mortality tables for nonsmokers will be considered acceptable:

(1) **Table NA:** 100% male 0% female nonsmoker tables designated as 1980 CSO-NA and 1980 CET-NA tables.

(2) **Table NB:** 80% male 20% female nonsmoker tables designated as 1980 CSO-NB and 1980 CET-NB tables.

(3) **Table NC:** 60% male 40% female nonsmoker tables designated as 1980 CSO-NC and 1980 CET-NC tables.

(4) **Table ND:** 50% male 50% female nonsmoker tables designated as 1980 CSO-ND and 1980 CET-ND tables.

(5) **Table NE:** 40% male 60% female nonsmoker tables designated as 1980 CSO-NE and 1980 CET-NE tables.

(6) **Table NF:** 20% male 80% female nonsmoker tables designated as 1980 CSO-NF and 1980 CET-NF tables.

(7) **Table NG:** 0% male 100% female nonsmoker tables designated as 1980 CSO-NG and 1980 CET-NG tables.

D. Tables SA, SG, NA and NG are not acceptable as blended tables unless the proportion of persons insured is anticipated to be 90% or more of one sex or the other.

[7/1/97; Recompiled 11/30/01]

13.9.9.10 UNFAIR DISCRIMINATION:

It shall not be a violation of Sections 59A-16-11 or 59A-16-13 NMSA 1978 for an insurer to issue the same kind of policy of life insurance on both a sex distinct and sex neutral basis.

[12/1/85; Recompiled 11/30/01]

PART 10: USE OF SMOKER/NONSMOKER MORTALITY TABLES

13.9.10.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.9.10.2 SCOPE:

This rule applies to all life insurers issuing plans of insurance with separate premium rates for smokers and non-smokers.

[7/1/97; Recompiled 11/30/01]

13.9.10.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-20-31 NMSA 1978.

[12/1/85; Recompiled 11/30/01]

13.9.10.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.9.10.5 EFFECTIVE DATE:

December 1, 1985, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[12/1/85, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.10.6 OBJECTIVE:

The purpose of these rules is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities and minimum cash surrender values and amount of paid-up nonforfeiture

benefits for plans of insurance with separate premium rates for smokers and nonsmokers.

[12/1/85; Recompiled 11/30/01]

13.9.10.7 DEFINITIONS:

A. **"1980 CSO table, with or without ten-year select mortality factors"** means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the society of actuaries committee to recommend new mortality tables for valuation of standard individual ordinary life insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the commissioners 1980 standard ordinary mortality table, with or without ten-year select mortality factors. The same select factors will be used for both smokers and nonsmokers tables.

B. **"1980 CET table"** means that mortality table consisting of separate rates of mortality for male and female lives, developed by the society of actuaries committee to recommend new mortality tables for valuation of standard individual ordinary life insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Nonforfeiture Law For Life Insurance, and referred to in those models as the commissioners 1980 extended term insurance table.

C. **"1958 CSO table"** means that mortality table developed by the society of actuaries special committee on new mortality tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model of the commissioners 1958 standard ordinary mortality table.

D. **"1958 CET table"** means that mortality table developed by the society of actuaries special committee on new mortality tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the commissioners 1958 extended term insurance table.

E. **"Smoker and nonsmoker mortality tables"** refers to the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined in 13 NMAC 9.10.7.1 through 9.10.7.4 [now Subsection A through D of 13.9.10.7 NMAC] which were developed by the society of actuaries task force on smoker/nonsmoker mortality and the California insurance department staff and recommended by the NAIC technical staff actuarial group.

F. **"Composite mortality"** tables refers to the mortality tables defined in 13 NMAC 9.10.7.1 through 9.10.7.4 [now Subsections A through D of 13.9.10.7 NMAC] as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

[12/1/85; Recompiled 11/30/01]

13.9.10.8 ALTERNATE TABLES:

A. For any policy of insurance delivered or issued for delivery in this state after the operative date of Section 59-16-8F(10) NMSA 1978 (now codified at Section 59A-20-31K NMSA 1978) for that policy form and before January 1, 1989, at the option of the company and subject to the conditions stated in 13 NMAC 9.10.9 [now 13.9.10.9 NMAC]:

(1) the 1958 CSO smoker and nonsmoker mortality tables may be substituted for the 1980 CSO table, with or without ten-year select mortality factors; and

(2) the 1958 CET smoker and nonsmoker mortality tables may be substituted for the 1980 CET table for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

B. Provided that, for any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits determined using the 1958 CSO or 1958 CET smoker and nonsmoker mortality tables, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured.

C. Provided further that the substitution of the 1958 CSO or 1958 CET smoker and nonsmoker mortality tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for the policy form and before a date not later than January 1, 1989.

D. For any policy of insurance delivered or issued for delivery in this state after the operative date of Section 59A-20-31 NMSA 1978 for that policy form, at the option of the company and subject to the conditions stated in 13 NMAC 9.10.9 [now 13.9.10.9 NMAC]:

(1) the 1980 CSO smoker and nonsmoker mortality tables, with or without ten-year select mortality factors, may be substituted for the 1980 CSO table, with or without ten-year select mortality factors; and

(2) the 1980 CET smoker and nonsmoker mortality tables may be substituted for the 1980 CET table for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

[12/1/85; Recompiled 11/30/01]

13.9.10.9 CONDITIONS:

For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may:

A. use composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

B. use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Section 7 of the NAIC Model Standard Valuation Law and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

C. use smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

[12/1/85; Recompiled 11/30/01]

PART 11: USE OF 1983 ANNUITY MORTALITY TABLES

13.9.11.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.9.11.2 SCOPE:

This rule applies to all life insurance companies issuing annuity contracts.

[7/1/97; Recompiled 11/30/01]

13.9.11.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-8-6 NMSA 1978.

[12/31/85; Recompiled 11/30/01]

13.9.11.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.9.11.5 EFFECTIVE DATE:

December 31, 1985, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[12/31/85, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.11.6 OBJECTIVE:

The purpose of this rule is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 table "a," the 1983 group annuity mortality (1983 GAM) table, the annuity 2000 mortality table, and the 1994 group annuity reserving (1994 GAR) table.

[12/31/85, 1/1/99; Recompiled 11/30/01]

13.9.11.7 DEFINITIONS:

As used in this rule:

A. **"1983 table a"** means the mortality table developed by the society of actuaries committee to recommend a new mortality basis for individual annuity valuation and adopted as a recognized mortality table for annuities in June, 1982 by the national association of insurance commissioners.

B. **"1983 GAM table"** means the mortality table developed by the society of actuaries committee on annuities and adopted as a recognized mortality table for annuities in December, 1983 by the national association of insurance commissioners.

C. **"1994 GAR table"** means that mortality table developed by the society of actuaries group annuity valuation table task force and shown on pages 865-919 of Volume XLVII of the Transactions of the Society of Actuaries (1995).

D. **"Annuity 2000 mortality table"** means that mortality table developed by the society of actuaries committee on life insurance research and shown on pages 211-249 of Volume XLVII of the Transactions of the Society of Actuaries (1995).

[12/31/85, 1/1/99; Recompiled 11/30/01]

13.9.11.8 INDIVIDUAL ANNUITY OR PURE ENDOWMENT CONTRACTS:

A. Except as provided in 13 NMAC 9.11.8.2 and 9.11.8.3 [now Subsections B and C of 13.9.11.8 NMAC], the 1983 table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after July 1, 1977.

B. Except as provided in 13 NMAC 9.11.8.3 [now Subsection C of 13.9.11.8 NMAC], either the 1983 table "a" or the annuity 2000 mortality table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after December 31, 1985.

C. Except as provided in 13 NMAC 9.11.8.4 [now Subsection D of 13.9.11.8 NMAC], the annuity 2000 mortality table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1999.

D. The 1983 table "a" without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after January 1, 1999, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(1) settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

(2) settlements involving similar actions such as workers' compensation claims; or

(3) settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

[12/31/85, 1/1/99; Recompiled 11/30/01]

13.9.11.9 GROUP ANNUITY OR PURE ENDOWMENT CONTRACTS:

A. Except as provided in 13 NMAC 9.11.9.2 and 9.11.9.3 [now Subsections B and C of 13.9.11.9 NMAC], the 1983 GAM table, the 1983 table "a" and the 1994 GAR table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables may be used for purposes of valuation for an annuity or pure endowment purchased on or after July 1, 1977 under a group annuity or pure endowment contract.

B. Except as provided in 13 NMAC 9.11.9.3 [now Subsection C of 13.9.11.9 NMAC], either the 1983 GAM table or the 1994 GAR table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after December 31, 1985 under a group annuity or pure endowment contract.

C. The 1994 GAR table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1999 under a group annuity or pure endowment contract.

[12/31/85, 1/1/99; Recompiled 11/30/01]

13.9.11.10 APPLICATION OF THE 1994 GAR TABLE:

In using the 1994 GAR table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n$$

where the q_x^{1994} and AA_xs are as specified in the 1994 GAR table.

[1/1/99; Recompiled 11/30/01]

PART 12: ANNUITY AND DEPOSIT FUND DISCLOSURE

13.9.12.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7-1-00; Recompiled 11/30/01]

13.9.12.2 SCOPE:

A. This rule applies to all group and individual annuity contracts and certificates except:

(1) registered or non-registered variable annuities or other registered products;

(2) immediate and deferred annuities that contain no nonguaranteed elements;

(3) annuities used to fund:

(a) an employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

(b) a plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

(c) a governmental or church plan defined in Section 414 or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

(d) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor; and

(4) structured settlement annuities.

B. Notwithstanding 13 NMAC 9.12.2.1.3 [now Paragraph (3) of Subsection A of 13.9.12.2 NMAC], this rule shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two (2) or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement.

[7-1-00; Recompiled 11/30/01]

13.9.12.3 STATUTORY AUTHORITY:

Sections 59A-16-4 and 59A-16-5 NMSA 1978.

[7-1-00; Recompiled 11/30/01]

13.9.12.4 DURATION:

Permanent.

[7-1-00; Recompiled 11/30/01]

13.9.12.5 EFFECTIVE DATE:

July 1, 2000, unless a later date is shown at the end of a section or paragraph.

[7-1-00; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.12.6 OBJECTIVE:

The purpose of this rule is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The rule specifies the minimum information which must be disclosed and the method for disclosing it in connection with the sale of annuity contracts. The goal of this rule is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

[7-1-00; Recompiled 11/30/01]

13.9.12.7 DEFINITIONS:

For purposes of this rule:

A. **"Buyer's guide"** means:

(1) for insurers selling only fixed deferred annuities, the text provided in 13 NMAC 9.12.12 [now 13.9.12.12 NMAC]; and

(2) for insurers selling equity-indexed annuities, the text provided in 13 NMAC 9.12.12 and 9.12.13 [now 13.9.12.12 NMAC and 13.9.12.13 NMAC].

B. **"Contract owner"** means the owner named in the annuity contract or the certificate holder in the case of a group annuity contract.

C. **"Determinable elements"** means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

D. **"Disclosure document"** means the written statement described in 13 NMAC 9.12.9 [now 13.9.12.9 NMAC].

E. **"Generic name"** means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity."

F. **"Guaranteed elements"** means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

G. **"Non-guaranteed elements"** means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

H. **"Structured settlement annuity"** means a "qualified funding asset" as defined in Section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under Section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

[7-1-00; Recompiled 11/30/01]

13.9.12.8 WHEN DISCLOSURE SHALL BE MADE:

A. Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall at or before the time of application be given both a disclosure document and a buyer's guide.

B. Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both a disclosure document and a buyer's guide no later than five (5) business days after the completed application is received by the insurer.

(1) With respect to an application received as a result of a direct solicitation through the mail:

(a) providing a buyer's guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that a buyer's guide be provided no later than five (5) business days after receipt of the application.

(b) providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that a disclosure document be provided no later than five (5) business days after receipt of the application.

(2) With respect to an application received via the internet:

(a) taking reasonable steps to make the buyer's guide available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that a buyer's guide be provided no later than five (5) business day[s] of receipt of the application;

(b) taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that a disclosure document be provided no later than five (5) business days after receipt of the application.

(3) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurance department of the state for a free annuity buyer's guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity buyer's guide.

C. Where a buyer's guide and disclosure document are not provided at or before the time of application, a free look period of no less than fifteen (15) days shall be provided

for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under state law or rule.

[7-1-00; Recompiled 11/30/01]

13.9.12.9 CONTENTS OF DISCLOSURE DOCUMENT:

Insurers shall define terms used in the disclosure document in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure document is directed. At a minimum, the following information shall be included in the disclosure document:

A. the generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity;

B. the insurer's name and address;

C. a description of the contract and its benefits, emphasizing its long-term nature, and including examples where appropriate:

(1) the guaranteed, non-guaranteed and determinable elements of the contract, and their limitations, if any, and an explanation of how they operate;

(2) an explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(3) periodic income options both on a guaranteed and non-guaranteed basis;

(4) any value reductions caused by withdrawals from or surrender of the contract;

(5) how values in the contract can be accessed;

(6) the death benefit, if available and how it will be calculated;

(7) a summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(8) impact of any rider, such as a long-term care rider;

D. specific dollar amount or percentage charges and fees, with an explanation of how they apply;

E. information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

[7-1-00; Recompiled 11/30/01]

13.9.12.10 REPORT TO CONTRACT OWNERS:

For annuities in the payout period with changes in non-guaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

A. the beginning and end date of the current report period;

B. the accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

C. the total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

D. the amount of outstanding loans, if any, as of the end of the current report period.

[7-1-00; Recompiled 11/30/01]

13.9.12.11 PENALTIES:

In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this rule shall be guilty of a violation of Chapter 59A, Article 16 NMSA 1978.

[7-1-00; Recompiled 11/30/01]

13.9.12.12 BUYER'S GUIDE TO FIXED DEFERRED ANNUITIES:

[The face page of the fixed deferred annuity buyer's guide shall read as follows:]

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted by. . .

It is important that you understand the differences among various annuities so you can choose the kind that best fits your needs. This guide focuses on *fixed deferred* annuity contracts. There is, however, a brief description of variable annuities. If you're thinking

of buying an equity-indexed annuity, an appendix to this guide will give you specific information. This guide isn't meant to offer legal, financial or tax advice. You may want to consult independent advisors. At the end of this guide are questions you should ask your agent or the company. Make sure you're satisfied with the answers before you buy.

WHAT IS AN ANNUITY?

An annuity is a contract in which an insurance company makes a series of income payments at regular intervals in return for a premium or premiums you have paid. Annuities are most often bought for future retirement income. Only an annuity can pay an income that can be guaranteed to last as long as you live.

An annuity is neither a life insurance nor a health insurance policy. It's not a savings account or a savings certificate. You shouldn't buy an annuity to reach short-term financial goals.

Your value in an annuity contract is the premiums you've paid, less any applicable charges, plus interest credited. The insurance company uses the value to figure the amount of most of the benefits that you can choose to receive from an annuity contract. This guide explains how interest is credited as well as some typical charges and benefits of annuity contracts.

A *deferred* annuity has two parts or *periods*. During the *accumulation period*, the money you put into the annuity, less any applicable charges, earns interest. The earnings grow tax-deferred as long as you leave them in the annuity. During the second period, called the *payout period*, the company pays income to you or to someone you choose.

WHAT ARE THE DIFFERENT KINDS OF ANNUITIES?

This guide explains major differences in different kinds of annuities to help you understand how each might meet your needs. But look at the specific terms of an individual contract you're considering and the disclosure document you receive. If your annuity is being used to fund or provide benefits under a pension plan the benefits you get will depend on the terms of the plan. Contact your pension plan administrator for information.

This buyer's guide will focus on individual fixed deferred annuities.

Single Premium or Multiple Premium

You pay the insurance company only one payment for a single premium annuity. You make a series of payments for a multiple premium annuity. There are two kinds of multiple premium annuities. One kind is a flexible premium contract. Within set limits, you pay as much premium as you want, whenever you want. In the other kind, a scheduled premium annuity, the contract spells out your payments and how often you'll make them.

Immediate or Deferred

With an *immediate* annuity, income payments start no later than one year after you pay the premium. You usually pay for an immediate annuity with one payment.

The income payments from a *deferred* annuity often start many years later. Deferred annuities have an accumulation period, which is the time between when you start paying premiums and when income payments start.

Fixed or Variable

* Fixed

During the accumulation period of a *fixed deferred* annuity, your money (less any applicable charges) earns interest at rates set by the insurance company or in a way spelled out in the annuity contract. The company guarantees that it will pay no less than a minimum rate of interest. During the payout period, the amount of each income payment to you is generally set when the payments start and will not change.

* Variable

During the accumulation period of a *variable* annuity the insurance company puts your premiums (less any applicable charges) into a separate account. You decide how the company will invest those premiums, depending on how much risk you want to take. You may put your premium into a stock, bond or other account, with no guarantees, or into a fixed account, with a minimum guaranteed interest. During the payout period of a variable annuity, the amount of each income payment to you may be fixed (set at the beginning) or variable (changing with the value of the investments in the separate account).

HOW ARE THE INTEREST RATES SET FOR MY FIXED DEFERRED ANNUITY?

During the accumulation period, your money (less any applicable charges) earns interest at rates that change from time to time. Usually, what these rates will be is entirely up to the insurance company.

Current Interest Rate

The current rate is the rate the company decides to credit to your contract at a particular time. The company will guarantee it will not change for some time period.

* The *initial rate* is an interest rate the insurance company may credit for a set period of time after you first buy your annuity. The initial rate in some contracts may be higher than it will be later. This is often called a bonus rate.

* The *renewal rate* is the rate credited by the company after the end of the set time period. The contract tells how the company will set the renewal rate, which may be tied to an external reference or index.

Minimum Guaranteed Rate

The *minimum guaranteed interest* rate is the lowest rate your annuity will earn. This rate is stated in the contract.

Multiple Interest Rates

Some annuity contracts apply different interest rates to each premium you pay or to premiums you pay during different time periods.

Other annuity contracts may have two or more accumulated values that fund different benefit options. These accumulated values may use different interest rates. **You get only one of the accumulated values depending on which benefit you choose.**

WHAT CHARGES MAY BE SUBTRACTED FROM MY FIXED DEFERRED ANNUITY?

Most annuities have charges related to the cost of selling or servicing it. These charges may be subtracted directly from the contract value. Ask your agent or the company to describe the charges that apply to your annuity. Some examples of charges, fees and taxes are:

Surrender or Withdrawal Charges

If you need access to your money, you may be able to take all or part of the value out of your annuity at any time during the accumulation period. If you take out part of the value, you may pay a *withdrawal* charge. If you take out all of the value and surrender, or terminate, the annuity, you may pay a *surrender* charge. In either case, the company may figure the charge as a percentage of the value of the contract, of the premiums you've paid or of the amount you're withdrawing. The company may reduce or even eliminate the surrender charge after you've had the contract for a stated number of years. A company may waive the surrender charge when it pays a death benefit.

Some annuities have stated terms. When the term is up, the contract may automatically expire or renew. You're usually given a short period of time, called a *window*, to decide if you want to renew or surrender the annuity. If you surrender during the window, you won't have to pay surrender charges. If you renew, the surrender or withdrawal charges may start over.

In some annuities, there is no charge if you surrender your contract when the company's current interest rate falls below a certain level. This may be called a *bail-out* option.

In a multiple-premium annuity, the surrender charge may apply to each premium paid for a certain period of time. This may be called a *rolling* surrender or withdrawal charge.

Some annuity contracts have a *market value adjustment* feature. If interest rates are different when you surrender your annuity than when you bought it, a market value adjustment may make the cash surrender value higher or lower. Since you and the insurance company share this risk, an annuity with a MVA feature may credit a higher rate than an annuity without that feature.

Be sure to read the Tax Treatment section and ask your tax advisor for information about possible tax penalties on withdrawals.

Free Withdrawal

Your annuity may have a limited *free withdrawal* feature. That lets you make one or more withdrawals without a charge. The size of the free withdrawal is often limited to a set percentage of your contract value. If you make a larger withdrawal, you may pay withdrawal charges. You may lose any interest above the minimum guaranteed rate on the amount withdrawn. Some annuities waive withdrawal charges in certain situations, such as death, confinement in a nursing home or terminal illness.

Contract Fee

A contract fee is a flat dollar amount charged either once or annually.

Transaction Fee

A transaction fee is a charge per premium payment or other transaction.

Percentage of Premium Charge

A percentage of premium charge is a charge deducted from each premium paid. The percentage may be lower after the contract has been in force for a certain number of years or after total premiums paid have reached a certain amount.

Premium Tax

Some states charge a tax on annuities. The insurance company pays this tax to the state. The company may subtract the amount of the tax when you pay your premium, when you withdraw your contract value, when you start to receive income payments or when it pays a death benefit to your beneficiary.

WHAT ARE SOME FIXED DEFERRED ANNUITY CONTRACT BENEFITS?

Annuity Income Payments

One of the most important benefits of deferred annuities is your ability to use the value built up during the accumulation period to give you a lump sum payment or to make income payments during the payout period. Income payments are usually made monthly but you may choose to receive them less often. The size of income payments is based on the accumulated value in your annuity and the annuity's *benefit rate* in effect when income payments start. The benefit rate usually depends on your age and sex, and the annuity payment option you choose. For example, you might choose payments that continue as long as you live, as long as your spouse lives or for a set number of years.

There is a table of guaranteed benefit rates in each annuity contract. Most companies have current benefit rates as well. The company can change the current rates at any time, but the current rates can never be less than the guaranteed benefit rates. When income payments start, the insurance company generally uses the benefit rate in effect at that time to figure the amount of your income payment.

Companies may offer various income payment options. You (the owner) or another person that you name may choose the option. The options are described here as if the payments are made to you.

* Life Only - The company pays income for your lifetime. It doesn't make any payments to anyone after you die. This payment option usually pays the highest income possible. You might choose it if you have no dependents, if you have taken care of them through other means or if the dependents have enough income of their own.

* Life Annuity with Period Certain - The company pays income for as long as you live and guarantees to make payments for a set number of years even if you die. This *period certain* is usually 10 or 20 years. If you live longer than the period certain, you'll continue to receive payments until you die. If you die during the period certain, your beneficiary gets regular payments for the rest of that period. If you die after the period certain, your beneficiary doesn't receive any payments from your annuity. Because the "period certain" is an added benefit, each income payment will be smaller than in a life-only option.

* Joint and Survivor - The company pays income as long as either you or your beneficiary lives. You may choose to decrease the amount of the payments after the first death. You may also be able to choose to have payments continue for a set length of time. Because the *survivor* feature is an added benefit, each income payment is smaller than in a life-only option.

Death Benefit

In some annuity contracts, the company may pay a death benefit to your beneficiary if you die before the income payments start. The most common death benefit is the contract value or the premiums paid, whichever is more.

CAN MY ANNUITY'S VALUE BE DIFFERENT DEPENDING ON MY CHOICE OF BENEFIT?

While all deferred annuities offer a choice of benefits, some use different accumulated values to pay different benefits. For example, an annuity may use one value if annuity payments are for retirement benefits and a different value if the annuity is surrendered. As another example, an annuity may use one value for long-term care benefits and a different value if the annuity is surrendered. You can't receive more than one benefit at the same time.

WHAT ABOUT THE TAX TREATMENT OF ANNUITIES?

Below is a general discussion about taxes and annuities. You should consult a professional tax advisor to discuss your individual tax situation.

Under current federal law, annuities receive special tax treatment. Income tax on annuities is deferred, which means you aren't taxed on the interest your money earns while it stays in the annuity. Tax-deferred accumulation isn't the same as tax-free accumulation. An advantage of tax deferral is that the tax bracket you're in when you receive annuity income payments may be lower than the one you're in during the accumulation period. You'll also be earning interest on the amount you would have paid in taxes during the accumulation period. Most states' tax laws on annuities follow the federal law.

Part of the payments you receive from an annuity will be considered as a return of the premium you've paid. You won't have to pay taxes on that part. Another part of the payments is considered interest you've earned. You must pay taxes on the part that is considered interest when you withdraw the money. You may also have to pay a 10% tax penalty if you withdraw the accumulation before age 59 1/2. The Internal Revenue Code also has rules about distributions after the death of a contract holder.

Annuities used to fund certain employee pension benefit plans (those under Internal Revenue Code Sections 401(a), 401(k), 403(b), 457 or 414) defer taxes on plan contributions as well as on interest or investment income. Within the limits set by the law, you can use pretax dollars to make payments to the annuity. When you take money out, it will be taxed.

You can also use annuities to fund traditional and Roth IRAs under Internal Revenue Code Section 408. If you buy an annuity to fund an IRA, you'll receive a disclosure statement describing the tax treatment.

WHAT IS A "FREE LOOK" PROVISION?

Many states have laws which give you a set number of days to look at the annuity contract after you buy it. If you decide during that time that you don't want the annuity, you can return the contract and get all your money back. This is often referred to as a

free look or *right to return* period. The free look period should be prominently stated in your contract. Be sure to read your contract carefully during the free look period.

HOW DO I KNOW IF A FIXED DEFERRED ANNUITY IS RIGHT FOR ME?

The questions listed below may help you decide which type of annuity, if any, meets your retirement planning and financial needs. You should think about what your goals are for the money you may put into the annuity. You need to think about how much risk you're willing to take with the money. Ask yourself:

* How much retirement income will I need in addition to what I will get from Social Security and my pension?

* Will I need that additional income only for myself or for myself and someone else?

* How long can I leave my money in the annuity?

* When will I need income payments?

* Does the annuity let me get money when I need it?

* Do I want a fixed annuity with a guaranteed interest rate and little or no risk of losing the principal?

* Do I want a variable annuity with the potential for higher earnings that aren't guaranteed and the possibility that I may risk losing principal?

* Or, am I somewhere in between and willing to take some risks with an equity-indexed annuity?

WHAT QUESTIONS SHOULD I ASK MY AGENT OR THE COMPANY?

* Is this a single premium or multiple premium contract?

* Is this an equity-indexed annuity?

* What is the initial interest rate and how long is it guaranteed?

* Does the initial rate include a bonus rate and how much is the bonus?

* What is the guaranteed minimum interest rate?

* What renewal rate is the company crediting on annuity contracts of the same type that were issued last year?

* Are there withdrawal or surrender charges or penalties if I want to end my contract early and take out all of my money? How much are they?

* Can I get a partial withdrawal without paying surrender or other charges or losing interest?

* Does my annuity waive withdrawal charges for reasons such as death, confinement in a nursing home or terminal illness?

* Is there a market value adjustment (MVA) provision in my annuity?

* What other charges, if any, may be deducted from my premium or contract value?

* If I pick a shorter or longer payout period or surrender the annuity, will the accumulated value or the way interest is credited change?

* Is there a death benefit? How is it set? Can it change?

* What income payment options can I choose? Once I choose a payment option, can I change it?

FINAL POINTS TO CONSIDER

Before you decide to buy an annuity, you should review the contract. Terms and conditions of each annuity contract will vary.

Ask yourself if, depending on your needs or age, this annuity is right for you. Taking money out of an annuity may mean you must pay taxes. Also, while it's sometimes possible to transfer the value of an older annuity into a new annuity, the new annuity may have a new schedule of charges that could mean new expenses you must pay directly or indirectly.

You should understand the long-term nature of your purchase. Be sure you plan to keep an annuity long enough so that the charges don't take too much of the money you put in. Be sure you understand the effect of all charges.

If you're buying an annuity to fund an IRA or other tax-deferred retirement program, be sure that you're eligible. Also, ask if there are any restrictions connected with the program.

Remember that the quality of service that you can expect from the company and the agent is a very important factor in your decision.

When you receive your annuity contract, **READ IT CAREFULLY!!** Ask the agent and company for an explanation of anything you don't understand. Do this *before* any free look period ends.

Compare information for similar contracts from several companies. Comparing products may help you make a better decision.

If you have a specific question or can't get answers you need from the agent or company, contact your state insurance department.

[7-1-00; Recompiled 11/30/01]

13.9.12.13 APPENDIX FOR EQUITY-INDEXED ANNUITIES:

This appendix to the buyer's guide for fixed deferred annuities will focus on equity-indexed annuities. Like other types of fixed deferred annuities, equity-indexed annuities provide for annuity income payments, death benefits and tax-deferred accumulation. You should read the buyer's guide for general information about those features and about provisions such as withdrawal and surrender charges.

WHAT ARE EQUITY-INDEXED ANNUITIES?

An equity-indexed annuity is a fixed annuity, either immediate or deferred, that earns interest or provides benefits that are linked to an external equity reference or an equity index. The value of the index might be tied to a stock or other equity index. One of the most commonly used indices is Standard & Poor's 500 Composite Stock Price Index (the S&P500),[1] which is an equity index. The value of any index varies from day to day and is not predictable.

[1] S&P is a registered trademark for the McGraw-Hill Companies, Inc., used with permission.

When you buy an equity-indexed annuity you own an insurance contract. You are not buying shares of any stock or index.

While immediate equity-indexed annuities may be available, this appendix will focus on deferred equity-indexed annuities.

HOW ARE THEY DIFFERENT FROM OTHER FIXED ANNUITIES?

An equity-indexed annuity is different from other fixed annuities because of the way it credits interest to your annuity's value. Some fixed annuities only credit interest calculated at a rate set in the contract. Other fixed annuities also credit interest at rates set from time to time by the insurance company. Equity-indexed annuities credit interest using a formula based on changes in the index to which the annuity is linked. The formula decides how the additional interest, if any, is calculated and credited. How

much additional interest you get and when you get it depends on the features of your particular annuity.

Your equity-indexed annuity, like other fixed annuities, also promises to pay a minimum interest rate. The rate that will be applied will not be less than this minimum guaranteed rate even if the index-linked interest rate is lower. The value of your annuity also will not drop below a guaranteed minimum. For example, many single premium contracts guarantee the minimum value will never be less than 90 percent of the premium paid, plus at least 3% in annual interest (less any partial withdrawals). The guaranteed value is the minimum amount available during a term for withdrawals, as well as for some annuitizations (see "Annuity Income Payments") and death benefits. The insurance company will adjust the value of the annuity at the end of each term to reflect any index increases.

WHAT ARE SOME EQUITY-INDEXED ANNUITY CONTRACT FEATURES?

Two features that have the greatest effect on the amount of additional interest that may be credited to an equity-indexed annuity are the indexing method and the participation rate. It is important to understand the features and how they work together. The following describes some other equity-indexed annuity features that affect the index-linked formula.

Indexing Method

The indexing method means the approach used to measure the amount of change, if any, in the index. Some of the most common indexing methods, which are explained more fully later on, include annual reset (ratcheting), high-water mark and point-to-point.

Term

The index term is the period over which index-linked interest is calculated; the interest is credited to your annuity at the end of a term. Terms are generally from one to ten years, with six or seven years being most common. Some annuities offer single terms while others offer multiple, consecutive terms. If your annuity has multiple terms, there will usually be a window at the end of each term, typically 30 days, during which you may withdraw your money without penalty. For installment premium annuities, the payment of each premium may begin a new term for that premium.

Participation Rate

The participation rate decides how much of the increase in the index will be used to calculate index-linked interest. For example, if the calculated change in the index is 9% and the participation rate is 70%, the index-linked interest rate for your annuity will be 6.3% (9% x 70% = 6.3%). A company may set a different participation rate for newly issued annuities as often as each day. Therefore, the initial participation rate in your annuity will depend on when it is issued by the company. The company usually

guarantees the participation rate for a specific period (from one year to the entire term). When that period is over, the company sets a new participation rate for the next period. Some annuities guarantee that the participation rate will never be set lower than a specified minimum or higher than a specified maximum.

Cap Rate or Cap

Some annuities may put an upper limit, or cap, on the index-linked interest rate. This is the maximum rate of interest the annuity will earn. In the example given above, if the contract has a 6% cap rate, 6%, and not 6.3%, would be credited. Not all annuities have a cap rate.

Floor on Equity Index-Linked Interest

The floor is the minimum index-linked interest rate you will earn. The most common floor is 0%. A 0% floor assures that even if the index decreases in value, the index-linked interest that you earn will be zero and not negative. As in the case of a cap, not all annuities have a stated floor on index-linked interest rates. But in all cases, your fixed annuity will have a minimum guaranteed value.

Averaging

In some annuities, the average of an index's value is used rather than the actual value of the index on a specified date. The index averaging may occur at the beginning, the end, or throughout the entire term of the annuity.

Interest Compounding

Some annuities pay simple interest during an index term. That means index-linked interest is added to your original premium amount but does not compound during the term. Others pay compound interest during a term, which means that index-linked interest that has already been credited also earns interest in the future. In either case, however, the interest earned in one term is usually compounded in the next.

Margin/Spread/Administrative Fee

In some annuities, the index-linked interest rate is computed by subtracting a specific percentage from any calculated change in the index. This percentage, sometimes referred to as the "margin," "spread," or "administrative fee," might be instead of, or in addition to, a participation rate. For example, if the calculated change in the index is 10%, your annuity might specify that 2.25% will be subtracted from the rate to determine the interest rate credited. In this example, the rate would be 7.75% (10% - 2.25% = 7.75%). In this example, the company subtracts the percentage only if the change in the index produces a positive interest rate.

Vesting

Some annuities credit none of the index-linked interest or only part of it, if you take out all your money before the end of the term. The percentage that is vested, or credited, generally increases as the term comes closer to its end and is always 100% at the end of the term.

HOW DO THE COMMON INDEXING METHODS DIFFER?

Annual Reset

Index-linked interest, if any, is determined each year by comparing the index value at the end of the contract year with the index value at the start of the contract year. Interest is added to your annuity each year during the term.

High-Water Mark

The index-linked interest, if any, is decided by looking at the index value at various points during the term, usually the annual anniversaries of the date you bought the annuity. The interest is based on the difference between the highest index value and the index value at the start of the term. Interest is added to your annuity at the end of the term.

Low-Water Mark

The index-linked interest, if any, is determined by looking at the index value at various points during the term, usually the annual anniversaries of the date you bought the annuity. The interest is based on the difference between the index value at the end of the term and the lowest index value. Interest is added to your annuity at the end of the term.

Point-to-Point

The index-linked interest, if any, is based on the difference between the index value at the end of the term and the index value at the start of the term. Interest is added to your annuity at the end of the term.

WHAT ARE SOME OF THE FEATURES AND TRADE-OFFS OF DIFFERENT INDEXING METHODS?

Generally, equity-indexed annuities offer *preset* combinations of features. You may have to make trade-offs to get features you want in an annuity. This means the annuity you chose may also have features you don't want.

FEATURES	TRADE-OFFS
Annual Reset	

Since the interest earned is "locked in" annually and the index value is "reset" at the end of each year, future decreases in the index will not affect the interest you have already earned. Therefore, your annuity using the annual reset method may credit more interest than annuities using other methods when the index fluctuates up and down often during the term. This design is more likely than others to give you access to index-linked interest before the term ends.	Your annuity's participation rate may change each year and generally will be lower than that of other indexing methods. Also an annual reset design may use a cap or averaging to limit the total amount of interest you might earn each year.
High-Water Mark	
Since interest is calculated using the highest value of the index on a contract anniversary during the term, this design may credit higher interest than some other designs if the index reaches a high point early or in the middle of the term, then drops off at the end of the term.	Interest is not credited until the end of the term. In some annuities, if you surrender your annuity before the end of the term, you may not get index-linked interest for that term. In other annuities, you may receive index-linked interest, based on the highest anniversary value to date and the annuity's vesting schedule. Also, contracts with this design may have a lower participation rate than annuities using other designs or may use a cap to limit the total amount of interest you might earn.
Low-Water Mark	
Since interest is calculated using the lowest value of the index prior to the end of the term, this design may credit higher interest than some other designs if the index reaches a low point early or in the middle of the term and then rises at the end of the term.	Interest is not credited until the end of the term. With some annuities, if you surrender your annuity before the end of the term, you may not get index-linked interest for that term. In other annuities, you may receive index-linked interest based on a comparison of the lowest anniversary value to date with the index value at surrender and the annuity's vesting schedule. Also, contracts with this design may have a lower participation rate than annuities using other designs or may use a cap to limit the total amount of interest you might earn.
Point-to-Point	
Since interest cannot be calculated before the end of the term, use of this design may permit a higher participation rate than annuities using other designs.	Since interest is not credited until the end of the term, typically six or seven years, you may not be able to get the index-linked interest until the end of the term.

WHAT IS THE IMPACT OF SOME OTHER EQUITY-INDEXED ANNUITY PRODUCT FEATURES?

Cap on Interest Earned

While a cap limits the amount of interest you might earn each year, annuities with this feature may have other product features you want, such as annual interest crediting or the ability to take partial withdrawals. Also, annuities that have a cap may have a higher participation rate.

Averaging

Averaging at the beginning of a term protects you from buying your annuity at a high point, which would reduce the amount of interest you might earn. Averaging at the end of the term protects you against severe declines in the index and losing index-linked interest as a result. On the other hand, averaging may reduce the amount of index-linked interest you earn when the index rises either near the start or at the end of the term.

Participation Rate

The participation rate may vary greatly from one annuity to another and from time to time within a particular annuity. Therefore, it is important for you to know how your annuity's participation rate works with the indexing method. A high participation rate may be offset by other features, such as simple interest, averaging, or a point-to-point indexing method. On the other hand, an insurance company may offset a lower participation rate by also offering a feature such as an annual reset indexing method.

Interest Compounding

It is important for you to know whether your annuity pays compound or simple interest during a term. While you may earn less from an annuity that pays simple interest, it may have other features you want, such as a higher participation rate.

WHAT WILL IT COST ME TO TAKE MY MONEY OUT BEFORE THE END OF THE TERM?

In addition to the information discussed in this buyer's guide about surrender and withdrawal charges and free withdrawals, there are additional considerations for equity-indexed annuities. Some annuities credit none of the index-linked interest or only part of it if you take out money before the end of the term. The percentage that is vested, or credited, generally increases as the term comes closer to its end and is always 100% at the end of the term.

ARE DIVIDENDS INCLUDED IN THE INDEX?

Depending on the index used, stock dividends may or may not be included in the index's value. For example, the S&P500 is a stock price index and only considers the prices of stocks. It does not recognize any dividends paid on those stocks.

HOW DO I KNOW IF AN EQUITY-INDEXED ANNUITY IS RIGHT FOR ME?

The questions listed below may help you decide which type of annuity, if any, meets your retirement planning and financial needs. You should consider what your goals are for the money you may put into the annuity. You need to think about how much risk you're willing to take with the money. Ask yourself:

Am I interested in a variable annuity with the potential for higher earnings that are not guaranteed and willing to risk losing the principal?

Is a guaranteed interest rate more important to me, with little or no risk of losing the principal?

Or, am I somewhere in between these two extremes and willing to take some risks?

HOW DO I KNOW WHICH EQUITY-INDEXED ANNUITY IS BEST FOR ME?

As with any other insurance product, you must carefully consider your own personal situation and how you feel about the choices available. No single annuity design may have all the features you want. It is important to understand the features and trade-offs available so you can choose the annuity that is right for you. Keep in mind that it may be misleading to compare one annuity to another unless you compare all the other features of each annuity. You must decide for yourself what combination of features makes the most sense for you. Also remember that it is not possible to predict the future behavior of an index.

QUESTIONS YOU SHOULD ASK YOUR AGENT OR THE COMPANY

You should ask the following questions about equity-indexed annuities in addition to the questions in the buyer's guide to Fixed Deferred Annuities.

* How long is the term?

* What is the guaranteed minimum interest rate?

* What is the participation rate? For how long is the participation rate guaranteed?

* Is there a minimum participation rate?

* Does my contract have an interest rate cap? What is it?

* Does my contract have an interest rate floor? What is it?

* Is interest rate averaging used? How does it work?

* Is interest compounded during a term?

* Is there a margin, spread, or administrative fee? Is that in addition to or instead of a participation rate?

* What indexing method is used in my contract?

* What are the surrender charges or penalties if I want to end my contract early and take out all of my money?

* Can I get a partial withdrawal without paying charges or losing interest? Does my contract have vesting? If so, what is the rate of vesting?

Final Points to Consider

Remember to read your annuity contract carefully when you receive it. Ask your agent or insurance company to explain anything you don't understand. If you have a specific complaint or can't get answers you need from the agent or company, contact your state insurance department.

[7-1-00; Recompiled 11/30/01]

PART 13: VALUATION OF LIFE INSURANCE POLICIES

13.9.13.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division, Post Office Box 1269, Santa Fe, NM 87504-1269.

[1/1/00; Recompiled 11/30/01]

13.9.13.2 SCOPE:

A. This rule applies to all life insurance policies, with or without nonforfeiture values, issued on or after the effective date of this rule.

B. This rule does not apply to:

(1) any individual life insurance policy issued on or after the effective date of this rule if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the effective date of this rule, that guarantees the premium rates of the new policy; this rule also shall not apply to subsequent policies issued as a

result of the exercise of such a provision, or a derivation of the provision, in the new policy;

(2) any universal life policy that meets all of the following requirements:

(a) secondary guarantee period, if any, is five (5) years or less;

(b) specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the 1980 CSO valuation tables and the applicable valuation interest rate; and

(c) the initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period;

(3) any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account;

(4) any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account;

(5) a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

[1/1/00; Recompiled 11/30/01]

13.9.13.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-8-5 and 59A-8-6 NMSA 1978.

[1/1/00; Recompiled 11/30/01]

13.9.13.4 DURATION:

Permanent.

[1/1/00; Recompiled 11/30/01]

13.9.13.5 EFFECTIVE DATE:

January 1, 2000, unless a later date is specified at the end of a section or paragraph.

[1/1/00; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.13.6 OBJECTIVE:

The purpose of this rule is to provide tables of select mortality factors and guidelines for their use, and to establish minimum standards for the valuation of plans with nonlevel premiums or benefits and plans with secondary guarantees. The method for calcaluating basic reserves defined in this rule will constitute the commissioners' reserve valuation method for policies to which this rule is applicable.

[1/1/00; Recompiled 11/30/01]

13.9.13.7 DEFINITIONS:

For purposes of this rule:

A. **"Basic reserves"** means reserves calculated in accordance with the principles of Section 59A-8-5E NMSA 1978.

B. **"Contract segmentation method"** means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined in 13 NMAC 9.13.8 [now 13.9.13.8 NMAC]. All calculations are made using the 1980 CSO valuation tables, (or any other valuation mortality table adopted by the NAIC after the effective date of this rule and promulgated by rule by the superintendent for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in 13 NMAC 9.13.13 [now 13.9.13.13 NMAC].

C. **"Deficiency reserves"** means the excess, if greater than zero, of minimum reserves, calculated in accordance with the principles of Section 59A-8-5E(1)(e) NMSA 1978, over basic reserves.

D. **"Guaranteed gross premiums"** means the premiums under a policy of life insurance that are guaranteed and determined at issue.

E. **"Maximum valuation interest rates"** means the calendar year statutory valuation interest rates defined in Section 59A-8-5B(4) NMSA 1978 that are to be used in determining the minimum standard for valuation of life insurance policies.

F. **"NAIC"** means the national association of insurance commissioners.

G. **"1980 CSO valuation tables"** means the commissioners' 1980 standard ordinary mortality table (1980 CSO table) without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and

variations of the 1980 CSO table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

H. **"Scheduled gross premium"** means the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in 13 NMAC 9.13.23.1.3 [now Paragraph (3) of Subsection A of 13.9.13.23 NMAC], if any, or the minimum premium described in 13 NMAC 9.13.23.1.4 [now Paragraph (4) of Subsection A of 13.9.12.23 NMAC].

I. **"Segmented reserves"** means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective gross premiums within the segment.

J. **"Tabular cost of insurance"** means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

K. **"Ten-year select factors"** means the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

L. **"Unitary reserves"** means the present value of all future guaranteed benefits less the present value of all future modified net premiums.

M. **"Universal life insurance policy"** means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

[1/1/00; Recompiled 11/30/01]

13.9.13.8 DETERMINATION OF SEGMENT LENGTH:

The length of a particular contract segment shall be set equal to the minimum of the value *t* for which G_t is greater than R_t where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

where x = original issue age

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2, . . .; t is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$ = guaranteed gross premium per thousand of face amount for year *t* of the segment,

ignoring policy fees only if level for the premium paying period of the policy.

If GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t shall be deemed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t shall be deemed to be 0.

$R_t = q_{x+k+ t}$

_____

$q_{x+t+k-1}$ where x, k and t are as defined above, and

$q_{x+t+k-1}$ = valuation mortality rate for deficiency reserves in policy year k+t but

using the mortality of 13 NMAC 9.13.13.2 [now Subsection B of

13.9.13.13 NMAC] if 13 NMAC 9.13.13.3 [now Subsection C of

13.9.13.13 NMAC] is elected for deficiency reserves.

If G_t never exceeds R_t the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy. However, R_t may be increased or decreased by one percent in any policy year, at the company's option, but R_t shall not be less than one.

[1/1/00; Recompiled 11/30/01]

13.9.13.9 COMPUTATION OF SEGMENTED RESERVES:

A. The uniform percentage for each segment is such that, at the beginning of the segment; the present value of the net premiums within the segment equals:

(1) the present value of the death benefits within the segment, plus

(2) the present value of any unusual guaranteed cash value (see 13 NMAC 9.13.18 [now 13.9.13.18 NMAC] occurring at the end of the segment; less

(3) any unusual guaranteed cash value occurring at the start of the segment, plus

(4) for the first segment only, the excess of item A over item B, as follows:

(a) **Item A:** A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(b) **Item B:** A net one year term premium for the benefits provided for in the first policy year.

B. The length of each segment is determined in accordance with 13 NMAC 9.13.7.2 and 9.13.8 [now Subsection B of 13.9.13.7 NMAC and 13.9.13.8 NMAC].

C. The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

D. For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

[1/1/00; Recompiled 11/30/01]

13.9.13.10 COMPUTATION OF UNITARY RESERVES:

A. Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy. and

B. Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of item C over item D, as follows:

(1) **Item C:** A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-

year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(2) **Item D:** A net one year term premium for the benefits provided for in the first policy year.

C. The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

[1/1/00; Recompiled 11/30/01]

13.9.13.11 GENERAL CALCULATION REQUIREMENTS APPLICABLE TO BASIC RESERVES AND DEFICIENCY RESERVES:

A. Any set of base select mortality factors may be used only for the first segment. However, if the first segment is less than ten (10) years, the appropriate ten-year select mortality factors may be used thereafter through the tenth policy year from the date of issue.

B. In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

C. Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following:

(1) reserves calculated ignoring the guarantee;

(2) reserves assuming the guarantee was made at issue; and

(3) reserves assuming that the policy was issued on the date of the guarantee.

D. The superintendent may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to the effective date of this rule. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the opinion of the appointed actuary prepared in conformance with the requirements of 13 NMAC 2.6, [now 13.2.6 NMAC] actuarial opinions and memoranda.

[1/1/00; Recompiled 11/30/01]

13.9.13.12 GENERAL CALCULATION REQUIREMENTS FOR BASIC RESERVES:

At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this rule and promulgated by rule by the superintendent for this purpose). If select mortality factors are elected, they may be:

A. the ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

B. the select mortality factors in 13 NMAC 9.13.25 through 9.13.30 [now 13.9.13.25 through 13.9.13.30 NMAC]; or

C. any other table of select mortality factors adopted by the NAIC after the effective date of this rule and promulgated by rule by the superintendent for the purpose of calculating basic reserves.

[1/1/00; Recompiled 11/30/01]

13.9.13.13 GENERAL CALCULATION REQUIREMENTS FOR DEFICIENCY RESERVES:

Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity z over the basic reserve. The quantity z is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity z and the corresponding net premiums used in the determination of quantity z may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this rule and promulgated by rule by the superintendent). If select mortality factors are elected, they may be:

A. the ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

B. the select mortality factors in 13 NMAC 9.13.25 through 9.13.30 [now 13.9.13.25 through 13.9.13.30 NMAC];

C. for durations in the first segment, x percent of the select mortality factors in 13 NMAC 9.13.25 through 9.13.30 [now 13.9.13.25 through 13.9.13.30 NMAC], subject to the following:

(1) x may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(2) x shall not be less than twenty percent (20%);

(3) x shall not decrease in any successive policy years;

(4) x is such that, when using the valuation interest rate used for basic reserves, item E is greater than or equal to item F;

(a) **Item E**: The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of x;

(b) **Item F**: The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

(5) x is such that the mortality rates resulting from the application of x are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date;

(6) the appointed actuary shall increase x at any valuation date where it is necessary to continue to meet all the requirements of this subsection;

(7) The appointed actuary may decrease x at any valuation date as long as x does not decrease in any successive policy years and as long as it continues to meet all the requirements of this subsection; and

(8) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(9) If x is less than 100 percent at any duration for any policy, the appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of 13 NMAC 2.6 [now 13.2.6 NMAC], actuarial opinions and memoranda, stating whether the mortality rates resulting from the application of x meet the requirements of this subsection for all policies subject to this rule. This opinion shall be supported by an actuarial report, subject to the appropriate actuarial standards of practice promulgated by the actuarial standards board of the American academy of actuaries. The x factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience;

D. any other table of select mortality factors adopted by the NAIC after the effective date of this rule and promulgated by rule by the superintendent for the purpose of calculating deficiency reserves.

[1/1/00; Recompiled 11/30/01]

13.9.13.14 CALCULATION OF MINIMUM VALUATION STANDARDS:

A. Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of 13 NMAC 9.13.15 through 9.13.22 [now 13.9.13.15 through 13.9.13.22 NMAC].

B. Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of 13 NMAC 9.13.23 [now 13.9.13.23 NMAC].

[1/1/00; Recompiled 11/30/01]

13.9.13.15 BASIC RESERVES FOR POLICIES WITH GUARANTEED NONLEVEL GROSS PREMIUMS OR GUARANTEED NONLEVEL BENEFITS (OTHER THAN UNIVERSAL LIFE POLICIES):

Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, either of the adjustments described below may be made in calculating segmented reserves and net premiums:

A. Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

B. Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

[1/1/00; Recompiled 11/30/01]

13.9.13.16 DEFICIENCY RESERVES FOR POLICIES WITH GUARANTEED NONLEVEL GROSS PREMIUMS OR GUARANTEED NONLEVEL BENEFITS (OTHER THAN UNIVERSAL LIFE POLICIES):

A. The deficiency reserve at any duration shall be calculated:

(1) on a unitary basis if the corresponding basic reserve determined by 13 NMAC 9.13.15 [now 13.9.13.15 NMAC] is unitary;

(2) on a segmented basis if the corresponding basic reserve determined by 13 NMAC 9.13.15 [now 13.9.13.15 NMAC] is segmented; or

(3) on a segmented basis if the corresponding basic reserve determined by 13 NMAC 9.13.15 [now 13.9.13.15 NMAC] is equal to both the segmented reserve and the unitary reserve.

B. This section shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (as specified in 13 NMAC 9.13.13 [now 13.9.13.13 NMAC] and rate of interest.

C. Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity z over the basic reserve, where z is obtained as indicated in 13 NMAC 9.13.13 [now 13.9.13.13 NMAC].

D. For deficiency reserves determined on a segmented basis, the quantity z is determined using segment lengths equal to those determined for segmented basic reserves.

[1/1/00; Recompiled 11/30/01]

13.9.13.17 MINIMUM VALUE FOR POLICIES WITH GUARANTEED NONLEVEL GROSS PREMIUMS OR GUARANTEED NONLEVEL BENEFITS (OTHER THAN UNIVERSAL LIFE POLICIES):

Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten-year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

[1/1/00; Recompiled 11/30/01]

13.9.13.18 UNUSUAL PATTERN OF GUARANTEED CASH SURRENDER VALUES:

A. For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an n-year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where n is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

B. The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an n-year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where:

(1) n is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

(a) the date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

(b) the mandatory expiration date of the policy; and

(2) the net premium for a given year during the n-year period is equal to the product of the net to gross ratio and the respective gross premium; and

(3) the net to gross ratio is equal to item G divided by item H as follows:

(a) **Item G:** The present value, at the beginning of the n-year period, of death benefits payable during the n-year period plus the present value, at the beginning of the n-year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the n-year period.

(b) **Item H:** The present value, at the beginning of the n-year period, of the scheduled gross premiums payable during the n-year period.

C. For purposes of this section, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(1) one hundred and ten percent (110%) of the scheduled gross premium for that year;

(2) one hundred and ten percent (100%) of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(3) five percent (5%) of the first policy year surrender charge, if any.

[1/1/00; Recompiled 11/30/01]

13.9.13.19 OPTIONAL EXEMPTION FOR YEARLY RENEWABLE TERM REINSURANCE:

At the option of the company, the following approach for reserves on YRT reinsurance may be used:

A. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

B. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in 13 NMAC 9.13.17 [now 13.9.13.17 NMAC].

C. For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

D. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with 13 NMAC 9.13.19.3.1 [now Paragraph (1) of Subsection C of 13.9.13.19 NMAC].

E. For purposes of this section, calculations shall be based on the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, (or any other table adopted after the effective date of this rule by the NAIC and promulgated by rule by the superintendent for this purpose).

F. A reinsurance agreement shall be considered YRT reinsurance for purposes of this section if only the mortality risk is insured.

G. If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

[1/1/00; Recompiled 11/30/01]

13.9.13.20 OPTIONAL EXEMPTION FOR ATTAINED-AGE-BASED YEARLY RENEWABLE TERM LIFE INSURANCE POLICIES:

At the option of the company, the following approach for reserves for attained-age-based YRT life insurance policies may be used:

A. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

B. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in 13 NMAC 9.13.17 [now 13.9.13.17 NMAC].

C. For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

D. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with 13 NMAC 9.13.20.3.1 [now Paragraph (1) Subsection C of 13.9.13.20 NMAC].

E. For purposes of this section, calculations shall be based on the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, (or any other table adopted after the effective date of this rule by the NAIC and promulgated by rule by the superintendent for this purpose).

F. A policy shall be considered an attained-age-based YRT life insurance policy for purposes of this section if:

(1) the premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(2) the premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

G. For policies that become attained-age-based YRT policies after an initial period of coverage, the approach provided in this section may be used after the initial period if:

(1) the initial period is constant for all insureds of the same sex, risk class and plan of insurance; or

(2) the initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

(3) after the initial period of coverage, the policy meets the conditions of 13 NMAC 9.13.20.5 [now Subsection E of 13.9.13.20 NMAC].

H. If this approach is elected, it must be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this rule.

[1/1/00; Recompiled 11/30/01]

13.9.13.21 EXEMPTION FROM UNITARY RESERVES FOR CERTAIN N-YEAR RENEWABLE TERM LIFE INSURANCE POLICES:

Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

A. the policy consists of a series of n-year periods, including the first period and all renewal periods, where n is the same for each period, except that for the final renewal period, n may be truncated or extended to reach the expiry age, provided that this final renewal period is less than 10 years and less than twice the size of the earlier n-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

B. the guaranteed gross premiums in all n-year periods are not less than the corresponding net premiums based upon the 1980 CSO valuation tables with or without the ten-year select mortality factors; and

C. there are no cash surrender values in any policy year.

[1/1/00; Recompiled 11/30/01]

13.9.13.22 EXEMPTION FROM UNITARY RESERVES FOR CERTAIN JUVENILE POLICIES:

Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

A. at issue, the insured is age twenty-four (24) or younger;

B. until the insured reaches the end of the juvenile period, which shall occur at or before age twenty-five (25), the gross premiums and death benefits are level, and there are no cash surrender values; and

C. after the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

[1/1/00; Recompiled 11/30/01]

13.9.13.23 CALCULATION OF MIMIMUM VALUATION STANDARD FOR FLEXIBLE PREMIUM AND FIXED PREMIUM UNIVERSAL LIFE INSURANCE POLICIES THAT CONTAIN PROVISIONS RESULTING IN THE ABILITY OF A POLICYOWNER TO KEEP A POLICY IN FORCE OVER A SECONDARY GUARANTEE PERIOD:

A. General:

(1) Policies with a secondary guarantee include:

(a) a policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

(b) a policy in which the minimum premium at any duration is less than the corresponding one year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, (or any other table adopted after the effective date of this rule by the NAIC and promulgated by rule by the superintendent for this purpose); or

(c) a policy with any combination of 13 NMAC 9.13.23.1.1.1 and 9.13.23.1.1.2 [now Subparagraphs (a) and (b) of Paragraph (1) of Subsection A of 13.9.13.23 NMAC].

(2) A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in 13 NMAC 9.13.23.2 and 9.13.23.3 [now Subsections B and C of 13.9.13.23 NMAC] shall be recalculated from issue to reflect these changes.

(3) Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

(4) For purposes of this section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue.

(5) The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in 13 NMAC 9.13.13.2, 9.13.13.3, and 9.13.13.4 [now Subsections B, C and D of 13.9.13.13 NMAC] may not be used to calculate the one-year valuation premiums.

(6) The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

B. Basic reserves for the secondary guarantees. Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined in 13 NMAC 9.13.8 [now 13.9.13.8 NMAC].

C. Deficiency reserves for the secondary guarantees. Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in 13 NMAC 9.13.16 [13.9.13.16 NMAC], with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

D. Minimum reserves. The minimum reserves during the secondary guarantee period are the greater of:

(1) the basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

(2) the minimum reserves required by other rules or rules governing universal life plans.

[1/1/00; Recompiled 11/30/01]

13.9.13.24 SELECT MORTALITY TABLES:

A. 13 NMAC 9.13.25 through 9.13.30 [now 13.9.13.25 NMAC through 13.9.12.30 NMAC] contain tables of select mortality factors that are referenced in 13 NMAC 9.13.12.2, 9.13.13.2, and 9.13.13.3 [now Subsection B of 13.9.13.12 NMAC and Subsections B and C of 13.9.13.13 NMAC].

B. The six tables of select mortality factors include: male aggregate, male nonsmoker, male smoker, female aggregate, female nonsmoker, and female smoker.

C. 13 NMAC 9.13.25 through 9.13.30 [now 13.9.13.25 NMAC through 13.9.13.30 NMAC] apply to both age last birthday and age nearest birthday mortality tables.

D. For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B table, the calculated select mortality factors are eighty percent (80%) of the appropriate male table plus twenty percent (20%) of the appropriate female table.

[1/1/00; Recompiled 11/30/01]

13.9.13.25 MALE AGGREGATE:

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	10
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	10
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	10
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79

49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	10
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	10
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	10
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	10
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	10
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	10
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	10
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	10
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	10
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	10
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	10
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	10
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	10
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	10
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	10
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	10
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	10
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	10
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	10
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	10
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	10
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	10
77	48	52	70	60	60	65	70	70	100	100	100	100	100	100	100	10
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	10
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	10
80	48	52	55	60	60 100	100	100	100	100	100	100	100	100	100	100	10
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	10
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	10
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	10
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	10
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	10

[1/1/00; Recompiled 11/30/01]

13.9.13.26 MALE NONSMOKERS:

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

[1/1/00; Recompiled 11/30/01]

13.9.13.27 MALE SMOKERS:

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94

23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100

68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

[1/1/00; Recompiled 11/30/01]

13.9.13.28 FEMALE AGGREGATE:

Issue	**Duration**															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

[1/1/00; Recompiled 11/30/01]

13.9.13.29 FEMALE NONSMOKERS:

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

[1/1/00; Recompiled 11/30/01]

13.9.13.30 FEMALE SMOKERS:

Issue	Duration															
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91

54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

[1/1/00; Recompiled 11/30/01]

PART 14: LIFE INSURANCE ILLUSTRATIONS

13.9.14.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[10/1/98; Recompiled 11/30/01]

13.9.14.2 SCOPE:

A. This rule applies to all group and individual life insurance policies and certificates sold on or after October 1, 1998.

B. This rule does not apply to:

(1) variable life insurance;

(2) individual and group annuity contracts;

(3) credit life insurance; or

(4) life insurance policies with no illustrated death benefits on any individual exceeding $10,000.

[10/1/98; Recompiled 11/30/01]

13.9.14.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-16-4, and 59A-16-5 NMSA 1978.

[10/1/98; Recompiled 11/30/01]

13.9.14.4 DURATION:

Permanent.

[10/1/98; Recompiled 11/30/01]

13.9.14.5 EFFECTIVE DATE:

October 1, 1998, unless a later date is cited at the end of a section or paragraph.

[10/1/98; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.9.14.6 OBJECTIVE:

The purpose of this rule is to establish requirements for life insurance policy illustrations that will protect consumers and foster consumer education. The rule provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations. The goals of this rule are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable. Insurers will, as far as possible, eliminate the use of footnotes and caveats and define terms used in the illustration in language that would

be understood by a typical person within the segment of the public to which the illustration is directed.

[10/1/98; Recompiled 11/30/01]

13.9.14.7 DEFINITIONS:

For the purposes of this rule:

A. **"Actuarial standards board"** means the board established by the American academy of actuaries to develop and promulgate standards of actuarial practice.

B. **"Basic illustration"** means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

C. **"Contract premium"** means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

D. **"Currently payable scale"** means a scale of non-guaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next ninety-five (95) days.

E. **"Disciplined current scale"** means a scale of non-guaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the actuarial standards board may be relied upon if the standards:

(1) are consistent with all provisions of this rule;

(2) limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

(3) do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

(4) do not permit assumed expenses to be less than minimum assumed expenses.

F. **"Generic name"** means a short title descriptive of the policy being illustrated such as "whole life," "term life" or "flexible premium adjustable life."

G. **"Guaranteed elements"** means the premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue.

H. **"Illustrated scale"** means a scale of non-guaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

(1) the disciplined current scale; or

(2) the currently payable scale.

I. **"Illustration"** means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years.

J. **"Illustration actuary"** means an actuary meeting the requirements of 13 NMAC 9.14.28 [now 13.9.14.28 NMAC] who certifies to illustrations based on the standard of practice promulgated by the actuarial standards board.

K. **"In-force illustration"** means an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

L. **"Lapse-supported illustration"** means an illustration of a policy form failing the test of self-supporting as defined in this rule, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five (5) years and 100 percent policy persistency thereafter.

M. **"Minimum assumed expenses"** means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form.

N. **"Non-guaranteed elements"** means the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

O. **"Non-term group life"** means a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

(1) every plan of coverage was selected by the employer or other group representative;

(2) some portion of the premium is paid by the group or through payroll deduction; and

(3) group underwriting or simplified underwriting is used.

P. **"Policy owner"** means the owner named in the policy or the certificate holder in the case of a group policy.

Q. **"Premium outlay"** means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

R. **"Self-supporting illustration"** means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteennth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

S. **"Supplemental illustration"** means an illustration furnished in addition to a basic illustration that meets the applicable requirements of this rule, and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

[10/1/98; Recompiled 11/30/01]

13.9.14.8 DETERMINING ASSUMED EXPENSES:

A. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

(1) fully allocated expenses;

(2) marginal expenses; and

(3) a generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the superintendent.

B. Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

[10/1/98; Recompiled 11/30/01]

13.9.14.9 POLICIES TO BE ILLUSTRATED:

A. Each insurer marketing policies to which this rule is applicable shall notify the superintendent whether a policy form is to be marketed with or without an illustration. For all policy forms being actively marketed on the effective date of this rule, the insurer shall identify in writing those forms and whether or not an illustration will be used with them. For policy forms filed after the effective date of this rule, the identification shall be

made at the time of filing. Any previous identification may be changed by notice to the superintendent.

B. If the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

C. If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this rule is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

D. Potential enrollees of non-term group life subject to this rule shall be furnished a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and non-guaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of this rule, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for non-term group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any non-term group life enrollee who requests it.

[10/1/98; Recompiled 11/30/01]

13.9.14.10 GENERAL REQUIREMENTS FOR ILLUSTRATIONS:

An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this rule, be clearly labeled "life insurance illustration" and contain the following basic information:

A. name of insurer;

B. name and business address of producer or insurer's authorized representative, if any;

C. name, age and sex of proposed insured, except where a composite illustration is permitted under this rule;

D. underwriting or rating classification upon which the illustration is based;

E. generic name of policy, the company product name, if different, and form number;

F. initial death benefit; and

G. dividend option election or application of non-guaranteed elements, if applicable.

[10/1/98; Recompiled 11/30/01]

13.9.14.11 PROHIBITED PRACTICES:

When using an illustration in the sale of a life insurance policy, an insurer or its producers or other authorized representatives shall not:

A. represent the policy as anything other than a life insurance policy;

B. use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

C. state or imply that the payment or amount of non-guaranteed elements is guaranteed;

D. use an illustration that does not comply with the requirements of this rule;

E. use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

F. provide an applicant with an incomplete illustration;

G. represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

H. use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;

I. except for policies that can never develop nonforfeiture values, use an illustration that is lapse-supported; or

J. use an illustration that is not self-supporting.

[10/1/98; Recompiled 11/30/01]

13.9.14.12 INTEREST RATE:

If an interest rate used to determine the illustrated non-guaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.

[10/1/98; Recompiled 11/30/01]

13.9.14.13 FORMAT FOR BASIC ILLUSTRATIONS:

A. The illustration shall be labeled with the date on which it was prepared.

B. Each page, including any explanatory notes or pages, shall be numbered and shall show its relationship to the total number of pages in the illustration (e.g., the fourth page of a seven-page illustration shall be labeled "page 4 of 7 pages").

C. The assumed dates of payment receipt and benefit pay-out within a policy year shall be clearly identified.

D. If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.

E. The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.

F. Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

G. If the illustration shows any non-guaranteed elements, they cannot be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled non-guaranteed.

H. The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page one for guaranteed elements.")

I. The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.

J. The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans and policy loan interest, as applicable.

K. Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.

L. Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(1) the benefits and values are not guaranteed;

(2) the assumptions on which they are based are subject to change by the insurer; and

(3) actual results may be more or less favorable.

N. If the illustration shows that the premium payer may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter duration than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.

O. If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may reflect those plans and the impact on future policy benefits and values.

[10/1/98; Recompiled 11/30/01]

13.9.14.14 NARRATIVE SUMMARY OF BASIC ILLUSTRATIONS:

A basic illustration shall include the following:

A. a brief description of the policy being illustrated, including a statement that it is a life insurance policy;

B. a brief description of the premium outlay or contract premium, as applicable, for the policy; for a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code;

C. a brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy;

D. identification and a brief definition of column headings and key terms used in the illustration; and

E. a statement containing in substance the following: "This illustration assumes that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

[10/1/98; Recompiled 11/30/01]

13.9.14.15 NUMERIC SUMMARY OF BASIC ILLUSTRATIONS:

A. Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five (5), ten (10) and twenty (20) and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary shall show policy years five (5), ten (10), twenty (20) and thirty (30).

(1) policy guarantees;

(2) insurer's illustrated scale;

(3) insurer's illustrated scale used but with the non-guaranteed elements reduced as follows:

(a) dividends at fifty percent (50%) of the dividends contained in the illustrated scale used;

(b) non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

(c) all non-guaranteed charges, including but not limited to, term insurance charges, mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.

B. In addition, if coverage would cease prior to policy maturity or age 100, the year in which coverage ceases shall be identified for each of the three (3) bases.

[10/1/98; Recompiled 11/30/01]

13.9.14.16 STATEMENTS IN BASIC ILLUSTRATIONS:

Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery.

A. A statement to be signed and dated by the applicant or policy owner reading as follows: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."

B. A statement to be signed and dated by the insurance producer or other authorized representative of the insurer reading as follows: "I certify that this illustration has been presented to the applicant and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

[10/1/98; Recompiled 11/30/01]

13.9.14.17 TABULAR DETAIL IN BASIC ILLUSTRATIONS:

A. A basic illustration shall include the following for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(1) the premium outlay and mode the applicant plans to pay and the contract premium, as applicable;

(2) the corresponding guaranteed death benefit, as provided in the policy; and

(3) the corresponding guaranteed value available upon surrender, as provided in the policy.

B. For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

C. Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a non-guaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

[10/1/98; Recompiled 11/30/01]

13.9.14.18 STANDARDS FOR SUPPLEMENTAL ILLUSTRATIONS:

A. A supplemental illustration may be provided so long as:

(1) it is appended to, accompanied by or preceded by a basic illustration that complies with this rule;

(2) the non-guaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration;

(3) it contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed;

(4) for a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.; and

B. If a supplemental illustration is provided, it shall include a notice referring to the basic illustration for guaranteed elements and other important information.

[10/1/98; Recompiled 11/30/01]

13.9.14.19 DELIVERY WHEN BASIC ILLUSTRATION USED:

A. If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this rule, shall be submitted to the insurer at the time of policy application. A copy also shall be provided to the applicant.

B. If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall conform to the requirements of this rule, shall be labeled "revised illustration" and shall be signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

[10/1/98; Recompiled 11/30/01]

13.9.14.20 DELIVERY WHEN BASIC ILLUSTRATION NOT USED:

A. If no illustration is used by an insurance producer or other authorized representative in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the producer or representative shall certify to that effect in writing on a form provided by the insurer. On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will

be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application.

B. If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

[10/1/98; Recompiled 11/30/01]

13.9.14.21 DELIVERY BY MAIL:

If the basic illustration or revised illustration is sent to the applicant or policy owner by mail from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subsection shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

[10/1/98; Recompiled 11/30/01]

13.9.14.22 RECORD RETENTION:

A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three (3) years after the policy is no longer in force. A copy need not be retained if no policy is issued.

[10/1/98; Recompiled 11/30/01]

13.9.14.23 ANNUAL REPORT FOR ILLUSTRATED UNIVERSAL LIFE POLICIES:

For universal life policies designated as ones for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information:

A. the beginning and end date of the current report period;

B. the policy value at the end of the previous report period and at the end of the current report period;

C. the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

D. the current death benefit at the end of the current report period on each life covered by the policy;

E. the net cash surrender value of the policy as of the end of the current report period;

F. the amount of outstanding loans, if any, as of the end of the current report period; and

G. for fixed premium policies: if, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

H. for flexible premium policies: if, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

[10/1/98; Recompiled 11/30/01]

13.9.14.24 ANNUAL REPORT FOR ALL OTHER ILLUSTRATED POLICIES:

For all other policies designated as ones for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information, where applicable:

A. current death benefit;

B. annual contract premium;

C. current cash surrender value;

D. current dividend;

E. application of current dividend; and

F. amount of outstanding loan.

[10/1/98; Recompiled 11/30/01]

13.9.14.25 ANNUAL REPORT FOR POLICIES THAT DO NOT BUILD NON-FORFEITURE VALUES:

Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years in which the insurer has changed non-guaranteed policy elements.

[10/1/98; Recompiled 11/30/01]

13.9.14.26 ANNUAL REPORT WITHOUT IN-FORCE ILLUSTRATIONS:

A. If the annual report does not include an in force illustration, it shall contain the following notice displayed prominently: **"IMPORTANT POLICY OWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling [insurer's phone number], writing to [insurer's name] at [insurer's address] or contacting your agent. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining an in force illustration.

B. Upon the request of the policy owner, the insurer shall furnish an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of 13 NMAC 9.14.10, 9.14.11, 9.14.13 and 9.14.17 [now 13.9.14.10 NMAC, 13.9.14.11 NMAC, 13.9.14.13 NMAC and 13.9.14.17 NMAC]. No signature or other acknowledgment of receipt of this illustration shall be required.

[10/1/98; Recompiled 11/30/01]

13.9.14.27 NOTICE OF CHANGE IN NON-GUARANTEED ELEMENTS:

If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of the change prominently displayed.

[10/1/98; Recompiled 11/30/01]

13.9.14.28 APPOINTMENT OF ILLUSTRATION ACTUARY:

The board of directors of each insurer shall appoint one or more illustration actuaries, who shall meet the following standards:

A. be a member in good standing of the American academy of actuaries;

B. be familiar with the standard of practice regarding life insurance policy illustrations;

C. not have been found by the sperintendent, following appropriate notice and hearing to have:

(1) violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as an illustration actuary;

(2) been found guilty of fraudulent or dishonest practices;

(3) demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or

(4) resigned or been removed as an illustration actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards;

D. not fail to notify the superintendent of any action taken by a superintendent or commissioner of insurance of another state similar to that in 13 NMAC 9.14.28.3 [now Subsection C of 13.9.14.28 NMAC].

[10/1/98; Recompiled 11/30/01]

13.9.14.29 CHANGE OF ILLUSTRATION ACTUARY:

If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the superintendent of that fact promptly and disclose the reason for the change.

[10/1/98; Recompiled 11/30/01]

13.9.14.30 ANNUAL CERTIFICATION BY ILLUSTRATION ACTUARY:

The illustration actuary shall annually:

A. certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Model Rule on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this rule;

B. disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five (5) years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If non-guaranteed elements illustrated for new policies are not consistent with those illustrated for similar in force policies, this must be disclosed in the annual certification. If non-guaranteed elements illustrated for both new and in force policies are not consistent with the non-

guaranteed elements actually being paid, charged or credited to the same or similar forms, this must be disclosed in the annual certification;

C. disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(1) fully allocated expenses;

(2) marginal expenses; or

(3) a generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the superintendent.

D. file a certification with the board and with the superintendent:

(1) annually for all policy forms for which illustrations are used; and

(2) before a new policy form is illustrated.

E. notify the board of directors of the insurer and the superintendent promptly if:

(1) an error in a previous certification is discovered;

(2) he or she is unable to certify the scale for any policy form illustration the insurer intends to use.

[10/1/98; Recompiled 11/30/01]

13.9.14.31 CERTIFICATION BY INSURER:

A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

A. that the illustration formats meet the requirements of this rule and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

B. that the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in 13 NMAC 9.14.30.3 [now Subsection C of 13.9.14.30 NMAC].

[10/1/98; Recompiled 11/30/01]

PART 15: VIATICAL SETTLEMENTS

13.9.15.1 ISSUING AGENCY:

Public Regulation Commission, Insurance Division.

[13.9.15.1 NMAC – N, 7-1-00]

13.9.15.2 SCOPE:

This rule applies to all persons soliciting, negotiating, financing, or transacting viatical settlements in New Mexico.

[13.9.15.2 NMAC – N, 7-1-00]

13.9.15.3 STATUTORY AUTHORITY:

NMSA 1978 Sections 59A-2-9 and 59A-20A-10.

[13.9.15.3 NMAC – N, 7-1-00]

13.9.15.4 DURATION:

Permanent.

[13.9.15.4 NMAC – N, 7-1-00]

13.9.15.5 EFFECTIVE DATE:

July 1, 2000, unless a later date is cited at the end of a section.

[13.9.15.5 NMAC – N, 7-1-00]

13.9.15.6 OBJECTIVE:

The purpose of this rule is to implement the Viatical Settlements Act, NMSA 1978 Section 59A-20A-1 et seq.

[13.9.15.6 NMAC – N, 7-1-00]

13.9.15.7 DEFINITIONS:

In addition to the definitions in NMSA 1978 Section 59A-20A-2, as used in this rule:

A. chronically ill means:

(1) being unable to perform at least two (2) activities of daily living (i.e., eating, toileting, transferring, bathing, dressing or continence);

(2) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(3) having a level of disability similar to that described in paragraph (1) of subsection A of 13.9.15.7 NMAC as determined by the Secretary of Health and Human Services;

B. insured means the person covered under the policy being considered for viatication;

C. life expectancy means the mean of the number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider considering medical records and appropriate experiential data;

D. net death benefit means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens;

E. patient identifying information means an insured's name, address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured; and

F. terminally ill means having an illness or sickness that can reasonably be expected to result in death in twenty-four (24) months or less.

[13.9.15.7 NMAC – N, 7-1-00]

13.9.15.8 LICENSE REQUIREMENTS:

A. A viatical settlement provider or broker transacting business in this state may continue to do so pending issuance of the provider or broker's license as long as its application for a license is filed with the Superintendent by July 1, 2000.

B. The Superintendent may ask for all information necessary to determine whether the applicant for a license as a viatical settlement provider or broker complies with the requirements of NMSA 1978 Section 59A-20A-3.

C. The license issued to a viatical settlement provider or broker shall be a limited license that allows the viatical settlement provider or broker to operate only within the scope of its license.

D. A viatical settlement provider or broker shall file with the Superintendent within thirty (30) days a supplement to its application showing any changes to the members, officers, representatives and designated employees authorized to act under its license.

[13.9.15.8 NMAC - N, 7-1-00]

13.9.15.9 RENEWAL OF LICENSE:

A. A viatical settlement provider or broker may renew its license yearly by filing an application for renewal no less than thirty (30) days before the anniversary date of licensure. The Superintendent shall refuse to renew a license if the licensee fails to:

(1) file a current copy of a letter of good standing obtained from the filing officer of the applicant's state of domicile;

(2) pay the renewal fee; and

(3) submit the reports required in NMSA 1978 Section 59A-20A-6.

B. If a viatical settlement provider has, at the time of renewal, viatical settlements for which the insured has not died, it shall do one of the following:

(1) renew or maintain it's current license until the earlier of:

(a) the date the viatical settlement provider properly assigns, sells, or otherwise transfers the viatical settlements for which the insured has not died; or

(b) the date that the last insured covered by a viatical settlement transaction has died; or

(2) appoint, in writing, either the viatical settlement provider that entered into the viatical settlement, the broker that received commissions from the viatical settlement, if applicable, or any other viatical settlement provider or broker licensed in this state, to make all inquiries to the viator or the viator's designee regarding the health status of the viator or any other matters.

[13.9.15.9 NMAC - N, 7-1-00]

13.9.15.10 STANDARDS FOR EVALUATION OF REASONABLE PAYMENTS:

A viatical settlement company or broker shall not enter into a viatical settlement that provides a payment to the viator that is unreasonable or unjust. In determining whether a payment is unreasonable or unjust, the Superintendent may consider, among other factors, the life expectancy of the viator, the applicable rating of the insurance company that issued the subject policy by a rating service generally recognized by the insurance industry, regulators and consumer groups, and the prevailing discount rates in the viatical settlement market in New Mexico, or if insufficient data is available for New Mexico, the prevailing rates nationally or in other states that maintain this data.

[13.9.15.10 NMAC - N, 7-1-00]

13.9.15.11 REPORTING REQUIREMENTS:

On March 1 of each calendar year, each viatical settlement provider licensed in this state shall report all viatical settlement transactions for which the viator is a resident of this state, and for all states in the aggregate, containing the following information for the previous calendar year:

A. For viatical settlements contracted during the reporting period:

(1) date of viatical settlement contract;

(2) viator's state of residence at the time of the contract;

(3) mean life expectancy of the insured at time of contract, in months;

(4) face amount of policy viaticated;

(5) net death benefit viaticated;

(6) estimated total premiums to keep policy in force for mean life expectancy;

(7) net amount paid to viator;

(8) source of policy (B-Broker; D-Direct Purchase; SM-Secondary Market);

(9) type of coverage (I-Individual or G-Group);

(10) whether or not viatical settlement was within the contestable or suicide period, or both;

(11) primary international classification of diseases (ICD) Diagnosis Code, in numeric format, as published by the U.S. Department of Health and Human Services; and

(12) type of funding (I-Institutional; P-Private).

B. For viatical settlements for which death has occurred during the reporting period:

(1) date of viatical settlement contract;

(2) viator's state of residence at the time of the contract;

(3) mean life expectancy of the insured at time of contract in months;

(4) net death benefit collected;

(5) total premiums paid to maintain the policy (WP-Waiver of Premium; NA-Not Applicable);

(6) net amount paid to viator;

(7) primary international classification of diseases (ICD) Diagnosis Code, in numeric format, as published by the U.S. Department of Health and Human Services;

(8) date of death;

(9) amount of time between date of contract and date of death, in months;

(10) difference between the number of months that passed between the date of contract and the date of death and the mean life expectancy in months as determined by the reporting company;

C. name and address of each viatical settlement broker through whom the reporting company purchased a policy from a viator who resided in this state at the time of contract;

D. number of policies reviewed and rejected; and

E. number of policies purchased in the secondary market as a percentage of total policies purchased.

[13.9.15.11 NMAC - N, 7-1-00]

13.9.15.12 PAYMENT OF PROCEEDS:

A. A trustee or escrow agent shall pay the proceeds of a viatical settlement made pursuant to NMSA 1978 Section 59A-20A-9D by means of wire transfer to the account of the viator or by certified check or cashier's check made payable to the viator.

B. A viatical settlement provider shall pay the proceeds of a viatical settlement to the viator in a lump sum except where the viatical settlement provider has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank, or an affiliate of either. Neither the viatical settlement provider nor the escrow agent may retain a portion of the proceeds.

[13.9.15.12 NMAC - N, 7-1-00]

13.9.15.13 ADVERTISING STANDARDS:

A. Advertising related to the viatical settlement shall be truthful and not misleading by fact or implication.

B. If the advertising statesthe speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

C. If the advertising states the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the advertiser during the past six (6) months.

[13.9.15.13 NMAC - N, 7-1-00]

13.9.15.14 VIATOR RETENTION PROVISIONS:

If a viatical settlement provider enters into a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain a provision that:

A. the viatical settlement provider will effect the transfer of only the amount of the death benefit viaticated. Benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company;

B. the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either:

(1) advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or

(2) send a copy of the instrument sent from the insurance company to the viatical settlement company that acknowledges the viator's interest in the policy; and

C. apportions the premiums to be paid by the viatical settlement company and the viator. The viatical settlement contract may specify that all premiums shall be paid by the viatical settlement company and may also require that the viator reimburse the viatical settlement provider for the premiums attributable to the retained interest.

[13.9.15.14 NMAC - N, 7-1-00]

13.9.15.15 DISCLOSURE DOCUMENTS:

A. A viatical settlement provider or broker shall provide a disclosure document containing the disclosures required in NMSA 1978 Section 59A-20A-8 and this section before or concurrent with taking an application for a viatical settlement contract.

B. The disclosure document shall contain the following language: "All medical, financial, personal, or patient identifying information solicited or obtained by a viatical settlement company or viatical settlement broker about a viator and insured, including the viator and insured's identity or the identity of family members, a spouse or a significant other, is confidential." The disclosure document shall advise the viator and the insured that such information may be provided to financing entities, including

individual and institutional purchasers.

C. A viatical settlement provider or broker shall provide a copy of Appendix A, set forth in 13.9.15.18 NMAC, before or concurrent with taking an application for a viatical settlement contract.

[13.9.15.15 NMAC - N, 7-1-00]

13.9.15.16 PROHIBITED PRACTICES:

A. A viatical settlement provider or broker shall obtain from a person that is provided with patient identifying information a signed affirmation that the person will not further divulge the information without procuring the express written consent of the insured for the disclosure, except that if a viatical settlement provider or broker is served with a subpoena and therefore compelled to produce records containing patient identifying information, it shall notify the viator and the insured in writing at their last known addresses within five (5) business days after receiving notice of the subpoena.

B. A viatical settlement provider shall not also act as a viatical settlement broker, whether entitled to collect a fee directly or indirectly, in the same viatical settlement.

C. A viatical settlement broker shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

D. A viatical settlement provider shall not use a longer life expectancy than is realistic in order to reduce the payout to which the viator is entitled.

E. A viatical settlement provider or broker shall not discriminate in the making or solicitation of viatical settlements on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation, or discriminate between viators with dependents and without.

F. A viatical settlement provider or broker shall not pay or offer to pay any finder's fee, commission or other compensation to any insured's physician, or to an attorney, accountant or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator with respect to the viatical settlement.

G. A viatical settlement provider shall not knowingly solicit investors who have treated or have been asked to treat the illness of the insured whose coverage would be the subject of the investment.

[13.9.15.16 NMAC - N, 7-1-00]

13.9.15.17 INSURANCE COMPANY PRACTICES:

A. Life insurance companies authorized to do business in this state shall respond to a request for verification of coverage from a viatical settlement provider or broker within thirty (30) calendar days of the date a request is received. The request shall be accompanied by:

(1) a current authorization consistent with applicable law, signed by the policyowner or certificateholder;

(2) in the case of an individual policy, a form substantially similar to Appendix B, which has been completed by the viatical settlement provider or broker in accordance with the instructions on the form.

(3) in the case of group insurance coverage a form substantially similar to Appendix C, which has been completed by the viatical settlement provider or broker in accordance with the instructions on the form, and which has previously been referred to the group policyholder and completed to the extent the information is available to the group policyholder.

B. A life insurance company and a viatical settlement provider or broker may use another verification of coverage form that has been mutually agreed upon in writing in advance of submission of the request.

C. A life insurance company may not charge a fee for responding to a request for verification of coverage from a viatical settlement provider or broker in excess of any usual and customary charges to contractholders, certificateholders or insureds for similar services.

D. The life insurance company may send an acknowledgment of receipt of the request for verification of coverage to the policyowner or certificateholder and, where the policy owner or certificate owner is other than the insured, to the insured. The acknowledgment may contain a general description of any accelerated death benefit that is available under a provision of or rider to the life insurance contract.

[13.9.15.17 NMAC - N, 7-1-00]

13.9.15.18 APPENDIX A: BUYER'S GUIDE

Selling Your Life Insurance Policy

Today it's possible for you to sell your life insurance policy to someone else (a viatical settlement provider) for an immediate cash payment. This financial arrangement, known as a viatical settlement, is best suited for people who are living with an immediate life-threatening illness and facing tough financial choices.

It may not always be in your best interest to sell your life insurance policy. Before you take action, you want to be sure you understand:

1. What future benefits you may lose

2. What other options may be available

Selling your life insurance policy is a complex financial arrangement. This guide will help you make an informed decision.

We recommend that you:

1. Evaluate your needs

2. Check all your options

3. Understand how the process works

4. Know your rights

5. Check with your state insurance department.

Step 1, Evaluate your needs

Before you sell your policy and give up valuable insurance protection, think about whether your need for life insurance has changed since you bought the policy. If it hasn't, selling your policy may not be the right choice. If you sell your policy now, your beneficiaries **will not** be paid a benefit at your death.

If you sell your policy now, remember premiums go up a lot as you grow older. You may not want to pay the higher cost to replace your coverage later.

Step 2, Check all of your options

You may be able to get the cash you need now without selling your policy.

Policy Cash Values

Contact your current life insurance agent or company to see if you have any cash value in your policy. Ask if you can:

1. borrow from the cash value and still keep the insurance in force,

2. cancel the policy for its current cash value,

3. use the cash value as collateral to get a loan from a financial institution.

Your insurance company must tell you about your options if you ask.

Accelerated Death Benefits

Find out if your policy has an "accelerated death benefit." It may be your best option.

Many life insurance policies do have an accelerated death benefit. With that benefit, policyholders who are terminally ill, affected with certain diseases or permanently confined in a nursing home can access 50% or more of a policy's death benefit while still living. An accelerated death benefit could pay you a large part of your policy's death benefit and you could keep your policy.

A very important feature of the accelerated benefit is that when the policyholder dies, the beneficiaries get the remaining death benefit. This means that eventually 100% of the policy benefits will be paid out either to the insured or the beneficiary.

Other considerations

Think about what it will mean if you do sell your policy. Check out the tax implications. Not all proceeds from a viatical settlement are tax-free.

Find out if creditors could claim any of the money you would get from a viatical settlement.

Find out if you will lose any public assistance benefits such as Medicaid or other government benefits if you accept a cash settlement for your life policy.

Comparison shop

To learn the market value of your policy, it's a good idea to contact three to five viatical settlement providers. Or you could use a viatical settlement broker who would contact several viatical settlement providers for you. Your financial advisor can help you decide whether to work with a viatical settlement provider or through a viatical settlement broker.

Summary

Everyone's financial situation is different. A viatical settlement may or may not be the best approach for you. Check it out for yourself. We recommend that you ask an advisor who is qualified to review your finances to help you review your options.

Step 3, How the process works

If you decide to sell your life insurance policy to a viatical settlement provider, you will enter into a viatical settlement agreement with the provider. You, the seller, agree to accept a cash payment for your policy. The amount will be less than the face amount the policy would pay upon your death. (For example, you might agree to accept a $75,000 cash payment for a $100,000 policy.)

The viatical settlement provider buying your policy:

1. becomes the new owner of your policy,

2. names the beneficiary,

3. collects the full death benefit when you die,

4. begins paying premiums on the policy, and

5. may sell your policy again.

There are four basic phases required to complete a viatical transaction.

Phase 1— Qualifying to sell your policy (underwriting)

The viatical settlement provider will need information about you before making an offer. Usually it will take some preliminary information from you over the phone and send you this paperwork to sign:

1. a medical release form so the viatical settlement provider can get and review your medical records

2. an authorization form to contact your insurance company to confirm benefit, premium, and ownership of your policy.

To avoid delays, it's important that you give complete and accurate information about your medical history.

If you apply with more than one viatical settlement provider, each will contact your doctor for medical records and your insurance company for policy information.

Phase 2—Calculating the offer

The viatical settlement provider uses the information it gets in the underwriting phase to make an offer. To develop an offer, a viatical settlement provider takes into account various factors including:

1. Estimated life expectancy and medical condition of the insured. Generally, the shorter the life expectancy of the insured, the more the viatical settlement provider will offer for the policy.

2. The amount of life insurance coverage.

3. Loans or advances, if any, previously taken against the policy.

4. Amount of premiums necessary to keep the life insurance policy in force.

5. The rating of the issuing insurance company.

6. Prevailing interest rates.

7. State laws, if any, that require a minimum payment.

Phase 3—Closing the agreement

1. If you accept an offer, a closing package is forwarded to you, the seller, for approval and signature. Closing documents typically include an offer letter, a viatical settlement contract, and the forms the insurance company needs to transfer ownership of the policy to the viatical settlement provider.

2. The closing documents are then returned to the viatical settlement provider for its signature.

3. The viatical settlement provider will put the cash payment owed to you in escrow, if required, and send the signed insurance change forms to the insurance company to record the change.

Phase 4—Receiving the payment

Once the insurance company notifies the viatical settlement provider that the changes on the life insurance policy have been recorded, the payment is released to you, the seller, within two business days.

In many states, you may have the right to change your mind about the settlement AFTER you receive the money, provided you return all the money. Typically the law allows 15 days to review your settlement arrangement.

Step 4, Know your rights

State laws

Many states have laws that provide important consumer protections. You'll want to contact your state insurance department to see which of the following consumer protections your state requires. Determine if:

1. A viatical settlement broker or viatical settlement provider arranging viatical settlements must be licensed with your insurance department.

2. The viatical settlement provider buying your policy must keep your identity and medical history confidential unless you give written consent to tell others.

3. To protect your proceeds, the viatical settlement provider buying your policy must put your money into an escrow account with an independent party during the transfer process.

4. You have the right to change your mind about the settlement AFTER you receive the money, provided you return all the money. You have 15 days to review your settlement arrangement.

5. The new owners of your policy are limited in how often they may contact you about your health status.

Federal tax laws

Two groups of people may receive benefits from a viatical settlement without owing federal income tax:

1. persons who have been diagnosed with a terminal illness and with a life expectancy of 24 months or less and

2. certain chronically ill individuals.

If you qualify for this federal tax-free treatment, you also must use a viatical settlement provider that is licensed in the state where you live, or, in states where licensing is not required, that complies with the standards of the National Association of Insurance Commissioners' Viatical Settlements Model Act.

Remember that, as when interpreting any tax laws, it's always best to check with your own financial advisor.

Avoiding consumer fraud

1. If you're in good health and someone asks you to sell your life insurance policy, proceed with caution. Remember that viatical settlements are intended for people living with life-threatening or chronic illnesses. Contact your state insurance department for more information.

2. If you've been contacted by someone who wants you to buy a policy and then sell it immediately, you should contact your state insurance department. You may be a target for fraud.

3. If you're asked to buy a life insurance policy for the sole purpose of selling it, you may be participating in fraud.

4. If you're asked to invest in a viatical settlement, we recommend you contact your state insurance department to learn more about the issues and risks that might be involved in such an investment.

Step 5, Check with your state insurance regulator

State licensing

Find out if your state licenses viatical settlement providers and brokers. For a complete list of authorized viatical settlement providers, brokers, and their representatives, call the Department of Insurance.

Seller checklist

Before you sell your policy be sure you know the answers to these questions.

Evaluating your needs

1. Do you still need life insurance?

2. Do you have dependents who might rely on your life insurance benefits should anything happen to you?

3. If you don't need life insurance protection now, what are the chances you'll need it in the future?

Current policy benefits

1. Can you borrow from the cash value?

2. Can you cancel the policy for its current cash value?

3. Can you use the cash value as collateral to get a loan from a financial institution?

4. Do you have an accelerated death benefit feature?

Taxes and other financial considerations

1. Is the money you get from selling the policy taxable?

2. Will the money you get from selling the policy affect your eligibility for government benefits?

3. Do you need the advice of a tax or estate planning specialist before you decide to sell your policy?

4. If you sell your policy, can any of your creditors claim the money?

Understanding the process

1. If you sell your policy, who will be the legal owner?

2. Is the viatical settlement provider buying your policy licensed?

3. If you sell your policy, how will the value you get be calculated? What interest rate will be used?

4. If you sell your policy but then change your mind, can you get your money back?

5. Will investors have specific information about you, your family or your health status?

6. How are fees or commissions paid to the viatical settlement broker or provider?

Protections in your state

Contact your state insurance department to find out if there are any laws governing viatical settlements.

[13.9.15.18 NMAC - N, 7-1-00]

13.9.15.19 APPENDIX B: VERIFICATION OF COVERAGE FOR INDIVIDUAL POLICIES

Appendix B

[13.9.15.19 NMAC - N, 7-1-00]

13.9.15.20 APPENDIX C: VERIFICATION OF GROUP LIFE INSURANCE BENEFITS

Appendix C

[13.9.15.20 NMAC - N, 7-1-00]

PART 16: USE OF 2001 COMMISSIONERS STANDARD ORDINARY MORTALITY TABLE

13.9.16.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[13.9.16.1 NMAC - N, 1-1-04]

13.9.16.2 SCOPE:

This rule applies to all life insurance companies issuing life insurance policies.

[13.9.16.2 NMAC - N, 1-1-04]

13.9.16.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-8-5 and 59A-20-31 NMSA 1978.

[13.9.16.3 NMAC - N, 1-1-04]

13.9.16.4 DURATION:

Permanent.

[13.9.16.4 NMAC - N, 1-1-04]

13.9.16.5 EFFECTIVE DATE:

January 1, 2004, unless a later date is cited at the end of a section. [13.9.16.5 NMAC - N, 1-1-04]

13.9.16.6 OBJECTIVE:

The purpose of this rule is to recognize, permit and prescribe the use of the 2001 commissioners standard ordinary (CSO) mortality table in accordance with Section 59A-8-5 NMSA 1978, Standard Valuation Law, Life Insurance and Annuities, Section 59A-20-31 NMSA 1978, Standard Nonforfeiture Law, Life Insurance, and 13.9.13 NMAC, Valuation of Life Insurance Policies.

[13.9.16.6 NMAC - N, 1-1-04]

13.9.16.7 DEFINITIONS:

A. 2001 CSO Mortality Table means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American academy of actuaries CSO task force from the valuation basic mortality table developed by the society of actuaries individual life insurance valuation mortality task force, and adopted by the national association of insurance commissioners ("NAIC") in December 2002. The 2001 CSO mortality table is included in the proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the "2001 CSO mortality table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

B. 2001 CSO mortality table (F) means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

C. 2001 CSO mortality table (M) means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO mortality table.

D. Composite mortality tables means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

E. Smoker and nonsmoker mortality tables means mortality tables with separate rates of mortality for smokers and nonsmokers.

[13.9.16.7 NMAC - N, 1-1-04]

13.9.16.8 2001 CSO MORTALITY TABLE:

A. At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in this regulation, the 2001 CSO mortality table may be used as the minimum standard for policies issued on or after January 1, 2004 and before the date specified in Subsection B to which Subparagraph (a) of Paragraph (1) of Subsection B of Section 59A-8-5 NMSA 1978, Subparagraph (f) of Paragraph (7) of Subsection F of Section 59A-20-31 NMSA 1978, and 13.9.13.12 and 13.9.13.13 NMAC are applicable. If the company elects to use the 2001 CSO mortality table, it shall do so for both valuation and nonforfeiture purposes.

B. Subject to the conditions stated in this rule, the 2001 CSO mortality table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which Subparagraph (a) of Paragraph (1) of Subsection B of Section 59A-8-5 NMSA 1978, Subparagraph (f) of Paragraph (7) of Subsection F of Section 59A-20-31 NMSA 1978, and 13.9.13.12 and 13.9.13.13 NMAC are applicable.

[13.9.16.8 NMAC - N, 1-1-04]

13.9.16.9 CONDITIONS:

A. For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

(1) composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(2) smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Subparagraph (e) of Paragraph (1) of Subsection E of Section 59A-8-5 NMSA 1978, and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(3) smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

B. For plans of insurance without separate rates for smokers and nonsmokers the composite mortality tables shall be used.

C. For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO mortality table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of 13.9.16.10 NMAC and 13.9.13 NMAC relative to use of the select and ultimate form.

D. When the 2001 CSO mortality table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the commissioner shall be based on an asset adequacy analysis as specified in 13.2.6.8 NMAC, actuarial opinions and memoranda. A commissioner may exempt a company from this requirement if it only does business in this state and in no other state.

[13.9.16.9 NMAC - N, 1-1-04]

13.9.16.10 APPLICABILITY OF THE 2001 CSO MORTALITY TABLE TO 13.9.13 NMAC:

A. The 2001 CSO mortality table may be used in applying 13.9.13 NMAC in the following manner, subject to the transition dates for use of the 2001 CSO mortality table in Section 4 of this rule (unless otherwise noted, the references in this section are to 13.9.13 NMAC):

(1) Subparagraph (b) of Paragraph (2) of Subsection B of Section 2: The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

(2) Subsection B of Section 7: All calculations are made using the 2001 CSO mortality rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in Paragraph 4. The value of "qx+k+t-1" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(3) Section 12: The 2001 CSO mortality table is the minimum standard for basic reserves.

(4) Section 13: The 2001 CSO mortality table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in Sections 5B(3)(a) to (i). In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO mortality table with those tests that utilize the 2001 CSO mortality table, unless the combination is explicitly required by regulation or necessary to be in compliance with relevant actuarial standards of practice.

(5) Section 17: The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO mortality table.

(6) Subsection E of Section 19: The calculations specified in Section 19 shall use the ultimate mortality rates in the 2001 CSO mortality table.

(7) Subsection E of Section 20: The calculations specified in Section 20 shall use the ultimate mortality rates in the 2001 CSO mortality table.

(8) Subsection B of Section 21: The calculations specified in Section 21 shall use the ultimate mortality rates in the 2001 CSO mortality table.

(9) Subparagraph (b) of Paragraph (1) of Subsection A of Section 23: The one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO mortality table.

B. Nothing in this section shall be construed to expand the applicability of 13.9.13 NMAC to include life insurance policies exempted by Subsection B of 13.9.13.2 NMAC.

[13.9.16.10 NMAC - N, 1-1-04]

13.9.16.11 GENDER-BLENDED TABLES:

A. For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 2004, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO mortality table (M) and the 2001 CSO mortality table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO mortality table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this subsection.

B. The company may choose from among the blended tables developed by the American academy of actuaries CSO task force and adopted by the NAIC in December 2002.

C. It shall not, in and of itself, be a violation of Section 59A-16-13 NMSA 1978 for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

[13.9.16.11 NMAC - N, 1-1-04]

PART 17: MILITARY SALES PRACTICES

13.9.17.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[13.9.17.1 NMAC - N, 1/1/08]

13.9.17.2 SCOPE:

This rule shall apply to the solicitation or sale of any life insurance or annuity product by an insurer or insurance producer to an active duty service member of the United States armed forces.

[13.9.17.2 NMAC - N, 1/1/08]

13.9.17.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-16-3, 59A-16-4, 59A-16-5 and 59A-16-15 NMSA 1978.

[13.9.17.3 NMAC - N, 1/1/08]

13.9.17.4 DURATION:

Permanent.

[13.9.17.4 NMAC - N, 1/1/08]

13.9.17.5 EFFECTIVE DATE:

January 1, 2008 unless a later date is cited at the end of a section.

[13.9.17.5 NMAC - N, 1/1/08]

13.9.17.6 OBJECTIVE:

The objective of this rule is to set forth standards to protect active duty service members of the United States armed forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair.

[13.9.17.6 NMAC - N, 1/1/08]

13.9.17.7 DEFINITIONS:

A. **Active Duty** means full-time duty in the active military service of the United States and includes members of the reserve component, national guard and reserve, while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active

duty for training under military calls or orders specifying periods of less than 31 calendar days.

B. **DoD** means department of defense.

C. **DoD personnel** means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the department of defense.

D. **Door to door** means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.

E. **General advertisement** means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or the insurance producer.

F. **Insurer** means an insurance company required to be licensed under the laws of this state to provide life insurance products, including annuities.

G. **Insurance producer** means a person required to be licensed under the laws of this state to sell, solicit or negotiate life insurance, including annuities.

H. **IRC** means the Internal Revenue Code.

I. **Known or knowingly** means, depending on its use herein, the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known, at the time of the act or practice complained of, that the person solicited is a service member.

J. **Life insurance,** as used in 13.9.17 NMAC, means insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income and unless otherwise specifically excluded, includes individually issued annuities.

K. **Military installation** means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

L. **MyPay** means the defense finance and accounting service web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

M. **Service member** means any active duty officer, commissioned and warrant, or enlisted member of the United States armed forces.

N. **SGLI** means servicemembers' group life insurance.

O. **Side fund** means a fund or reserve that is part of or otherwise attached to a life insurance policy, excluding individually issued annuities, by rider, endorsement or other mechanism which accumulates premium or deposits with interest or by other means. The term does not include:

(1) accumulated value or cash value or secondary guarantees provided by a universal life policy;

(2) cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or

(3) a premium deposit fund which:

(a) contains only premiums paid in advance which accumulate at interest;

(b) imposes no penalty for withdrawal;

(c) does not permit funding beyond future required premiums;

(d) is not marketed or intended as an investment; and

(e) does not carry a commission, either paid or calculated.

P. **Specific appointment** means a prearranged appointment agreed upon by both parties and definite as to place and time.

Q. **United States armed forces** means all components of the army, navy, air force, marine corps, and coast guard.

R. **VGLI** means veterans' group life insurance.

[13.9.17.7 NMAC - N, 1/1/08]

13.9.17.8 EXEMPTIONS:

A. This rule shall not apply to solicitations or sales involving:

(1) credit insurance;

(2) group life insurance or group annuities where there is no in-person, face-to-face solicitation of individuals by an insurance producer or where the contract or certificate does not include a side fund;

(3) an application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the superintendent of insurance; or, when a term conversion privilege is exercised among corporate affiliates;

(4) individual stand-alone health policies, including disability income policies;

(5) contracts offered by SGLI or VGLI as authorized by 38 U.S.C. Section 1965 et seq;

(6) life insurance contracts offered through or by a non-profit military association, qualifying under Section 501 (c) (23) of the IRC, and which are not underwritten by an insurer; or

(7) contracts used to fund:

(a) an employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act;

(b) a plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, as amended, if established or maintained by an employer;

(c) a government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;

(d) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(e) settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(f) prearranged funeral contracts.

B. Nothing herein shall be construed to abrogate the ability of nonprofit organizations or other organizations to educate members of the United States Armed forces in accordance with DoD instruction 1344.07 - personal commercial solicitation on DoD installations or successor directive.

C. For purposes of this rule, general advertisements, direct mail and internet marketing shall not constitute "solicitation." Telephone marketing shall not constitute "solicitation" provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation. Provided however, nothing in Subsection C of 13.9.17.8 NMAC shall be construed to

exempt an insurer or insurance producer from 13.9.17 NMAC in any in-person, face-to-face meeting established as a result of the "solicitation" exemptions identified in Subsection C of 13.9.17.8 NMAC.

[13.9.17.8 NMAC - N, 1/1/08]

13.9.17.9 PRACTICES DECLARED FALSE, MISLEADING, DECEPTIVE OR UNFAIR ON A MILITARY INSTALLATION:

A. The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance are declared to be false, misleading, deceptive or unfair:

(1) knowingly soliciting the purchase of any life insurance product "door to door" or without first establishing a specific appointment for each meeting with the prospective purchaser.

(2) soliciting service members in a group or "mass" audience or in a "captive" audience where attendance is not voluntary.

(3) knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

(4) making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation.

(5) soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

(6) posting unauthorized bulletins, notices or advertisements.

(7) failing to present DD form 2885, personal commercial solicitation evaluation, to service members solicited or encouraging service members solicited not to complete or submit a DD form 2885.

(8) knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States armed forces without first obtaining for the insurer's files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of the DoD or any branch of the armed forces.

B. The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

(1) using DoD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members; or

(2) using an insurance producer to participate in any United States armed forces sponsored education or orientation program.

[13.9.17.9 NMAC - N, 1/1/08]

13.9.17.10 CORRUPT PRACTICES, IMPROPER INFLUENCES OR INDUCEMENTS REGARDLESS OF LOCATION:

The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

A. submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States armed forces to direct a service member's pay to a third party for the purchase of life insurance; the foregoing includes, but is not limited to, using or assisting in using a service member's MyPay account or other similar internet or electronic medium for such purposes; Subsection A of 13.9.17.10 NMAC does not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form;

B. knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship; for purposes of 13.9.17.10 NMAC, a formal banking relationship is established when the depository institution:

(1) provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301 et seq. and the regulations promulgated thereunder; and

(2) permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums;

C. employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's leave and earnings statement or equivalent or successor form as "savings" or "checking" and where the service member has no formal banking relationship as defined in Paragraph (2) of Subsection A of 13.9.17.7 NMAC;

D. entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship;

E. using DoD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to the family members of such personnel;

F. offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member;

G. knowingly offering or giving anything of value to a service member for his or her attendance to any event where an application for life insurance is solicited; or

H. advising a service member to change his or her income tax withholding or state of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

[13.9.17.10 NMAC - N, 1/1/08]

13.9.17.11 ACTS OR PRACTICES THAT LEAD TO CONFUSION REGARDLESS OF LOCATION:

A. The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval or affiliation and are declared to be false, misleading, deceptive or unfair:

(1) making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the United States government, the United States armed forces, or any state or federal agency or government entity; examples of prohibited insurance producer titles include, but are not limited to, "battalion insurance counselor," "unit insurance advisor," "servicemen's group life insurance conversion consultant" or "veteran's benefits counselor;" or

(2) soliciting the purchase of any life insurance product through the use of or in conjunction with any third party organization that promotes the welfare of or assists members of the United States Armed forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the United States government, or the United States armed forces.

B. Nothing in 13.9.17.11 NMAC shall be construed to prohibit a person from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Such designations include, but are not limited to, chartered life underwriter, chartered

financial consultant, certified financial planner, master of science in financial services, or masters of science financial planning.

C. The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs or investment returns and are declared to be false, misleading, deceptive or unfair:

(1) using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid; or

(2) excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product "costs nothing" or is "free."

[13.9.17.11 NMAC - N, 1/1/08]

13.9.17.12 OTHER ACTS OR PRACTICES REGARDLESS OF LOCATION:

A. The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive or unfair:

(1) making any representation regarding the availability, suitability, amount, cost, exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading or deceptive;

(2) making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading or deceptive; or

(3) suggesting, recommending or encouraging a service member to cancel or terminate his or her SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member's separation from the United States armed forces.

B. The following acts or practices by an insurer and or insurance producer regarding disclosure are declared to be false, misleading, deceptive or unfair:

(1) deploying, using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance;

(2) failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-face meeting with a prospective purchaser;

(3) excluding individually issued annuities, failing to clearly and conspicuously disclose the fact that the product being sold is life insurance;

(4) failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the Military Personnel Financial Services Protection Act, Pub. L. No. 109-290; or

(5) excluding individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time the application is taken:

(a) an explanation of any free look period with instructions on how to cancel if a policy is issued; and

(b) either a copy of the application or a written disclosure; the copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost; a basic illustration that meets the requirements of 13.9.5 NMAC, Life Insurance Disclosure and 13.9.14 NMAC, Life Insurance Illustrations shall be deemed sufficient to meet this requirement for a written disclosure.

[13.9.17.12 NMAC - N, 1/1/08]

13.9.17.13 ACTS OR PRACTICES REGARDING DISCLOSURE REGARDLESS OF LOCATION:

The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive or unfair:

A. excluding individually issued annuities, recommending the purchase of any life insurance product which includes a side fund to a service member unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable;

B. offering for sale or selling a life insurance product which includes a side fund to a service member who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance:

(1) "insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and/or survivors or dependents;

(2) "other military survivor benefits" include, but are not limited to: the death gratuity, funeral reimbursement, transition assistance, survivor and dependents' educational assistance, dependency and indemnity compensation, "TRICARE" healthcare benefits, survivor housing benefits and allowances, federal income tax forgiveness, and social security survivor benefits;

C. excluding individually issued annuities, offering for sale or selling any life insurance contract which includes a side fund:

(1) unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

(2) unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product; for this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage; this schedule will be provided for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and

(3) which by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premiums due;

D. excluding individually issued annuities, offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance, Section 59A-20-31 NMSA 1978; or

E. selling any life insurance product to an individual known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service except for an accidental death coverage, e.g., double indemnity, which may be excluded.

[13.9.17.13 NMAC - N, 1/1/08]

PART 18: USE OF PREFERRED RISK MORTALITY TABLES

13.9.18.1 ISSUING AGENCY:

Office of Superintendent of Insurance (OSI), Post Office Box 1689, Santa Fe, NM 87504-1689.

[13.9.18.1 NMAC - N, 12/31/2007; A, 7/24/2018]

13.9.18.2 SCOPE:

This rule applies to all insurers issuing life insurance policies.

[13.9.18.2 NMAC - N, 12/31/2007]

13.9.18.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-8-5 NMSA 1978.

[13.9.18.3 NMAC - N, 12/31/2007]

13.9.18.4 DURATION:

Permanent.

[13.9.18.4 NMAC - N, 12/31/2007]

13.9.18.5 EFFECTIVE DATE:

December 31, 2007 unless a later date is cited at the end of a section.

[13.9.18.5 NMAC - N, 12/31/2007]

13.9.18.6 OBJECTIVE:

The purpose of this regulation is to recognize, permit and prescribe the use of mortality tables that reflect differences in mortality between preferred and standard lives in determining minimum reserve liabilities.

[13.9.18.6 NMAC - N, 12/31/2007]

13.9.18.7 DEFINITIONS:

A. "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the AAA CSO task force from the *Valuation Basic Mortality Table* developed by the SOA individual life insurance valuation mortality task force, and adopted by the NAIC in December 2002. The *2001 CSO Mortality Table* is included in the *Proceedings of the NAIC*, second quarter 2002, and supplemented by the *2001 CSO Preferred Class Structure Mortality Table* defined in Subsection B of 13.9.18.7 NMAC. Unless the context indicates otherwise, the *2001 CSO Mortality Table* includes both the ultimate form of that table and the select and ultimate form of that table and includes both the *Smoker and Nonsmoker Mortality Tables* and the *Composite Mortality Tables*. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables. Mortality tables in the *2001 CSO Mortality Table* include the following:

(1) "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the *2001 CSO Mortality Table*;

(2) "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the *2001 CSO Mortality Table*;

(3) "Composite Mortality Tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers; and

(4) "Smoker and Nonsmoker Mortality Tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

B. "2001 CSO Preferred Class Structure Mortality Table" means mortality tables with separate rates of mortality for super preferred nonsmokers, preferred nonsmokers, residual standard nonsmokers, preferred smokers, and residual standard smoker splits of the *2001 CSO Nonsmoker and Smoker Tables* as adopted by the at the September, 2006 national meeting and published in the *Proceedings of the NAIC*, third quarter 2006. Unless the context indicates otherwise, the *2001 CSO Preferred Class Structure Mortality Table* includes both the ultimate form of that table and the select and ultimate form of that table. It includes both the *Smoker and Nonsmoker Mortality Tables*. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

C. "AAA" means the American academy of actuaries.

D. "CSO" means commissioners standard ordinary.

E. "NAIC" means the national association of insurance commissioners.

F. "SOA" means the society of actuaries.

G. "Statistical agent" means an entity with proven systems for protecting the confidentiality of individual insured and insurer information, demonstrated resources for and history of ongoing electronic communications and data transfer ensuring data integrity with insurers, which are its members or subscribers and a history of and means for aggregation of data and accurate promulgation of the experience modifications in a timely manner.

H. "Superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

[13.9.18.7 NMAC - N, 12/31/2007; A, 7/24/2018]

13.9.18.8 2001 CSO PREFERRED CLASS STRUCTURE TABLE:

At the election of the insurer, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in this rule, the *2001 CSO Preferred Class Structure Mortality Table* may be substituted in place of the *2001 CSO Smoker or Nonsmoker Mortality Table* as the minimum valuation standard for policies issued on or after January 1, 2007. For policies issued on or after January 1, 2004 and prior to January 1, 2007, these tables may be substituted with the consent of the superintendent and subject to the conditions of 13.9.18.9 NMAC. In determining such consent, the superintendent may rely on the consent of the commissioner of the company's state of domicile. No such election shall be made until the company demonstrates at least twenty percent of the business to be valued on this table is in one or more of the preferred classes. A table from the *2001 CSO Preferred Class Structure Mortality Table* used in place of a *2001 CSO Mortality Table*, pursuant to the requirements of this rule, will be treated as part of the *2001 CSO Mortality Table* only for purposes of reserve valuation pursuant to the requirements of 13.9.16 NMAC, Use Of 2001 Commissioners Standard Ordinary Mortality Table.

[13.9.18.7 NMAC - N, 12/31/2007; A, 7/24/2018]

13.9.18.9 CONDITIONS:

A. For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the *Super Preferred Nonsmoker*, *Preferred Nonsmoker*, and *Residual Standard Nonsmoker Tables* to substitute for the *Nonsmoker Mortality Table* found in the *2001 CSO Mortality Table* to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the *Residual Standard Nonsmoker Table*, the appointed actuary shall certify that:

(1) the present value of death benefits over the next 10 years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class; and

(2) the present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

B. For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the *Preferred Smoker* and *Residual Standard Smoker Tables* to substitute for the *Smoker Mortality Table* found in the *2001 CSO Mortality Table* to determine minimum reserves. At the time of election and annually thereafter,

for business valued under the *Preferred Smoker Table*, the appointed actuary shall certify that:

(1) the present value of death benefits over the next 10 years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the *Preferred Smoker Valuation Basis Table* corresponding to the valuation table being used for that class; and

(2) the present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the *Preferred Smoker Valuation Basis Table*.

C. Unless exempted by the superintendent, every authorized insurer using the *2001 CSO Preferred Class Structure Table* shall annually file with the superintendent, with the NAIC, or with a statistical agent designated by the NAIC and acceptable to the superintendent, statistical reports showing mortality and such other information as the superintendent may deem necessary or expedient for the administration of the provisions of this rule. The form of the reports shall be established by the superintendent or the superintendent may require the use of a form established by the NAIC or by a statistical agent designated by the NAIC and acceptable to the superintendent.

D. The use of the *2001 CSO Preferred Class Structure Table* for the valuation of policies issued prior to January 1, 2007 shall not be permitted in any statutory financial statement in which a company reports, with respect to any policy or portion of a policy coinsured, either of the following:

(1) In cases where the mode of payment of the reinsurance premium is less frequent than the mode of payment of the policy premium, a reserve credit that exceeds, by more than the amount specified in this paragraph as Y, the gross reserve calculated before reinsurance. Y is the amount of the gross reinsurance premium that (a) provides coverage for the period from the next policy premium due date to the earlier of the end of the policy year and the next reinsurance premium due date, and (b) would be refunded to the ceding entity upon the termination of the policy.

(2) In cases where the mode of payment of the reinsurance premium is more frequent than the mode of payment of the policy premium, a reserve credit that is less than the gross reserve, calculated before reinsurance, by an amount that is less than the amount specified in this paragraph as Z. Z is the amount of the gross reinsurance premium that the ceding entity would need to pay the assuming company to provide reinsurance coverage from the period of the next reinsurance premium due date to the next policy premium due date minus any liability established for the proportionate amount not remitted to the reinsurer.

(3) For purposes of this condition, the reserve (i) for the mean reserve method shall be defined as the mean reserve minus the deferred premium asset, and (ii) for the mid-terminal reserve method shall include the unearned premium reserve. A company may estimate and adjust its accounting on an aggregate basis in order to meet the conditions to use the *2001 CSO Preferred Class Structure Table*.

[13.9.18.9 NMAC - N, 12/31/2007; A, 7/24/2018]

13.9.18.10 SEPARABILITY:

If any provision of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected.

[13.9.18.10 NMAC - N, 7/24/2018]

PART 19: PREFERRED RISK MORTALITY TABLES FOR PRENEED INSURANCE

13.9.19.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[13.9.19.1 NMAC - N, 1/1/2009]

13.9.19.2 SCOPE:

This rule applies to "funeral plans," as defined in Section 59A-49-4 NMSA 1978, to "preneed funeral contracts or prearrangements," as defined in 13.9.5.7 NMAC, and to similar policies and certificates. In case of any conflict with 13.9.16 NMAC or 13.9.18 NMAC, the provisions of 13.9.19 NMAC, as affecting funeral plans, preneed insurance or prearrangements, or similar policies and certificates, shall control.

[13.9.19.2 NMAC - N, 1/1/2009]

13.9.19.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-8-5, and 59A-20-31 NMSA 1978.

[13.9.19.3 NMAC - N, 1/1/2009]

13.9.19.4 DURATION:

Permanent.

[13.9.19.4 NMAC - N, 1/1/2009]

13.9.19.5 EFFECTIVE DATE:

January 1, 2009, unless a later date is cited at the end of a section.

[13.9.19.5 NMAC - N, 1/1/2009]

13.9.19.6 OBJECTIVE:

The purpose of this regulation is to establish for preneed insurance minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 commissioners standard ordinary (CSO) life valuation mortality table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance. This rule is based on the national association of insurance commissioners' "preneed life insurance minimum standards for determining reserve liabilities and nonforfeiture values model regulation" (model 817) adopted in March, 2008.

[13.9.19.6 NMAC - N, 1/1/2009]

13.9.19.7 DEFINITIONS:

A. **"2001 CSO mortality table"** means the definition in 13.9.16 NMAC and 13.9.18 NMAC.

B. **"Ultimate 1980 CSO"** means the commissioners' 1980 standard ordinary life valuation mortality tables (1980 CSO) without ten-year (10-year) selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

C. **"Preneed insurance"** means "funeral plans," as defined in Section 59A-49-4 NMSA 1978, and "preneed funeral contracts or prearrangements," as defined in 13.9.5.7 NMAC.

[13.9.19.7 NMAC - N, 1/1/2009]

13.9.19.8 MINIMUM VALUATION MORTALITY STANDARDS:

For preneed insurance, as defined in paragraph C of 13.9.19.7 NMAC, and similar policies and contracts, the minimum mortality standard for determining reserve liabilities and nonforfeiture values for both male and female insured shall be the Ultimate 1980 CSO.

[13.9.19.8 NMAC - N, 1/1/2009]

13.9.19.9 MINIMUM VALUATION INTEREST RATE STANDARDS:

A. The interest rates used in determining the minimum standard for valuation of preneed insurance shall be the calendar year statutory valuation interest rates as defined in Section 59A-8-5 NMSA 1978.

B. The interest rates used in determining the minimum standard for nonforfeiture values for preneed insurance shall be the calendar year statutory nonforfeiture interest rates as defined in Section 59A-20-31 NMSA 1978.

[13.9.19.9 NMAC - N, 1/1/2009]

13.9.19.10 MINIMUM VALUATION METHOD STANDARDS:

A. The method used in determining the standard for the minimum valuation of reserves of preneed insurance shall be the method defined in Section 59A-8-5 NMSA 1978.

B. The method used in determining the standard for the minimum nonforfeiture values for preneed insurance shall be the method defined in Section 59A-20-31 NMSA 1978.

[13.9.19.10 NMAC - N, 1/1/2009]

13.9.19.11 TRANSITION RULES:

A. For preneed insurance policies issued on or after the effective date of this regulation and before January 1, 2012, the 2001 CSO may be used as the minimum standard for reserves and minimum standard for nonforfeiture benefits for both male and female insureds.

B. If an insurer elects to use the 2001 CSO as a minimum standard for any policy issued on or after the effective date of this regulation and before January 1, 2012, the insurer shall provide, as a part of the actuarial opinion memorandum submitted in support of the company's asset adequacy testing, an annual written notification to the domiciliary commissioner or superintendent of insurance. The notification shall include:

(1) a complete list of all preneed insurance policy forms that use the 2001 CSO as a minimum standard;

(2) a certification signed by the appointed actuary stating that the reserve methodology employed by the company in determining reserves for the preneed insurance policies issued after the effective date and using the 2001 CSO as a minimum standard, develops adequate reserves (for the purposes of this certification, the preneed insurance policies using the 2001 CSO as a minimum standard cannot be aggregated with any other policies.); and

(3) supporting information regarding the adequacy of reserves for preneed insurance policies issued after the effective date of this regulation and using the 2001 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

C. Preneed insurance policies issued on or after January 1, 2012, must use the Ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

[13.9.19.11 NMAC - N, 1/1/2009]

PART 20 SUITABILITY IN ANNUITY TRANSACTIONS

13.9.20.1 ISSUING AGENCY:

The New Mexico Office of Superintendent of Insurance ("OSI").

[13.9.20.1 NMAC – N, 10/1/2022]

13.9.20.2 SCOPE:

This rule applies to any sale or recommendation of an annuity in New Mexico or to a resident of New Mexico, regardless of an insurance producer’s state of domicile.

[13.9.20.2 NMAC – N, 10/1/2022]

13.9.20.3 STATUTORY AUTHORITY:

Chapter 59A, Article 16 NMSA 1978 and Section 59A-2-9 NMSA 1978.

[13.9.20.3 NMAC – N, 10/1/2022]

13.9.20.4 DURATION:

Permanent.

[13.9.20.4 NMAC – N, 10/1/2022]

13.9.20.5 EFFECTIVE DATE:

October 1, 2022, unless a later date is cited at the end of a section.

[13.9.20.5 NMAC – N, 10/1/2022]

13.9.20.6 OBJECTIVE:

A. This rule requires an insurance producer as defined in Section 59A-12-2E NMSA 1978 to act in the best interest of a consumer when making a recommendation of an annuity and require an insurer to establish and maintain a system to supervise recommendations so that the insurance needs and financial objectives of the consumer at the time of the transaction are effectively addressed.

B. Another objective of this rule is to regulate trade practices in the insurance business and related businesses in accordance with the intent of Congress, as expressed in the Act of Congress approved March 9, 1945, being c. 20, 59 Stat. 33, also designated as 15 U.S.C. Sections 1011 to 1015, inclusive, by defining, or providing for determination of, practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices so defined or determined.

[13.9.20.6 NMAC – N, 10/1/2022]

13.9.20.7 DEFINITIONS:

For the purposes of this rule:

A. "Annuity" means an annuity that is an insurance product under state law that is individually solicited, whether the product is classified as an individual or group annuity.

B. "Cash compensation" means any discount, concession, fee, service fee, commission, sales charge, loan, override or cash benefit received by an insurance producer in connection with the recommendation or sale of an annuity from an insurer, intermediary or directly from the consumer.

C. "Comparable standards" means:

(1) for broker-dealers and registered representatives of broker-dealers, applicable SEC and FINRA rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including, but not limited to, the most current version of Regulation Best Interest as promulgated by the SEC and codified at 84 F.R. 33318, and any amendments or successor rules thereto;

(2) for investment advisers registered under federal or state securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on such investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940 or the New Mexico Uniform Securities Act, Section C of Chapter 58, Article 13 NMSA 1978, including but not limited to, SEC Form ADV and interpretations; and

(3) for plan fiduciaries or fiduciaries, the duties, obligations, prohibitions and all other requirements attendant to such status under ERISA or the IRC and any amendments or successor statutes thereto.

D. "Consumer profile information" means information that is reasonably appropriate to determine whether a recommendation addresses the consumer's financial situation, insurance needs and financial objectives including, at a minimum, the following:

(1) age;

(2) annual income;

(3) financial situation and needs, including debts and other obligations;

(4) financial experience;

(5) insurance needs;

(6) financial objectives;

(7) intended use of the annuity;

(8) financial time horizon;

(9) existing assets or financial products, including investment, annuity and insurance holdings;

(10) liquidity needs;

(11) liquid net worth;

(12) risk tolerance, including but not limited to, willingness to accept non-guaranteed elements in the annuity;

(13) financial resources used to fund the annuity; and

(14) tax status.

E. "Continuing education credit" or "CE credit" means one continuing education credit hour as defined in 13.4.7.7 NMAC.

F. "Continuing education provider" or "CE provider" means an individual or entity that is approved to offer continuing education courses pursuant to Section 59A-12-26 NMSA 1978 and 13.4.7 NMAC.

G. "ERISA" means the federal Employee Retirement and Income Security Act.

H. "Financial professional" means an insurance producer who is regulated and acting as:

(1) a broker-dealer registered under federal or state securities laws or a registered representative of a broker-dealer;

(2) an investment adviser registered under federal or state securities laws or a representative of an investment adviser working with a registered adviser; or

(3) a plan fiduciary, as defined in ERISA or IRC.

I. "FINRA" means the financial industry regulatory authority or a succeeding agency.

J. "Intermediary" means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer's annuities by insurance producers.

K. "IRC" means the Internal Revenue Code.

L. "Material conflict of interest" means a financial interest of an insurance producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation. It does not include cash compensation or non-cash compensation.

M. "Non-cash compensation" means any form of compensation that is not cash compensation, including but not limited to health insurance, office rent, office support and retirement benefits.

N. "Non-guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest-based credits, charges or elements of formulas used to determine any of these that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

O. "Recommendation" means advice provided by an insurance producer to an individual consumer that is intended to result or does result in a purchase, exchange or replacement of an annuity in accordance with that advice. Recommendation does not include general communication to the public, generalized customer service assistance or administrative support, general educational information and tools, prospectuses or other product and sales material.

P. "Replacement" means a transaction in which a new annuity is to be purchased and it is known or should be known to the proposing insurance producer, or to the proposing insurers whether or not an insurance producer is involved, that because of the transaction, an existing annuity or other insurance policy has been or is to be any of the following:

(1) lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or which benefits would be paid;

(4) reissued with any reduction in cash value; or

(5) used in a financed purchase.

Q. "SEC" means the United States securities and exchange commission.

[13.9.20.7 NMAC – N, 10/1/2022]

13.9.20.8 EXCEPTIONS:

Unless otherwise specifically stated, this rule shall not apply to transactions involving:

A. a direct response solicitation when there is no recommendation based on information collected from the consumer pursuant to this rule;

B. a contract used to fund:

(1) an employee pension or welfare benefit plan that is covered by ERISA;

(2) a plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, as amended, if established or maintained by an employer;

(3) a government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under Section 457 of the IRC; or

(4) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

C. a settlement of or assumption of liability associated with personal injury litigation or any dispute or claim resolution process; or

D. a formal prepaid funeral contract.

[13.9.20.8 NMAC – N, 10/1/2022]

13.9.20.9 DUTIES OF INSURERS AND INSURANCE PRODUCERS:

A. Best interest obligations. An insurance producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the insurance producer's or the insurer's financial interest ahead of the consumer's interest. An insurance producer has acted in the best interest of the consumer if the insurance producer has satisfied the following obligations regarding care, disclosure, conflict of interest and documentation as outlined in this rule.

(1) Care obligation. An insurance producer, in making a recommendation, shall exercise reasonable diligence, care and skill to:

(a) know the consumer's financial situation, insurance needs and financial objectives;

(b) understand the available recommendation options after making a reasonable inquiry into options available to the insurance producer;

(c) have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs and financial objectives over the life of the product, after consideration of the information provided in the consumer profile information;

(d) communicate the basis or bases of the recommendation;

(e) make reasonable efforts to obtain consumer profile information from the consumer before the recommendation of an annuity;

(f) consider the types of products the insurance producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the insurance producer or other possible alternative products or strategies available in the market at the time of the recommendation. An insurance producer shall be held to standards applicable to insurance producers with similar authority and licensure;

(g) consider the consumer profile information, characteristics of the insurer and product cost, rates, benefits and features in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs and financial objectives, while understanding that:

(i) the level of importance of each factor of the care obligation may vary depending on the facts and circumstances of a particular case; and

(ii) each factor shall not be considered in isolation.

(h) in the case of an exchange or replacement of an annuity, consider the whole transaction, which includes consideration of whether:

(i) the consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(ii) the replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

(iii) the consumer has had another annuity exchange or replacement and in particular, an exchange or replacement within the preceding 60 months.

(i) The care obligation requirements of this rule:

(i) include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features; apply to a particular annuity as a whole and to the underlying subaccounts to which funds are allocated at the time of annuity purchase or exchange and to riders and similar producer enhancements, if any;

(ii) do not require recommendation in all situations of an annuity with the lowest one-time or multiple occurrence compensation structure;

(iii) do not impose additional ongoing monitoring obligations on a producer, but such obligations may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the producer and a consumer; and

(iv) do not create a fiduciary obligation or relationship.

(2) Disclosure obligation. Before or at the time of the recommendation or sale of an annuity, an insurance producer shall have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees; any annual fees, potential charges for and features of riders or other options of the annuity limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components and market risk. These requirements are intended to supplement and not replace other disclosure requirements of this rule. Before the recommendation or sale of an annuity, an insurance producer shall prominently disclose to a consumer on a form substantially similar to Appendix A located at the end of this rule the following information:

(a) a description of the scope and terms of the insurance producer's relationship with the consumer and the role of the insurance producer in the transaction;

(b) an affirmative statement of whether the insurance producer is licensed and authorized to sell the following products:

(i) fixed annuities;

(ii) fixed indexed annuities;

(iii) variable annuities;

(iv) life insurance;

(v) mutual funds;

(vi) stocks and bonds; and

(vii) certificates of deposit;

(c) an affirmative statement describing the insurers for which the insurance producer is authorized, contracted or appointed, or otherwise able to sell insurance products, using the following descriptions:

(i) from one insurer;

(ii) from two or more insurers; or

(iii) from two or more insurers although primarily contracted with one insurer;

(d) a description of the sources and types of cash compensation and non-cash compensation to be received by the insurance producer, including whether the insurance producer is to be compensated for the sale of a recommended annuity by commission as part of a premium or other remuneration received from the insurer, intermediary or other insurance producer or by a fee as a result of a contract for advice or consulting services; and

(e) a notice of a consumer's or consumer's representative's right to request additional information regarding cash compensation that discloses:

(i) a reasonable estimate of the amount of cash compensation to be received by the insurance producer, which may be stated as a range of mounts or percentages; and

(ii) whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages.

(3) Conflict of interest obligation. An insurance producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.

(4) Documentation obligation. At the time of recommendation or sale an insurance producer shall:

(a) make a written record of any recommendation and the basis for the recommendation subject to this rule;

(b) obtain a consumer signed statement on a form substantially similar to Appendix B located at the end of this rule documenting:

(i) a consumer's refusal to provide the consumer profile information, if any; and

(ii) a consumer's understanding of the ramification of not providing their consumer profile information or providing insufficient consumer profile information; and

(c) obtain a consumer signed statement on a form substantially similar to Appendix C acknowledging that the annuity transaction is not recommended if a consumer decides to enter into an annuity transaction that is not based on the insurance producer's recommendation.

B. Application of the best interest obligation. Any requirement applicable to an insurance producer under this section shall apply to every insurance producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the insurance producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational material, product wholesaling or other back-office product support and general supervision of an insurance producer do not, in and of themselves, constitute material control or influence.

C. Transactions not based on a recommendation.

(1) Except as provided in this rule, an insurance producer shall have no obligation to a consumer under the care obligation related to any annuity transaction if:

(a) no recommendation is made;

(b) a recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;

(c) a consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or

(d) a consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer.

(2) An insurer's issuance of an annuity under the above conditions shall be reasonable under all circumstances known to the insurer at the time the annuity is issued.

D. Supervision system.

(1) Except as permitted in circumstances of transactions not based on a recommendation, an insurer may not issue an annuity recommendation to a consumer unless there is a reasonable basis to believe the annuity would effectively address the consumer's financial situation, insurance needs and financial objectives based on the consumer's profile information.

(2) An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with this rule, including, but not limited to developing and implementing the following:

(a) procedures to inform its insurance producers of the requirements of this rule and incorporate the requirements of this rule into relevant insurance producer training manuals;

(b) product-specific training and training materials which explain all material features of its annuity products and requirements of this rule to its insurance producers;

(c) procedures for the review of each recommendation prior to issuance of an annuity that are designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the consumer's financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system to identify selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(d) reasonable procedures to detect recommendations that are not in compliance with this rule. This may include, but is not limited to, confirmation of the consumer's consumer profile information, systematic consumer surveys, insurance producer and consumer interviews, confirmation letters, insurance producer statements

or attestations and programs of internal monitoring and sampling procedures and may be accomplished after the issuance or delivery of an annuity;

(e) reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether an insurance producer has provided to the consumer the information required by this rule;

(f) reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information; and

(g) reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited time period. The requirements of this rule are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited time period.

(3) An insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(4) Nothing in this rule restricts an insurer from contracting for the performance of a function (including maintenance of procedures). An insurer shall take appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 59A-1-18 NMSA 1978 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with this rule.

(5) An insurer's supervision system shall include supervision of contractual performance. This includes, but is not limited to the following:

(a) monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

(b) annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly preformed.

(6) An insurer is not required to include the following in its supervision system:

(a) an insurance producer's recommendations to a consumer of products other than the annuities offered by the insurer; and

(b) consideration of or comparison to options available to the insurance producer or compensation relating to those options other than annuities or other products offered by the insurer.

E. Prohibited practices. Neither an insurance producer nor an insurer shall dissuade, or attempt to dissuade a consumer from:

(1) truthfully responding to an insurer's request for confirmation of the consumer profile information;

(2) filing a complaint; or

(3) cooperating with the investigation of a complaint.

F. Safe harbor. Recommendations and sales of annuities made in compliance with comparable standards shall satisfy the requirements of this rule. This provision applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue.

(1) This provision shall not limit the superintendent's ability to investigate and enforce the provisions of this rule.

(2) This provision shall not limit the insurer's obligation to comply with this rule, although the insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

(3) For this safe harbor to apply, an insurer shall:

(a) monitor the relevant conduct of the financial professional seeking to rely on safe harbor, or the entity responsible for the supervision of the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under the federal or state securities laws using information collected in the normal course of business; and

(b) provide to the entity responsible for supervising the financial professional seeking to rely on this safe harbor, such as the financial professional's broker-dealer or investment-adviser registered under federal or state securities laws, information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

[13.9.20.9 NMAC – N, 10/1/2022]

13.9.20.10 INSURANCE PRODUCER TRAINING:

An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this rule.

A. An insurance producer who engages in the sale of annuity products shall complete a one-time four-credit training course approved by OSI and provided by an OSI-approved education provider.

B. An insurance producer who holds a life insurance line of authority on the effective date of this rule and who desires to sell annuities shall complete the requirements of this section within six months of the effective date of this rule. An insurance producer who obtains a life insurance line of authority on or after the effective date of this rule may not engage in the sale of annuities until the required annuity training course has been completed.

C. The minimum length of the training required under this rule shall be sufficient to qualify for at least four CE credits but may be longer.

D. The training required under this rule shall include information on the following topics:

(1) the types of annuities and various classifications of annuities;

(2) identification of the parties to an annuity;

(3) how product-specific annuity contract features affect consumers;

(4) the application of income taxation of qualified and non-qualified annuities;

(5) the primary uses of annuities; and

(6) appropriate standards of conduct, sales practices, replacement and disclosure requirements.

E. A provider of courses intended to comply with this Section shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

F. A provider of an annuity training course intended to comply with this rule shall register as a CE provider in this state and shall comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth in Section 59A-12-26 NMSA 1978 and 13.4.7 NMAC.

G. An insurance producer who has completed an annuity training course approved by OSI prior to the effective date of this rule shall, within six months of the effective date of this rule, complete either:

(1) a new four-credit training course approved by OSI after the effective date of this rule; or

(2) An additional one-time, one-credit training course approved by OSI and provided by an OSI-approved education provider on appropriate sales practices, replacement and disclosure requirements under this rule.

H. Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with Section 59A-12-26 NMSA 1978 and 13.4.7 NMAC.

I. A provider of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with Section 59A-12-26 NMSA 1978 and 13.4.7 NMAC.

J. Satisfaction of the training requirements of another state that are substantially similar to the provisions of this rule shall be deemed to satisfy the training requirements of this rule.

K. Satisfaction of the components of the training requirements of any course or courses with components substantially similar to the provisions of this rule shall be deemed to satisfy the training requirements of this rule.

L. An insurer shall verify that an insurance producer has completed the annuity training course required by this rule before allowing the insurance producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this rule by obtaining certificates of completion of the training course or obtaining reports provided by OSI-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

[13.9.20.10 NMAC – N, 10/1/2022]

13.9.20.11 RECORD KEEPING:

A. An insurer, general agent, independent agency or insurance producer shall maintain and make available to OSI, upon request, records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information used in making the recommendations that were the basis for each insurance transaction for five years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

B. Records required to be maintained by this rule may be maintained in any form that accurately reproduces the actual document.

[13.9.20.11 NMAC – N, 10/1/2022]

13.9.20.12 COMPLIANCE MITIGATION; PENALTIES; ENFORCEMENT:

A. An insurer is responsible for compliance with this rule. If a violation occurs, either because of the action or inaction of the insurer or its insurance producer, the superintendent may order:

(1) an insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this rule by the insurer, an entity contracted to perform the insurer's supervisory duties or by an insurance producer;

(2) a general agency, independent agency or an insurance producer to take reasonably appropriate corrective action for any consumer harmed by an insurance producer's violation of this rule; and

(3) appropriate penalties and sanctions.

B. Any applicable penalty under Section 59A-1-18 NMSA 1978 for a violation of this rule may be reduced or eliminated according to a schedule adopted by the superintendent if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

[13.9.20.12 NMAC – N, 10/1/2022]

13.9.20.13 APPENDICES:

A. CONSUMER DISCLOSURE

APPENDIX A
CONSUMER DISCLOSURE

CONSUMER INFORMATION

First Name: _____ Last Name: _____

INSURANCE PRODUCER INFORMATION

First Name: _____ Last Name: _____
Business/Agency Name: _____ Website: _____

Business/Mailing Address:

_____

Business Telephone Number: _____ Email Address:

_____

National Producer Number ("NPN") _____ Domicile State:

_____

What Types of Products Can I Sell You?

I am licensed to sell annuities to You in accordance with state law. If I recommend that You buy an annuity, it means I believe that it effectively meets Your financial situation, insurance needs and financial objectives. Other financial products, such as life insurance or stocks, bonds and mutual funds may also meet Your needs.

I offer the following products:

- ☐ Fixed or Fixed Indexed Annuities
- ☐ Variable Annuities
- ☐ Life Insurance

I need a separate license to provide advice about or to sell non-insurance financial products. Below, I have checked any non-insurance financial products that I am licensed and authorized to provide advice about or to sell.

- ☐ Mutual Funds
- ☐ Stocks/Bonds
- ☐ Certificates of Deposit

Whose Annuities Can I Sell to You?

I am authorized to sell:

- ☐ Annuities from only one insurer
- ☐ Annuities from two or more insurers
- ☐ Annuities from two or more insurers, although I primarily sell annuities from: _____

How I am Paid for My Work?

It is important for You to understand how I am paid for my work. Depending on the particular annuity You purchase, I may be paid a commission or a fee. Commissions are generally paid to Me by the insurer while fees are generally paid to Me by the Consumer (You). If You have questions about how I am paid, please ask Me.

Depending on the annuity You buy, I will or may be paid cash compensation as follows:

☐ Commission, which is usually paid by the insurer or other sources. If other sources, they come from: _____.

☐ Fees (such as a fixed amount, an hourly rate, or a percentage of Your payment), which are usually paid directly by the Consumer.

☐ Other:

_____
_____.

If you have questions about the above compensation I will be paid for this transaction, please ask me.

I may also receive other indirect compensation resulting from this transaction (sometimes called "non-cash" compensation), such as health or retirement benefits, office rent and support, or other incentives from the insurer or other sources.

By signing below, You acknowledge that You have read and understand the information provided to You in this document.

_____
Consumer Signature

_____
Date

_____
Insurance Producer Signature

_____
Date

B. CONSUMER REFUSAL TO PROVIDE INFORMATION

APPENDIX B
CONSUMER REFUSAL TO PROVIDE INFORMATION
Do Not Sign Unless You Have Read and Understand the Information in this Form

WHY ARE YOU BEING GIVEN THIS FORM?

You are buying a financial product: an annuity.

To recommend a product that effectively meets Your needs, objectives and situation, the agent, broker or insurer needs information about You, Your financial situation, insurance needs and financial objectives.

If You sign this form, it means You have not given the agent, broker or insurer some or all the information needed to decide if the annuity effectively meets Your needs, objectives and situation. You may lose protections under the New Mexico Insurance Code if You sign this form or provide inaccurate information.

Statement of Purchaser:

- I **REFUSE** to provide this information at this time.
- I have chosen to provide **LIMITED** information at this time.

_____
Consumer Signature

_____
Date

C. CONSUMER DECISION TO PURCHASE AN ANNUITY NOT BASED ON A RECOMMENDATION

APPENDIX C
Consumer Decision to Purchase an Annuity NOT Based on a Recommendation
Do Not Sign This Form Unless You Have Read and Understand It.

WHY ARE YOU BEING GIVEN THIS FORM?

You are buying a financial product: an annuity.

To recommend a product that effectively meets Your needs, objectives and situation, the agent, broker or insurer has the responsibility to learn about You, your financial situation, insurance needs and financial objectives.

If You sign this form, it means You know that you are buying an annuity that was not recommended.

Statement of Purchaser:

I understand that I am buying an annuity, but the agent, broker or insurer did not recommend that I buy it. If I buy it **without a recommendation**, I understand I may lose protections under the New Mexico Insurance Code.

_____
Consumer Signature

_____
Date

_____
Insurance Producer Signature

_____
Date

PART 21 TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING

13.9.21.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.9.21.1 NMAC – N, 11/1/2023]

13.9.21.2 SCOPE:

This regulation shall apply to reinsurance treaties that cede liabilities pertaining to covered policies, as that term is defined in Subsection B of 13.9.21.7 NMAC, issued by any life insurance company domiciled in this state. This regulation and the credit for reinsurance regulation, 13.2.8.1 *et seq* NMAC, shall both apply to such reinsurance treaties; provided, that in the event of a direct conflict between the provisions of this regulation and 13.2.8.1 *et seq* NMAC, the provisions of this regulation shall apply, but only to the extent of the conflict. Except expressly exempted, this rule will apply to all covered policies in effect as of or after the effective date of the rule.

[13.9.21.2 NMAC – N, 11/1/2023]

13.9.21.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-12E-17 (2022) NMSA 1978.

[13.9.21.3 NMAC – N, 11/1/2023]

13.9.21.4 DURATION:

Permanent.

[13.9.21.4 NMAC – N, 11/1/2023]

13.9.21.5 EFFECTIVE DATE:

November 1, 2023, unless a later date is cited at the end of a section.

[13.9.21.5 NMAC – N, 11/1/2023]

13.9.21.6 OBJECTIVE:

The purpose of this rule is to conform with established, uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees; and to ensure that, with respect to each such financing arrangement, funds consisting of primary security and other security, as defined in Subsections F and G of 13.9.21.7 NMAC, are held by or on behalf of ceding insurers in the forms and amounts required herein. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer (1) are issued by the ceding insurer or its affiliates; or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any if its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).

[13.9.21.6 NMAC – N, 11/1/2023]

13.9.21.7 DEFINITIONS:

A. "Actuarial method" means the methodology used to determine the required level of primary security, as described in 13.9.21.9 & 13.9.21.10 NMAC.

B. "Covered policies" means the following: Subject to the exemptions described in 13.9.21.13 NMAC, Covered policies are those policies, other than grandfathered policies, of the following policy types:

(1) Life insurance policies with guaranteed nonlevel gross premiums, guaranteed nonlevel benefits, or both, except for flexible premium universal life insurance policies; or

(2) Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

C. "Grandfathered policies" means policies of the types described in Paragraphs (1) and (2) of Subsection B of 13.9.21.7 NMAC that were:

(1) issued prior to January 1, 2015; and

(2) ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in 13.9.21.13 NMAC had that section then been in effect.

D. "Non-Covered policies" means any policy that does not meet the definition of covered policies, including grandfathered policies.

E. "Required level of primary security" means the dollar amount determined by applying the actuarial method to the risks ceded with respect to covered policies, but not more than the total reserve ceded.

F. "Primary security" means the following forms of security:

(1) cash;

(2) securities listed by the securities valuation office of the national association of insurance commissioners meeting the requirements of Paragraph (2) of Subsection B of Section 59A-12E-16, NMSA 1978, but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

(3) For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

(a) commercial loans in good standing of CM3 quality and higher;

(b) policy Loans; and

(c) derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

G. "Other security" means any security acceptable to the superintendent other than security meeting the definition of primary security.

H. "Valuation manual" means the valuation manual adopted by the national association of insurance commissioners ("NAIC"), by the process specified in Paragraph (1) of Subsection F of Section 59A-8A-2 NMSA 1978 (2014), with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed. As of the effective date of this regulation, the current edition of the Valuation Manual is that effective as of January 1, 2023. Future editions of the Valuation Manual shall be adopted by means of the process described in 13.9.21.8 NMAC.

I. "VM-20" means **"Requirements for Principle-Based Reserves for Life Products,"** including all relevant definitions, from the Valuation Manual.

[13.9.21.7 NMAC – N, 11/1/2023]

13.9.21.8 UPDATING THE VALUATION MANUAL:

If the national association of insurance commissioners amends the Valuation Manual by the means described in Paragraph (1) of Subsection F of Section 59A-8A-2 NMSA 1978 (2014), the superintendent shall issue a bulletin, pursuant to 13.1.2.8 NMAC, stating that the Valuation Manual has been officially amended, stating the effective date of the amended Valuation Manual, and providing a link to the amended manual.

[13.9.21.8 NMAC – N, 11/1/2023]

13.9.21.9 THE ACTUARIAL METHOD:

The actuarial method to establish the required level of primary security for each reinsurance treaty subject to this regulation shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

A. For covered policies described in Paragraph (1) of Subsection B of 13.9.21.7 NMAC, the actuarial method is the greater of the deterministic reserve or the net premium reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the covered policies do not meet the requirements of the stochastic reserve exclusion test in the Valuation Manual, then the actuarial method is the greatest of the deterministic reserve, the stochastic reserve, or the NPR. In addition, if such covered policies are reinsured in a reinsurance treaty that also contains covered policies described in Paragraph (2) of Subsection B of 13.9.21.7 NMAC, the ceding insurer may elect to instead use Subsection B of 13.9.21.9 NMAC as the actuarial method for the entire reinsurance agreement. Whether this subsection or Subsection B of 13.9.21.9 NMAC are used, the actuarial method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

B. For covered policies described in Paragraph (2) of Subsection B of 13.9.21.7 NMAC, the actuarial method is the greatest of the deterministic reserve, the stochastic reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

C. Except as provided in Subsection D of 13.9.21.9 NMAC, the actuarial method is to be applied on a gross basis to all risks with respect to the covered policies as originally issued or assumed by the ceding insurer.

D. If the reinsurance treaty cedes less than one hundred percent of the risk with respect to the covered policies then the required level of primary security may be reduced as follows:

(1) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the covered policies, the required level of primary security, as well as any adjustment under Paragraph (3) of Subsection D of 13.9.21.9 NMAC, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

(2) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the required level of primary security may be reduced by an amount determined by applying the actuarial method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the covered policies, except that for covered policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the required level of primary security may be reduced by the statutory reserve retained by the ceding insurer on those covered policies, where the retained reserve of those covered policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(3) If a portion of the covered policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the required level of primary security may be reduced by the amount resulting by applying the actuarial method including the reinsurance section of VM-20 to the portion of the covered policy risks ceded in the exempt arrangement, except that for covered policies issued prior to Jan 1, 2017, this adjustment is not to exceed [cx/ (two* number of reinsurance premiums per year)] where cx is calculated using the same mortality table used in calculating the net premium reserve; and

(4) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the required level of primary security. It is possible for any combination of Paragraphs (1) through (4) of Subsection D of 13.9.21.9 NMAC to apply. Such adjustments to the required level of primary security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the required level of primary security due to the cession of less than one hundred percent of the risk. The adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

E. In no event will the required level of primary security resulting from application of the actuarial method exceed the amount of statutory reserves ceded.

F. If the ceding insurer cedes risks with respect to covered policies, including any riders, in more than one reinsurance treaty subject to this regulation, in no event will the aggregate required level of primary security for those reinsurance treaties be less than the required level of primary security calculated using the actuarial method as if all risks ceded in those treaties were ceded in a single treaty subject to this regulation;

G. If a reinsurance treaty subject to this regulation cedes risk on both covered and non-covered policies, credit for the ceded reserves shall be determined as follows:

(1) The actuarial method shall be used to determine the required level of primary security for the covered policies, and 13.9.21.11 NMAC shall be used to determine the reinsurance credit for the covered policy reserves; and

(2) credit for the non-covered policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of Paragraph (1) of Subsection G of 13.9.21.9 NMAC, is held by or on behalf of the ceding insurer in accordance with Sections 59A-12E-3 through 16, NMSA 1978 (2022). Any primary security used to meet the requirements of this subparagraph may not be used to satisfy the required level of primary security for the covered policies.

[13.9.21.9 NMAC – N, 11/1/2023]

13.9.21.10 VALUATION USED FOR THE PURPOSES OF CALCULATIONS:

For the purposes of both calculating the required level of primary security pursuant to the actuarial method, as described in 13.9.21.9 NMAC, and determining the amount of primary security and other security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

A. For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer's general account and without taking into consideration the effect of any prescribed or permitted practices; and

B. for all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the actuarial method if adopted by the NAIC's Life Actuarial (A) Task Force no later than the Dec. 31st on or immediately preceding the valuation date for which the required level of primary security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the actuarial method in the manner specified in VM-20.

[13.9.21.10 NMAC – N, 11/1/2023]

13.9.21.11 REQUIREMENTS APPLICABLE TO COVERED POLICIES TO OBTAIN CREDIT FOR REINSURANCE; OPPORTUNITY FOR REMEDIATION:

A. Requirements: Subject to the exemptions described in 13.9.21.13 NMAC and the provisions of Subsection B of 13.9.21.11 NMAC, credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to covered policies pursuant to Sections 59A-12E-3 through -15 NMSA 1978 or Section 59A-12E-16 NMSA 1978 if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

(1) The ceding insurer's statutory policy reserves with respect to the covered policies must be established in full and in accordance with the applicable requirements of Sections 59A-8A-1 through -12 NMSA and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this regulation must not exceed the proportionate share of those reserves ceded under the contract.

(2) The ceding insurer must determine the required level of primary security with respect to each reinsurance treaty subject to this regulation and provide support for its calculation as determined to be acceptable to the superintendent.

(3) Funds consisting of primary security, in an amount at least equal to the required level of primary security, must be held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of Section 59A-12E-16 NMSA 1978, on a funds withheld, trust, or modified coinsurance basis; and

(4) Funds consisting of other security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (3) above, must be held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of Section 59A-12E-16 NMSA.

(5) Any trust used to satisfy the requirements of this section shall comply with all of the conditions and qualifications of 13.2.8.19 NMAC through 13.2.8.23 NMAC, except that:

(a) funds consisting of primary security or other security held in trust, shall for the purposes identified in 13.9.21.10 NMAC, be valued according to the valuation rules set forth in that Section, as applicable; and

(b) there are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of Paragraph (3) of Subsection A of 13.9.21.11 NMAC; and

(c) the reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the primary security within the trust (when aggregated with primary security outside the trust that is held by or on behalf of the ceding insurer in the manner required by Paragraph (3) of Subsection A of

13.9.21.11 NMAC below one hundred two percent of the level required by Paragraph (3) of Subsection A of 13.9.21.11 NMAC at the time of the withdrawal or substitution; and

(d) the determination of reserve credit under 13.2.8.22 NMAC shall be determined according to the valuation rules set forth in 13.9.21.10 NMAC, as applicable.

(6) The reinsurance treaty must be approved by the superintendent.

B. Requirements at inception date and on an on-going basis; Remediation:

(1) The requirements of Subsection A of 13.9.21.11 NMAC must be satisfied as of the date that risks under covered policies are ceded (if such date is on or after the effective date of this regulation) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under Paragraph (3) of Subsection A of 13.9.21.11 NMAC or Paragraph (4) of Subsection A of 13.9.21.11 NMAC with respect to any reinsurance treaty under which covered policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

(2) Prior to the due date of each Quarterly or Annual Statement, each life insurance company that has ceded reinsurance within the scope of 13.9.21.2 NMAC shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which covered policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of Paragraph (3) of Subsection A of 13.9.21.11 NMAC and Paragraph (4) of Subsection A of 13.9.21.11 NMAC were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of primary security actually held pursuant to Paragraph 3 of Subsection A of 13.9.21.11 NMAC, unless either:

(a) The requirements of Paragraphs (3) and (4) of Subsection A of 3.9.21.11 NMAC were fully satisfied as of the valuation date as to such reinsurance treaty; or

(b) Any deficiency has been eliminated before the due date of the Quarterly or Annual Statement to which the valuation date relates through the addition of primary security, other security, or both as the case may be, in such amount and in such form as would have caused the requirements of Paragraphs (3) and (4) of 13.9.21.11NMAC to be fully satisfied as of the valuation date.

(3) Nothing in Paragraph (2) of Subsection B of 13.9.21.11 NMAC shall be construed to allow a ceding company to maintain any deficiency under Paragraphs (3) or (4) of 13.9.21.11 NMAC for any period of time longer than is reasonably necessary to eliminate it.

[13.9.21.11 NMAC – N, 11/1/2023]

13.9.21.12 PROHIBITION AGAINST AVOIDANCE:

No insurer that has covered policies as to which this regulation applies (as set forth in 13.9.21.2 NMAC) shall take any action or series of actions, or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of such action, transaction or arrangement or series thereof is to avoid the requirements of this regulation, or to circumvent its purpose and intent, as set forth in 13.9.21.6 NMAC.

[13.9.21.12 NMAC – N, 11/1/2023]

13.9.21.13 EXEMPTIONS:

This rule does not apply to the situations described in this section:

A. Reinsurance of:

(1) policies that satisfy the criteria for exemption set forth in 13.9.13.20 NMAC or 13.9.13.21 NMAC and which are issued before the effective date of this regulation;

(2) portions of policies that satisfy the criteria for exemption set forth in 13.9.21.19 NMAC and which are issued before the effective date of this regulation;

(3) any universal life policy that meets all of the following requirements:

(a) secondary guarantee period, if any, is five years or less;

(b) specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Commissioners Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and

(c) the initial surrender charge is not less than one hundred percent of the first year annualized specified premium for the secondary guarantee period.

(4) Credit life insurance;

(5) any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or

(6) any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

B. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Paragraph (3) of Subsection D and Subsection E of Section 59A-12E-3, and Sections 59A-12E-4, and 59A-12E-6 NMSA 1978;

C. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Paragraphs (1) and (2) of Subsection D of Section 59A-12E-3 NMSA 1978, or Section 59A-12E-5 NMSA 1978, and that, in addition:

(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1 ("SSAP 1"); and

(2) is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in Sections 59A-5A-4, 59A-5A-5, 59A-5A-6, 59A-5A-7 NMSA 1978, respectively, when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or

D. reinsurance ceded to an assuming insurer that meets the applicable requirements of Paragraphs (1) and (2) of Subsection D of Section 59A-12E-3 NMSA 1978, or 59A-12E-5 NMSA 1978, and that, in addition:

(1) Is not an affiliate, as that term is defined in Subsection B of Section 59A-37-2 NMSA 1978 of:

(a) The insurer ceding the business to the assuming insurer; or

(b) any insurer that directly or indirectly ceded the business to that ceding insurer.

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

(3) is both:

(a) Licensed or accredited in at least 10 states (including its state of domicile), and

(b) not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) is not, or would not be, below five hundred percent of the authorized control level risk based capital as that term is defined in Subsection B of Section 59A-5A-2 NMSA 1978 when its risk-based capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer's reported surplus; or

E. reinsurance ceded to an assuming insurer that meets the requirements of Subsection F of Section 59A-12E-17 NMSA 1978; or

F. reinsurance not otherwise exempt under Subsection A through E of 13.9.21.13 NMAC if the superintendent, after consulting with the NAIC financial analysis working group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this regulation (as described in 13.9.21.6 NMAC);

(2) the risks are included within the scope of this regulation only as a technicality; and

(3) the application of this regulation to those risks is not necessary to provide appropriate protection to policyholders. The superintendent shall publicly disclose any decision made pursuant to this Subsection F of 13.9.21.13 NMAC to exempt a reinsurance treaty from this regulation, as well as the general basis therefore (including a summary description of the treaty).

[13.9.21.13 NMAC – N, 11/1/2023]

13.9.21.14 SEVERABILITY:

If any provision of this regulation is held invalid, the remainder shall not be affected.

[13.9.21.14 NMAC – N, 11/1/2023]

CHAPTER 10: HEALTH INSURANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: MOTHERS AND NEWLY BORN CHILDREN HEALTH SECURITY

13.10.2.1 ISSUING AGENCY:

[Public Regulation Commission] New Mexico Department of Insurance.

[3/1/96; Recompiled 11/30/01]

13.10.2.2 SCOPE:

This rule applies to any person, insurer, health maintenance organization, fraternal benefit society, nonprofit health care plan, New Mexico comprehensive health insurance pool, or health insurance alliance, transacting health insurance or providing health care services as defined herein, in this state.

[3/1/96; Recompiled 11/30/01]

13.10.2.3 STATUTORY AUTHORITY:

Authority for this rule derives from the superintendent's powers under Sections 59A-2-9, 59A-16-4, 59A-16-5, 59A-16-18, 59A-16-20, 59A-18-14, 59A-22-34, 59A-22-36, 59A-23B-3, 59A-44-30, 59A-44-31, 59A-46-38, 59A-47-25, 59A-54-13, and 59A-56-7 NMSA 1978.

[3/1/96; Recompiled 11/30/01]

13.10.2.4 DURATION:

Permanent.

[3/1/96; Recompiled 11/30/01]

13.10.2.5 EFFECTIVE DATE:

This rule shall take effect March 1, 1996 [unless a later date is cited at the end of a section].

[3/1/96; Recompiled 11/30/01]

13.10.2.6 OBJECTIVE:

The objectives of this rule are to ensure that necessary postpartum health care is provided to newly born children and their mothers in the safest manner and at the earliest possible time, and to regulate trade practices in the insurance business and related businesses by prohibiting unfair or deceptive acts or practices.

[3/1/96; Recompiled 11/30/01]

13.10.2.7 DEFINITIONS:

A. As used in this rule, the following terms have the meanings given in the cited section of the New Mexico Statutes Annotated 1978:

(1) Approved health plans, Section 59A-56-3(B) NMSA 1978;

(2) Fraternal benefit society, Section 59A-44-1 NMSA 1978;

(3) Health insurance alliance, Section 59A-56-3(A) NMSA 1978;

(4) Health maintenance organization, Section 59A-46-2(M) NMSA 1978;

(5) Insurer, Section 59A-1-8 NMSA 1978;

(6) Insurance Code, Section 59A-1-1 NMSA 1978;

(7) Superintendent, Section 59A-1-12 NMSA 1978;

(8) Health facility, Section 50-23-3(E) NMSA 1978.

B. As used in this rule, the following terms have the meanings given here:

(1) "Attending physician" means the attending obstetrician, pediatrician or other physician attending the mother or newly born child.

(2) "Inpatient" means a patient admitted for treatment to a health facility.

(3) "Maternity benefits" means coverage for prenatal, intrapartum, perinatal or postpartum care.

(4) "Medically necessary" means that the patient's health, in the opinion of the attending physician, would be adversely affected by lack of appropriate treatment.

(5) "New Mexico comprehensive health insurance pool" means an entity organized pursuant to Section 59A-54-4(A) NMSA 1978.

(6) "Nonprofit health care plan" means a health care plan organized pursuant to Section 59A-47-4 NMSA 1978.

(7) "Pool policy" means a health insurance policy delivered or issued for delivery in this state pursuant to the Comprehensive Health Insurance Pool Act, Article 54 NMSA 1978.

[3/1/96; Recompiled 11/30/01]

13.10.2.8 INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES:

A. All individual and group health insurance policies delivered or issued for delivery in this state and which provide maternity coverage shall also provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96

hours of inpatient care following a caesarian section for a mother and her newly born child in a health facility unless earlier discharge is made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, including, but not limited to, the criterion that family members or other support person(s) should be available to the mother for the first few days following discharge. In addition, a decision for early discharge should be individualized and should be a mutual decision between the mother and the attending physician. Inpatient care in excess of a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a caesarian section for a mother and her newly born child in a health facility shall be covered if determined to be medically necessary by the attending physician.

B. Notwithstanding the provisions of subsection 8.1 of this section [now Subsection A of 13.10.2.8 NMAC], an individual or group insurance policy delivered or issued for delivery in this state that provides coverage for postpartum care to a mother and her newly born child in the home shall not be required to provide for coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section, unless such inpatient care is determined to be medically necessary by the attending physician, or early discharge is inconsistent with the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, or this rule.

C. Postpartum care in the home shall be made in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

D. Postpartum care in the home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

E. Each insurer providing maternity coverage in this state shall mail a written description of the coverage required under this rule, in a form approved by the superintendent, to the expectant mother covered by the insurer and to her attending physician, upon receipt by the insurer of notification of the diagnosis of pregnancy of the expectant mother.

F. In addition to the notification provided in subsection 8.5 [now Subsection E of 13.19.2.8 NMAC], each insurer providing maternity coverage in this state shall mail a written statement, in a form approved by the superintendent, to the expectant mother

covered by the insurer, notifying the expectant mother of her right to complain to the superintendent if there is concern that the mother or her newly born child has not received the coverage required by this rule. In the event of a complaint, the insurer will have the burden of proof to demonstrate that the coverage provided was in compliance with this rule.

[3/1/96; Recompiled 11/30/01]

13.10.2.9 MINIMUM HEALTHCARE PROTECTION ACT POLICIES AND BENEFIT PLANS:

A. All healthcare policies or healthcare benefit plans offered under the authority of the Minimum Healthcare Protection Act delivered or issued for delivery in this state and which provide maternity coverage shall also provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section for a mother and her newly born child in a health facility unless earlier discharge is made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, including, but not limited to, the criterion that family members or other support person(s) should be available to the mother for the first few days following discharge. In addition, a decision for early discharge should be individualized and should be a mutual decision between the mother and the attending physician. Inpatient care in excess of a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a caesarian section for a mother and her newly born child in a health facility shall be covered if determined to be medically necessary by the attending physician.

B. Notwithstanding the provisions of subsection 9.1 of this section [now Subsection A of 13.10.2.9 NMAC], an approved healthcare policy or healthcare benefit plan offered under the authority of the Minimum Healthcare Protection Act delivered or issued for delivery in this state that provides coverage for postpartum care to a mother and her newly born child in the home shall not be required to provide for coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section, unless such inpatient care is determined to be medically necessary by the attending physician, or early discharge is inconsistent with the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, or this rule.

C. Postpartum care in the home shall be made in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

D. Postpartum care in the home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

E. Each insurer providing coverage under the authority of the Minimum Healthcare Protection Act through a healthcare policy or healthcare benefit plan which provides maternity coverage in this state shall mail a written description of the coverage required under this rule, in a form approved by the superintendent, to the expectant mother covered by the insurer and to her attending physician, upon receipt by the insurer of notification of the diagnosis of pregnancy of the expectant mother.

F. In addition to the notification provided in subsection 9.5 [now Subsection E of 13.10.2.9 NMAC], each insurer providing coverage under the authority of the Minimum Healthcare Protection Act through a healthcare policy or healthcare benefit plan which provides maternity coverage in this state shall mail a written statement, in a form approved by the superintendent, to the expectant mother covered by the insurer, notifying the expectant mother of her right to complain to the superintendent if there is concern that the mother or her newly born child has not received the coverage required by this rule. In the event of a complaint, the insurer will have the burden of proof to demonstrate that the coverage provided was in compliance with this rule.

[3/1/96; Recompiled 11/30/01]

13.10.2.10 HEALTH MAINTENANCE ORGANIZATION CONTRACTS:

A. All individual and group health maintenance organization contracts delivered or issued for delivery in this state and which provide maternity coverage shall also provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section for a mother and her newly born child in a health facility unless earlier discharge is made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, including, but not limited to, the criterion that family members or other support person(s) should be available to the mother for the first few days following discharge. In addition, a decision for early discharge should be individualized and should be a mutual decision between the mother and the attending physician. Inpatient care in excess of a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a caesarian section for a mother and her newly born child in a health facility shall be covered if determined to be medically necessary by the attending physician.

B. Notwithstanding the provisions of subsection 10.1 of this section [now Subsection A of 13.10.2.10 NMAC], an individual or group health maintenance organization contract

delivered or issued for delivery in this state that provides coverage for postpartum care to a mother and her newly born child in the home shall not be required to provide for coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section, unless such inpatient care is determined to be medically necessary by the attending physician, or early discharge is inconsistent with the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, or this rule.

C. Postpartum care in the home shall be made in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

D. Postpartum care in the home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

E. Each health maintenance organization which provides maternity coverage in this state shall mail a written description of the coverage required under this rule, in a form approved by the superintendent, to the expectant mother enrolled in the health maintenance organization and to her attending physician, upon receipt by the health maintenance organization of notification of the diagnosis of pregnancy of the expectant mother.

F. In addition to the notification provided in subsection 10.5 [now Subsection E of 13.10.2.10 NMAC], each health maintenance organization which provides maternity coverage in this state shall mail a written statement, in a form approved by the superintendent, to the expectant mother covered by the health maintenance organization, notifying the expectant mother of her right to complain to the superintendent if there is concern that the mother or her newly born child has not received the coverage required by this rule. In the event of a complaint, the health maintenance organization will have the burden of proof to demonstrate that the coverage provided was in compliance with this rule.

[3/1/96; Recompiled 11/30/01]

13.10.2.11 FRATERNAL BENEFIT SOCIETY CONTRACTS:

A. All fraternal benefit society contracts delivered or issued for delivery in this state which provide maternity coverage shall also provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of

inpatient care following a caesarian section for a mother and her newly born child in a health facility unless earlier discharge is made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, including, but not limited to, the criterion that family members or other support person(s) should be available to the mother for the first few days following discharge. In addition, a decision for early discharge should be individualized and should be a mutual decision between the mother and the attending physician. Inpatient care in excess of a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a caesarian section for a mother and her newly born child in a health facility shall be covered if determined to be medically necessary by the attending physician.

B. Notwithstanding the provisions of subsection 11.1 of this section [now Subsection A of 13.10.2.11 NMAC], a fraternal benefit society contract delivered or issued for delivery in this state that provides coverage for postpartum care to a mother and her newly born child in the home shall not be required to provide for coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section, unless such inpatient care is determined to be medically necessary by the attending physician, or early discharge is inconsistent with the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, or this rule.

C. Postpartum care in the home shall be made in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

D. Postpartum care in the home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

E. Each fraternal benefit society which provides maternity coverage in this state shall mail a written description of the coverage required under this rule, in a form approved by the superintendent, to the expectant mother covered by the fraternal benefit society and to her attending physician, upon receipt by the fraternal benefit society of notification of the diagnosis of pregnancy of the expectant mother.

F. In addition to the notification provided in subsection 11.5 [now Subsection E of 13.10.2.11 NMAC], each fraternal benefit society which provides maternity coverage in this state shall mail a written statement, in a form approved by the superintendent, to

the expectant mother covered by the fraternal benefit society, notifying the expectant mother of her right to complain to the superintendent if there is concern that the mother or her newly born child has not received the coverage required by this rule. In the event of a complaint, the fraternal benefit society will have the burden of proof to demonstrate that the coverage provided was in compliance with this rule.

[3/1/96; Recompiled 11/30/01]

13.10.2.12 NONPROFIT HEALTH PLAN CONTRACTS:

A. All subscriber contracts of a nonprofit health care plan delivered or issued for delivery in this state and which provide maternity coverage shall also provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section for a mother and her newly born child in a health facility unless earlier discharge is made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, including, but not limited to, the criterion that family members or other support person(s) should be available to the mother for the first few days following discharge. In addition, a decision for early discharge should be individualized and should be a mutual decision between the mother and the attending physician. Inpatient care in excess of a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a caesarian section for a mother and her newly born child in a health facility shall be covered if determined to be medically necessary by the attending physician.

B. Notwithstanding the provisions of sub-section 12.1 of this section [now Subsection A of 13.10.2.12 NMAC], a subscriber contract of a nonprofit health care plan delivered or issued for delivery in this state that provides coverage for postpartum care for a mother and her newly born child in the home shall not be required to provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section, unless such inpatient care is determined to be medically necessary by the attending physician, or early discharge is inconsistent with the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, or this rule.

C. Postpartum care in the home shall be made in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

D. Postpartum care in the home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum

care, and the mother. The home visits shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

E. Each nonprofit health care plan which provides maternity coverage in this state shall mail a written description of the coverage required under this rule, in a form approved by the superintendent, to the expectant mother covered by the nonprofit health care plan and to her attending physician, upon receipt by the nonprofit health care plan of notification of the diagnosis of pregnancy of the expectant mother.

F. In addition to the notification provided in subsection 12.5 [now Subsection E of 13.10.2.12 NMAC], each nonprofit health care plan which provides maternity coverage in this state shall mail a written statement, in a form approved by the superintendent, to the expectant mother covered by the nonprofit health care plan, notifying the expectant mother of her right to complain to the superintendent if there is concern that the mother or her newly born child has not received the coverage required by this rule. In the event of a complaint, the nonprofit health care plan will have the burden of proof to demonstrate that the coverage provided was in compliance with this rule.

[3/1/96; Recompiled 11/30/01]

13.10.2.13 NEW MEXICO COMPREHENSIVE HEALTH INSURANCE POOL POLICIES:

A. All pool policies delivered or issued for delivery in this state by the New Mexico comprehensive health insurance pool and which provide maternity coverage shall also provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section for a mother and her newly born child in a health facility unless earlier discharge is made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, including, but not limited to, the criterion that family members or other support person(s) should be available to the mother for the first few days following discharge. In addition, a decision for early discharge should be individualized and should be a mutual decision between the mother and the attending physician. Inpatient care in excess of a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a caesarian section for a mother and her newly born child in a health facility shall be covered if determined to be medically necessary by the attending physician.

B. Notwithstanding the provisions of subsection 13.1 of this section [now Subsection A of 13.10.2.13 NMAC], a pool policy delivered or issued for delivery in this state that provides coverage for postpartum care to a mother and her newly born child in the home shall not be required to provide for coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section, unless such inpatient care is determined to be medically

necessary by the attending physician, or early discharge is inconsistent with the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, or this rule.

C. Postpartum care in the home shall be made in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

D. Postpartum care in the home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

E. Each insurer providing coverage through the New Mexico comprehensive health insurance pool under a policy which provides maternity coverage in this state shall mail a written description of the coverage required under this rule, in a form approved by the superintendent, to the expectant mother covered by the insurer and to her attending physician, upon receipt by the insurer of notification of the diagnosis of pregnancy of the expectant mother.

F. In addition to the notification provided in subsection 13.5 [now Subsection E of 13.10.2.13 NMAC], each insurer providing coverage through the New Mexico comprehensive health insurance pool under a policy which provides maternity coverage in this state shall mail a written statement, in a form approved by the superintendent, to the expectant mother covered by the insurer, notifying the expectant mother of her right to complain to the superintendent if there is concern that the mother or her newly born child has not received the coverage required by this rule. In the event of a complaint, the insurer will have the burden of proof to demonstrate that the coverage provided was in compliance with this rule.

[3/1/96; Recompiled 11/30/01]

13.10.2.14 HEALTH INSURANCE ALLIANCE CONTRACTS:

A. All approved health plans offered through the New Mexico health insurance alliance delivered or issued for delivery in this state and which provide maternity coverage shall also provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section for a mother and her newly born child in a health facility unless earlier discharge is made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of

pediatrics and the American college of obstetricians and gynecologists, including, but not limited to, the criterion that family members or other support person(s) should be available to the mother for the first few days following discharge. In addition, a decision for early discharge should be individualized and should be a mutual decision between the mother and the attending physician. Inpatient care in excess of a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a caesarian section for a mother and her newly born child in a health facility shall be covered if determined to be medically necessary by the attending physician.

B. Notwithstanding the provisions of subsection 14.1 of this section [now Subsection A of 13.10.2.14 NMAC], an approved health plan offered through the New Mexico health insurance alliance delivered or issued for delivery in this state that provides coverage for postpartum care to a mother and her newly born child in the home shall not be required to provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarian section, unless such inpatient care is determined to be medically necessary by the attending physician, or early discharge is inconsistent with the most current version of the "Guidelines for Perinatal Care" prepared by the American academy of pediatrics and the American college of obstetricians and gynecologists, or this rule.

C. Postpartum care in the home shall be made in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

D. Postpartum care in the home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

E. Each insurer providing coverage through the New Mexico health insurance alliance under a policy which provides maternity coverage in this state shall mail a written description of the coverage required under this rule, in a form approved by the superintendent, to the expectant mother covered by the insurer and to her attending physician, upon receipt by the insurer of notification of the diagnosis of pregnancy of the expectant mother.

F. In addition to the notification provided in subsection 14.5 [now Subsection E of 13.10.2.14 NMAC], each insurer providing coverage through the New Mexico health insurance alliance under a policy which provides maternity coverage in this state shall mail a written statement, in a form approved by the superintendent, to the expectant mother covered by the insurer, notifying the expectant mother of her right to complain to the superintendent if there is concern that the mother or her newly born child has not

received the coverage required by this rule. In the event of a complaint, the insurer will have the burden of proof to demonstrate that the coverage provided was in compliance with this rule.

[3/1/96; Recompiled 11/30/01]

13.10.2.15 INCENTIVES OR PENALTIES PROHIBITED:

No person, insurer, health maintenance organization, fraternal benefit society, nonprofit health care plan, New Mexico comprehensive health insurance pool, or health insurance alliance, transacting health insurance or providing health care services, as defined herein, in this state, shall provide, directly or indirectly, any financial incentive or disincentive, or grant or deny any special favor or advantage of any kind or nature whatsoever, to any person to encourage or cause early discharge of a hospital inpatient from postpartum care. Notwithstanding the above, this section does not prohibit use of prospective payment systems including, but not limited to, capitation and diagnostic related groupings, that are designed to promote efficiency in appropriate health care delivery.

[3/1/96; Recompiled 11/30/01]

13.10.2.16 PENALTIES:

In addition to any other penalty provided by law or rule, violation of the provisions of this rule is subject to penalties for violation of the Insurance Code.

[3/1/96; Recompiled 11/30/01]

13.10.2.17 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[3/1/96; Recompiled 11/30/01]

PART 3: MINIMUM STANDARDS FOR SHORT-TERM PLANS

13.10.3.1 ISSUING AGENCY:

Office of Superintendent of Insurance.

[13.10.3.1 NMAC - N, 10/01/2020]

13.10.3.2 SCOPE:

This rule applies to every health insurer who offers or issues a short-term plan to a resident of New Mexico.

[13.10.3.2 NMAC - N, 10/01/2020]

13.10.3.3 STATUTORY AUTHORITY:

Section 59A-23G-1 et seq. NMSA 1978.

[13.10.3.3 NMAC - N, 10/01/2020]

13.10.3.4 DURATION:

Permanent.

[13.10.3.4 NMAC - N, 10/01/2020]

13.10.3.5 OBJECTIVE:

Establish regulatory requirements for short-term health benefit plans. The rule will standardize and simplify the terms and coverages, facilitate public understanding and comparison of coverage, and prohibit provisions that may be misleading or confusing in connection with such plans.

[13.10.3.5 NMAC - N, 10/01/2020]

13.10.3.6 EFFECTIVE DATE:

October 1, 2020, unless a later date is cited at the end of a section.

[13.10.3.6 NMAC - N, 10/01/2020]

13.10.3.7 DEFINITIONS:

A. The definitions in Section 59A-23G-2 NMSA 1978 apply to this rule.

B. Unless inconsistent with a term defined in this rule, or the usage of a term in this rule, the definitions in 13.10.29 NMAC apply.

[13.10.3.7 NMAC – N, 10/01/2020]

13.10.3.8 GENERAL REQUIREMENTS:

A. Duration and non-renewability. The term of a short-term plan shall not exceed three months and shall not be extendable or renewable. Continuation and conversion

rights of short-term plan dependents extend only to the original termination date of the policy.

B. When issuance prohibited. A short-term plan shall not be issued to an individual, if that person was enrolled in any short-term plan that provided the same or similar coverage during the preceding 12 months.

C. Guaranteed issue. A short-term plan shall be guaranteed issue to eligible applicants without regard to health status or any preexisting condition(s).

D. Cancellation and rescission. A short-term plan shall not be cancelled or rescinded except as provided herein:

(1) A short-term plan shall not be rescinded except in the case of intentional misrepresentation, concealment or fraud by the insured or covered person.

(2) A short-term plan shall not be canceled except:

(a) as the result of change to or implementation of federal or state laws that no longer permit the continued offering of the coverage; or

(b) due to the covered person's:

(i) nonpayment of premium;

(ii) violation of published policies of the carrier approved by the superintendent;

(iii) fraudulent acts or material misrepresentation; or

(iv) material breach of the terms of the plan.

(c) Nothing in this section shall be construed to provide a covered person with any benefits they would not otherwise be entitled to under a short-term plan.

(3) Notice required.

(a) When a short-term plan is cancelled for nonpayment of premium, the insurer shall notify the covered person in writing ten days prior to the cancellation date that the plan will be canceled, unless payment is made prior to the cancellation date.

(b) When cancellation or rescission is for any other authorized reason, the insurer shall notify the covered person in writing 20 days prior to the cancellation or rescission date, or the expiration date of the short-term plan, whichever occurs first. An insurer may provide less than 20 days notice only if the remaining duration of the plan is less than 20 days. In such case, notice shall be provided no later than 10 days prior to

the cancellation or rescission date or the expiration date of the plan, whichever occurs first. The notice shall specifically state the reason(s) for the cancellation or rescission.

(c) A written notice required by this subsection shall be printed in 12 point or larger font, and phrased in simple language.

E. Prohibition against pre-existing condition exclusion. A carrier shall not exclude coverage of a benefit covered under a short-term plan due to any preexisting condition(s) or other conditions disclosed on the application of coverage.

F. Waiting periods. A carrier shall not impose a waiting period for a benefit covered under a short-term plan.

[13.10.3.8 NMAC - N, 10/01/2020]

13.10.3.9 MANDATORY DISCLOSURES:

A. Disclosure Required. A short-term plan shall not be offered or issued without providing the prospective insured applicant a disclosure in the form and with the content specified in this section.

B. Disclosure format. The standard disclosure shall be displayed prominently in the plan and in the plan application, and shall also be delivered as a separate document to the applicant upon delivery of the application.

C. Delivery of disclosure. The applicant must sign an acknowledgement of receipt of the form.

(1) The carrier shall retain each acknowledged disclosure form for five years. Signed forms shall be available for review by the superintendent upon request.

(2) The standard disclosure form shall not be used until it has been filed with and approved in writing by the superintendent.

(3) The standard disclosure form shall include the following information and shall be presented on the first page of any application for coverage in 12-point or larger font:

THIS IS SHORT-TERM, LIMITED DURATION HEALTH INSURANCE COVERAGE. THIS PLAN ONLY LASTS FOR [Insert Duration] AND IS NONREWABLE. THIS COVERAGE IS UNAVAILABLE TO ANY INDIVIDUAL WHO HAS BEEN INSURED BY A SHORT-TERM PLAN WITHIN THE PREVIOUS TWELVE-MONTH PERIOD.

THIS PLAN MAY HAVE DOLLAR LIMITATIONS ON BENEFITS.

THIS COVERAGE DOES NOT COMPLY WITH ALL AFFORDABLE CARE ACT REQUIREMENTS. TO SEE IF YOU QUALIFY FOR FINANCIAL ASSISTANCE AND ENROLL IN AFFORDABLE CARE ACT COVERAGE VISIT WWW.BEWELLNM.COM. YOU MAY QUALIFY FOR A SPECIAL ENROLLMENT PERIOD IF YOU HAVE RECENTLY LOST COVERAGE.

[13.10.3.9 NMAC - N, 10/01/2020]

13.10.3.10 COMPLIANCE FILING REQUIREMENTS:

A. Qualified health plan standard requirements. A short-term plan is subject to the same rate, form, and compliance filings as qualified health plans.

B. Network access plan. An insurer who offers a short-term plan shall file a network access plan(s) in SERFF for review and approval by the superintendent annually on October 1.

[13.10.3.11 NMAC - N, 10/01/2020]

13.10.3.11 PENALTIES:

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, the superintendent may impose a penalty for any violation of this rule in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.

[13.10.3.10 NMAC - N, 10/01/2020]

13.10.3.12 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.3.11 NMAC - N, 10/01/2020]

PART 4: ADVERTISING ACCIDENT AND HEALTH INSURANCE

13.10.4.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.10.4.2 SCOPE:

A. This rule applies to any accident and health insurance policy advertisement which the insurer knows or reasonably should know is intended for presentation, distribution or dissemination in New Mexico when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, producer or solicitor, as those terms are defined in the Insurance Code, Section 59A-1-1 NMSA 1978 et seq.

B. This rule also applies to the following insurance policies to the extent this rule is not in conflict with the specifically applicable rule:

(1) Medicare supplements (13 NMAC 10.8) [now 13.10.8 NMAC];

(2) Managed Health Care (13 NMAC 10.13) [now 13.10.13 NMAC];

(3) Long-Term Care (13 NMAC 10.15) [now 10.13.15 NMAC]; and

(4) any other policy for which the Insurance Code rules require pre-approval of advertisements.

[7/1/97; Recompiled 11/30/01]

13.10.4.3 STATUTORY AUTHORITY:

Sections 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.10.4.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.10.4.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.4.6 OBJECTIVE:

The purpose of this rule is to protect prospective purchasers with respect to the advertisement of accident and health insurance. The rule is intended to assure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as accident and health insurance. The rule establishes guidelines and permissible and impermissible standards of conduct in the advertising of accident and health insurance in a manner which prevents unfair, deceptive and misleading advertising and is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance agents and companies.

[7/1/97; Recompiled 11/30/01]

13.10.4.7 DEFINITIONS:

The following definitions apply for purposes of this rule:

A. **"Accident and health insurance policy"** means any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or health benefits, medical, surgical or hospital expense benefits, or dental or vision benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium, double indemnity or accelerated death benefits included in life insurance and annuity contracts.

B. **"Advertisement:"**

(1) Advertisement means:

(a) printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays;

(b) descriptive literature and sales aids of all kinds issued by an insurer, agent, producer, broker or solicitor for presentation to members of the insurance-buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, form letters and lead-generating devices of all kinds as herein defined;

(c) prepared sales talks, presentations and material for use by agents, brokers, producers and solicitors whether prepared by the insurer or the agent, broker, producer or solicitor; and

(d) advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.

(2) Advertisement does not mean:

(a) material to be used solely for the training and education of an insurer's employees, agents or brokers;

(b) material used in-house by insurers;

(c) communications within an insurer's own organization not intended for dissemination to the public;

(d) individual communications of a personal nature with current policyholders other than material urging the policyholders to increase or expand coverages;

(e) correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

(f) court-approved material ordered by a court to be disseminated to policyholders; or

(g) a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided, the announcement clearly indicates that it is preliminary to the issuance of a booklet.

C. **"Certificate"** means any certificate issued under a group accident and health insurance policy which has been delivered or issued for delivery in this state.

D. **"Exception"** means any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of a risk not assumed under the policy.

E. **"Institutional advertisement"** means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of accident and health insurance, or the promotion of the insurer as a seller of accident and health insurance.

F. **"Insurer"** means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan and any other legal entity which is defined as an "insurer" in the Insurance Code and is engaged in the advertisement of itself, or an accident and health insurance policy.

G. **"Invitation to contract"** means an advertisement which is neither an invitation to inquire nor an institutional advertisement.

H. **"Invitation to inquire"** means an advertisement having as its objective the creation of a desire to inquire further about accident and health insurance and which is limited to a brief description of coverage, and which shall contain a provision in the

following or substantially similar form: "This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable]."

I. **"Lead-generating device"** means any communication directed to the public which, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of accident and health insurance.

J. **"Limitation"** means any provision which restricts coverage under the policy other than an exception or a reduction.

K. **"Person"** means any natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

L. **"Reduction"** means any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable and the reduction has not been used.

[7/1/97; Recompiled 11/30/01]

13.10.4.8 SYSTEM OF CONTROL AND IDENTIFICATION:

A. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All these advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised.

B. Advertising materials which are reproduced in quantity shall be identified by form numbers or other identifying means. This identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

[7/1/97; Recompiled 11/30/01]

13.10.4.9 METHOD OF DISCLOSURE OF REQUIRED INFORMATION:

All information required to be disclosed by this rule shall be set out conspicuously and in close conjunction with the statements to which the information relates or under appropriate captions of sufficient prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

[7/1/97; Recompiled 11/30/01]

13.10.4.10 FORM AND CONTENT OF ADVERTISEMENTS:

A. The format and content of an advertisement of an accident or health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the superintendent from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

C. An insurer must clearly identify its accident and health insurance policy as an insurance policy. A policy trade name must be followed by the words "Insurance Policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

D. No insurer, agent, broker, producer, solicitor or other person shall solicit a resident of this state for the purchase of accident and health insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement:

(1) contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or

(2) otherwise violates the provisions of this rule.

E. No insurer, agent, broker, producer, solicitor or other person shall solicit residents of this state for the purchase of accident and health insurance through the use of a true or fictitious name which is deceptive or misleading with regard to the status, character, or proprietary or representative capacity of the person or the true purpose of the advertisement.

[7/1/97; Recompiled 11/30/01]

13.10.4.11 ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED OR PREMIUMS PAYABLE:

A. **Deceptive words, phrases or illustrations prohibited:**

(1) No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of this information or use of these words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(2) No advertisement shall contain or use words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that medicare and your present insurance leave out," "the policy will help to replace your income," (when used to express loss of time benefits), or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

(3) An advertisement which also is an invitation to join an association, trust or discretionary group must solicit insurance coverage on a separate and distinct application which requires separate signatures for each application. The separate and distinct applications required need not be on a separate document or contained in a separate mailing. The insurance program must be presented so as not to mislead or deceive the prospective members that they are purchasing insurance as well as applying for membership, if that is the case.

(4) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after six months." Words and phrases used in an advertisement to describe these policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered.

(5) An advertisement of accident and health insurance sold by direct response shall not state or imply that because "no insurance agent will call and no commissions will be paid to 'agents' that it is 'a low cost plan,'" or use other similar words or phrases because the cost of advertising and servicing these policies is a substantial cost in the marketing by direct response.

(6) No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax-free," "extra cash," "extra income," "extra pay," or substantially similar words or phrases because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

(7) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless these statements of monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term "juxtaposition" means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit must appear in the advertisement.

(8) No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(9) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED POLICY," "THIS IS A CANCER ONLY POLICY," or "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."

(10) To facilitate the insured's right of freedom of choice in the selection of insurance coverage, any advertisement or sales material furnished an applicant relating to any policy which provides limited coverage in terms of the practitioners whose services are covered shall clearly disclose the practitioner limitations.

B. **Exceptions, reductions and limitations:**

(1) An advertisement which is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.

(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of these periods.

(3) An advertisement shall not use the words "only," "just," "merely," "minimum," "necessary" or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: "This policy is subject to the following minimum exceptions and reductions."

C. **Preexisting conditions:**

(1) An advertisement which is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of the loss is traceable

to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used.

(2) When an accident and health insurance policy does not cover losses resulting from preexisting conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement if it is an invitation to contract shall disclose that a medical examination is required.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement which reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, the application form shall contain a question or statement substantially as follows: "Do you understand that this policy will not pay benefits during the first [insert number] month(s) after the issue date for a disease or physical condition which you now have or have had in the past? YES or NO" or substantially the following statement: "I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] month(s) after the issue date on account of disease or physical condition which I now have or have had in the past."

[7/1/97; Recompiled 11/30/01]

13.10.4.12 NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELLABILITY AND TERMINATION:

An advertisement which is an invitation to contract shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

[7/1/97; Recompiled 11/30/01]

13.10.4.13 TESTIMONIALS OR ENDORSEMENTS BY THIRD PARTIES:

A. Testimonials and endorsements used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained therein, and the advertisement, including the statement, is subject to all the provisions of these rules. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained.

B. A person shall be deemed a "spokesperson" if the person making the testimonial or endorsement:

(1) has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;

(2) has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;

(3) has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or

(4) is in any way directly or indirectly compensated for making a testimonial or endorsement.

C. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence thereto. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, that fact shall be disclosed in the advertisement by language substantially as follows: "paid endorsement." The requirement of this disclosure may be fulfilled by use of the phrase "paid endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement whichever is larger. In the case of television or radio advertising, the required disclosure must be accomplished in the introductory portion of the advertisement and must be given prominence.

D. The disclosure requirements of this rule shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually for the scale for TV or radio performances.

E. An advertisement shall not state or imply that an insurer or an accident and health insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, that fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed.

F. When a testimonial refers to benefits received under an accident and health insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report of examination of the insurer, whichever

is the longer period of time. The use of testimonials which do not correctly reflect the present practices of the insurer or which are not applicable to the policy or benefit being advertised is not permissible.

[7/1/97; Recompiled 11/30/01]

13.10.4.14 USE OF STATISTICS:

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. This type of advertisement shall not imply that the statistics are derived from the policy advertised unless that is the fact, and when applicable to other policies or plans shall specifically so state.

(1) An advertisement shall specifically identify the accident and health insurance policy to which statistics relate and where statistics are given which are applicable to a different policy, it must be stated clearly that the data do not relate to the policy being advertised.

(2) An advertisement using statistics which describe an insurer, such as assets and liabilities, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, must be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and health insurance which refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in the advertisement.

[7/1/97; Recompiled 11/30/01]

13.10.4.15 IDENTIFICATION OF PLAN OR NUMBER OF POLICIES:

A. When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

B. When an advertisement which is an invitation to contract refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that these benefits are provided only though a combination of the policies.

[7/1/97; Recompiled 11/30/01]

13.10.4.16 DISPARAGING COMPARISONS AND STATEMENTS:

A. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

B. An advertisement shall not contain statements such as "no red tape" or "here is all you do to receive benefits."

C. Advertisements which state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are unacceptable unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages.

D. Advertisements which state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are unacceptable.

[7/1/97; Recompiled 11/30/01]

13.10.4.17 JURISDICTIONAL LICENSING AND STATUS OF INSURER:

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any division or agency of this state or the United States government.

C. An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. "Approval" of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition.

D. Advertisements must disclose that premium rates and forms have not been approved by the superintendent, if that is the fact.

[7/1/97; Recompiled 11/30/01]

13.10.4.18 IDENTITY OF INSURER:

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.

C. Advertisements, envelopes or stationery which employ words, letters, initials, symbols or other devices which are so similar to those used in governmental agencies or by other insurers are not permitted if they may lead the public to believe:

(1) that the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers; or

(2) that the advertiser is the same as, is connected with or is endorsed by the governmental agencies or the other insurers.

D. No advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

E. No advertisement in the form of envelopes or stationery of any kind may use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement is connected with a governmental agency, such as the social security administration.

F. No advertisement may incorporate the word "medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from medicare. This type of advertisement shall not use the phrase "[ ] medicare department of the [ ] insurance company," or language of similar import.

G. No advertisement may imply that the reader may lose a right or privilege or benefit under federal, state or local law if the reader fails to respond to the advertisement.

H. The use of letters, initials, or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark.

I. The use of the name of an agency or "[ ] underwriters" or "[ ] plan" in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.

J. The use of an address so as to mislead or deceive as to true identity of the insurer, its location or licensing status is prohibited.

K. No insurer may use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

L. All advertisements used by agents, producers, brokers or solicitors of an insurer must have prior written approval of the insurer before they may be used.

M. An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead-generating device, must disclose that fact in the initial contact with the consumer.

[7/1/97; Recompiled 11/30/01]

13.10.4.19 GROUP OR QUASI-GROUP IMPLICATIONS:

A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless that is the fact.

B. This rule prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

[7/1/97; Recompiled 11/30/01]

13.10.4.20 INTRODUCTORY, INITIAL OR SPECIAL OFFERS:

A. An advertisement of an individual policy shall not directly or by implication represent that:

(1) a contract or combination of contracts is an introductory, initial or special offer; or

(2) applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact.

B. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses these enrollment periods as the usual method of advertising accident and health insurance.

C. Advertisements of a particular insurance product shall indicate the date by which the applicant must mail the application, which shall be not less than ten days and not more than forty days from the date that the enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance.

(1) The phrase "any one insurer" in 13 NMAC 10.4.20.3 [now Subsection C of 13.10.4.20 NMAC] includes all the affiliated companies of a group of insurance companies under common management or control.

(2) The phrase "a particular insurance product" in 13 NMAC 10.4.20.3 [now Subsection C of 13.10.4.20 NMAC] means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

D. This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact.

E. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or

more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

F. Special awards, such as a "safe drivers' award" shall not be used in connection with advertisements of accident and health insurance.

[7/1/97; Recompiled 11/30/01]

13.10.4.21 STATEMENTS ABOUT AN INSURER:

An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations.

[7/1/97; Recompiled 11/30/01]

13.10.4.22 ENFORCEMENT PROCEDURES:

A. **Advertising file:** Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in the other state, with a notation attached to each advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. This file shall be subject to regular and periodical inspection by the department of insurance. All these advertisements shall be maintained in the file for a period of either five years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

B. **Certificate of compliance:** Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of this rule must file with the department of insurance, with its annual statement, a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his or her knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of this rule and the insurance laws of New Mexico as implemented and interpreted by this rule.

[7/1/97; Recompiled 11/30/01]

13.10.4.23 FILING FOR PRIOR REVIEW:

The superintendent may, in the superintendent's discretion, require the filing with the department of insurance, for review prior to use, of any accident and health insurance advertising material. This advertising material must be filed by the insurer with the department of insurance not less than thirty days prior to the date the insurer desires to use the advertisement.

[7/1/97; Recompiled 11/30/01]

PART 5: GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT

13.10.5.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[11/1/98; Recompiled 11/30/01]

13.10.5.2 SCOPE:

This rule applies to all group insurance contracts provided by an insurance company or a nonprofit health care plan and all group health maintenance organization contracts issued for delivery in this state, renewed, amended, or under which the level of benefits or premium is altered or modified, covering persons as employees of employers or as members of unions or associations.

[11/1/98; Recompiled 11/30/01]

13.10.5.3 STATUTORY AUTHORITY:

Sections 59A-18-16.1, 59A-46-30 and 59A-47-33 NMSA 1978.

[11/1/98; Recompiled 11/30/01]

13.10.5.4 DURATION:

Permanent.

[11/1/98; Recompiled 11/30/01]

13.10.5.5 EFFECTIVE DATE:

November 1, 1998, unless a later date is cited at the end of a section or paragraph.

[11/1/98; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.5.6 OBJECTIVE:

The purpose of this rule is to set forth the requirements for discontinuance and replacement of group contracts.

[11/1/98; Recompiled 11/30/01]

13.10.5.7 DEFINITIONS:

As used in this rule:

A. **"accrued liability"** means liabilities established on the date an injury is sustained or an illness commences.

B. **"group contract"** means a contract for health or disability insurance or an HMO contract made with an employer or other entity that covers a group of persons, identified as individuals, because of their relationship to the covered entity.

C. **"HMO"** means health maintenance organization as defined in 59A-46-2 NMSA 1978.

D. **"prior carrier"** means the carrier of group coverage provided by the employer or other entity immediately prior to the effective date of discontinuance and which has or has not been replaced by a succeeding carrier's coverage plan.

E. **"succeeding carrier"** means the carrier of group coverage provided by an employer or other entity which is issued within ninety days after the discontinuance of the prior plan.

F. **"totally disabled"** means:

(1) for covered employees, the inability because of injury or disease to perform regular or customary occupational duties; and after benefits have been paid for twenty-four months, the inability to perform the duties of any gainful occupation for which the employee is reasonably fitted by training, education, or experience; or

(2) for dependents or retired employees, the inability because of injury or disease to engage in substantially all of the normal activities of a person in good health of like age and sex.

[11/1/98; Recompiled 11/30/01]

13.10.5.8 EFFECTIVE DATE OF DISCONTINUANCE FOR NON-PAYMENT OF PREMIUM:

A. If a group contract provides for automatic discontinuance of the contract after a premium has remained unpaid through the grace period allowed for the payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period. The carrier shall, however, be entitled to the premium due for coverage provided during the grace period.

B. If the carrier treats the group contract as continuing in force after the end of the grace period by recognizing claims incurred after the end of the grace period, the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the group contract holder responsible for making premium payments to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered to the last known address of the policyholder.

[11/1/98; Recompiled 11/30/01]

13.10.5.9 REQUIREMENTS FOR NOTICE OF DISCONTINUANCE:

A. The carrier shall notify the group contract holder of the date the group contract will discontinue and that, unless otherwise provided in the group contract, the carrier shall not be liable for claims for losses incurred after the date of discontinuance.

B. The carrier shall also be responsible for notifying all persons covered by the group contract of the discontinuance within ten working days of notice to the group contract holder in whatever manner the carrier customarily uses to provide such notice. The notice shall:

(1) indicate the effective date of the discontinuance;

(2) advise, in any instance in which the plan involves employee contributions, that if the group contract holder continues to collect contributions for the coverage after the date of discontinuance, the group contract holder may be held solely liable for the benefits with respect to the period for which the contributions have been collected;

(3) state that, unless otherwise provided in the group contract, the carrier shall not be liable for claims for losses incurred after the date of discontinuance; and

(4) encourage covered persons to refer to their certificates in order to determine what rights, if any, are available to them upon the discontinuance.

[11/1/98; Recompiled 11/30/01]

13.10.5.10 EXTENSION OF BENEFITS:

Every group contract must include a provision for reasonable extension of benefits in the event of total disability on the date of discontinuance of the group contract, as required by this section.

A. In the case of a group life plan which contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), discontinuance of the group contract shall not operate to terminate the extension.

B. In the case of a disability income contract providing benefits for loss of time from work, or specific indemnity during hospital confinement on an accrued liability basis, discontinuance of the group contract during a disability or confinement shall have no effect on benefits payable for that disability or confinement.

C. In the case of hospital or medical expense coverage and HMO plans other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required. The provision will be considered reasonable if it provides an extension of at least twelve months under major medical and comprehensive medical type coverage and HMO plans, and under other types of hospital or medical expense coverage provides either an extension of at least ninety days or an accrued liability for expenses incurred during a period of disability or during a period of at least ninety days starting with a specific event which occurred while coverage was in force (e.g., an accident).

D. Any applicable extension of benefits or accrued liability shall be described in the group contract as well as in group insurance certificates. The benefits payable during any period of extension or accrued liability may be subject to the group contract's regular benefit limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits or benefit restrictions for services provided by unaffiliated providers of an HMO) but in no event shall benefits be reduced solely because of the discontinuance of the group contract except as otherwise permitted by this rule.

[11/1/98; Recompiled 11/30/01]

13.10.5.11 LIABILITY OF PRIOR CARRIER WHEN GROUP CONTRACT REPLACED:

A. The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group contract holder or other entity secures replacement coverage from a new carrier, the same carrier, self-insures, or foregoes the provision of coverage.

B. The prior carrier, if an HMO, may limit the extension of benefits for a totally disabling illness, injury, or condition to services provided by or through its participating providers, unless services are rendered on an emergency basis.

[11/1/98; Recompiled 11/30/01]

13.10.5.12 LIABILITY OF SUCCEEDING CARRIER WHEN GROUPCONTRACT REPLACED:

A. Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits shall be covered by that carrier's plan of benefits.

B. Each person not covered under the succeeding carrier's plan of benefits in accordance with 13 NMAC 10.5.12.1 [now Subsection A of 13.10.5.12 NMAC] must nevertheless be covered by the succeeding carrier in accordance with the following standards if the individual was validly covered (including by extension of benefits) under the prior plan on the date of discontinuance and if the individual is a member of the class of individuals eligible for coverage under the succeeding carrier's plan. Any reference in this rule to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.

(1) The minimum level of benefits to be provided by the succeeding carrier:

(a) when the succeeding carrier is not an HMO, shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan;

(b) when the succeeding carrier is an HMO, shall be the HMO's own level of benefits, reduced by benefits provided or payable by the prior plan.

(2) Benefits must be provided by the succeeding carrier until at least the earliest of the following dates:

(a) the date the individual becomes eligible under the succeeding carrier's plan according to 13 NMAC 10.5.12.1 [now Subsection A of 13.10.5.12 NMAC];

(b) the date the individual's benefits would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage (e.g., at termination of employment or ceasing to be an eligible dependent); or

(c) in the case of an individual who was totally disabled, and in the case of a type of coverage for which 13 NMAC 10.5.10 [now 13.10.5.10 NMAC] requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by 13 NMAC 10.5.10 [now 13.10.5.10 NMAC] or, if the prior carrier's group contract is not subject to 13 NMAC 10.5.10 [now 13.10.5.10 NMAC], would have been required of that carrier had its group contract been subject to 13 NMAC 10.5.10 [now 13.10.5.10 NMAC].

C. The conversion privilege shall be available to those individuals whose benefits cease, if the individual has not become eligible under the succeeding carrier's plan as described in 13 NMAC 10.5.12.1 [now Subsection A of 13.10.5.12 NMAC].

D. The succeeding carrier, in applying any deductibles, co-insurance, co-payments, or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provision of the prior carrier's plan during the 90 days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible provision.

E. In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of 13 NMAC 10.5.11, 10.5.12, and 10.5.13 [now 13.10.5.11 NMAC, 13.10.5.12 NMAC and 13.10.5.13 NMAC], benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage had not been replaced by the succeeding carrier.

[11/1/98; Recompiled 11/30/01]

13.10.5.13 LIABILITY WHEN THE SUCCEEDING CARRIER IS AN HMO:

A. 13 NMAC 10.5.12.2.1 and 10.5.12.4 [now Paragraph (1) of Subsection B of 13.10.5.12 NMAC and Subsection D of 13.10.5.12 NMAC] do not apply to federally qualified HMOs as long as they are not permitted to require actively at work, hospital non-confinement rules, medical evidence of insurability, or pre-existing condition limitations.

B. In situations where services for a totally disabled person are provided by the succeeding HMO, the succeeding HMO may bill the prior carrier for the reasonable cash value of services provided when the prior carrier has an obligation under its required extension of benefits. The prior carrier shall make direct payment to the succeeding HMO for the cost of the services provided.

[11/1/98; Recompiled 11/30/01]

PART 6: PREPAID DENTAL PLANS

13.10.6.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.10.6.2 SCOPE:

A. This rule applies to all prepaid dental organizations in the state of New Mexico.

B. The health services division may issue further rules in areas of its responsibilities from time to time and those rules must be considered when interpreting this rule.

[11/20/79; Recompiled 11/30/01]

13.10.6.3 STATUTORY AUTHORITY:

Sections 59A-2-9 NMSA 1978.

[7/1/97; Recompiled 11/30/01]

13.10.6.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.10.6.5 EFFECTIVE DATE:

November 20, 1979, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.6.6 OBJECTIVE:

The purpose of this rule is to specify the requirements for prepaid dental organizations in accordance with the Prepaid Dental Plan Law, Section 59A-48-1 NMSA 1978 et seq.

[7/1/97; Recompiled 11/30/01]

13.10.6.7 DEFINITIONS:

For the purpose of this rule:

A. **"Agent"** means a person appointed by a prepaid dental plan to transact business in this state to act as its representative in any given locality for the purpose of soliciting members to be enrolled by contract providing dental care.

B. **"Director of the health services division"** means the chief officer of the health services division of the department of health of the state of New Mexico.

[11/20/79; Recompiled 11/30/01]

13.10.6.8 LICENSING OF PREPAID DENTAL PLANS:

For the protection of the public in New Mexico, the superintendent will issue, renew and permit to exist any prepaid dental plan to enroll members in a group to provide a prepaid dental plan in compliance with the provisions of Section 59A-48-1 NMSA 1978 et seq., with respect to the requirements in this rule.

[11/20/79; Recompiled 11/30/01]

13.10.6.9 GENERAL REQUIREMENTS AND COMPLIANCE:

A. Where this rule requires a prepaid dental plan to have policies, procedures, plans, class specification, orders, reports, minutes of meetings, contracts, agreements, records, duty schedules, or other such items, such requirement means written documents compiled and indexed in one or more manuals which shall be readily available for examination by the superintendent or the director of the health services division or their representatives.

B. Any prepaid dental plan submitting an application for a certificate of authority to the superintendent shall, at the same time, submit to the director of the health services division a plan of compliance detailing the manner in which the prepaid dental plan will comply with the requirements of the rules of the department of insurance and the health services division.

C. The prepaid dental plan shall be cleared by the director of the health services division first before it may be approved for a certificate of authority by the superintendent.

[11/20/79; Recompiled 11/30/01]

13.10.6.10 PREPAID DENTAL PLAN CERTIFICATION:

A. The prepaid dental plan shall submit a statement describing its proposed dental care plan, facilities, and personnel to the director of the health services division for certification. The statement shall indicate the manner which the prepaid dental plan will comply with the following requirements:

(1) The prepaid dental plan shall have an organized system for the delivery of those dental care services. The system shall include general dentists, and may include specialists, licensed dental hygienists and other professional and technical personnel. The system shall include a procedure which promotes a continuing relationship to be established between a member and the same general dentist and a procedure for effective referrals to assure continuity of care to members.

(2) The prepaid dental plan shall list (using full-time equivalents for providers) the proposed or actual:

(a) names of members enrolled and whether they have elected dependent coverage;

(b) dentist staffing for the projected enrollment, identifying board of eligibility or certification of each dentist listed when such identification exist; in lieu of such identification all staff dentists will be considered general dentists;

(c) dental support staff by number and type;

(d) provision for providing specialty dental services.

(3) All care provided by the prepaid dental plan whether provided by its own personnel or on a contract basis shall be by licensed practitioners of the healing arts when such licensure is required by law and shall otherwise be in accordance with applicable laws and rules.

(4) Emergency dental services described in 13 NMAC 10.6.11.1 [now Subsection A of 13.10.6.11 NMAC] shall be available for enrolled members on a seven day per week and 24 hours per day basis.

B. Dental services provided on a continuing basis by other than organization employees shall be covered by written service agreements which specify the terms and conditions upon which they will provide any or all of those dental services contained in 13 NMAC 10.6.11 [now 13.10.6.11 NMAC].

[11/20/79; Recompiled 11/30/01]

13.10.6.11 MINIMUM BENEFITS:

All plans shall include at least the following basic dental services which shall be covered by the prepaid charges set forth in the evidence of coverage. If other dental services will be available to eligible members on a voluntary basis, they must be listed in the plan. Dental services not included in the plan shall be shown as exclusions.

A. **Emergency services:** Emergency dental services are those necessary to control bleeding, relieve pain, and eliminate acute infection.

B. **Diagnostic services:** Diagnostic dental services are those services necessary to identify dental abnormalities. They shall include but need not be limited to radiographs and clinical examination.

C. **Preventive services:** Preventive dental services shall include but need not be limited to oral prophylaxis, the application of topical fluorides when applicable, and a viable maintenance care recall system accompanied by evidence that this recall system is fully implemented.

D. **Therapeutic services:** Therapeutic services shall include:

(1) pulp therapy for permanent and primary teeth exclusive of root canal therapy,

(2) restoration of carious (decayed) permanent and primary teeth with materials other than cast restorations,

(3) routine tooth extractions.

E. **Out of area care:** In the event a member requires emergency dental services as defined in 13 NMAC 10.6.11.1 [now Subsection A of 13.10.6.11 NMAC] while located outside the geographic area served by the plan and the member pays for such services, reimbursement shall become the responsibility of the dental service provider from which the patient has elected to receive care under the contract.

[11/20/79; Recompiled 11/30/01]

13.10.6.12 GEOGRAPHIC AREA STATEMENT:

A. The prepaid dental plan shall submit a statement which describes the geographic area or areas to be served.

(1) A geographic area should be reasonably contiguous and one within which services offered and provided will be reasonably accessible to members and prospective members.

(2) The organization shall attach a map or maps to the statement on which are indicated the boundaries of the proposed geographic area or areas and the locations of all facilities in which dental care will be provided by contractors to the organization.

(3) All advertising matter and sales material provided to prospective enrollees must include a description on the geographic area or areas in terms readily understandable by the general public.

B. The director of the health services division shall not disapprove any plan on the basis its proposed geographic area includes all or part of any geographic area served or proposed to be served by any other plan.

[11/20/79; Recompiled 11/30/01]

13.10.6.13 CHIEF EXECUTIVE OFFICER OF PREPAID DENTAL PLAN:

A. The prepaid dental plan shall appoint a designated representative who shall have appropriate education and/or experience to qualify him for the management of the organization. The prepaid dental plan shall define in writing, the authority and duties of the chief executive officer. The chief executive officer shall be appointed representative of the prepaid dental plan and shall be the executive officer of the prepaid dental plan. The person shall be responsible for implementation of established policies in the operation of the organization and for providing liaison between prepaid dental plan providers of dental care and providers of other services for the prepaid dental plan. The person shall be in charge of the management of the prepaid dental plan and shall be authorized and empowered to carry out the provisions of this article and shall be charged with the responsibility of doing so. The chief executive officer shall establish in writing a plan indicating the line of authority during periods of his absence.

B. When there is a change of chief executive officer, the prepaid dental plan shall notify the director of the health services division and the superintendent within ten days after the effective date of change.

C. The prepaid dental plan shall require providers to assure that all employees and health practitioners covered by service agreements are adequately knowledgeable and qualified to perform the duties assigned to them through employment or by contract.

[11/20/79; Recompiled 11/30/01]

13.10.6.14 DENTAL DIRECTOR:

A. The prepaid dental plan shall designate a New Mexico licensed dentist as dental director.

B. The dental director shall be responsible for planning and implementing the method for the continuing review and evaluation of dental care provided and the continuing education of the providers of dental services. The dental director may also serve as the chief executive officer provided he has appropriate education and/or experience to qualify him for the management of the organization.

C. The dental director's responsibility shall include, but not be limited to:

(1) supervision including performance planning and evaluation of dental staff.

(2) coordination of activities of dental staff.

(3) development of dental care policies.

[11/20/79; Recompiled 11/30/01]

13.10.6.15 DENTAL RECORDS:

A. The prepaid dental plan shall assure that a unit dental record system capable of readily providing necessary clinical information is maintained.

B. The dental record shall be maintained at the appropriate provider facility in accordance with acceptable professional standards and shall include records covering all symptoms presented, diagnosis made and dental treatment provided to each member of the prepaid dental plan by its provider group(s) during the term of his membership. This requirement applies to all dental services provided to members whether provided by employees of the organization or nonemployees (contractors) at the request of the prepaid dental plan.

C. Dental records shall be confidential and shall not be disclosed except upon release by the patient, subpoena or court order.

D. Pursuant to the requirements of Section 59A-48-1 NMSA 1978 et seq., the dental records of the prepaid dental plan's provider group(s) shall be made available for review by representatives of the health services division or the superintendent. During routine surveys, the health services division or the superintendent or their representatives will review dental records of members of the prepaid dental plan on a random sample basis. On complaint or special investigations, specific dental records will be reviewed. Confidentially of patient records shall be maintained.

E. If the member discontinues membership in the prepaid dental plan it shall furnish, upon his request, copies of his records. A reasonable charge may be made for these copies based upon the cost of duplicating them.

[11/20/79; Recompiled 11/30/01]

13.10.6.16 QUALITY ASSURANCE:

A. The prepaid dental plan shall provide an effective method for a continuing review and evaluation of the dental care provided to ensure that treatment and level of care were appropriate and adequate, that the quality of dental care provided met with acceptable standards, and that corrective action occurred or will occur if indicated.

B. There shall be a quality assurance committee appointed by the prepaid dental plan consisting of the chief executive officer or his designee, the dental director, practitioners of the dental healing arts, allied health professionals, and consumers who

shall be members of the plan. Services performed by practitioners of the dental healing arts shall be reviewed and evaluated by members of this committee and evaluated by colleagues within their disciplines. The committee shall adopt administrative procedures covering frequency of meetings, types of records to be kept, and arrangements for committee reports and their dissemination.

C. The plan shall submit for approval of the director of the health services division a quality assurance plan which shall include procedures to be used for each of the following:

(1) establishment of standards for dental care at equivalent to those utilized by the professional standards review organization for medicare and medicaid reimbursement;

(2) surveillance of care provided;

(3) analysis of problems identified;

(4) correction of deficiencies including a time schedule for correction of the deficiencies;

(5) follow-up (periodic reassessment of the plan).

[11/20/79; Recompiled 11/30/01]

PART 7: FINANCIAL REPORTING REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

13.10.7.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[6/1/98; Recompiled 11/30/01]

13.10.7.2 SCOPE:

This rule applies to all health maintenance organizations (HMOs).

[6/1/98; Recompiled 11/30/01]

13.10.7.3 STATUTORY AUTHORITY:

Sections 59A-46-9, 59A-46-12, 59A-46-22 and 59A-46-23 NMSA 1978.

[6/1/98; Recompiled 11/30/01]

13.10.7.4 DURATION:

Permanent.

[6/1/98; Recompiled 11/30/01]

13.10.7.5 EFFECTIVE DATE:

June 1, 1998, unless a later date is cited at the end of a section or paragraph.

[6/1/98; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.7.6 OBJECTIVE:

The purpose of this rule is to ensure that HMO's meet minimum fiscal operational requirements sufficient to assume the risk of their covered subscribers and to establish requirements for the membership of HMO policy-making bodies.

[6/1/98; Recompiled 11/30/01]

13.10.7.7 DEFINITIONS:

In addition to the definitions in 59A-46-2 NMSA 1978, the following terms have the meanings given here.

A. **"Health professional"** includes physicians, dentists, registered nurses, licensed practical nurses, podiatrists, optometrists, chiropractic physicians, physician assistants, certified nurse practitioners, certified nurse-midwives, registered lay midwives, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists, and other professionals engaged in the delivery of health care services who are licensed to practice in New Mexico, are certified, and are practicing under the authority of an HMO, medical group, hospital, individual practice association, or other entity authorized by applicable New Mexico law.

B. **"Individual practice association (IPA)"** means a partnership, association, corporation, or other legal entity which delivers or arranges for the delivery of health services and which has entered into written services arrangements with health professionals, a majority of whom are licensed to practice medicine or osteopathy.

C. **"Medical group"** means a partnership, association, corporation, or other group:

(1) that is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists,

optometrists, and podiatrists) as are necessary for the provision of health services for which the group is responsible;

(2) a majority of the members of which are licensed to practice medicine or osteopathy; and

(3) the members of which:

(a) after the end of the 48 month period beginning after the month in which the HMO for which the group provides health services becomes a qualified HMO, as their principal professional activity (over 50 percent individually) engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility (over 35 percent in the aggregate of their professional responsibility) for the delivery of health services to enrollees of an HMO;

(b) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other similar plan unrelated to the provision of specific health services;

(c) share health (including medical) records and substantial portions of major equipment and of professional, technical, and administrative staff;

(d) establish an arrangement whereby an enrollee's enrollment status is not known to the health professional who provides health services to the enrollee.

D. **"Party-in-interest"** means:

(1) Any director, officer, partner, or employee responsible for management or administration of an HMO, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the HMO, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valued at more than 5 percent of the assets of the HMO, and, in the case of an HMO organized as a nonprofit corporation, a founder or member of the corporation under applicable state corporation law;

(2) Any entity in which a person described in 13 NMAC 10.7.7.4.1 [now Paragraph (1) of Subsection D of 13.10.7.7 NMAC]:

(a) is an officer or director;

(b) is a partner (if the entity is organized as a partnership);

(c) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(d) has a mortgage, deed of trust, note, or other interest valued at more than 5 percent of the assets of such entity;

(3) Any spouse, child, or parent of an individual described in 13 NMAC 10.7.7.4.1 [now Paragraph (1) of Subsection D of 13.10.7.7 NMAC].

E. **"Policy-making body of an HMO"** means a board of directors, board of trustees, executive committee, governing board, or other body of individuals which has the authority to establish policy for the HMO.

F. **"Significant business transaction"** means any business transaction or series of transactions during any one fiscal year of the HMO, the total value of which exceeds the lesser of $25,000 or 5 percent of the total operating expenses of the HMO.

[6/1/98; Recompiled 11/30/01]

13.10.7.8 INVESTMENTS:

An HMO shall be treated as a life insurance company for purposes of applying the provisions of Chapter 59A, Article 9 NMSA 1978.

[6/1/98; Recompiled 11/30/01]

13.10.7.9 ANNUAL REPORTS:

In addition to the requirements of Section 59A-46-9 NMSA 1978, each HMO shall provide to the superintendent on or before March 1 of each year, unless for good cause shown the superintendent authorizes an extension of time, the following:

A. a copy of the report, if any, filed with the U.S. department of health and human services' health care financing administration containing the information required to be reported by disclosing entities under regulations implementing Sections 1124 and 1902(a)(38) of the Social Security Act (see 42 CFR 420.206 and 42 CFR 455.104, respectively); and

B. a description of any of the following significant business transactions between the HMO and any party-in-interest that occurred during the previous fiscal year, and a justification that the costs of any such transaction do not exceed the costs which would have been incurred if the transaction had been undertaken with someone not a party-in-interest (or, if the costs are higher, a justification that such costs are consistent with prudent management and fiscal soundness):

(1) sale, exchange, or lease of property;

(2) furnishing, for consideration, goods, services (including management services), or facilities, but not including salaries paid to employees for services provided

in the normal course of their employment and health services provided to enrollees by hospitals and other providers and by staff, medical groups, individual practice associations, or any combination of them; and

(3) lending money or otherwise extending credit.

[6/1/98; Recompiled 11/30/01]

13.10.7.10 ACCOUNTANTS:

A. **Independent accountant:** Whenever the superintendent orders, or this rule requires, that a financial statement or other report be audited or be accompanied by the opinion of a certified public accountant or public accountant, the accountant shall be independent of the HMO.

B. **Change of independent accountant:** When the HMO submits financial statements required by this rule and the certifying accountant is an accountant other than the accountant who certified the HMO's most recent filing, the HMO must provide the superintendent with a separate letter stating whether, in the twenty-four (24) months preceding the engagement of the new accountant, there was any disagreement with the former accountant on any matter involving accounting principles or practices, financial statement disclosures, or auditing procedures, which the former accountant would have referred to in his or her opinion or report to the superintendent if such issues were not resolved to his or her satisfaction. The letter must be verified by a principal officer of the HMO. The HMO shall also request the former accountant to provide it with a letter addressed to the superintendent stating whether the former accountant agrees with the statements contained in the HMO's letter and, if not, stating the reasons the former accountant disagrees with the statements in the letter. The two letters must be submitted to the superintendent within 45 days after the HMO engages the new accountant.

[6/1/98; Recompiled 11/30/01]

13.10.7.11 DUPLICATION OF FEDERAL REPORTING REQUIREMENTS:

If the reporting requirements of this rule duplicate any federal reporting requirements, the HMO may request a waiver of the reporting requirements of this rule. In requesting such a waiver, the HMO must clearly state which federally required information will be duplicated by complying with which reporting requirement of this rule. The superintendent will grant such waivers only when the HMO's federally reported information is provided and is in a clear and easily discernible format.

[6/1/98; Recompiled 11/30/01]

13.10.7.12 FISCAL OPERATION:

Each HMO shall have a fiscally sound operation as demonstrated by:

A. total assets being greater than total unsubordinated liabilities by an amount at least equal to the net worth requirements delineated in Section 59A-46-13 NMSA 1978;

B. sufficient cash flow and adequate liquidity to meet obligations as they become due;

C. if the HMO did not increase its net worth during the three most recent fiscal years, a financial plan satisfactory to the superintendent, which shall include:

(1) a detailed marketing plan;

(2) statements of revenues and expenses on an accrual basis;

(3) statements of sources and uses of funds; and

(4) balance sheets.

D. a plan for handling insolvency that meets the requirements in Section 59A-46-13F NMSA 1978 which contains at least one of the five kinds of assurances permitted by that paragraph;

E. insurance policies or other arrangements secured and maintained by the HMO and approved by the superintendent to insure the HMO against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks; and

F. the financial projections required by Section 59A-46-3C(8) NMSA 1978 which shall include projections until break-even, if such break-even is beyond the three-year period provided in that section.

[6/1/98; Recompiled 11/30/01]

13.10.7.13 ADMINISTRATIVE AND MANAGERIAL ARRANGEMENTS:

Each HMO shall have administrative and managerial arrangements satisfactory to the superintendent as demonstrated by at least the following:

A. a policy-making body which exercises oversight and control over the HMO's policies and personnel to assure that management actions are in the best interests of the HMO and its enrollees; and

B. personnel and systems sufficient for the HMO to organize, plan, control and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of HMO. At a minimum, the HMO shall be

managed by an executive whose appointment and removal are under the control of the HMO's policy-making body.

[6/1/98; Recompiled 11/30/01]

13.10.7.14 PROTECTION OF ENROLLEES:

Each HMO shall adopt at least one of the following arrangements to protect its enrollees from incurring liability for payment of any fees which are the legal obligation of the HMO:

A. a contractual arrangement with any provider regularly used by the enrollees of the HMO prohibiting the provider from holding any enrollee liable for payment of any fees which are the legal obligation of the HMO;

B. a stand-by reinsurance agreement or membership in a guaranty association that is acceptable to the superintendent;

C. adequate financial reserves acceptable to the superintendent; or

D. other arrangements acceptable to the superintendent to protect enrollees.

[6/1/98; Recompiled 11/30/01]

13.10.7.15 FINANCIAL RISK:

Each HMO shall assume full financial risk on a prospective basis for the provision of basic health services, except that it may:

A. obtain insurance or make other arrangements for the cost of providing to any enrollee basic health services the aggregate value of which exceeds $5,000 in any year;

B. obtain insurance or make other arrangements for the cost of basic health care services provided to enrollees other than through the HMO because medical necessity required provision of such services prior to the time the services could be secured through the HMO;

C. obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any fiscal year exceed 115 percent of its income for that fiscal year; or

D. make arrangements with physicians or other health professionals, health care institutions, or any combination of individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health care services by physicians or other health professionals or through the institutions.

[6/1/98; Recompiled 11/30/01]

13.10.7.16 TRANSACTIONS WITH PARTY-IN-INTEREST:

With respect to any significant business transaction by the HMO with a party-in-interest:

A. The HMO shall disclose to its policy-making body all material facts concerning the transaction and the party-in-interest's interest in the transaction.

B. The policy-making body shall make such facts and the policy-making body's actions, if any, part of its minutes or, if no minutes are required of the policy-making body, shall otherwise make them a record of the HMO.

C. The HMO shall hand deliver or send by certified mail to the superintendent prior notice of the transaction. Such notice shall be given with reasonable time for the superintendent to object. The superintendent shall approve or disapprove such transaction within 30 days after receipt of the notice, and if no approval or disapproval has been granted within 30 days, the transaction shall be deemed approved by the superintendent.

[6/1/98; Recompiled 11/30/01]

13.10.7.17 POLICY-MAKING BODIES OF HMOS:

No later than one year after becoming operational as a certified HMO, an HMO shall either:

A. assure that at least one-third of the membership of the HMO's policy-making body are enrollees of the HMO and that they reside in, or in proximity to, the service area of the HMO. No enrollee who is a party-in-interest shall be included in the minimum one-third member representation on the policy-making body. Persons serving on the policy-making body are not prohibited from receiving payments of directors' fees or other similar fees, or interest and dividends derived from enrollment in an HMO cooperative.

B. create an advisory board to the policy-making body. At least one-third of the members of the advisory board must be enrollees of the HMO who meet the criteria of 13 NMAC 10.7.17.1 [now Subsection A of 13.10.7.17 NMAC]. The advisory board shall meet at least annually and at least annually shall file a report of its recommendations with the policy-making body of the HMO. The report and any minority reports shall be forwarded to the superintendent annually.

[6/1/98; Recompiled 11/30/01]

13.10.7.18 FACILITATING PARTICIPATION BY FEDERAL OR STATE AGENCIES IN HMOs:

The superintendent may waive or modify any part of this rule in order to facilitate the purchase of HMO services by federal or state agencies in New Mexico.

[6/1/98; Recompiled 11/30/01]

PART 8: HEALTH INSURANCE FOR SENIORS [REPEALED]

[This part was repealed on April 23, 2019]

PART 9: MINIMUM HEALTHCARE PROTECTION

13.10.9.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.10.9.2 SCOPE:

This rule applies to policies or plans issued after the effective date of this rule by health insurers, fraternal benefit societies, health maintenance organizations and nonprofit healthcare plans in accordance with the provisions of the Minimum Healthcare Protection Act, Section 59A-23B-1 NMSA 1978 , et seq. as amended.

[5/1/92; Recompiled 11/30/01]

13.10.9.3 STATUTORY AUTHORITY:

59A-2-9 and 59A-23B-11 NMSA 1978.

[5/1/92; Recompiled 11/30/01]

13.10.9.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.10.9.5 EFFECTIVE DATE:

May 1, 1992, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[5/1/92, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.9.6 OBJECTIVE:

This rule is intended to address limitations in access to healthcare by authorizing health insurers, fraternal benefit societies, health maintenance organizations and nonprofit healthcare plans to offer minimum healthcare services, policies or plans at affordable rates to those residents of the state who may not desire or be able to afford more comprehensive healthcare services, policies or plans.

[5/1/92; Recompiled 11/30/01]

13.10.9.7 DEFINITIONS:

Policies or plans issued pursuant to the Minimum Healthcare Protection Act which contain the following terms shall define such terms in the following manner:

A. **"Group"** means a group of fewer than twenty members at initial enrollment formed for purposes other than obtaining insurance coverage. Where a group is an employer, group shall mean any person, firm, corporation, partnership or association actively engaged in business which, on at least fifty percent of its working days during the preceding year, employed fewer than twenty employees.

B. **"Home healthcare"** as defined in Section 59A-22-36D NMSA 1978, means health services provided on a part-time, intermittent basis to an individual confined to his or her home due to physical illness.

C. **"Hospital"** means a facility which is maintained by the state or any political subdivision of the state or any place which is currently licensed as an acute care hospital by the department of health and has accommodations for resident bed patients, a licensed professional registered nurse always on duty or call, a laboratory and an operating room where surgical operations are performed, but the term does not include convalescent, nursing or rest homes or facilities primarily for the treatment of substance abuse.

D. **"Medicare"** means the federal Health Insurance for the Aged Act.

E. **"Nurse midwife"** means any person licensed by the board of nursing as a registered nurse who is registered with the public health division of the department of health as a certified nurse midwife.

F. **"Nurse practitioner"** means any person licensed by the board of nursing as a registered nurse approved for expanded practice as a certified nurse practitioner pursuant to the Nursing Practice Act.

G. **"Physician"** means any person who holds a license provided for in Chapter 61, Article 6 or 10 NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical condition.

H. **"Physician assistant"** means an individual duly qualified under the laws of New Mexico and the rules of the medical examiners board who is in good standing with that board and is registered to practice under the direction and supervision of a board-approved physician.

I. **"Policy or plan"** as defined in Section 59A-23B-3A NMSA 1978, means a healthcare benefit policy or healthcare benefit plan that the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan chooses to offer to individuals, families or groups of fewer than twenty members formed for purposes other than obtaining insurance coverage and that meets the requirements of Section 59A-23B-3B NMSA 1978. For purposes of this rule, policy or plan shall not mean a healthcare policy or healthcare benefit plan that an insurer, health maintenance organization, fraternal benefit society or nonprofit healthcare plan chooses to offer outside the authority of the Minimum Healthcare Protection Act.

[5/1/92; Recompiled 11/30/01]

13.10.9.8 ELIGIBILITY CRITERIA:

A. Pursuant to Section 59A-23B-3B NMSA 1978, the individual, family or group obtaining coverage under the policy or plan shall have been without healthcare insurance, a health services plan or employer sponsored healthcare coverage for the six-month period immediately preceding the effective date of their coverage under a policy or plan except that for groups in existence for less than six months, the group has been without healthcare coverage since the formation of the group.

B. For purposes of the Minimum Healthcare Protection Act and this rule, a group which is otherwise eligible will be deemed to have been without healthcare coverage whether or not individuals within the group have other healthcare coverage either individually or as the dependents of other persons.

C. With respect to individuals eligible for medicaid benefits, the provisions of Sections 59A-18-31, 59A-22-38, 59A-23-7, 59A-46-34 and 59A-47-36 NMSA 1978 shall apply to policies or plans issued in the state on or after the effective date of the Minimum Healthcare Protection Act.

[5/1/92; Recompiled 11/30/01]

13.10.9.9 POLICY OR PLAN CRITERIA; MINIMUM REQUIREMENTS:

A. **Mandatory provisions:** Policies or plans issued pursuant to the Minimum Healthcare Protection Act shall meet the criteria set forth in Section 59A-23B-3B NMSA 1978 regarding eligibility, managed care provisions and minimum healthcare services to covered individuals.

B. **Optional provisions:** Policies or plans issued pursuant to the Minimum Healthcare Protection Act may include the managed care and cost control features provided in Section 59A-23B-3C NMSA 1978 regarding panels of healthcare service providers, second opinions before elective surgery, utilization review and a maximum limit on the cost of healthcare services covered in any calendar year of not less than $50,000. Pursuant to Section 59A-23B-3D NMSA 1978 a policy or plan may include additional managed care and cost control provisions that the superintendent of insurance determines to have the potential for controlling costs in a manner that does not cause discriminatory treatment of individuals, families or groups covered by the policy or plan.

C. **Pre-existing conditions:** Pursuant to Section 59A-23B-3E NMSA 1978, notwithstanding any other provisions of law, a policy or plan shall not exclude coverage for losses incurred for a pre-existing condition more than six months from the effective date of coverage. The policy or plan shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within six months before the effective date of coverage.

D. **Home healthcare coverage:**

(1) For purposes of the Minimum Healthcare Protection Act and this rule, home healthcare coverage offered shall include:

(a) services provided by a registered nurse or a licensed practical nurse;

(b) health services provided by physical, occupational and respiratory therapists and speech pathologists;

(c) health services provided by a home health aide; and

(d) medical supplies, drugs and medicines and laboratory services, to the extent they would have been covered if provided to the insured on an inpatient basis.

(2) Home healthcare coverage may be limited to:

(a) services provided on the written order of a licensed physician, provided such order is renewed at least every sixty (60) days;

(b) services provided, directly or through contractual agreements, by a home health agency licensed in the state in which the home health services are delivered; and

(c) services, as set forth in 13 NMAC 10.9.9.4.1 [now Paragraph (1) of Subsection D of 13.10.9.9 NMAC], without which the insured would have to be hospitalized.

(3) A day of home healthcare shall consist of up to four (4) continuous hours of home healthcare services. Home healthcare services provided in hourly increments of less than four (4) hours shall be calculated in proportion to the relationship which the hours of service provided bear to a four (4) hour day, e.g., two (2) hours of home healthcare constitute one-half (½) day of home healthcare, etc.

(4) Provided, however, that home healthcare coverage, alone or in combination with inpatient hospitalization coverage, shall not exceed twenty five (25) days pursuant to the provisions of Section 59A-23B-3B(3)(a) NMSA 1978.

E. **Usual, customary and reasonable charges:**

(1) For purposes of a policy or plan issued pursuant to the Minimum Healthcare Protection Act and this rule, a usual, customary and reasonable charge shall be the lesser of:

(a) the customary charge which would be made by the healthcare services provider for the same service or medical supplies in the absence of insurance;

(b) the general level of charge for a comparable service or medical supplies made by other healthcare service providers in the same geographic area; or

(c) the actual charge made by the healthcare services provider.

(2) This provision does not apply to charges of providers who are paid under contractual arrangements at specified levels of reimbursement as permitted by Section 59A-23B-3C NMSA 1978.

F. **Enrollment waiting period:** A policy or plan issued pursuant to this rule which does not exclude coverage for pre-existing conditions as permitted by this rule may impose, in lieu of such exclusion, a six-month waiting period for enrollment of members of a group who have pre-existing medical conditions on the effective date of the group's coverage.

[5/1/92; Recompiled 11/30/01]

13.10.9.10 POLICY OR PLAN DISCLOSURE REQUIREMENTS:

A. Upon offering coverage under a policy or plan for any individual, family or group member, an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall provide the individual, family or group member with a written disclosure statement in accordance with the requirements of Section 59A-23B-

5A and B NMSA 1978. Provided, however, that in the event of a lapse in healthcare coverage, a disclosure statement need not be offered by the same carrier upon reinstatement of the same policy or plan.

B. Before any insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan issues a policy or plan contract, the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall obtain from the prospective policyholder, contract holder or member a signed written statement in accordance with the requirements of Section 59A-23B-5C and D NMSA 1978.

[5/1/92; Recompiled 11/30/01]

13.10.9.11 FORMS AND RATES; RATING STANDARDS:

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 department of insurance 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 of insurance.

C. The superintendent shall approve rates for individual and family policies or plans and disapprove any rate if the benefits offered in such policies or plans are unreasonably restricted in relation to the premium charged.

D. Rates for group policies or plans, as such terms are defined in this rule, shall be reviewed for approval by the superintendent in accordance with the rating standards contained in the Small Group Rate and Renewability Act, Section 59A-23C-1 NMSA 1978, et seq.

[5/1/92; Recompiled 11/30/01]

13.10.9.12 ADVERTISING:

All printed, radio or television communication intended to be used for marketing a policy or plan in the state and the disclosures required by NMSA 1978 Section 59A-23B-5A NMSA 1978 shall be submitted for review and approval by the superintendent of insurance prior to use. The superintendent of insurance shall complete the review within thirty days or the materials submitted shall be deemed approved for use.

[5/1/92; Recompiled 11/30/01]

13.10.9.13 PENALTIES:

The superintendent of insurance may revoke, suspend or refuse to continue the license or certificate of authority of any person who fails to comply with this rule and may

impose such other applicable administrative penalties as may be authorized by the Insurance Code.

[5/1/92; Recompiled 11/30/01]

PART 10: MEDICAL INSURANCE POOL PLAN OF OPERATION

13.10.10.1 ISSUING AGENCY:

Office of Superintendent of Insurance.

[11/30/1998; 13.10.10.1 NMAC - Rn & A, 13 NMAC 10.10.1, 4/13/2001; A, 9/01/2020]

13.10.10.2 SCOPE:

This rule applies to all insurers as defined in Section 59A-54-3 NMSA 1978.

[11/30/1998; 13.10.10.2 NMAC - Rn, 13 NMAC 10.10.2, 4/13/2001]

13.10.10.3 STATUTORY AUTHORITY:

Section 59A-54-17 NMSA 1978.

[11/30/1998; 13.10.10.3 NMAC - Rn, 13 NMAC 10.10.3, 4/13/2001]

13.10.10.4 DURATION:

Permanent.

[11/30/1998; 13.10.10.4 NMAC - Rn, 13 NMAC 10.10.4, 4/13/2001]

13.10.10.5 EFFECTIVE DATE:

November 30, 1998, unless a later date is cited at the end of a section.

[11/30/1998; 13.10.10.5 NMAC - Rn & A, 13 NMAC 10.10.5, 4/13/2001]

13.10.10.6 OBJECTIVE:

The purpose of this rule is to implement the Medical Insurance Pool Act, Chapter 59A, Article 54 NMSA 1978.

[11/30/1998; 13.10.10.6 NMAC - Rn, 13 NMAC 10.10.6, 4/13/2001; A, 8/31/2006]

13.10.10.7 DEFINITIONS:

In addition to the definitions in Section 59A-54-3 NMSA 1978, as used in this rule:

A. Act means the Medical Insurance Pool Act, Chapter 59A, Article 54 NMSA 1978.

B. plan or plan of operation means this rule.

[11/30/1998; 13.10.10.7 NMAC - Rn, 13 NMAC 10.10.7, 4/13/2001; A, 8/31/2006]

13.10.10.8 MEMBERSHIP:

A. All insurers admitted in New Mexico as of June 19, 1987 shall be members of this pool. Each insurer admitted after June 19, 1987 shall automatically become a member of the pool on the date of its admission. An insurer which ceases to be admitted after June 19, 1987 shall automatically cease to be a member effective on the day following the termination or expiration of its certificate of authority to transact health insurance; provided, however, that such insurer shall remain liable for any assessment based on net losses sustained by the pool prior to the cessation of its status as a member in the pool.

B. The board shall make all determinations regarding the eligibility of insurers as pool members. If an insurer is aggrieved by a final action or decision of the board, or if the board does not act on such complaint within 60 days, the insurer may appeal to the superintendent within 60 days after the action or decision of the board or the board's failure to act on such complaint.

C. Any member who is determined by the board to have failed to pay, in a timely fashion, any assessment or penalty due to the pool shall cease to be a member. The superintendent shall be advised of any insurer failing to continue its membership.

[11/30/1998; 13.10.10.8 NMAC - Rn, 13 NMAC 10.10.8, 4/13/2001; A, 9/01/2020]

13.10.10.9 BOARD OF DIRECTORS:

A. Appointed members. The superintendent shall announce his appointments to the board at the annual membership meeting.

B. Elected members.

(1) Prior to the annual membership meeting, members shall be contacted by mail by the administrator, or as otherwise directed by the board, to solicit nominations to succeed each board director who was elected by the general membership of the pool and whose term is scheduled to expire on June 30 of that year. If applicable, such nominee will ensure the required representation as set forth in Subsection C of Section 59A-54-4 NMSA 1978. Such nominees shall be made known to the members of the pool at least 30 days prior to the annual membership meeting.

(2) The board shall compile a list of all members of the pool. At least 30 days prior to the annual membership meeting, a notice and proxy shall be sent to all members of the pool soliciting votes for membership on the board.

(3) At the annual membership meeting, the pool administrator shall tabulate the results and prepare a list of the nominees who have received the most votes for election to the board. Each pool member shall be entitled to cast one vote in electing a member to the board and shall be permitted to cast such vote in person or by proxy.

(4) In order to achieve consistent participation and representation, each elected member of the pool shall designate a person to serve on the board as its representative, with the ability to reappoint a person in the case of a permanent vacancy, with the provision for one identified alternate person.

C. Succession. The appointed members of the board of directors shall serve until their successors have been duly appointed to serve. The previously elected members of the board of directors shall serve until the end of their term, until they resign, or until they are no longer eligible under the law to be a member of the board of directors, whichever occurs first.

[11/30/1998; 13.10.10.9 NMAC - Rn, 13 NMAC 10.10.9, 4/13/2001; A, 8/31/2006; A, 12/31/09; A, 9/01/2020]

13.10.10.10 ANNUAL MEMBERSHIP MEETING:

An annual meeting of the board shall be held no later than March 31 of each year, at such time and place as the board may determine. At each annual meeting, the board shall:

A. review the plan and submit to the superintendent any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the pool; review each outstanding contract or agreement, if any, and make necessary or desirable corrections, improvements, or additions;

B. review operating expenses and outstanding contractual obligations and determine if an assessment is necessary for the proper administration of the pool and, if so, the amount; if such assessment is deemed to be necessary, the board shall levy such assessment based on the criteria set forth in Section 59A-54-10 NMSA 1978; the board may adopt other or additional methods of adjusting the formula to achieve equity of assessments among pool members; the board may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations; the assessment shall be imposed annually as provided by Subsection F of Section 59A-54-5 NMSA 1978 by the pool administrator; any assessment of less than $50 may be deferred by the board;

C. review operating policies and practices, policy forms, and rates for coverage issued by the pool;

D. review, consider, and act on any other matters deemed by it to be necessary and proper for the administration of the pool;

E. review and evaluate the performance of the pool administrator.

[11/30/1998; 13.10.10.10 NMAC - Rn, 13 NMAC 10.10.10, 4/13/2001; A, 9/01/2020]

13.10.10.11 MEETING PROCEDURES:

A. Special meetings. Special meetings of the board may be called by a majority of the directors or the chairman of the board, and will be held at the time and place fixed by the person calling the special meeting.

B. Notice. Written notice stating the time, place and, if a special meeting, the purpose, will be delivered either personally or by email at the direction of the person calling the meeting, to each director at least 24 hours before the scheduled date of the meeting. If mailed, a notice is deemed delivered when deposited, postage or charges prepaid, addressed to the director. If emailed, a notice is deemed delivered when sent, addressed to the director. The board may establish dates and times for regularly scheduled meetings.

C. Quorum. A majority of the current members of the board in attendance either in person or by telephone will constitute a quorum at board meetings. The act of a majority of directors voting in person or by written proxy at a meeting at which a quorum is present will be the act of the board, except a two-thirds majority of the entire board is required for actions dealing with the levy of assessments, approval and discharge of the pool administrator, removal of officers, or for the pool to borrow money or to encumber assets of the pool. The directors may act only as a board with each director having one vote.

D. Proxy. A written proxy may be given only to other board members and shall be submitted to the chair at the time the vote is taken. No director shall be allowed to cast more than one proxy vote. Any action required or permitted to be taken at a meeting of the directors may be taken without a meeting if a consent in writing setting forth the action so taken is signed, either wet-ink or electronically, by all of the directors.

E. Waiver of notice. Whenever any notice is required to be given to any director, a waiver thereof in writing signed or emailed by the person entitled to the notice is equivalent to the giving of timely notice. The attendance of a director at a meeting constitutes a waiver of notice of the meeting except when attendance is for the sole purpose of objecting because the meeting is not lawfully called or convened.

F. Record of meetings. A written record of the proceedings of each board meeting shall be made. The original of this record shall be retained by the administrator, or as otherwise directed by the board, and a copy shall be forwarded to all members of the board for approval at a subsequent board meeting. Copies shall be available upon request.

G. Participation methods. Members of the board, or any committee designated by the board, may participate in a meeting of the board, or of any committee, by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and such participation in a meeting shall constitute presence in person at the meeting.

H. Consent required for action without meeting. Any action required by the act or this plan to be taken at a meeting of the board, or any action which may be taken at a meeting of the board or of a committee of the board, may be taken without a meeting if a consent in writing, setting forth the actions so taken, is signed, either wet-ink or electronically, by all of the directors, or all of the members of the committee, as the case may be. The consent to action without a meeting shall have the same effect as a unanimous vote of the board or of the committee taking the action.

[11/30/1998; 13.10.10.11 NMAC -Rn & A, 13 NMAC 10.10.11, 4/13/2001; A, 8/31/2006; A, 12/31/2009; A, 9/01/2020]

13.10.10.12 OFFICERS:

A. The officers of the board will be the chairman of the board, a vice-chairman, a secretary and treasurer, and such other officers as the board may decide, who will be elected annually by the board at its annual meeting to serve until their successors are elected and qualified. An officer, except the chairman, may be removed with or without cause by the board, or may resign. Vacancies and newly created offices will be filled by the board. One person may hold more than one office, but no person may be both chairman of the board and secretary. Officers will perform the duties, and will have the power and authority, assigned by the board, incident to the office, and provided in this plan.

B. The chairman of the board shall preside at meetings of the board and shall assume such duties as shall be designated from time to time by the board. The chairman, when authorized by the board, will execute and deliver documents in the name of the pool.

C. The vice-chairman of the board shall function in the absence of the chairman.

D. The secretary will review the records of the pool and the minutes of the proceedings of the directors; will give all notices required; and when authorized will execute, attest, seal, and deliver documents of the board.

E. The treasurer will be responsible for reviewing financial records and accounts for the pool.

[11/30/1998; 13.10.10.12 NMAC - Rn, 13 NMAC 10.10.12, 4/13/2001; A, 9/01/2020]

13.10.10.13 COMMITTEES:

A. Appointment. The board shall appoint such committees as it may from time to time deem necessary. Such committees may include, but are not limited to, an executive, finance, policy, procurement and legal committees.

B. Delegation of authority. The board may authorize a committee to take any action that the board has the power to take except for action on assessments, premiums, changes in policy benefits, and changes in the plan of operation as long as the motion to delegate the authority passes by a vote sufficient to fulfill the vote requirements for the board itself to take the delegated action.

C. Expenses. Members of special or standing committees may be allowed expenses for attending committee meetings as determined by the board subject to the Per Diem and Mileage Act.

[11/30/1998; 13.10.10.13 NMAC - Rn, 13 NMAC 10.10.13, 4/13/2001; A, 12/31/2009; A, 9/01/2020]

13.10.10.14 OPERATIONS:

In addition to the powers granted in Section 59A-54-7 NMSA 1978:

A. The board may employ such persons, firms, or corporations to perform such executive and administrative functions as are necessary for the board's performance of the duties imposed on the pool. The board may use the mailing address of the pool administrator or as otherwise directed by the board. Such persons, firms, or corporations shall keep such records of its activities as may be required by the board. The pool administrator shall maintain the financial records of the pool. Board records and documents may be maintained by the administrator or as otherwise directed by the board.

B. The board may hire or contract with such persons or organizations as attorneys at law, actuaries, accountants, claims personnel, and such other specialists or persons or organizations with expertise in such areas and whose advice or assistance is deemed by the board to be necessary to the discharge of its duties imposed by law. The board may agree to compensate such persons or organizations so as to best serve the interest of the pool and the public.

C. The board may open one or more bank accounts for use in pool business. The board may make reasonable delegations of deposit and withdrawal authority to such

accounts consistent with prudent fiscal policy. The board may borrow money from any person or organization, including a member or from a contracting firm or entity as the board may deem advantageous for the pool and the public. The pool administrator is responsible for handling, safeguarding, and disbursing the funds of the pool subject and responsible to the board.

D. The board may review the act and other appropriate insurance laws and regulations in order to make recommendations to the superintendent for the improved operation of the pool.

E. The board shall promptly inform the superintendent of the failure of any member to pay an assessment after 30 days' written notice to the member that payment is due. If a member fails to pay its assessment and penalty within 30 days' written notice of the penalty, the board may disenroll the member from the pool. The penalty and notice and any notice of disenrollment shall be mailed by registered mail return receipt requested. If a member loses its membership status, the pool administrator shall promptly forward notice of disenrollment to the superintendent. Reinstatement of membership can only occur if all assessments and penalties still owing are paid in full and if the superintendent notifies the pool that the former member has a current certificate of authority to transact insurance business in New Mexico.

F. A penalty of one percent of the unpaid assessment or $1,000.00, whichever is larger, plus interest on the assessment will be assessed against delinquent members. Interest shall be paid at a rate of prime rate plus two percent per annum. The prime rate shall be defined as the prime rate as published in the money rates section of the Wall Street journal on the last day of publication prior to the date the unpaid assessment is paid. If an insurer wishes to contest an assessment but is willing to pay, under protest, the amount of the assessment during the pendency of the adjudication process, no penalty will be assessed. If the member is successful in its protest, then the pool shall refund the amount of the assessment to the member and pay the member interest at the rate earned by the pool in the interim. The fact that a member is paying under protest must be disclosed at the time of payment.

[11/30/1998; 13.10.10.14 NMAC - Rn & A, 13 NMAC 10.10.4, 4/13/2001; A, 9/01/2020]

13.10.10.15 POOL RESPONSIBILITIES:

A. The pool will provide and accept applications for health insurance, and for any other insurance plans developed by the board, which contain standard policy provisions as specified by the act.

B. The pool shall develop a plan for the periodic advertising of the general availability of health insurance coverage from the pool.

C. The pool may develop and promulgate a list of health conditions, the existence of which would make an applicant eligible for coverage without demonstrating the need for rejection of coverage by one carrier.

D. The pool may adopt any additional provisions necessary or proper for the execution of the powers and duties of the pool.

[11/30/1998; 13.10.10.15 NMAC - Rn, 13 NMAC 10.10.15, 4/13/2001]

13.10.10.16 INTERESTED PARTIES:

No contract or transaction between the pool and one or more of its directors, or between the pool and any other corporation, partnership, association, or other organization in which one or more of its directors are directors or officers, or have a financial interest, shall be void or voidable solely for this reason, or solely because the director is present at or participates in the meeting of the board or committee thereof which authorizes the contract or transaction, or solely because his or their votes are counted for such purpose, if:

A. the material facts as to his relationship or interest and as to the contract or transaction are disclosed or are known to the board or the committee, and the board or committee in good faith authorizes the contract or transaction by the affirmative votes of a majority of the disinterested directors, even though the disinterested directors be less than a quorum; or

B. the material facts as to his relationship or interest and as to the contract or transaction are disclosed or are known to the directors entitled to vote thereon, and the contract or transaction is specifically approved in good faith by vote of the directors; or

C. the contract or transaction is fair to the pool as of the time it is authorized, approved, or ratified, by the board, or a committee thereof; common or interested directors may be counted in determining the presence of a quorum at a meeting of the board or of a committee which authorizes the contract or transaction.

[11/30/1998; 13.10.10.16 NMAC - Rn, 13 NMAC 10.10.16, 4/13/2001]

13.10.10.17 RECORDS AND REPORTS:

A. The fiscal year of the pool shall coincide with the calendar year.

B. The board shall make an annual report to the superintendent as required by the act. The annual report shall include an audited financial report for the preceding calendar year in a form approved by the superintendent and a review of the activities of the pool during the preceding calendar year.

[11/30/1998; 13.10.10.17 NMAC - Rn, 13 NMAC 10.10.17, 4/13/2001; A, 9/01/2020]

13.10.10.18 BROKER/AGENT POLICY:

A. The board may enter into an agreement with a licensed insurance broker or agent to submit pool applications for insurance coverage.

B. The applications submitted must conform to pool rules and regulations.

C. Upon submission of an application by the broker or agent and issuance of a policy by the pool, the broker or agent shall become entitled to a referral fee established by the board.

D. In order to be entitled to the payment established by the board, the broker or agent must execute an agreement entered into between the pool and the broker or agent.

E. No broker or agent shall be authorized to accept applications for pool coverage unless he or she has an errors and omissions insurance policy in an amount not less than $500,000. Proof of such coverage must be provided to the pool administrator.

[11/30/1998; 13.10.10.18 NMAC - Rn & A, 13 NMAC 10.10.18, 4/13/2001]

13.10.10.19 INDEMNIFICATION:

A. All persons, except the superintendent and his staff, described in the act shall be indemnified by the pool for all expenses incurred in the defense of any action, suit, or proceeding brought against such person on account of any action taken by him in the performance of his powers and duties under the act, unless such person shall be finally adjudged to have committed a breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of his office. In the event of settlement before final adjudication, such indemnity shall be provided only if the pool is advised by independent counsel that such person did not, in such counsel's opinion, commit such a breach of duty. The expense of such indemnification shall be assessed against member insurers in accordance with Section 59A-54-10 NMSA 1978. Any reference to persons in this section shall include the board or a committee thereof.

B. The indemnification provided by this section will not be deemed exclusive of any other rights to which those indemnified may be entitled under any other laws, including but not limited to Section 59A-54-18 NMSA 1978, agreements, votes of disinterested directors, or otherwise, both as to action in such person's official capacity and as to action in another capacity while holding such office, and will continue as to a person who has ceased to be a director, employee, or agent and will inure to the benefit of the heirs and personal representative of that person.

C. The pool, upon resolution adopted by the board, may purchase and maintain insurance on behalf of any person who is or was a director, employee, or agent of the

pool who, while a director, employee, or agent of the pool, is or was serving at the request of the pool as a director, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, other enterprise or employee benefit plan, against any liability asserted against and incurred by the person in any such capacity or arising out of the person's status as such, whether or not the pool would have the power to indemnify the person against such liability under the provisions of this section.

[11/30/1998; 13.10.10.19 NMAC - Rn, 13 NMAC 10.10.19, 4/13/2001; A, 9/01/2020]

13.10.10.20 CONFORMITY TO STATUTE:

In case of a conflict between the provisions of the act and this plan, the provisions of the act shall control.

[11/30/1998; 13.10.10.20 NMAC - Rn, 13 NMAC 10.10.20, 4/13/2001]

13.10.10.21 GRIEVANCE PROCEDURES:

Any person, including any pool member, applicant for coverage, or any claimant, aggrieved by actions of the pool, shall submit their complaints in writing to the pool administrator and those complaints shall be resolved in accordance with grievance procedures established by the board. The grievance procedures must be exhausted before commencement of any suit against the pool, the pool administrator, or the board.

[11/30/1998; 13.10.10.21 NMAC - Rn, 13 NMAC 10.10.21, 4/13/2001]

13.10.10.22 INITIAL ASSESSMENTS:

Each insurer, as defined in Section 59A-54-3 NMSA 1978 shall be assessed an initial assessment of $500 at the time it becomes a member of the pool.

[11/30/1998; 13.10.10.22 NMAC - Rn, 13 NMAC 10.10.22, 4/13/2001]

13.10.10.23 PREMIUM INFORMATION:

All reports regarding premium information requested of the members by the pool for purposes of determining assessment amounts must be signed by an officer of the member. No adjustments to that premium information will be accepted from any member after the date for submission of the information has passed, with the exception of errors relating to categories of premiums not allowed to be assessed by the Act or other laws.

[11/30/1998; 13.10.10.23 NMAC - Rn, 13 NMAC 10.10.23, 4/13/2001; A, 9/01/2020]

13.10.10.24 ASSESSMENT POLICY:

A. Interim and final assessments to pool members shall be mailed at least 30 days prior to the due date for payment.

B. To determine the amount of premium upon which a member's final assessment will be based for a particular year, the administrator shall mail the reporting form to each member no later than April 1 of the following year. The reporting form shall be completed, signed by an officer of the member, and returned to the pool. The amount of premium reported shall be reviewed by the pool administrator with the assistance of the Office of Superintendent of Insurance.

C. Any proposed adjustment to the amount of premium reported shall be reviewed for approval by the board. If any adjustment to the amount of premium is made as a result of that review, the member affected by the adjustment will be notified in writing of the adjustment.

D. Any member who wishes to appeal the amount of its interim or final assessment may do so in writing to the board. Any appeal must be submitted to the board within 30 days of notice of the assessment. The submission must include the basis for the appeal and all relevant facts and legal argument the appellant wishes the board to have before it when deciding the appeal. At the discretion of the board, oral presentations to the board may be allowed.

[13.10.10.24 NMAC - N, 4/13/2001; A, 9/01/2020]

13.10.10.25 REFUNDS AND ADJUSTMENTS:

After the final assessments for a particular year have been determined and collected, the pool administrator and the board shall determine if any member has overpaid its assessments. If any such overpayment has been made, the pool administrator, upon approval by the board, shall refund to the member the amount of the overpayment. No interest shall be paid by the pool on the overpayment, unless such payment was paid under protest as specified in Subsection F of Section 14 of this rule.

[13.10.10.25 NMAC - N, 4/13/2001; A, 9/01/2020]

PART 11: HEALTH INSURANCE ALLIANCE PLAN OF OPERATION AND ELIGIBILITY CRITERIA

13.10.11.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[13.10.11.1 NMAC - N, 6-1-01]

13.10.11.2 SCOPE:

This rule applies to all persons who transact the business of health insurance in New Mexico or have dealings with the **alliance**.

[13.10.11.2 NMAC - N, 6-1-01]

13.10.11.3 STATUTORY AUTHORITY:

Sections 59A-56-5 and 59A-56-21 NMSA 1978.

[13.10.11.3 NMAC - N, 6-1-01]

13.10.11.4 DURATION:

Permanent.

[13.10.11.4 NMAC - N, 6-1-01]

13.10.11.5 EFFECTIVE DATE:

June 1, 2001, unless a later date is cited at the end of a section.

[13.10.11.5 NMAC - N, 6-1-01]

13.10.11.6 OBJECTIVE:

The purpose of this rule is to implement the Health Insurance Alliance Act, Chapter 59A, Article 56 NMSA 1978.

[13.10.11.6 NMAC - N, 6-1-01]

13.10.11.7 DEFINITIONS:

In addition to the definitions in Section 59A-56-3 NMSA 1978, as used in this rule:

A. act means the Health Insurance Alliance Act, Chapter 59A, Article 56 NMSA 1978;

B. alliance means the New Mexico health insurance alliance;

C. plan or plan of operation means this rule.

[13.10.11.7 NMAC - N, 6-1-01]

13.10.11.8 MEMBERSHIP:

A. All persons listed in Section 59A-56-4 NMSA 1978 of the act shall organize and remain members of the **alliance** as a condition of their authority to transact insurance business in New Mexico.

B. Such persons who were authorized to transact insurance business in New Mexico as of March 4, 1994, shall be members of this **alliance**. Each insurer admitted thereafter shall automatically become a member of the **alliance** effective on the date of its admission. A member which ceases to be admitted after said date shall automatically cease to be a member effective on the day following the termination or expiration of its certificate of authority to transact the business of health insurance as defined in the act; provided, however, that such member shall remain liable for any assessment or assessments based on net losses sustained by the **alliance** through the end of the year of cessation. This liability shall constitute a claim against the member's deposit with the insurance division.

C. Issues of determination of eligibility of any person or entity as an **alliance** member shall be resolved by the board of directors. If a member is aggrieved by the final action or decision of the board, or if the board does not act on such complaint within 60 days, the member may appeal to the superintendent. Such appeal must be filed within 60 days after the action or decision of the board or the board's failure to act on such complaint.

[13.10.11.8 NMAC - N, 6-1-01]

13.10.11.9 BOARD OF DIRECTORS:

A. There shall be a board of directors, who shall be appointed or elected in accordance with the provisions of the act.

(1) The elected directors shall be elected by the members of the **alliance** as hereinafter provided.

(a) There shall be an annual membership meeting of all the **alliance** members no later than June 30 of each year for transaction of any appropriate business, including the election of member representatives to the board of directors.

(b) Prior to the annual membership meeting, the board of directors or its nominating committee shall select a nominee to succeed each board director who was elected by the general membership of the **alliance** and not appointed by the governor, and whose term is scheduled to expire on June 30 of that year. Such nominee will ensure that the required representation of members as set forth in the act is maintained. Nominees shall be made known to the members of the **alliance** at least 30 days prior to the annual membership meeting.

(c) The board of directors shall compile a list of all members of the **alliance**. At least 30 days prior to the annual membership meeting, a notice and proxy shall be

sent to all members of the **alliance** soliciting votes for membership of the board of directors. Each **alliance** member shall be entitled to cast one vote in electing a member to the board and shall be permitted to cast such vote in person, by mail or facsimile, or by proxy.

(d) The results of the election shall be tabulated and announced at the annual meeting.

(2) In the event a director elected by the general membership, or his or her alternate, is or becomes for any reason unable or unwilling to serve on the board, the superintendent of insurance shall appoint a person (representing the designated interest) to serve as a director until the next general meeting of the membership of the **alliance**, at which time the membership shall elect a director in accordance with paragraph 1 of subsection A to complete the remainder of the original term.

(3) In the event a director appointed by the governor, or his or her alternate, is or becomes for any reason unable or unwilling to serve on the board, the governor shall appoint a person (representing the designated interest) to serve as a director through the remainder of the original term.

(4) Any elected or appointed director shall serve until his or her successor has been duly elected or appointed and qualified to serve.

B. An annual meeting of the board shall be held no later than June 30 of each year, at such time and place as the board of directors may determine. At each annual meeting, the board shall:

(1) review the plan and submit to the superintendent any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the **alliance**;

(2) review underwriting policies and practices, policy forms and rates for coverage issued by the **alliance**;

(3) review, consider and act on any other matters deemed by it to be necessary and proper for the administration of the **alliance**; and

(4) review and evaluate the performance of the administration of the **alliance** and contracted consultants and vendors;

C. Special meetings of the board may be called by a majority of the directors or the chair of the board, and will be held at the time and place fixed by the person or persons calling the special meeting.

D. Written notice stating the time, place and, if a special meeting, the purpose of any meeting of the board will be delivered either personally, by mail, or by facsimile at

the direction of the person or persons calling the meeting, to each director at least 72 hours before the scheduled date of the meeting. If mailed or sent by facsimile, a notice is deemed delivered when deposited, postage or charges prepaid, with the transmitting agency, addressed to the director. The board may establish dates and times for regularly scheduled meetings.

E. A majority of the directors appointed or elected present either in person or by telephone will constitute a quorum at the board meetings. The act of a majority of directors voting in person, by telephone, or by written proxy at a meeting at which a quorum is present shall be the act of the board, except a two-thirds majority of the directors appointed or elected shall be required for actions dealing with the levy of the assessments, approval and discharge of any contracted third-party administrator, removal of officers, or for the **alliance** to borrow money or to encumber assets of the **alliance**. The directors may act only as a board with each director having one vote.

F. Except as provided in this section, a written proxy may be given only to other board members and shall be delivered to the chair before the vote for which the proxy is effective. The written proxy shall specify the vote or meeting for which it shall be effective.

(1) A director may designate an alternate to serve in his or her place but only if the alternate represents the same interest as the director. One alternate for each director may be designated in writing and approved by the chair. An alternate shall have the same rights and privileges as a director when serving in his or her stead and no proxy or other additional designation shall be required.

(2) Whenever any notice is required to be given to any director, a waiver thereof in writing signed by the person entitled to the notice is equivalent to the giving of timely notice. The attendance of a director at a meeting constitutes a waiver of notice of the meeting except when attendance is for the sole purpose of objecting because the meeting is not lawfully called or convened.

G. The board may contract with an administrator. If it chooses to do so, the administrator shall be selected through a competitive bid process.

(1) The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) the bidder's proven ability to administer health insurance programs;

(b) an estimate of total charges for administering the **alliance** for the proposed contract period; and

(c) the bidder's ability to administer the **alliance** in a cost efficient manner.

(2) The administrator shall serve for a period of up to four years subject to annual renegotiation of fees and services and removal for cause or earlier expiration of the contract term. At least one year prior to the expiration of the administrator's period of service, the board may invite all interested parties, including the current administrator, to submit proposals to serve as the administrator for the succeeding four-year period or such shorter contract term as the board deems appropriate. Selection of the administrator for a succeeding period shall be made at least six months prior to the expiration of the administrator's contract. If the board chooses to renew its contract with the then current administrator, it need not engage in a competitive bid process.

H. The board may hire such persons or organizations as attorneys at law, actuaries, accountants, claims personnel and such other specialists or persons or organizations with expertise in such areas and whose advice or assistance is deemed by the board to be necessary to the discharge of its duties imposed by law. The board may agree to compensate such person or organizations so as to best serve the interest of the **alliance** and the public. Except in connection with the hiring of a new administrator, the **alliance** may, but need not, utilize a competitive bid process in connection with the selection of any contractor or consultant.

I. A written record of the proceedings of each board meeting shall be made. The original of the record shall be retained in the office of the **alliance** and a copy shall be forwarded to the superintendent's office. Copies of such minutes shall be available upon request.

J. The directors may be paid their expenses, if any, of attendance at each meeting of the board of directors according to the limitations provided by the New Mexico Per Diem and Mileage Act for non-salaried public officers, and shall receive no other compensation, perquisite or allowance from the **alliance** except de minimus benefits provided in connection with the scheduling or conduct of meetings, including meals, snacks or other benefits of minimal value. Members of special or standing committees may be allowed expenses for attending committee meetings as determined by the board of directors but subject to the Per Diem and Mileage Act and the provisions of the preceding sentence.

K. Members of the board of directors, or any committee designated by the board of directors, may participate in a meeting of the board of directors, or any committee, by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and such participation in a meeting shall constitute presence in person at the meeting for all purposes.

[13.10.11.9 NMAC - N, 6-1-01]

13.10.11.10 OFFICERS:

A. The officers of the board will be the chair of the board, a vice chair, and a secretary, and such other officers as the board may decide, who, except for the chair, will be elected annually by the board at its annual meeting to serve until their successors are elected and qualified. The superintendent shall serve as chair, unless he declines, in which event he shall appoint the chair. An officer, except the chair, may be removed with or without cause by the board, or may resign. Vacancies and newly created offices will be filled by the board. One person may hold more than one office, but no person may be both chair of the board and secretary. Officers will perform the duties, and will have the power and authority, assigned by the board, incident to the office, and provided in this plan.

B. The chair shall preside at meetings of the board of directors and shall assume such duties as shall be designated from time to time by the board of directors and as are consistent with the provisions of the act. The chair, when authorized by the board, will execute and deliver documents in the name of the **alliance**.

C. The vice chair of the board of directors shall function in the absence of the chair.

D. The secretary shall be responsible for the records of the **alliance** and the minutes of the proceedings of the directors; will give all notices required; and when authorized will execute, attest, seal, and deliver documents of the board.

[13.10.11.10 NMAC - N, 6-1-01]

13.10.11.11 COMMITTEES:

A. The board shall have the standing committees set forth below. Members of the committees shall be named by and serve at the pleasure of the chair. In addition to the authority specified, the committees shall have such duties and responsibilities as may be delegated to them from time to time by the board.

(1) Executive committee. The executive committee shall be comprised of the chair, the vice-chair, and the secretary, as well as the chairs of the finance and marketing committees and such other members of the board as the chair may designate. The executive committee shall have the authority to act for the board between meetings, subject to ratification by the board, and shall act as the board's audit committee.

(2) Finance committee. The finance committee shall be comprised of the chair and such other persons as the chair may designate. The finance committee shall be responsible for oversight of the financial affairs of the **alliance**, and for developing policies and procedures to manage such affairs, subject to approval by the board.

(3) Marketing committee. The marketing committee shall be comprised of at least one member of the board and such other persons as the chair may designate. The

marketing committee shall have the authority to approve marketing expenditures within a budget and limits approved by the board.

(4) Grievance committee. The grievance committee shall be comprised of members of the board. The committee shall include at least three members, and shall be responsible for hearing and determining grievances in accordance with 13.10.11.17 NMAC and for resolving such other matters as may be delegated to it by the board. The chair may designate alternates to serve in the event a conflict of interest prevents a board member from participating in any grievance procedure.

B. The board may establish such other committees as it may from time to time deem necessary.

[13.10.11.11 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.12 OPERATIONS:

A. The board, in addition to the powers prescribed in the act, shall have the specific authority to enter into contracts and undertake such other activities as are necessary or proper to carry out the provisions and purposes of the act, including the authority, with the approval of the superintendent, to enter into contracts with similar alliances of other states for the joint performance of common administrative functions. The board may employ such persons, firms or corporations to perform such administrative or other functions as are necessary for the operations of the **alliance**. Such persons, firms or corporations shall keep such records of their activities as may be required by the board.

B. The board may open one or more bank accounts for use in **alliance** business. Reasonable delegation of deposit and withdrawal authority for such accounts for **alliance** business may be made, consistent with prudent fiscal policy. The board may borrow money from any person, or organization as the board may deem advantageous for the **alliance** and the public. The **alliance** administration is responsible, within such authority as may be granted to it by the board, for the handling, safe-guarding, and disbursement of funds of the **alliance**, subject to and responsible to the board. The **alliance** administration may maintain the financial records of the **alliance** as directed by the board.

C. The board may review the act and other appropriate insurance laws and regulations in order to make recommendations to the superintendent for the improved operation of the **alliance**.

D. The board shall provide and accept applications for health insurance in accordance with the eligibility criteria set forth in this rule, and for any other insurance plans developed by the board of directors, which contain standard policy provisions as specified by the act.

E. The board shall adopt a plan for the periodic advertising of the general availability of health insurance coverage from the **alliance** and the eligibility requirements and procedures for enrollment in an approved health plan and to maintain public awareness of the **alliance**.

F. The board shall establish procedures to determine the amount of and method for collecting on assessments pursuant to the act. The board shall impose the initial administrative assessment. The board shall promptly inform the superintendent of the failure of any member to pay an assessment after 30 days' written notice to the member that payment is due. A minimum penalty of $1000, plus interest at the rate used by the IRS on the assessment, will be assessed against any member who fails to pay the assessment within the time prescribed by the board unless such other minimum penalty is established by the board and approved by the superintendent.

G. The board annually shall review operating expenses and outstanding contractual obligations and determine if an assessment is necessary for the proper administration of the **alliance** and, if so, the amount. If such assessment is deemed to be necessary, the board shall levy such assessment based upon the criteria set forth in Section 59A-56-11 NMSA 1978. The board may adopt other or additional methods of adjusting the formula to achieve equity of assessments among **alliance** members, within the provisions of the act. The board may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The assessment shall be imposed annually.

H. The **alliance** may adopt any additional policies or procedures necessary or proper for the execution of the powers and duties of the **alliance**.

[13.10.11.12 NMAC - N, 6-1-01]

13.10.11.13 INTERESTED PARTIES:

No contract or transaction between the **alliance** and one or more of its directors, or between the **alliance** and any other corporation, partnership, association or other organization in which one or more if its directors are directors or officers, or have a financial interest, shall be void or voidable based only on one or more of the following:

A. the financial interest;

B. the presence at or participation in the meeting authorizing the contract or transaction; or

C. the counting of the director's vote for such purpose, if:

(1) the material facts as to his relationship or interest and as to the contract or transaction are disclosed or are known to the board of directors or the committee, and the board or committee in good faith authorized the contract or transaction by the

affirmative votes of a majority of the disinterested directors or the committee, and the board or committee in good faith authorized the contract or transaction by the affirmative votes of a majority of the disinterested directors, even though the disinterested directors be less than a quorum; or

(2) the material facts as to his relationship or interest and as to the contract or transaction are disclosed or are known to the directors entitled to vote thereon, and the contract or transaction is specifically approved in good faith by vote of the directors; or

(3) the contract or transaction is fair as to the **alliance** as of the time it is authorized, approved or ratified, by the board of directors, or a committee thereof. Common or interested directors may be counted in determining the presence of a quorum at a meeting of the board of directors or of a committee which authorized the contract or transaction.

[13.10.11.13 NMAC - N, 6-1-01]

13.10.11.14 RECORDS AND REPORTS:

A. The fiscal year of the **alliance** shall be determined by the board.

B. The board of directors shall conduct periodic audits to assure the general accuracy of the financial data submitted to the **alliance** pursuant to Section 59A-56-11 NMSA 1978. The board shall cause the **alliance** to have an annual audit of its financial statements by an independent certified public accountant.

C. The **alliance** shall be subject to and responsible for examination by the superintendent. Not later than March 1 of each year, the board of directors shall submit to the superintendent an audited financial report for the preceding calendar year in a form approved by the superintendent. The report shall also review the activities of the **alliance** during the preceding calendar year.

D. All policy forms issued through the **alliance** shall conform to the requirements of the act and must be filed with and approved by the superintendent before their use.

[13.10.11.14 NMAC - N, 6-1-01]

13.10.11.15 AGENTS:

The **alliance** may pay referral or servicing fees or commissions subject to applicable provisions in the Insurance Code, or may require carriers to pay a commission to the insurance agent who refers an applicant to the **alliance** if that applicant is accepted. No agent shall be eligible to receive a commission or referral fee on or in connection with a plan issued through the **alliance** unless the agent has completed a continuing education course sanctioned by the **alliance** and has been certified by the **alliance**. Agents that have not enrolled any individual or group in the **alliance** for a period of two

(2) years shall recertify. The **alliance** may decertify an agent for good cause, subject only to review pursuant to the grievance procedures set forth in 13.10.11.17 NMAC.

[13.10.11.15 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.16 INDEMNIFICATION:

A. All persons, except the superintendent and his staff, described in the act shall be indemnified by the **alliance** for all expenses incurred in the defense of any action, suit or proceeding brought against such person on account of any action taken by him in the performance of his powers and duties under the act, unless such person shall be finally adjudged to have committed a breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance or reckless disregard of the responsibilities of his office. This right of indemnification shall not extend to acts or omissions arising solely from a member's administration of an approved health plan. In the event of settlement before final adjudication, such indemnity shall be provided only if the **alliance** is advised by independent counsel that such person did not, in such counsel's opinion, commit such a breach of duty. The expense of such indemnification shall be assessed against member insurers in accordance with Section 59A-56-11 NMSA 1978. Any reference to persons in this article shall include the board or a committee thereof.

B. The indemnification provided by this section will not be deemed exclusive of any other rights to which those indemnified may be entitled under any other laws, agreements, voted of disinterested directors, or otherwise, both as to action in such person's official capacity and as to the action in another capacity while holding such office, and will continue as to a person who had ceased to be a director, employee or agent and will inure to the benefit of the heirs and personal representative of that person.

C. The **alliance**, upon resolution adopted by the board, may purchase and maintain insurance on behalf of any person who is or was a director, employee or agent of the **alliance** who, while a director, employee or agent of the **alliance** or is or were serving at the request of the **alliance** as a director, employee or agent of another foreign or domestic corporation, partnership, joint venture, trust, other enterprise or employee benefit plan, against any liability asserted against and incurred by the person in any such capacity or arising out of the person's status as such, whether or not the **alliance** would have the power to indemnify the person against such liability under the provisions of this section.

[13.10.11.16 NMAC - N, 6-1-01]

13.10.11.17 COMPLAINT AND GRIEVANCE PROCEDURES:

In the event an insured, an agent, a group or a member believes the performance of the **alliance** or a member does not meet its expectations or conform to a policy or plan issued by a member through the **alliance**, that person may bring the matter to the

attention of the **alliance** by a complaint or grievance. The **alliance** shall act promptly and impartially when considering all complaints and grievances.

A. Definitions. As used in this section:

(1) complaint means a relatively minor verbal or written expression of concern which may lend itself to resolution on an informal basis and which relates to the operation or decision of the **alliance** or a member of the **alliance**;

(2) grievance means a more serious written expression of concern or a complaint which had not been resolved to the person's satisfaction; both situations require a thorough investigation and a formal response to the parties;

(3) group means a small employer group eligible for coverage or covered by an insurance policy, nonprofit health care plan contract or HMO plan issued through the **alliance** by a member; and

(4) insured means a person covered under an insurance policy or a nonprofit health care plan contract, or enrolled in an HMO plan issued through the **alliance** by a member;

B. Handling a complaint. Complaints should be made to the executive director of the **alliance**. The executive director has the discretionary power to handle complaints on an informal basis. The grievance procedure outlined in Subsection C of 13.10.11.17 NMAC will be followed if the complainant or the responding party wishes to appeal the decision of the executive director, if a determination has already been made by the executive director, or if the executive director decides that the issue at hand needs to be reviewed by the grievance committee of the **alliance**.

C. Grievance procedure.

(1) Between an insured or group and a member.

(a) If the grievance is between an insured or a group and a member, the insured or group shall complete all internal complaint and grievance procedures offered by a member prior to filing a grievance with the **alliance**.

(b) An insured or group must submit the grievance in writing to the **alliance** within 30 days following completion of the member's internal complaint or grievance process. If the member has no internal complaint or grievance process, or if the member has failed to respond to the complaint or grievance within 30 days after the insured or the group had made the complaint or grievance, the grievance must be submitted in writing to the **alliance** within 90 days after the incident occurred.

(c) The grievance should accurately describe the incident and must be signed by the insured or group filing the grievance.

(d) Upon receipt of the written grievance, the executive director of the **alliance** shall conduct a thorough review of the grievance and mail a response to the insured or group and to the member. If the parties are satisfied with the solution, the grievance matter shall be considered resolved.

(e) If the insured or group or the member is not satisfied with the solution proposed by the executive director, the grievance may be appealed in writing to the grievance committee of the **alliance**. Such appeal must be submitted within 30 days of the first grievance response and must include the reason for the appeal.

(2) Against the Alliance.

(a) Any person (including the insured, an agent, a group or a member) filing a grievance against the **alliance** must submit the grievance in writing to the **alliance** within 90 days after the incident occurred or within 90 days after the executive director makes an adverse decision on the complaint.

(b) The grievance should accurately describe the incident and must be signed by the person filing the grievance.

(c) Upon receipt of the written grievance, the executive director shall conduct a thorough review of the grievance and mail a response to the person. If the person is satisfied with the solution, the grievance matter shall be considered resolved.

(d) If the person is not satisfied with the solution proposed by the executive director, the grievance may be appealed in writing to the grievance committee of the **alliance**. Such appeal must be submitted within 30 days of the first grievance response and must include the reasons for the appeal.

D. Grievance committee.

(1) The grievance committee shall be composed of at least three members of the **alliance's** board of directors. Any director who represents a member or insured who is involved in a grievance shall not serve on the committee hearing the grievance.

(2) The committee shall convene 30 days after receipt of the appeal. The person filing the grievance will be invited to appear before the committee, along with any other parties involved in the grievance, to explain the appeal. After reviewing all previous findings of the plan and the executive director, and such other information as the committee may reasonably request, the committee will render a decision and deliver such in writing to all parties within 60 days after receipt of the appeal, unless good cause exists to extend the time. All decisions of the grievance committee are considered final.

(3) If any party involved is dissatisfied with the decision of the grievance committee, they may contact the New Mexico insurance division or they may pursue

other remedies available to them. Prior to the filing of any legal proceedings or suit against the **alliance** or a member of the **alliance**, the complaint and grievance procedure prescribed in 13.10.11.17 NMAC must be utilized by any party alleging a claim.

(4) In adopting and utilizing this procedure to resolve disputes between a group or an insured and a member, the **alliance** and its grievance committee are providing a forum for alternative dispute resolution. Neither the **alliance** nor its grievance committee shall be a proper party to any dispute or suit between an insured or a group and a member.

[13.10.11.17 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.18 AMENDMENTS:

The plan of operation may be altered, amended, or repealed by a two-thirds vote of directors elected or appointed, and approval of such action by the superintendent.

[13.10.11.18 NMAC - N, 6-1-01]

13.10.11.19 ELIGIBILITY CRITERIA:

A. The eligibility criteria in 13.10.11.20 NMAC through 13.10.11.33 NMAC apply to approved health plans for small employers; the eligibility criteria in 13.10.11.34 NMAC apply to approved health plans for individual coverage.

B. Members may utilize their normal business practices in implementing an approved health plan to the extent such practices are not inconsistent with the act, this rule, other applicable laws and regulations, or the approved health plan's benefit design.

C. Any misrepresentation relating to an employer's eligibility as a small employer or to an individual's eligibility for coverage may be grounds for rescission or cancellation of coverage and such other action as may be appropriate under law.

[13.10.11.19 NMAC - N, 6-1-01]

13.10.11.20 ELIGIBILITY AS A SMALL EMPLOYER:

A. An employer is eligible as a small employer if:

(1) the employer, if a corporation, is incorporated in New Mexico or is authorized to do business in New Mexico; if a person or other organization, is a resident of this state or has its principal place of business in this state; and

(2) at least 50 percent of all of its employees, eligible or not, live in New Mexico; and

(3) on at least 50 percent of its working days during either of the two preceding calendar years, the employer had at least two and no more than 50 eligible employees.

(a) If the employer has been in business for less than one calendar year, the determination of whether an employer is a small employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year.

(b) A spouse or dependent of an employee, whether or not working in the business, may, at the employer's discretion, be counted as a separate employee for the sole purpose of determining the number of eligible employees. A spouse or dependent enrolling who is not employed in the business must still enroll for dependent coverage and need not complete an employee application; a spouse or dependent employed in the business has the option of enrolling as a dependent or an employee.

(c) Any self-employed person and all employees who comprise the "two to 50 group" of eligible employees must work for the qualifying business a minimum of 20 hours per week on a regular basis.

(d) Casual laborers and volunteers are not eligible.

(e) An employee eligible or enrolled in medicare shall be considered an eligible employee for the sole purpose of determining whether an employer is a small employer, provided that that employee otherwise qualifies as an eligible employee.

B. Affiliated companies, or companies eligible to file a combined New Mexico tax return, must be considered one employer. Companies eligible to file a combined New Mexico tax return include two or more integrated corporations that are more than 50 percent owned and controlled by the same person or entity and for which at least one of the following conditions exists:

(1) there is a unity of operations evidenced by central purchasing, advertising, accounting or other centralized services;

(2) there is a centralized management or executive force and centralized system of operation; or

(3) the operations of the corporation are dependent upon or contribute property or services to one another individually or as a group. Subsection R of Section 7-2A-2 and Section 7-2A-8.3 NMSA 1978.

C. The eligibility status of a small employer shall be determined as of the date of enrollment or renewal.

D. A small employer is not eligible for an **alliance** plan for three years after any termination of coverage issued to the employer through the **alliance**, if the termination was due to a failure to pay premiums timely, or to fraud, misuse of coverage, or violation of **alliance** policies. Any small employer applying for coverage under this paragraph within three years of the date of termination of its prior coverage through the **alliance** must complete a new application for coverage and be subject to all requirements, including preexisting condition requirements, that apply to a new employer group. All applications for coverage submitted by a small employer within three years of the date its prior coverage through the **alliance** has terminated must be approved by the executive director.

E. A small employer is not eligible for an **alliance** plan if it offers any other comprehensive group health insurance coverage to its employees, other than coverage sponsored by a recognized labor union. For purposes of this paragraph, comprehensive group health insurance coverage includes individual health insurance coverage if paid for or reimbursed by the employer, but excludes either individual or group coverage providing only a specific limited form of health insurance such as accident or disability income insurance coverage or a specific health care service such as dental care.

F. A small employer shall remit all premiums due for its employees and their dependents to the **alliance**.

[13.10.11.20 NMAC - N, 6-1-01]

13.10.11.21 ELIGIBILITY OF EMPLOYEES OF SMALL EMPLOYERS:

A. Eligible employees.

(1) An employee of a small employer (or a self-employed person who is eligible under Subparagraph (b) of Paragraph (3) of Subsection A of 13.10.11.20 NMAC) is eligible to enroll in an approved health plan if:

(a) the employee (or the self-employed person) has completed the employer's waiting period;

(b) the employee (and any self-employed person) is working at least 20 hours per week on a regular basis (other than as a volunteer); and

(c) the employee (or the self-employed person) does not come within one of the categories of ineligible employees described in Subsection B of 13.10.11.21 NMAC.

(2) An individual already covered under an approved health plan may retain coverage after he or she first becomes eligible for medicare as primary coverage. If an individual who has a family coverage policy elects to terminate his or her coverage through the **alliance** when he or she becomes eligible for medicare, the family coverage under the approved health plan shall continue for any person in the family who is not

eligible for medicare. The family rate shall be based on the age of the employee, unless the employee has terminated coverage, in which case the rate shall be based on the age of the eldest enrolled member of the family. The rate shall be adjusted to reflect the number of persons actually enrolled in the approved health plan.

B. Ineligible employees. An employee of a small employer, or a self-employed person, is not eligible to enroll in an approved health plan if:

(1) at the time of application, he is eligible for medicare and the group has fewer than 20 employees;

(2) if he is an inmate of a public institution; or

(3) if he or she previously was terminated by the carrier for cause under any plan.

C. Participation requirement. As of the date of the group's enrollment or renewal, at least 50 percent of the employer's eligible employees who are not otherwise covered under another comprehensive health plan or program must elect to be covered under the **alliance** plan. For purposes of this subsection, comprehensive health insurance coverage includes coverage sponsored by any recognized labor union and any group health insurance or individual health insurance coverage that is not paid for or reimbursed by the employer. If the employer is deemed to be a small group by virtue of having one employee and a dependent, then at least two persons must be covered under the **alliance** plan. Management or class subsets or carve-outs cannot be used to satisfy or circumvent participation requirements for the employer group.

[13.10.11.21 NMAC - N, 6-1-01]

13.10.11.22 DOCUMENTATION REQUIRED:

The **alliance** shall require documentation that the employer qualifies as a small employer and satisfies eligibility and participation requirements. The **alliance** is particularly concerned that self-employed individuals are actively working for their business at least 20 hours per week. Required documentation must be received in the **alliance** office by the 15th of the month in order to be eligible for an effective date of the first of the following month. If the 15th of the month falls on a weekend or holiday, the documentation must be received by the **alliance** before 5:00 p.m. on the next business day.

[13.10.11.22 NMAC - N, 6-1-01]

13.10.11.23 DOCUMENTATION FOR NEW GROUPS AND EXISTING GROUPS ENROLLING WITH A NEW CARRIER:

The **alliance** requires:

A. a completed application;

B. the employer's federal EID and New Mexico gross receipts tax ID numbers; or, for a new business that has not yet obtained tax ID numbers, a current valid business license;

C. a waiver of coverage, in the form specified by the **alliance**, signed by each eligible employee who does not desire coverage. If the employee has other coverage, the name of the carrier, as well as the subscriber and group names must be specified; and

D. for groups that file New Mexico department of labor employer's quarterly wage and contribution report (schedule A - SUTA), the employer's most recent SUTA.

(1) The employer must identify on the SUTA form each employee who is not eligible for coverage and must specify the reason that the employee is ineligible, e.g., on medicare, working less 20 hours per week, etc. For each employee who is not eligible, the employer must specify the employee's date of hire and hours per week worked.

(2) If an employer submits a SUTA but desires to enroll employees who are not identified on that report, the employer must submit the following applicable documentation for each such employee:

(a) for any new employees not yet identified on the most recent SUTA, W-4 forms;

(b) for each working owner, dependent or partner not identified on the SUTA, an affidavit, signed under oath, that the individual is working in the business at least 20 hours per week on a regular basis.

E. If the employer group is required to file a SUTA but has not yet done so because it is a new business (i.e., established within three months prior to the date of application), the employer shall submit an affidavit, signed under oath, that the employer is actively engaged in an ongoing business and reasonably expects to average between two and 50 employees for the next two years, together with a list of current employees. Each individual enrolling as an employee must submit a witnessed affidavit that the individual is working in the business at least 20 hours per week on a regular basis.

F. If the employer group is not required to file a SUTA, the employer must submit a witnessed affidavit that the employer is actively engaged in an ongoing business, and is working in the business at least 20 hours per week on a regular basis, together with the relevant portion of its latest complete federal income tax filing, as specified below, in order to allow the **alliance** to verify the existence of the business and validate actively working requirements through documented earned income/loss. The following forms, as

applicable to the employer's business, are required. NOTE: If wages are reported on any of these forms, the employer must submit either a SUTA or a W-2 form.

(1) 1120 corporate return.

(2) 1120S corporate return.

(3) 1065 and Schedule K-1 for each eligible partner who elects coverage.

(4) Schedule C for business income profit or loss report for sole-proprietors.

(5) Schedule E for real estate or rental income.

(6) Schedule F for farm income.

[13.10.11.23 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.24 DOCUMENTATION FOR GROUPS RENEWING WITH THE SAME CARRIER:

A. For groups that file New Mexico department of labor employer's quarterly wage and contribution report (schedule A - SUTA), the employer's most recent SUTA.

(1) The employer must identify on the SUTA form each employee who is not eligible for coverage and must specify the reason that the employee is ineligible, (e.g., on medicare, working part time (i.e., less 20 hours per week), terminated, etc). For each employee who is not eligible, the employer must specify the employee's date of hire and hours per week worked.

(2) The employer must submit an enrollment application for each employee desiring coverage who has not previously submitted an application and a waiver of coverage, in the form specified by the **alliance**, for each eligible employee who does not desire coverage and who has not previously submitted a waiver to the **alliance**. If the employee has other coverage, the name of the carrier, as well as the subscriber and group names must be specified;

(3) If an employer submits a SUTA but desires to enroll employees who are not identified on that report, the employer must submit the following applicable documentation for each such employee:

(a) for any new employees not yet identified on the most recent SUTA, W-4 forms;

(b) for each owner, working spouse or partner not identified on the SUTA, a witnessed affidavit that the individual is working in the business at least 20 hours per week on a regular basis.

B. If the employer group is not required to file a SUTA, the employer must submit its current business license, if it is required to have a business license, and a witnessed affidavit by each individual requesting coverage as a subscriber, that the individual is working in the business at least 20 hours per week on a regular basis.

[13.10.11.24 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.25 HMO SERVICE AREA REQUIREMENTS:

In order to be eligible to enroll in an **alliance** plan offered by an HMO, an employee or spouse must live or work within the HMO's service area. The HMO may approve exceptions on an individual basis in accordance with the HMO's usual business practice.

[13.10.11.25 NMAC - N, 6-1-01]

13.10.11.26 WAITING PERIOD:

The employer must establish a waiting period for new employees. The minimum waiting period is 30 days. The maximum waiting period is 180 days. The waiting period must be the same for all employees of a small employer. At the time a small employer first obtains coverage through the **alliance**, the small employer, at its discretion, may elect to waive the waiting period for all employees who are otherwise then eligible for and enrolling in the plan.

[13.10.11.26 NMAC - N, 6-1-01]

13.10.11.27 ENROLLMENT PERIODS:

Applications must be received by the **alliance** office within the time period for enrollment specified above.

A. Timely enrollment. Employees and their dependents shall be entitled to enroll in an **alliance** plan during the following timely enrollment periods.

(1) New employees and their dependents may enroll in the plan within 31 days of completion of their employer's waiting period.

(2) An individual may enroll in the plan if:

(a) at the time the individual was first eligible to be covered under the small employer's plan, the individual was covered under another group health benefit plan;

(b) the individual's coverage under the other group plan terminates involuntarily except for cause; and

(c) the individual enrolls in the small employer's plan within 31 days of the effective date of termination of his or her coverage under the other group plan.

(3) A new dependent of an eligible or enrolled employee may enroll in the plan within 31 days of becoming eligible by virtue of marriage, birth, adoption or placement for adoption, or entry of a guardianship order. If the eligible employee is not then enrolled in the plan, he must also enroll in the plan within this period in order to obtain coverage for the dependent.

B. Late enrollment. Each approved health plan shall hold an annual open enrollment period for 30 days prior to an enrolled group's anniversary date, for coverage effective as of the anniversary date. Eligible employees or dependents who do not enroll within the time specified in subsection A shall be entitled to enroll during this open enrollment period without evidence of insurability. No late enrollments will be approved outside of a group's annual open enrollment period. The board of directors may require that all plans hold their annual 30-day open enrollment period at the same time, regardless of the group's anniversary date, in which case coverage shall be effective as of the first of the month following the close of the open enrollment period.

[13.10.11.27 NMAC - N, 6-1-01]

13.10.11.28 EFFECTIVE DATES:

A. If the documentation required by the **alliance** is received by the 15th of the month, coverage shall be reviewed for an effective date as of the first day of the following month. If the documentation required by the **alliance** is received after the 15th of the month, coverage shall not be effective until the first day of the month after the month following that in which the complete documentation is received. (Note: If the 15th of the month falls on a weekend or holiday, the documentation must be received by the **alliance**, or delivered to its post office box, before 5:00 p.m. on the next business day.)

B. Coverage for an eligible employee and/or dependent shall be effective as of the first day of the month following fulfillment of enrollment and eligibility requirements, unless an earlier effective date is required by law (as in the case of newborn or adopted children). (See 13.10.11.29 NMAC.)

C. Coverage for persons eligible to enroll and enrolling during an open enrollment period held pursuant to Subsection B of 13.10.11.27 NMAC shall be effective as of the first day of the month following enrollment.

D. The small employer shall notify the **alliance** of the termination of, or cancellation of insurance for, any employee or dependent by the end of the month following the month in which the employee was terminated or his coverage cancelled. Premiums for the month following the month in which termination or cancellation is effective shall be refunded if previously paid, provided that the **alliance** has been timely notified in writing.

E. The small employer shall notify the **alliance** of its intent to terminate its group insurance through the **alliance** no later than the 10th of the month following the last month of coverage. Premiums for any month following the last intended month of coverage will not be refunded unless notice of termination is received by the **alliance** on or before the 10th of that month. (Note: If the 10th of the month falls on a weekend or holiday, the documentation must be received by the **alliance**, or delivered to its post office box, before 5:00 pm on the next business day.)

[13.10.11.28 NMAC - N, 6-1-01]

13.10.11.29 FAMILY COVERAGE:

A. Family coverage must be offered for:

(1) the employee's lawful spouse;

(2) the employee's natural-born or legally adopted unmarried child;

(3) the employee's stepchild who is living in the employee's home and is chiefly dependent on the employee for support; and

(4) a child who is living in the employee's home and for whom the employee or his or her spouse has been appointed the legal guardian by a state court of competent jurisdiction.

B. Family coverage must be offered to the family of an employee who is not eligible for coverage because of his or her eligibility for medicare, provided that the dependents enrolling meet the timely enrollment requirements set forth in 13.10.11.27 NMAC.

C. Coverage of a dependent unmarried individual terminates on the first day of the month following the date when the individual becomes 26.

(1) Attainment of the limiting age does not terminate coverage of a dependent child as a dependent when the individual continues to be incapable of self-sustaining employment by reason of mental retardation or physical handicap and is primarily dependent upon the employee or primary insured for support and maintenance.

(2) A dependent child aged 26 or older is not eligible to enroll, even if that child became disabled prior to attaining that age unless coverage is required under the "no-loss, no-gain" rules for replacement group policies set forth in 13.10.5 NMAC, Group Coverage Discontinuance and Replacement.

D. A newly born child of the family member or the individual in whose name the **alliance** coverage is issued must be covered from birth if enrolled within 31 days of birth. If payment of a specific premium is required to provide coverage for the child, the particular policy or plan may require that notification of the birth of a child and payment

of the required premium shall be furnished to the carrier within 31 days after the date of birth in order to have the coverage from birth.

E. Adopted children are eligible for coverage on the same basis as other dependents. Coverage shall be effective from the date of placement (i.e., physical custody) for the purpose of adoption, if the child is enrolled and any additional premium is paid within 31 days from such date. Coverage continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

F. Coverage of children is subject to all requirements of federal and state law, including but not limited to the requirements of Sections 59A-22-34.2 and 59A-46-38.1 NMSA 1978.

G. A dependent is not eligible for coverage if the dependent would be ineligible as an employee under Subsection B of 13.10.11.21 NMAC.

[13.10.11.29 NMAC - N, 6-1-01; A, 3-31-08; A, 8-15-12]

13.10.11.30 PRE-EXISTING CONDITION EXCLUSIONS:

A. Definitions. As used in this section:

(1) pre-existing condition means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information;

(2) creditable coverage means, with respect to an individual, coverage of the individual pursuant to:

(a) an employment-based group health plan;

(b) health insurance coverage;

(c) Part A or Part B of Title 18 of the Social Security Act (medicare);

(d) Title 19 of the Social Security Act (medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title;

(e) 10 USCA Chapter 55 (military benefits);

(f) a medical care program of the Indian Health Service or of an Indian nation, tribe or pueblo;

(g) the Comprehensive Health Insurance Pool Act (CHIP);

(h) a health plan offered pursuant to 5 USCA Chapter 89;

(i) a public health plan as defined in federal regulations; or

(j) a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act; and

(3) **enrollment date** means the date of enrollment of the individual in the **alliance** plan or, if earlier, the first day of the waiting period for that enrollment.

B. Allowable provisions.

(1) An **alliance** indemnity plan may include a pre-existing condition exclusion only if the exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was actually recommended or received within the six-month period ending on the enrollment date.

(a) The pre-existing condition exclusion cannot extend for more than six months from the enrollment date.

(b) The period of the pre-existing condition exclusion must be reduced on a day-for-day basis by the aggregate of the periods of creditable coverage applicable to the employee or dependent as of the enrollment date.

(2) An HMO plan issued through the **alliance** may not include a pre-existing condition exclusion.

C. Prohibited applications. No pre-existing condition exclusion may be imposed:

(1) on a child who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage; or

(2) on a child who is adopted or placed for adoption before his 18th birthday and who, as of the last day of the 30-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or

(3) that relates to or includes pregnancy as a preexisting condition.

[13.10.11.30 NMAC - N, 6-1-01]

13.10.11.31 CONTINUATION COVERAGE:

A. In addition to continuation coverage under the act, other forms of continuation coverage may be available under federal law or other provisions of state law. Details of these other programs may be obtained from an employer, an agent, or the insurance division. With respect to continuation of coverage provided under the act:

(1) An employee is eligible for continuation coverage under the act only if the employee has been continuously covered under an **alliance** plan as an active employee for at least six months, even if the employer group ceases to do business or terminates its group coverage under the **alliance**. If the employee has family coverage, this coverage would continue as well, provided other conditions of eligibility continue to be met. An employee must apply for continuation coverage through the **alliance** within 31 days of the loss of his or her eligibility for group coverage through the **alliance**.

(2) A covered dependent is eligible for individual continuation coverage under the Alliance Act only if the dependent has been continuously covered under an **alliance** plan as a dependent of an active employee for at least six months, and then only if the dependent applies for continuation coverage within 31 days of:

(a) the death of the employee;

(b) the divorce, annulment or dissolution of marriage or legal separation of the spouse from the employee;

(c) termination of the employee's employment for any reason, including the termination of the employer's group coverage or dissolution of the group; or

(d) for covered dependent children, upon attainment of the limiting age of 26, as provided in Subsection C of 13.10.11.29 NMAC.

(e) a covered dependent may not continue coverage if, at the time of the qualifying event specified above, the employee himself is covered under continuation coverage; provided that a spouse and any dependent children may continue coverage if the qualifying event is the death of the continuee.

(3) No person is eligible to enroll or to remain on continuation coverage if he or she resides outside of the United States for a period of over six months or, if continuation coverage under this section became effective after the effective date of this rule, he or she either moves from the state of New Mexico or resides outside of the state of New Mexico for a period of over six months.

(4) Continuation coverage under the act is considered to be individual coverage for purposes of state and federal law. Persons electing to continue coverage under the act shall be subject to the provisions of 13.10.11.34 NMAC. Premiums for this continuation coverage shall be calculated at individual coverage rates.

B. An individual who is eligible for and elects COBRA continuation shall remain on the small employer's plan as required by COBRA; COBRA rights shall be administered by the small employer who shall be responsible for collecting premiums and submitting them to the **alliance**. An individual who is eligible for state six-month continuation may elect to remain on the group plan for the continuation period provided that the plan itself continues and appropriate premiums are submitted through the small employer. The **alliance** does not list bill. An individual may move to an individual plan at any time during the continuation period; provided, however, that any COBRA continuee who moves to an individual plan after the effective date of this rule shall be deemed to be covered as an individual and not as a COBRA continuee as of the date of his or her enrollment in the individual plan.

[13.10.11.31 NMAC - N, 6-1-01; A, 8-15-12]

13.10.11.32 COVERAGE OF OUT-OF-COUNTRY SERVICES:

Services provided outside of the United States will be covered only if they are for emergency treatment.

[13.10.11.32 NMAC - N, 6-1-01]

13.10.11.33 CHANGES TO COVERAGE:

A group must select one carrier (member) for all participants as of the effective date of the group coverage. A group may only change carriers and plan design, (e.g., level of deductible or co-pay/co-insurance), at the group's anniversary date. All changes must be received by the **alliance** by the 15th day of the month prior to the group's anniversary date. (Note: If the 15th of the month falls on a weekend or holiday, the documentation must be received by the **alliance**, or delivered to its post office box, before 5:00 p.m. on the next business day.)

[13.10.11.33 NMAC - N, 6-1-01]

13.10.11.34 INDIVIDUAL COVERAGE:

A. Eligibility as an individual.

(1) An individual is eligible for an **alliance** plan outside of a small employer if:

(a) as of the date of application for coverage the individual is a resident of the state of New Mexico and has an aggregate of 18 or more months of creditable coverage, as defined in the act, provided that during this period the individual did not have a break in creditable coverage lasting 95 days or longer; and either

(i) the individual's most recent coverage was under a group health plan, governmental plan or church plan, or

(ii) the individual was covered by a group health plan, governmental plan or church plan less than 95 days prior to the date the individual applies for coverage through the **alliance**;

(b) the individual is a resident of the state of New Mexico and is entitled to continuation coverage under the act, as provided in 13.10.11.31 NMAC;

(c) the individual is a resident of the state of New Mexico and his coverage has been terminated pursuant to the provisions of Section 59A-23E-14 NMSA 1978 (i.e., when a carrier has withdrawn from the small group market) or Section 59A-23E-19 NMSA 1978 (i.e., when a carrier has withdrawn from the individual market).

(2) The **alliance** may require the individual to provide an affidavit, signed under oath, stating that the individual is or will be a resident of the state of New Mexico as of the effective date of coverage.

(3) Notwithstanding the foregoing, an individual is not eligible for coverage if the coverage is being paid for or reimbursed by the individual's employer, unless the individual is either self-employed or employed by his own corporation and in either case has no other employees, or if on the effective date of coverage the individual:

(a) has or is eligible for coverage under a group health plan, as defined in the Alliance Act;

(b) is eligible for coverage under medicare or medicaid;

(c) has other health insurance coverage as defined by Subsection R of Section 59A-23E-2 NMSA 1978 (which is not terminating);

(d) was terminated from the most recent coverage within the coverage period described in Paragraph 1 of Subsection A of 13.10.11.34 NMAC as a result of nonpayment of premium or fraud*;* or

(e) has been offered the option of coverage under a COBRA continuation provision or a similar state program (other than through the **alliance**), and either did not elect or did not exhaust the coverage available under the offered program.

(4) An individual may elect to obtain coverage for his or her eligible dependents under an individual plan. The requirements of 13.10.11.29 NMAC shall apply to the eligibility and enrollment of dependents under individual coverage.

(5) A covered dependent is eligible for individual continuation coverage under the act only if the dependent has been continuously covered under an **alliance** plan as a dependent of a covered individual for at least six months, and then only if the dependent applies for continuation coverage within 31 days of:

(a) the death of the individual;

(b) the divorce, annulment or dissolution of marriage or legal separation of the spouse from the individual; or

(c) for covered dependent children, upon attainment of the limiting age of 26, as provided in Subsection C of 13.10.11.29 NMAC.

(6) No person is eligible to enroll or to remain on continuation coverage if he or she resides outside of the United States for a period of over six months or, if continuation coverage under this section became effective after the effective date of this rule, he or she moves from the state of New Mexico or resides outside of the state of New Mexico for a period of over six months.

(7) Continuation coverage under the act is considered to be individual coverage for purposes of state and federal law. Persons electing to continue coverage under the act shall be subject to the provisions of 13.10.11.34 NMAC. Premiums for this continuation coverage shall be calculated at individual coverage rates.

B. Effective date.

(1) If the documentation required by the **alliance** is received by the 15th of the month, coverage shall be reviewed for an effective as of the first day of the following month. If the complete documentation required by the **alliance** is received after the 15th of the month, coverage shall be not be effective until the first day of the month after the month following that in which the documentation is received. (If the 15th of the month falls on a weekend or holiday, the documentation must be received by the **alliance**, or delivered to its post office box, before 5:00 p.m. on the next business day.)

(2) The effective date of a continuee's individual coverage shall be the first of the month following termination of the individual's group coverage through the **alliance** provided the required documentation is received.

C. Renewability.

(1) Coverage under an **alliance** plan for an individual can be terminated or non-renewed only in the event of the following:

(a) the individual loses eligibility by residing outside of the state of New Mexico for a period of over six months, and the individual:

(i) obtained individual coverage through the **alliance** after the date on which this residency requirement first became effective; and

(ii) is not covered as a continuee under state six-month continuation; termination under this paragraph is allowed if the individual is covered under 13.10.11.31 NMAC.

(b) nonpayment of premium;

(c) fraud; or

(d) termination of the plan.

(2) If coverage under an **alliance** plan is terminated or not renewed because of termination of the plan, the individual shall have the right to transfer to any other **alliance** plan. If the individual's coverage terminates for any reason, covered dependents shall be given the opportunity to obtain conversion coverage directly from the member.

D. HMO service area requirements. In order to be eligible to enroll in an **alliance** plan offered by an HMO, an individual must live or work within the HMO's service area. The HMO may approve exceptions on an individual basis in accordance with the HMO's usual business practice. If the individual moves from the service area, the individual may enroll in the HMO's affiliated indemnity plan offered through the **alliance**.

E. Coverage of out-of-country services. Services provided outside of the United States will be covered only if they are for emergency treatment.

F. Pre-existing condition exclusions. An individual or dependent enrolling for individual coverage shall not be subject to any pre-existing condition exclusion.

G. Individual rates. Premium rates for individuals, including **alliance** continuees, shall be based on the age of the individual on the effective date of the individual or continuation coverage. Rates, excepting age-based increases or tier changes, shall be guaranteed for 12 months from that effective date and from each annual anniversary thereafter. Any applicable age-based increase shall not be considered a violation of the guarantee and shall become effective on the first of the month following the individual's birthday. Any applicable tier-change increase shall not be considered a violation of the guarantee and shall become effective on the first of the month in which the change in dependents becomes effective. Changes in premiums for renewal periods shall take effect on the anniversary of the effective date of individual or continuation coverage.

H. Plan selection. Individuals must select a carrier (member) as of the effective date of individual coverage and may not thereafter change carriers except on the annual anniversary of the effective date of individual coverage or if the carrier withdraws from participation in the **alliance**. An individual may change plan design, e.g., level of deductible or co-pay/co-insurance, as of any annual anniversary of the effective date of individual coverage.

[13.10.11.34 NMAC - N, 6-1-01; A, 3-31-08; A, 8-15-12]

13.10.11.35 CERTIFICATES OF CREDITABLE COVERAGE:

Members shall be responsible for issuing certificates of creditable coverage for groups and individuals. A member may transfer this responsibility to an individual group only by means of a written agreement signed by both parties. The member may charge a reasonable fee for such service, subject to the approval of the **alliance**.

[13.10.11.35 NMAC - N, 6-1-01; A, 3-31-08]

PART 12: STANDARDIZED HEALTH CLAIM FORMS

13.10.12.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.10.12.2 SCOPE:

A. Except as otherwise specifically provided, the requirements of this rule apply to issuers as defined herein.

B. Nothing in this rule shall prevent an issuer from requesting additional information that is not contained on the forms required under this rule to determine eligibility of the claim for payment if required under the terms of the policy or certificate issued to the claimant.

C. Nothing in this rule shall prohibit an issuer from accepting alternative forms or procedures for filing claims as are specified in a written contract between the health care practitioner or institutional care practitioner and issuer; however, such a contract does not relieve a health care practitioner, institutional care practitioner or issuer from data reporting requirements under federal law or other state law.

D. Nothing in this rule shall prohibit electronic claims submission if agreed upon by the issuer and health care practitioner or institutional care practitioner.

[7/1/94; Recompiled 11/30/01]

13.10.12.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-18-27.1 NMSA 1978.

[7/1/94; Recompiled 11/30/01]

13.10.12.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.10.12.5 EFFECTIVE DATE:

July 1, 1994, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[7/1/94, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.12.6 OBJECTIVE:

The purpose and intent of this rule is to implement the provisions of Section 59A-18-27.1 NMSA 1978, to standardize the forms used in the billing and reimbursement of health care expenses, to reduce the number of forms utilized, to increase efficiency in the reimbursement of health care through standardization and to encourage the use of and prescribe a timetable for implementation of electronic interchange of health care expense and reimbursement data.

[7/1/94; Recompiled 11/30/01]

13.10.12.7 DEFINITIONS:

A. **"CDT - 1"** codes means the current dental terminology prescribed by the American dental association.

B. **"CPT - 4"** codes means the current procedural terminology published by the American medical association.

C. **"HCFA"** means the health care financing administration of the U.S. department of health and human services.

D. **"HCFA form 1450"** means the health insurance claim form published by HCFA for use by institutional care practitioners, or any successor form published by HCFA to replace form 1450.

E. **"HCFA form 1500"** means the health insurance claim form published by HCFA for use by health care practitioners, or any successor form published by HCFA to replace form 1500.

F. **"HCPCS"** means HCFA's common procedure coding system, a coding system which describes products, supplies, procedures and health professional services and includes the American medical association's (AMA's) *Physician Current Procedural Terminology*, *Fourth Edition* (CPT-4) codes, alphanumeric codes, and related modifiers. This includes:

(1) **HCPCS level 1 codes** which are the AMA's CPT-4 codes and modifiers for professional services and procedures;

(2) **HCPCS level 2 codes** which are national alphanumeric codes and modifiers for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT-4;

(3) **HCPCS level 3 codes** which are local alphanumeric codes and modifiers for items and services not included in HCPCS level 1 or HCPCS level 2.

G. **"Health care practitioner"** means:

(1) an acupuncturist licensed under Chapter 61, Article 14A NMSA 1978;

(2) a chiropractor licensed under, Chapter 61, Article 4 NMSA 1978;

(3) a corporation or partnership of health care practitioners defined in this section;

(4) a dentist licensed under Chapter 61, Article 5 NMSA 1978;

(5) a nurse licensed under Chapter 61, Article 3 NMSA 1978 ;

(6) an ophthalmologist otherwise defined as a health care practitioner in this section;

(7) an optometrist licensed under Chapter 61, Article 2 NMSA 1978;

(8) a physician licensed under Chapter 61, Article 6 NMSA 1978;

(9) a podiatrist licensed under Chapter 61, Article 8 NMSA 1978;

(10) a psychologist licensed under Chapter 61, Article 9 NMSA 1978;

(11) a speech, physical, respiratory or occupational therapist licensed under Chapter 61, Articles 12, 12A, 12B, or 14B NMSA 1978;

(12) a counselor or therapist licensed under Chapter 61, Article 9A NMSA 1978;

(13) an osteopath licensed under Chapter 61, Article 10 NMSA 1978; and

(14) a home health care provider.

H. **"ICD - 9 - CM codes"** means the disease codes in the *International Classification of Diseases, Ninth Revision*, clinical modifications published by the U.S. department of health and human services.

I. **"Institutional care practitioner"** means a health facility as defined under Chapter 24, Article 1 NMSA 1978.

J. **"Issuer"** means an insurer, fraternal benefit society, non profit health care plan, health maintenance organization, prepaid plan, third party administrator, and any other entity reimbursing the costs of health care expenses, other than a governmental agency.

K. **"J512 form"** means the uniform dental claim form approved by the American dental association for use by dentists.

L. **"Medicare"** means the health insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

M. **"Medical assistance or medicaid"** means Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) as then constituted or later amended; and

N. **"Revenue codes"** means the codes established for use by institutional care practitioners by the national uniform billing committee.

[7/1/94, 7/1/97; Recompiled 11/30/01]

13.10.12.8 REQUIREMENTS FOR USE OF HCFA FORM 1500:

A. Issuers shall accept from health care practitioners other than dentists the HCFA form 1500 for claims for professional services.

B. Issuers may not require health care practitioners to use any coding system for the initial filing of claims for health care services other than the following:

(1) HCPCS codes; and

(2) ICD - 9 - CM codes.

C. Issuers may not require health care practitioners to use any other descriptor with a code or to furnish additional information with the initial submission of a HCFA form 1500 except under the following circumstances:

(1) when the procedure code used describes a treatment or service that is not otherwise classified; or

(2) when the procedure code is followed by the CPT-4 modifier 22, 52 or 99. Health care practitioners may use item 19 of the HCFA form 1500 to explain multiple modifiers, unless item 19 is used for other purposes in accordance with the instructions for this form.

D. Health care practitioners utilizing HCFA form 1500 shall:

(1) follow HCFA's instructions for use of the form;

(2) when amending a form previously submitted to the issuer, insert the word "amended" in the space provided in Box 19 of the form;

(3) if billing patients directly, provide a properly completed HCFA form 1500 in addition to any other explanatory information used to bill the patient when requested by the patient;

(4) if billing for services based on the amount of time involved, define on line 19 the time interval in item 24 G of the HCFA form 1500. If not defined, units will be assumed to be days of treatment; and

(5) provide the unique physician identification number assigned by HCFA in box 17a, and the federal tax identification number or social security number in Item 25.

[7/1/94, 7/1/97; Recompiled 11/30/01]

13.10.12.9 REQUIREMENTS FOR USE OF HCFA FORM 1450:

A. Issuers shall accept from institutional care practitioners the HCFA form 1450 for claims for health care services.

B. Issuers may not require institutional care practitioners to use any coding system for the initial filing of claims for health care services other than the following:

(1) ICD - 9 - CM codes;

(2) revenue codes;

(3) HCPCS codes; and

(4) if charges include direct service furnished by a health care practitioner, the information outlined in Section 5 of this rule.

C. Hospitals may use the HCFA form 1500 to supplement a HCFA form 1450 if necessary in billing patients or their representatives or filing claims with issuers for outpatient services.

D. Institutional care providers that utilize HCFA form 1450 for submission of claims to issuers and that bill patients directly shall provide a properly completed HCFA form 1450 in addition to any other explanation information used to bill the patient when requested by the patient.

[7/1/94, 7/1/97; Recompiled 11/30/01]

13.10.12.10 REQUIREMENTS FOR USE OF J512 FORM:

A. Issuers shall accept the J512 form for claims for professional dental services.

B. Issuers may not require a dentist to use any code other than the CDT-1 codes for the initial filing of claims for dental care services, unless the use of supplemental codes are defined and permitted in a written contract between the issuer and dentist.

C. Dentists utilizing the J512 form for submission of claims for professional dental services shall:

(1) follow the instructions for the form provided by the American dental association CDT - 1; and

(2) if billing patients directly, provide a properly completed J512 form in addition to any other form used to bill the patient when requested by the patient.

[7/1/94; Recompiled 11/30/01]

13.10.12.11 GENERAL PROVISIONS:

A. Issuers shall:

(1) accept the most current editions of the HCFA form 1500, HCFA form 1450, or J512 form completed in accordance with the most current instructions for these forms from health care practitioners and institutional care practitioners; and

(2) modify their claim reimbursement practices to encompass the coding changes for all billing and claim filing by the effective date of the changes set forth by the developers of the forms, codes and procedures required under this rule.

B. Health care practitioners and institutional care practitioners utilizing HCFA form 1500, HCFA form 1450, or the J512 form shall use the most current version of the forms and applicable instructions. Claims filed in paper form shall be printed on 8.5 x 11 inch paper.

C. Issuers may require that claims be submitted on HCFA form 1500, HCFA form 1450, or the J512 form.

[7/1/94; Recompiled 11/30/01]

PART 13: MANAGED HEALTH CARE - BENEFITS

13.10.13.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Division of Insurance, Post Office Box 1269, Santa Fe, New Mexico 87504-1269.

[13.10.13.1 NMAC - Rp, 13.10.13.1 NMAC, 09/01/2009]

13.10.13.2 SCOPE:

A. Applicability. This rule applies to health care insurers that are required to obtain a certificate of authority or licensure in this state and which provide, offer, or administer managed health care plans.

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

(1) traditional fee-for-service indemnity plans;

(2) only short-term travel, accident-only, student health, specified disease, or other limited benefits; or

(3) credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit, including a stand-alone dental benefit plan, whether indemnity, PPO, or non-profit plan.

C. Conflicts. This rule relates to and should be read in conjunction with 13.10.16 NMAC, 13.10.17 NMAC, 13.10.21 NMAC, 13.10.22 NMAC, and 13.10.23 NMAC. If any provision in this rule conflicts with any provision of 13.10.17 NMAC, Grievance Procedures, or 13.10.16 NMAC, Provider Grievance, promulgated prior to the effective date of this rule, the provision in this rule shall apply.

[13.10.13.2 NMAC - Rp, 13.10.13.2 NMAC, 09/01/2009]

13.10.13.3 STATUTORY AUTHORITY:

Sections 59A-1-18, 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-15-16, 59A-18-21, 59A-19-5, 59A-19-6, 59A-22-19, 59A-22-20, 59A-22-21, 59A-22-42, 59A-22-43, 59A-22A-4, 59A-22A-5, 59A-22A-6, 59A-22A-7, 59A-23E-15, 59A-44-41, 59A-46-23, 59A-46-25,

59A-46-30, 59A-47-24, 59A-47-25, 59A-47-27, 59A-47-33, 59A-57-2, 59A-57-4, 59A-57-5, 59A-57-6, 59A-57-8, and 59A-57-11 NMSA 1978.

[13.10.13.3 NMAC - Rp, 13.10.13.3 NMAC, 09/01/2009]

13.10.13.4 DURATION:

Permanent.

[13.10.13.4 NMAC - Rp, 13.10.13.4 NMAC, 09/01/2009]

13.10.13.5 EFFECTIVE DATE:

September 1, 2009, unless a later date is cited at the end of a section.

[13.10.13.5 NMAC - Rp, 13.10.13.5 NMAC, 09/01/2009]

13.10.13.6 OBJECTIVE:

The purpose of this rule is to ensure the availability, accessibility, and quality of health care services provided by health care insurers through managed health care plans. The rule provides uniform definitions; standards regarding patient rights and responsibilities; requirements regarding supplemental services and prescription drug coverage, when offered; and requirements for consumer assistance offices and consumer advisory boards within managed health care plans.

[13.10.13.6 NMAC - Rp, 13.10.13.6 NMAC, 09/01/2009]

13.10.13.7 DEFINITIONS:

In addition to the following, this rule is subject to the definitions found in the Grievance Procedures Rule, 13.10.17 NMAC.

A. "Certified nurse-midwife" means any person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico department of health as a certified nurse-midwife.

B. "Certified nurse practitioner" means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the board of nursing.

C. "Continuous quality improvement" means an ongoing and systematic effort to measure, evaluate, and improve a managed health care plan's process in order to continually improve the quality of health care services provided to its covered persons.

D. "Covered person" means an individual entitled to receive health care benefits provided by a health benefits plan, and includes individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.

E. "Cytologic screening" means a papanicolaou test or liquid based cervical cytopathology, a human papillomavirus test and a pelvic exam for symptomatic as well as asymptomatic female patients.

F. "Division" means the New Mexico division of insurance.

G. "Emergency care" means health care procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

(1) jeopardy to the person's health;

(2) serious impairment of bodily functions;

(3) serious dysfunction of any bodily organ or part; or

(4) disfigurement to the person.

H. "Evidence of coverage" means a clear and conspicuous written statement of the essential features and medical services covered by the managed health care plan (MHCP), which may include a separate summary of benefits, as more particularly described at 13.10.23.8 NMAC, and which is provided to the covered person by the MHCP.

I. "FDA" means the United States food and drug administration.

J. "Grievance" means a complaint, and other documentation, as more particularly defined at 13.10.17.7 NMAC, submitted by or on behalf of a covered person.

K. "Health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

L. "Health care insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, prepaid dental plan, a multiple employer

welfare arrangement or any other person providing a plan of health insurance or a managed health care plan subject to state insurance law and regulation.

M. "Health care professional" means a physician or other health care professional, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

N. "Health care services" means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

O. "Health maintenance organization (HMO)" means any person who undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for covered person responsibility for copayments or deductibles.

P. "Independent quality review organization (IQRO)" means an organization independent of the health care insurer or managed health care plan that performs external quality audits of managed health care plans and submits reports of its findings to both the managed health care plan and to the division.

Q. "Managed care" means a system or technique(s) generally used by third party payors or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following:

(1) prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services;

(2) contracts with selected health care providers;

(3) financial incentives or disincentives for covered persons to use specific providers, services, prescription drugs, or service sites;

(4) controlled access to and coordination of services by a case manager; and

(5) payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

R. "Managed health care plan (MHCP or plan)" means a policy, contract, certificate or agreement offered or issued by a health care insurer, provider service network, or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services, except as otherwise provided in this subsection. A MHCP either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under

contract with or employed by the health care insurer, provider service network, or plan administrator. Effective immediately, a MHCP does not include a traditional fee-for-service indemnity health benefit plan or a health benefit plan that covers only short-term travel, accident-only, limited benefit, an indemnity, PPO dental or non-profit dental benefit plan, student health plan, or specified disease policies. For purposes of this section, "plan administrator" shall include and apply to an HMO or other health care insurer not required to be licensed under Section 59A-12A-2 NMSA 1978, but which is acting as a "plan administrator" as defined under the act." A MHCP includes a health benefits plan as defined under Subsection D of Section 59A-22A-3 NMSA 1978, as "the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available."

S. "Obstetrician-gynecologist" means a physician who is board eligible or board certified by the American board of obstetricians and gynecologists or by the American college of osteopathic obstetricians and gynecologists.

T. "Participating provider" means a provider who, under a contract (or through other arrangement) with the health care insurer offering a managed health care plan, or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the managed health care plan or health care insurer.

U. "Physician assistant" means a skilled person who is a graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of physician assistants, and who is licensed in the state of New Mexico to practice medicine under the supervision of a licensed physician.

V. "Primary care practitioner (PCP)" means a health care professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to covered persons, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary care practitioners shall include but not be limited to general practitioners, family practice physicians, internists, pediatricians, and obstetricians-gynecologists, physician assistants and nurse practitioners. Pursuant to 13.10.21.7 NMAC, other health care professionals may also provide primary care.

W. "Prospective enrollee" means:

(1) in the case of an individual who is a member of a group, an individual eligible for enrollment in a MHCP through that individuals group; or

(2) in the case of an individual who is not a member of a group or whose group has not purchased or does not intend to buy a MHCP, an individual who has

expressed an interest in purchasing individual plan coverage and is eligible for coverage by the plan.

X. "Provider" means a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services within the scope of their license.

Y. "Registered lay midwife" means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

Z. "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic persons and includes the x-ray examination of the breast using equipment that is specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Screening mammography includes two views for each breast. Screening mammography includes the professional interpretation of the film, but does not include diagnostic mammography.

AA. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the managed health care plan, or in the case of an individual contract, the person in whose name the contract is issued.

BB. "Summary of benefits" means a summary of the benefits and exclusions, required to be given prior to or at the time of enrollment to a prospective subscriber by the health care insurer or group contract holder.

CC. "Tertiary care facility" means a hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

DD. "Traditional fee-for-service indemnity benefit" means a fee-for-service indemnity benefit as defined at 13.10.17.7 NMAC, as a fee-for-service indemnity benefit, not associated with any financial incentives that encourage covered persons to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

EE. "Urgent care" means medically necessary health care services provided in emergencies or after a primary care physician's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

FF."Utilization review" means a system for reviewing the appropriate and efficient allocation of medical services and hospital resources given or proposed to be given to a patient or group of patients.

[13.10.13.7 NMAC - Rp, 13.10.13.7 NMAC, 09/01/2009]

13.10.13.8 PATIENT RIGHTS AND RESPONSIBILITIES:

A. Each health care insurer through its managed health care plan (MHCP) shall implement written policies and procedures regarding the rights of covered persons and implementation of such rights.

B. At the time of enrollment, each health care insurer through its MHCP shall provide each subscriber, and upon request, a covered person, or a covered person's representative, in compliance with state or federal law, with a summary of benefits and exclusions, premium information and provider listing, along with information on how to access or obtain the evidence of coverage. Basic consumer information, including the phone number of the managed health care bureau, shall be included on a newly issued covered person's health insurance card, or on a separate wallet-sized card, to include the phone number and website of the managed health care bureau, issued simultaneously with the newly issued health insurance card.

C. The evidence of coverage shall include a complete statement that a covered person shall have the right, at a minimum:

(1) to available and accessible services when medically necessary, and in an HMO, as determined by the primary care or treating physician in consultation with the MHCP, 24 hours per day, seven days per week for urgent or emergency care services, and for other health care services as defined by the contract or the evidence of coverage;

(2) to be treated with courtesy and consideration, and with respect for the covered person's dignity and need for privacy;

(3) to be provided with information concerning the health care insurer's policies and procedures regarding products, services, providers, appeals procedures and other information about the MHCP and the benefits provided;

(4) in an HMO, to choose a primary care practitioner within the limits of the covered benefits, plan network, and as provided by this rule, including the right to refuse care of specific health care professionals;

(5) to receive from the covered person's physician(s) or provider, in terms that the covered person understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of the health care insurers or MHCP's

position on treatment options; if the covered person is not capable of understanding the information, the explanation shall be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the covered person's medical record;

(6) to all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the covered person understands;

(7) to prompt notification, as required in this rule, of termination or changes in benefits, services or provider network;

(8) to file a complaint or appeal with the health care insurer or the superintendent and to receive an answer to those complaints in accordance with existing law;

(9) to privacy of medical and financial records maintained by the health care insurer and its health care providers, in accordance with existing law;

(10) to know upon request of any financial arrangements or provisions between the health care insurer and its providers which may restrict referral or treatment options or limit the services offered to covered persons;

(11) to adequate access to qualified health professionals for the treatment of covered benefits near where the covered person lives or works within the service area of the MHCP;

(12) in an HMO, and to the extent available and applicable to the MHCP, to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating provider, and an explanation of a covered person's financial responsibility when services are provided by a non-participating provider, or provided without required preauthorization;

(13) in a MHCP that provides benefits for out-of-network coverage, to an approved example of the financial responsibility incurred by a covered person when going out-of-network; inclusion of the entire "billing examples" provided by the superintendent available on the division's website at the time of the filing of the plan will be deemed satisfaction of this requirement; any substitution for, or changes to, the division's "billing examples" requires written approval by the superintendent;

(14) to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that a covered person must follow for prior authorization and utilization review;

(15) to a complete explanation of why care is denied, an opportunity to appeal the decision to the health care insurer's internal review, the right to a secondary appeal, and the right to request the superintendent's assistance.

D. The health care insurer shall establish and implement written policies and procedures regarding the responsibilities of covered persons. A complete statement of these responsibilities shall be included in the evidence of coverage.

[13.10.13.8 NMAC - Rp, 13.10.13.8 NMAC, 09/01/2009]

13.10.13.9 SUPPLEMENTAL HEALTH CARE SERVICES:

A. A health care insurer, through its MHCP, may provide to its covered persons supplemental health care services that are not basic health care services. For HMOs, basic health care services are defined and described at 13.10.21.8 NMAC. These supplemental health care services may be limited as to time and cost.

B. Additional fees: A health care insurer may determine the level and scope of any supplemental health care service provided to its covered persons in a MHCP, whether or not the service is listed in this section, and may charge additional fees for those services.

C. The following are not required as basic health care services, but may be provided as supplemental health care services:

(1) consultation with and referral to physicians and other health care professionals such as dentists, nurses, podiatrists, optometrists, chiropractic physicians, physician assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists, certified nurse midwives and other professionals engaged in the delivery of health services who are licensed to practice, are certified, and are practicing under authority of the MHCP, a medical group, an independent practice association or other authority authorized by applicable New Mexico law when treatment exceeds that included in basic health care services;

(2) corrective appliances, prosthetics, and artificial aids, including hearing aids, except as required in Section 13-7-10 NMSA 1978;

(3) mental health services, including, but not limited to, outpatient evaluative, crisis intervention and short term therapeutic mental health services and inpatient psychiatric care, except as required in Section 59A-23E 18 NMSA 1978;

(4) cosmetic surgery;

(5) pharmaceuticals and other medicines prescribed on an outpatient basis by licensed physicians nurse practitioners, physician assistants or certified nurse-midwives to treat or prevent illness;

(6) ambulance services, other than for emergencies or otherwise deemed medically necessary;

(7) care for military service-connected disabilities for which a covered person is legally entitled to services and for which facilities are reasonably available to the covered person;

(8) care for conditions that state or local law requires be treated in a public facility;

(9) dental services not required as a basic health care service;

(10) vision care;

(11) personal or comfort items;

(12) long-term physical therapy and rehabilitation;

(13) durable medical equipment for home use, such as wheel chairs, surgical beds, respirators, and dialysis machines;

(14) diagnosis, medical treatment and referral services for the abuse of or addiction to alcohol or drugs, including inpatient substance abuse care in a facility licensed to provide residential alcohol and drug abuse services, except as required by Section 59A-23-6 NMSA 1978;

(15) home health care services which, if offered, at a minimum shall comply with Section 59A-22-36 and Section 59A-46-40 NMSA 1978;

(16) skilled or intermediate nursing care;

(17) custodial or domiciliary care;

(18) hearing care, except as required for children by Section 59A-22-34.5 NMSA 1978;

(19) experimental or investigational medical, surgical, other health care procedures or treatments, including drugs, unless approved as a basic health care service treatment or procedure by the health care insurer. As used in this section, "experimental" or "investigational" as related to drugs, devices, medical treatments or procedures means:

(a) the drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished;

(b) reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;

(c) reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or

(d) except as required by 13.10.13.10 NMAC, the drug or device is used for a purpose that is not approved by the FDA;

(e) for the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in Subsection A of 13.10.13.10 NMAC; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure;

(f) as used in this section, "experimental" or "investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

[13.10.13.9 NMAC - Rp, 13.10.13.10 NMAC, 09/01/2009]

13.10.13.10 PRESCRIPTION DRUGS:

A. No MHCP that provides coverage for prescription drugs as a basic or supplemental health care service or pursuant to inpatient, urgent, or emergency medical services shall limit or exclude coverage for any drug approved by the FDA on the basis that the drug has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided that:

(1) the drug has been recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American hospital formulary service drug information," and "drug information for the healthcare provider," or

(2) as provided for cancer clinical trials, pursuant to Section 59A-22-43 NMSA.

B. Coverage of a drug includes medically necessary services associated with the administration of the drug provided that such services would not be otherwise excluded from coverage.

C. Coverage of a drug includes coverage for prescription contraceptive drugs or devices, pursuant to Sections 59A-22-42 and 59A-46-44 NMSA 1978.

D. Nothing in this section requires:

(1) coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;

(2) coverage for experimental or investigational drugs not approved for any indication by the **(3)** reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in a managed health care plan, contract, or policy, subject to the exceptions listed in Subsection D of 13.10.13.10 NMAC.

E. Every MHCP must allow covered persons to obtain drugs not on the formulary as though the drug were included in the formulary, based on the type of drug, how the drug is administered, and the medically necessary services, when the treatment for which the drug is prescribed is a covered benefit, and when the participating provider in consultation with the MHCP determines that:

(1) the formulary drug has been or is reasonably expected to be less effective for the covered person; or

(2) the formulary drug has caused or is reasonably expected to cause adverse reactions in the covered person.

[13.10.13.10 NMAC - Rp, 13.10.13.12 NMAC, 09/01/2009]

13.10.13.11 COORDINATION OF BENEFITS:

A. A health care insurer may or may not coordinate benefits in some or all of its group and individual managed health care plan contracts. However, a health care insurer which does coordinate benefits may do so only pursuant to the provisions in its plan contracts, all of which shall be fair, reasonable, and consistent with the objectives of this rule and shall comply with all applicable rules and regulations governing coordination of benefits.

B. A provision regarding coordination of benefits shall be presumed to be unfair and unreasonable if it:

(1) may relieve the health care insurer of a duty otherwise arising from a contract to deliver any health care service to any covered person in need of such service because the covered person may be or is entitled to coverage of the service by another health carrier; or

(2) results in any covered person who cooperates with such provision having greater personal liability for any particular health care service furnished by or through the health care insurer or received in reliance on the health care insurer than such person would have had in the absence of any other health carrier.

[13.10.13.11 NMAC - Rp, 13.10.13.24 NMAC, 09/01/2009]

13.10.13.12 COST SHARING:

A. All cost sharing (including copayments, deductibles, co-insurance, or similar charges) required of covered persons by the health care insurer or managed health care plan for the provision of health care services shall be reasonable and shall include any applicable state and federal taxes.

B. Any cost sharing requirement for the provision of testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency is presumptively unreasonable and is prohibited. For purpose of this rule, a public health emergency exists when declared by the state of New Mexico or federal government.

C. Cost sharing requirements, including any variations in contribution requirements based on the type of health care service rendered or provider used, shall be disclosed to covered persons in MHCP contracts, enrollment materials, and in the evidence of coverage.

D. No female covered person shall be assessed a higher cost sharing requirement, over and above the cost sharing required of all covered persons to be seen by a primary care physician, for choosing a women's health care provider as her primary care physician

E. Health care services for any disease or condition for which cost sharing is prohibited under Paragraph B of this section shall be subject to the Surprise Billing Protection Act, Sections 59A-57A-1 through 13, NMSA 1978 (the "Act"). Where there is no data available in the Act's benchmarking databases for a particular billing code, then the health care insurer or managed health care plan shall reimburse under the Act at one hundred fifty percent of the Medicare reimbursement rate applicable for the year in which the benchmarking data first becomes available.

[13.10.13.12 NMAC - Rp, 13.10.13.27 NMAC, 09/01/2009; A/E, 3/12/2020; A, 7/1/2020]

13.10.13.13 CONSUMER ASSISTANCE:

A. Consumer assistance office: Each MHCP shall establish and adequately staff a consumer assistance office. Those MHCPs currently doing business in New Mexico

shall submit to the superintendent for approval a plan of how the MHCP's consumer assistance office will be organized and established. At a minimum, the plan shall address:

(1) the staffing of the consumer assistance office, including whether the planned hours and level of staffing are sufficient for the numbers and types of covered persons served by the MHCP;

(2) the MHCP's arrangements to meet the needs of covered persons with special needs;

(3) how the consumer assistance staff will be trained;

(4) how the independence of staff assigned to assist consumers is assured; and

(5) whether staff will have the authority to assist consumers in filing and pursuing a grievance or appeal.

B. A MHCP new to this state shall submit a plan for establishing a consumer assistance office to the superintendent as part of its application for licensure.

C. The superintendent shall approve or reject a plan submitted by a MHCP within 45 days after the plan is submitted to the superintendent. If the superintendent rejects a plan submitted by a MHCP, the superintendent shall state in writing in a letter addressed to the MHCP the specific grounds for rejection.

D. Consumer advisory board: Each MHCP shall establish and maintain a consumer advisory board.

(1) The consumer advisory board shall meet at least quarterly and shall advise the MHCP about the MHCP's general operations from the perspective of the enrollee as a consumer of health care.

(2) The consumer advisory board shall review the operations of and be advisory to the MHCP's consumer assistance office.

(3) All members of the consumer advisory board shall be current enrollees of the MHCP, employees of groups which subscribe to the MHCP, or be representatives of consumer organizations which represent the interests of health care consumers. No member of the consumer advisory board shall be an employee of the MHCP, nor shall the board members' immediate family be employees of the MHCP.

(4) The MHCP shall implement procedures whereby, when specific recommendations are made by the advisory board, representatives of the MHCP with

responsibility for the substantive areas addressed in the recommendation will consider the matters raised in the recommendation and timely respond to the advisory board.

(5) The MHCP shall inform enrollees of the advisory board's existence and role in the operation of the MHCP in the evidence of coverage.

[13.10.13.13 NMAC - Rp, 13.10.13.30 NMAC, 09/01/2009]

13.10.13.14 PENALTIES:

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurer by the superintendent in accordance with Sections 59A-1-18, 59A-46-25, 59A-57-11 NMSA 1978.

[13.10.13.14 NMAC - Rp, 13.10.13.32 NMAC, 09/01/2009]

13.10.13.15 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.13.15 NMAC - Rp, 13.10.13.33 NMAC, 09/01/2009]

PART 14: MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE CONTRACTS

13.10.14.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[13.10.14.1 NMAC - Rp 13 NMAC 10.14.1, 10-1-03]

13.10.14.2 SCOPE:

This rule applies to all individual and group health insurance coverages except credit insurance.

[13.10.14.2 NMAC - Rp 13 NMAC 10.14.2, 10-1-03]

13.10.14.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-8-4, 59A-8-6, 59A-8-7, and 59A-8-8 NMSA 1978.

[13.10.14.3 NMAC - Rp 13 NMAC 10.14.3, 10-1-03]

13.10.14.4 DURATION:

Permanent.

[13.10.14.4 NMAC - Rp 13 NMAC 10.14.4, 10-1-03]

13.10.14.5 EFFECTIVE DATE:

October 1, 2003, unless a later date is cited at the end of a section.

[13.10.14.5 NMAC - Rp 13 NMAC 10.14.5, 10-1-03]

13.10.14.6 OBJECTIVE:

The objective of this rule is to promote solvency by establishing minimum standards for the computation of reserves, which place a sound value on liabilities issued under both individual and group health insurance contracts.

[13.10.14.6 NMAC - Rp 13 NMAC 10.14.6, 10-1-03]

13.10.14.7 DEFINITIONS:

As used in this valuation standard, the following terms have the meanings given here.

A. "Annual claim cost." The net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a $100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be $12, while the gross premium for this benefit might be $18. The additional $6 would cover expenses and profit or contingencies.

B. "Claims accrued." That portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

C. "Claims reported." When an insurer has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date, the claim is considered as a reported claim for annual statement purposes.

D. Claims unaccrued. That portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

E. "Claims unreported." When an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

F. "Date of disablement." The earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

G. "Elimination period." A specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

H. "Gross premium." The amount of premium charged by the insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.

I. "Group insurance." The term group insurance includes blanket insurance and franchise insurance and any other forms of group insurance.

J. "Level premium." A premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

K. "Long-term care insurance." Any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid or other

basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

L. "Modal premium." This refers to the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is $100 and if, instead, monthly premiums of $9 are paid then the modal premium is $9.

M. "Negative reserve." Normally the terminal reserve is a positive value. However, if the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

N. "Preliminary term reserve method." Under this method of valuation the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

O. "Present value of amounts not yet due on claims." The reserve for "claims unaccrued" (see definition), which may be discounted at interest.

P. "Reserve." The term "reserve" is used to include all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits which result in:

(1) claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

(2) claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

Q. "Terminal reserve." This is the reserve at the end of a contract year, and is defined as the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

R. "Unearned premium reserve." This reserve values that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of $120 was paid on November 1, $20 would be earned as of December 31 and the remaining $100 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

S. "Valuation net modal premium." This is the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, thevaluation net modal premium is the quarterly equivalent of the valuation net annual premium.

[13.10.14.7 NMAC - Rp 13 NMAC 10.14.7, 10-1-03]

13.10.14.8 GENERAL PROVISIONS:

A. When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

B. With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

C. Such a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

D. Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

E. Adequacy of an insurer's health insurance reserves is to be determined on the basis of claim, premium, and contract reserves combined. However, 13.10.14.9 through 13.10.14.20 NMAC emphasize the importance of determining appropriate reserves for claim, premium, and contract reserves separately.

[13.10.14.8 NMAC - Rp 13 NMAC 10.14.8, 10-1-03]

13.10.14.9 CLAIM RESERVES:

A. Claim reserves are required for all incurred but unpaid claims on all health insurance policies.

B. Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

C. All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

[13.10.14.9 NMAC - Rp 13 NMAC 10.14.9, 10-1-03]

13.10.14.10 MINIMUM STANDARDS FOR CLAIM RESERVES FOR DISABILITY INCOME:

A. Interest. The maximum interest rate for claim reserves is specified in 13.10.14.24 NMAC.

B. Morbidity. Minimum standards with respect to morbidity are those specified in 13.10.14.22 and 13.10.14.23 NMAC, except that, at the option of the insurer:

(1) For claims with a duration from date of disablement of less than two years, reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(2) For group disability income claims with a duration from date of disablement of more than two years but less than five years, reserves may, with the approval of the superintendent, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:

(a) an analysis of the credibility of the experience;

(b) a description of how all of the insurer's experience is proposed to be used in setting reserves;

(c) a description and qualification of the margins to be included;

(d) a summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

(e) a copy of the approval of the proposed plan of modification by the superintendent of the state of domicile; and

(f) any other information deemed necessary by the superintendent.

C. Duration of Disablement. For contracts with an elimination period, the duration of disablement should be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

[13.10.14.10 NMAC - Rp 13 NMAC 10.14.10, 10-1-03]

13.10.14.11 MINIMUM STANDARDS FOR CLAIM RESERVES FOR ALL OTHER BENEFITS:

A. Interest. The maximum interest rate for claim reserves is specified in 13.10.14.24 NMAC.

B. Morbidity or other contingency. The reserve should be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

[13.10.14.11 NMAC - Rp 13 NMAC 10.14.11, 10-1-03]

13.10.14.12 CLAIM RESERVE METHODS GENERALLY:

A generally accepted actuarial reserving method or other reasonable method, if, after a public hearing, the method is approved by the superintendent prior to the statement date, or a combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

[13.10.14.12 NMAC - Rp 13 NMAC 10.14.12, 10-1-03]

13.10.14.13 PREMIUM RESERVES:

A. Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

B. If premiums due and unpaid are carried as an asset, such premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums must be carried as an offsetting liability.

C. The gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation may be appropriately discounted to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

[13.10.14.13 NMAC - Rp 13 NMAC 10.14.13, 10-1-03]

13.10.14.14 MINIMUM STANDARDS FOR UNEARNED PREMIUM RESERVES:

A. The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:

(1) the valuation net modal premium on the contract reserve basis applying to the contract; or

(2) the gross modal premium for the contract if no contract reserve applies.

B. However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.

[13.10.14.14 NMAC - Rp 13 NMAC 10.14.14, 10-1-03]

13.10.14.15 PREMIUM RESERVE METHODS GENERALLY:

The insurer may employ suitable approximations and estimates; including, but not limited to groupings, averages and aggregate estimation; in computing premium reserves. Such approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

[13.10.14.15 NMAC - Rp 13 NMAC 10.14.15, 10-1-03]

13.10.14.16 CONTRACT RESERVES:

The contract reserve is in addition to claim reserves and premium reserves.

A. Contract reserves required. Contract reserves are required, unless otherwise specified in Subsection B of 13.10.14.16 NMAC, for:

(1) all individual and group contracts with which level premiums are used; or

(2) all individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The values specified in this Paragraph (2) of Subsection A of 13.10.14.16 NMAC shall be determined on the basis specified in 13.10.14.17 NMAC.

B. Contracts not requiring a contract reserve:

(1) contracts which cannot be continued after one year from issue; or

(2) contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

C. Consistent method required. The methods and procedures for contract reserves should be consistent with those for claim reserves for any contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

[13.10.14.16 NMAC - Rp 13 NMAC 10.14.16, 10-1-03]

13.10.14.17 BASIS FOR MINIMUM STANDARDS FOR CONTRACT RESERVES:

A. Morbidity or other Contingency. Minimum standards with respect to morbidity are those set forth in 13.10.14.22 and 13.10.14.23 NMAC. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated.

B. Unspecified standards. Contracts for which tabular morbidity standards are not specified in 13.10.14.22 and 13.10.14.23 NMAC shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the superintendent. The morbidity tables shall contain a pattern of incurred claims cost that reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

C. Interest. The maximum interest rate is specified in 13.10.14.24 NMAC.

D. Termination Rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in 13.10.14.25 NMAC except as noted in Subsection E of 13.10.14.17 NMAC.

E. Exceeding specified rates.

(1) Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(a) eighty percent of the total termination rate used in the calculation of the gross premiums, or

(b) eight percent.

(2) For long-term care individual policies or group certificates issued after January 1, 1997, the contract reserve may be established on a basis of separate:

(a) mortality, as specified in 13.10.14.25 NMAC; and

(b) terminations other than mortality, where the terminations are not to exceed (i) for policy years one through four, the lesser of eighty percent of the voluntary lapse rate used in the calculation of gross premiums and eight percent or (ii) for policy years five and later, the lesser of one hundred percent of the voluntary lapse rate used in the calculation of gross premiums and four percent.

F. Aggregate basis. Where a morbidity standard specified in 13.10.14.22 and 13.10.14.23 NMAC is on an aggregate basis, such morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the superintendent.

G. Reserve Method.

(1) For insurance except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(2) For long-term care insurance, the minimum reserve is calculated as follows:

(a) for individual policies and group certificates issued on or before December 31, 1996, reserves calculated on the two-year full preliminary term method;

(b) for individual policies and group certificates issued on or after January 1, 1997, reserves calculated on the one-year full preliminary term method.

(3) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

(a) on the one year preliminary term method if such benefits are provided at any time before the twentieth anniversary;

(b) on the two year preliminary term method if such benefits are only provided on or after the twentieth anniversary.

H. Preliminary term method. The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

I. Negative Reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

J. Nonforfeiture benefits for long-term care insurance. The contract reserve on a policy basis shall not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the above specifications.

[13.10.14.17 NMAC - Rp 13 NMAC 10.14.17, 10-1-03]

13.10.14.18 ALTERNATIVE VALUATION METHODS AND ASSUMPTIONS GENERALLY:

Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above; an insurer may use any reasonable assumptions as to interest rates, termination and/or mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following: the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so

valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

[13.10.14.18 NMAC - Rp 13 NMAC 10.14.18, 10-1-03]

13.10.14.19 TESTS FOR ADEQUACY AND REASONABLENESS OF CONTRACT RESERVES:

Annually, an appropriate review shall be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of 13.10.14.17 NMAC.

[13.10.14.19 NMAC - Rp 13 NMAC 10.14.19, 10-1-03]

13.10.14.20 PREMIUM RATE RESTRICTIONS:

In the event a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

[13.10.14.20 NMAC - Rp 13 NMAC 10.14.20, 10-1-03]

13.10.14.21 REINSURANCE:

Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

[13.10.14.21 NMAC - Rp 13 NMAC 10.14.21, 10-1-03]

13.10.14.22 MINIMUM MORBIDITY STANDARDS FOR VALUATION OF SPECIFIED INDIVIDUAL CONTRACT HEALTH INSURANCE BENEFITS:

A. Disability Income Benefits Due to Accident or Sickness.

(1) Contract Reserves.

(a) For contracts issued on or after January 1, 1997, the 1985 commissioners individual disability tables A (85CIDA); or The 1985 commissioners individual disability tables B (85CIDB). Each insurer shall elect, with respect to all individual contracts

issued in any one statement year, whether it will use tables A or tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(b) For contracts issued on or after January 1, 1965 and prior to january 1, 1997, the 1964 commissioners disability table (64 CDT).

(2) Claim Reserves.

(a) For claims incurred on or after July 1, 2003, the 1985 commisioners individual disability table A (85CIDA) with claim termination rates multiplied by the adjustment factors in 13.10.14.26 NMAC. The 85CIDA table so adjusted shall be known as the 1985 commissioners individual disability table C (85CIDC).

(b) For claims incurred prior to July 1, 2003, each insurer may elect which of the following: (i) the minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred or (ii) the standard in Subparagraph (a). Once the insurer elects to calculate reserves for all open claims on the latter, all future valuations must be on that basis.

B. Hospital Benefits, Surgical Benefits and Maternity Benefits. (Scheduled benefits or fixed time period benefits only).

(1) Contract Reserves.

(a) [RESERVED]

(b) Contracts issued on or after January 1, 1997, the 1974 *medical expense tables, table A, transactions of the society of actuaries, volume 03X*, page 63. Refer to the paper (in the same volume, page 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in t*able A: "development of the 1974 medical expense benefits,"* Houghton and Wolf.

(2) Claim reserves. No specific standard. See Subsection E of 13.10.14.22 NMAC.

C. Cancer expense benefits. (Scheduled benefits or fixed time period benefits only).

(1) Contract reserves. Contracts issued on or after January 1, 1997, the 1985 NAIC cancer claim cost tables.

(2) Claim reserves. No specific standard. See Subsection E of 13.10.14.22 NMAC.

D. Accidental Death Benefits.

(1) Contract reserve. Contracts issued on or after January 1, 1997, the 1959 accidental death benefits table.

(2) Claim reserves. Actual amount incurred.

E. Other Individual Contract Benefits.

(1) Contract Reserves. For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(2) Claim Reserves. For all benefits other than disability, claim reserves are to be determined as provided in the standards.

[13.10.14.22 NMAC - Rp 13 NMAC 10.14.22, 10-1-03]

13.10.14.23 MINIMUM MORBIDITY STANDARDS FOR VALUATION OF SPECIFIED GROUP CONTRACT HEALTH INSURANCE BENEFITS:

A. Disability Income Benefits Due to Accident or Sickness.

(1) Contract reserves. Contracts issued on or after January 1, 1997, the 1987 commissioners group disability income table (87CGDT).

(2) Claim reserves.

(a) For claims incurred on or after January 1, 1997, the 1987 commissioners group disability income table (87CGDT).

(b) For claims incurred prior to January 1, 1997, use of the 87CGDT is optional.

B. Other Group Contract Benefits.

(1) Contract reserves. For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(2) Claim reserves. For all benefits other than disability, claim reserves are to be determined as provided in the standards.

[13.10.14.23 NMAC - Rp 13 NMAC 10.14.23, 10-1-03]

13.10.14.24 SPECIFIC STANDARDS FOR INTEREST:

A. For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

B. For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

C. For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

[13.10.14.24 NMAC - Rp 13 NMAC 10.14.24, 10-1-03]

13.10.14.25 SPECIFIC STANDARDS FOR MORTALITY:

A. Unless Subsection B of 13.10.14.25 NMAC applies, the mortality basis used for all policies except long-term care individual policies and group certificates and for long-term care individual policies and group certificates issued before January 1, 1997 shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the health insurance contract. For long-term care insurance individual policies or group certificates issued on or after January 1, 1997, the mortality basis used shall be the 1983 group annuity mortality table without projection.

B. Other mortality tables adopted by the NAIC and promulgated by the superintendent may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the superintendent. The request for such approval must include the proposed mortality table and the reason that the standard specified in Subsection A of 13.10.14.25 NMAC is inappropriate.

[13.10.14.25 NMAC - Rp 13 NMAC 10.14.25, 10-1-03]

13.10.14.26 ADJUSTMENT FACTORS:

Duration	**Adjustment Factor**	**Adjusted Termination Factor***
Week 1	0.366	0.04831
2	0.366	0.04172
3	0.366	0.04063
4	0.366	0.04355

5	0.365	0.04088
6	0.365	0.04271
7	0.365	0.04380
8	0.365	0.04344
9	0.370	0.04292
10	0.370	0.04107
11	0.370	0.03848
12	0.370	0.03478
13	0.370	0.03034
Month 4	0.391	0.08758
5	0.371	0.07346
6	0.435	0.07531
7	0.500	0.07245
8	0.564	0.06655
9	0.613	0.05520
10	0.663	0.04705
11	0.712	0.04486
12	0.756	0.04309
13	0.800	0.04080
14	0.844	0.03882
15	0.888	0.03730
16	0.932	0.03448
17	0.976	0.03026

18	1.020	0.02856
19	1.049	0.02518
20	1.078	0.02264
21	1.107	0.02104
22	1.136	0.01932
23	1.165	0.01865
24	1.195	0.01792
Year 3	1.369	0.16839
4	1.204	0.10114
5	1.199	0.07434
6 & later	1.000	**

* The adjusted termination rates derived from the application of the adjustment factors to the DTS Valuation Table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (*Transactions of the Society of Actuaries* (TSA) XXXVII, pp. 457-463) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

** Applicable DTS Valuation Table duration rate from exhibits 3c and 4 (TSA XXXVII, pp. 462-463).

[13.10.14.26 NMAC - N, 10-1-03]

PART 15: LONG-TERM CARE INSURANCE

13.10.15.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[1-1-99; A, 1-1-99; 13.10.15.1 NMAC - Rn & A, 13 NMAC 10.15.1, 1-1-04]

13.10.15.2 SCOPE:

This rule applies to all long-term care insurance policies and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or

after January 1, 1999 by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. Additionally, this rule is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if: 1) the benefits of the disability inicome policy are dependent upon or vary in amount based on the receipt of long-term care services; 2) the disability income policy is advertised, marketed or offered as insurance for long-term care services; or 3) benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

[1-1-99; A, 1-1-99; 13.10.15.2 NMAC - Rn & A, 13 NMAC 10.15.2, 1-1-04]

13.10.15.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-23A-6 and 59A-23A-9 NMSA 1978.

[1-1-99; 13.10.15.3 NMAC - Rn, 13 NMAC 10.15.3, 1-1-04]

13.10.15.4 DURATION:

Permanent.

[1-1-99; 13.10.15.4 NMAC - Rn, 13 NMAC 10.15.4, 1-1-04]

13.10.15.5 EFFECTIVE DATE:

January 1, 1999, unless a later date is cited at the end of a section.

[1-1-99; 13.10.15.5 NMAC - Rn & A, 13 NMAC 10.15.5, 1-1-04]

13.10.15.6 OBJECTIVE:

The purpose of this rule is to implement Chapter 59A, Article 23A NMSA 1978 to promote the public interest and the availability of long-term care insurance coverage, and to facilitate flexibility and innovation in the development of long-term care insurance.

[1-1-99; 13.10.15.6 NMAC - Rn, 13 NMAC 10.15.6, 1-1-04]

13.10.15.7 DEFINITIONS:

In additon to the definitions in Section 59A-23A-4 NMSA 1978, the following terms have the meanings given here.

A. "Basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

B. "Basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

C. "Converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Superintendent to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made.

D. "Exceptional increase" means only those increases filed by an insurer as exceptional for which the superintendent determines the need for the premium rate increase is justified: 1) due to a change in laws or rules applicable to long-term care coverage in this state or 2) due to increased and unexpected utilization that affects a majority of insurers of similar products.

E. "Incidental" as used in Subsection J of 13.10.15.33 NMAC, means that the value of the long-term care benefits prpovided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy, measured as of the date of issue.

F. "Issuer" means an insurer, health care service plan, or other entity marketing or providing long-term care insurance or benefits in this state.

G. "Managed-care plan" means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

H. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

I. "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Paragraph (1) of Subsection C of Section 59A-23A-4 NMSA 1978 are not considered similar to certificates of policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit

classifications. For the purpose of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits

[1-1-99; 13.10.15.7 NMAC - Rn & A, 13 NMAC 10.15.7, 1-1-04]

13.10.15.8 USE OF CERTAIN POLICY TERMS:

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements.

A. Activities of daily living means at least bathing, continence, dressing, eating, toileting and transferring.

B. Acute condition means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. Adult day care means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

D. Bathing means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

E. Cognitive impairment means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. Continence means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

H. Eating means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

I. Hands-on assistance means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

J. Home health care services means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. Medicare shall be defined as The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended, or Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof, or words of similar import.

L. Mental or nervous disorder shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

M. Personal care means the provision of hands-on services to assist an individual with activities of daily living (such as bathing, eating, dressing, transferring and toileting).

N. Skilled nursing care, intermediate care, personal care, home care, and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

O. Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. Transferring means moving into or out of a bed, chair or wheelchair.

Q. All providers of services, including but not limited to skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, personal care facility, and home care agency shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

[1-1-99; 13.10.15.8 NMAC - Rn, 13 NMAC 10.15.8, 1-1-04]

13.10.15.9 RENEWABILITY:

The terms guaranteed renewable and noncancelable shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of 13.10.15.20 NMAC.

A. No policy issued to an individual shall contain renewal provisions other than guaranteed renewable or noncancelable.

B. The term guaranteed renewable may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

C. The term noncancelable may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

D. The term "level premium" may only be used when the insurer does not have the right to change the premium.

[1-1-99; 13.10.15.9 NMAC - Rn & A, 13 NMAC 10.15.9, 1-1-04]

13.10.15.10 LIMITATIONS AND EXCLUSIONS:

A. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) preexisting conditions or diseases;

(2) mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) alcoholism and drug addiction;

(4) illness, treatment or medical condition arising out of:

(a) war or act of war (whether declared or undeclared);

(b) participation in a felony, riot or insurrection;

(c) service in the armed forces or units auxiliary thereto;

(d) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(e) aviation (this exclusion applies only to non-fare-paying passengers).

(5) treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers compensation, employers liability or occupational disease law, or any motor vehicle no-fault law, services provided

by a member of the covered persons immediate family and services for which no charge is normally made in the absence of insurance.

B. This section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

[1-1-99; 13.10.15.10 NMAC - Rn, 13 NMAC 10.15.10, 1-1-04]

13.10.15.11 EXTENSION OF BENEFITS:

Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

[1-1-99; 13.10.15.11 NMAC - Rn, 13 NMAC 10.15.11, 1-1-04]

13.10.15.12 CONTINUATION OF COVERAGE OR CONVERSION REQUIRED:

A. Group long-term care insurance issued in this state on or after July 1, 1997 shall provide covered individuals with a basis for continuation or conversion of coverage.

B. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) termination of group coverage resulted from an individuals failure to make any required payment of premium or contribution when due; or

(2) the terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(a) providing benefits identical to or benefits determined by the Superintendent to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(b) the premium for which is calculated in a manner consistent with the requirements of Subsection C of 13.10.15.14 NMAC.

[1-1-99; 13.10.15.12 NMAC - Rn, 13 NMAC 10.15.12, 1-1-04]

13.10.15.13 CONTINUATION OF COVERAGE:

A. Group policies which restrict provision of benefits and services to, or contain incentives to use, certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Superintendent shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

B. Notwithstanding any other provision of Subsection B of 13.10.15.12 NMAC, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

[1-1-99; 13.10.15.13 NMAC - Rn, 13 NMAC 10.15.13, 1-1-04]

13.10.15.14 CONVERSION:

A. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers and/or facilities, the Superintendent, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

B. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy or following payment direction of the insurer, if later. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

C. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

D. Notwithstanding any other provision of Subsection B of 13.10.15.12 NMAC, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted

policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

E. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individuals coverage under the group policy remained in force and effect.

[1-1-99; 13.10.15.14 NMAC - Rn, 13 NMAC 10.15.14, 1-1-04]

13.10.15.15 DISCONTINUANCE AND REPLACEMENT:

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

A. shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

B. shall not vary or otherwise depend on the individuals health or disability status, claim experience or use of long-term care services.

[1-1-99; 13.10.15.15 NMAC - Rn, 13 NMAC 10.15.15, 1-1-04]

13.10.15.16 LIMITATIONS ON PREMIUM RATE INCREASES:

A. The initial premium charged an insured covered by a long-term care policy shall not increase during the initial three (3) years in which the policy is in force.

B. The premium charged to an insured shall not increase due to either:

(1) the increasing age of the insured at ages beyond sixty-five (65); or

(2) the duration the insured has been covered under the policy.

C. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under 13.10.15.43 NMAC, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

D. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under 13.10.15.43 NMAC, the initial annual premium shall be based on the reduced benefits.

[1-1-99; 13.10.15.16 NMAC - Rn, 13 NMAC 10.15.16, 1-1-04]

13.10.15.17 UNINTENTIONAL LAPSE:

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. Designation of person to receive notice.

(1) No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either:

(a) a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium;

(b) or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

(2) The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured.

(3) The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address.

(4) In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

(5) The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

B. Payroll and pension deduction plans. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A of this section need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

C. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A of this section, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

[1-1-99; 13.10.15.17 NMAC - Rn, 13 NMAC 10.15.17, 1-1-04]

13.10.15.18 REINSTATEMENT:

In addition to the requirement in 13.10.15.17 NMAC, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policy holder or certificate holder became cognitively impaired or lost functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof for cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

[1-1-99; 13.10.15.18 NMAC - Rn & A, 13 NMAC 10.15.18, 1-1-04]

13.10.15.19 REQUIRED DISCLOSURE PROVISIONS:

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder. A long-term care insurance policy or certificate, other than the one where the insured does not have the right to change premium, shall include a statement that premium rates may change.

B. Riders and endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased

benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and customary or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as Preexisting Condition Limitations.

E. Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Paragraphs (6) and (7) of Section 59A-23A-6C NMSA 1978 shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph Limitations or Conditions on Eligibility for Benefits.

F. Disclosure of tax consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

[1-1-99; 13.10.15.19 NMAC - Rn & A, 13 NMAC 10.15.19, 1-1-04]

13.10.15.20 REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS:

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2) of this subsection, this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2004.

(2) For certificates issued on or after the effective date of this amended rule under a long-term care insurance policy as defined in Paragraph (1) of Subsection C of Section 59A-23A-4 NMSA 1978, which policy was in force at the time this amended rule became effective, the provisions of this section shall apply on the policy anniversary following July 1, 2004.

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or the certificate holder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect untill a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective; and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (2) of this subsection if the premium rate or rate schedule is changed;

(5) Information regarding each premium rate increase on this form or similar policy forms over the past ten (10) years for this state that a minimum identifies:

(a) The policy forms for which premium rates have been increased;

(b) The calendar years when the form was available for purchase; and

(c) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(6) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(7) An insurer shall have the right to exclude form the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired form other nonaffiliated insurers when those increases occurred prior to the acquisition.

(8) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from

nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four (24) month period following the acquisition of the block or policies, the acquiring insurer may exclude the rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with paragraph (5) of this subsection.

(9) If the acquiring insurer in Paragraph (8) of this subsection files for a subsequent rate increase, even within the 24 month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Paragraph (8) of this subsection, the acquiring insurer must make all disclosure required by Paragraph (5) of this subsection, including disclosure of the earlier rate increase referenced in Paragraph (8) of this subsection.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection B of this section. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in 13.10.15.50 and 13.10.15.53 NMAC to comply with the requirements of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least sixty (60) days prior to the implementation of the premium rate schedule

increase by the insurer. The notice shall include the information required by Subsection B of this section when the rate increase is implemented.

[13.10.15.20 NMAC - N, 1-1-04]

13.10.15.21 INITIAL FILING REQUIREMENTS:

A. This section applies to any long-term care policy issued in this state on or after January 1, 2004.

B. An insurer shall provide the information listed in this subsection to the superintendent along with the form and rate filing required by law.

(1) A copy of the disclosure documents required by 13.10.15.20 NMAC; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate

schedule is reasonably expected to be sustainable over the life of the form with no future premium rate increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include: (i) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held, (ii) a statement that the assumptions used for reserves contain reasonable margins for adverse experience, (iii) a statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted), and (iv) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situation where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the superintendent may request a demonstration under Subsection C of this section based on a standard age distribution.

(e) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences

C. The superintendent may request an actuarial demonstration that benefits are reasonable in relation to premiums.

[13.10.15.21 NMAC - N, 1-1-04]

13.10.15.22 PROHIBITION AGAINST POST-CLAIM UNDERWRITING:

A. All applications for long-term care insurance policies or certificates, except those which are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(1) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

B. Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery: "Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form]/[is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address [insert address]."

(3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

(a) a report of a physical examination;

(b) an assessment of functional capacity;

(c) an attending physicians statement; or

(d) copies of medical records.

C. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

D. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated, and shall annually furnish this information to the Superintendent in the format prescribed by the National Association of Insurance Commissioners in 13.10.15.49 NMAC.

[1-1-99; 13.10.15.22 NMAC - Rn, 13 NMAC 10.15.20, 1-1-04]

13.10.15.23 MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES:

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits by:

(1) requiring that the insured/claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community or institutional setting before home health care services are covered;

(3) limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(5) excluding coverage for personal care services provided by a home health aide;

(6) requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) requiring that the insured/claimant have an acute condition before home health care services are covered;

(8) limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

[1-1-99; 13.10.15.23 NMAC - Rn, 13 NMAC 10.15.21, 1-1-04]

13.10.15.24 REQUIREMENT TO OFFER INFLATION PROTECTION:

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the offer required by Subsection A of this section shall be made to the group policyholder; except, if the policy is issued to a group defined in Paragraph (1) of Subsection C of Section 59A-24A-4 NMSA 1978 other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

C. The offer required by Subsection A of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. Outline of coverage.

(1) Insurers shall include the following information in or with the outline of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

E. Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. Rejection by the applicant.

(1) The inflation protection required by Paragraph (1) of Subsection A of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

(2) The rejection shall be considered a part of the application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection."

[1-1-99; 13.10.15.24 NMAC - Rn & A, 13 NMAC 10.15.22, 1-1-04]

13.10.15.25 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE:

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced provided, however, that the certificate holder has been notified of the replacement.

(1) "Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?"

(2) "Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?"

(a) "If so, with which company?"

(b) "If that policy lapsed, when did it lapse?"

(3) "Are you covered by Medicaid?"

(4) "Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?"

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

C. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, policy number, and address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

D. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 13.9.6 NMAC, Replacement of Life Insurance and Annuities. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care replacement requirements of this section and the life insurance replacement requirements of 13.9.6 NMAC, Replacement of Life Insurance and Annuities.

[1-1-99; 13.10.15.25 NMAC - Rn, 13 NMAC 10.15.23, 1-1-04]

13.10.15.26 SOLICITATIONS OTHER THAN DIRECT RESPONSE:

Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above Notice to Applicant was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

[1-1-99; 13.10.15.26 NMAC - Rn, 13 NMAC 10.15.24, 1-1-04]

13.10.15.27 DIRECT RESPONSE SOLICITATIONS:

Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider

certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] Within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

[1-1-99; 13.10.15.27 NMAC - Rn, 13 NMAC 10.15.25, 1-1-04]

13.10.15.28 REPORTING REQUIREMENTS:

For purposes of this section, policy means only long-term care insurance and report means on a statewide basis.

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agents total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

C. Each insurer shall report annually by June 30th:

(1) the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A of this section.

(2) the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(3) the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

[1-1-99; 13.10.15.28 NMAC - Rn, 13 NMAC 10.15.26, 1-1-04]

13.10.15.29 LICENSING:

No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses.

[1-1-99; 13.10.15.29 NMAC - Rn, 13 NMAC 10.15.27, 1-1-04]

13.10.15.30 DISCRETIONARY POWERS OF SUPERINTENDENT:

The Superintendent may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that:

A. The modification or suspension would be in the best interest of the insureds; and

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(1) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(2) the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(3) the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

[1-1-99; 13.10.15.30 NMAC - Rn, 13 NMAC 10.15.28, 1-1-04]

13.10.15.31 RESERVE STANDARDS:

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Section 59A-8-5 NMSA 1978. Claim reserves must also be established in the case when such policy or rider is in claim status.

B. Reserves for policies and riders should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

C. In the development and calculation of reserves, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) definition of insured events;

(2) covered long-term care facilities;

(3) existence of home convalescence care coverage;

(4) definition of facilities;

(5) existence or absence of barriers to eligibility;

(6) premium waiver provision;

(7) renewability;

(8) ability to raise premiums;

(9) marketing method;

(10) underwriting procedures;

(11) claims adjustment procedures;

(12) waiting period;

(13) maximum benefit;

(14) availability of eligible facilities;

(15) margins in claim costs;

(16) optional nature of benefit;

(17) delay in eligibility for benefit;

(18) inflation protection provisions; and

(19) guaranteed insurability option.

D. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

E. When long-term care benefits are provided other than as described in this section, reserves shall be determined in accordance with Sections 59A-8-6 and 59A-8-7 NMSA 1978.

[1-1-99; 13.10.15.31 NMAC - Rn, 13 NMAC 10.15.29, 1-1-04]

13.10.15.32 LOSS RATIO:

This section does not apply to policies or certificates providing nonforfeiture benefits in accordance with Subsection C of 13.10.15.43 NMAC based on acceptance of the offer of non-forfeiture benefits required by Subsection A of 13.10.15.43 NMAC. This section shall not apply to long-term care insurance policies or certificates covered by 13.10.15.20 and 13.10.15.33 NMAC.

A. Effective January 1, 1999, benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums, provided the expected lifetime loss ratio and future expected loss ratio is at least sixty-five percent (65%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In

evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(1) statistical credibility of incurred claims experience and earned premiums;

(2) the period for which rates are computed to provide coverage;

(3) experienced and projected trends;

(4) concentration of experience within early policy duration;

(5) expected claim fluctuation;

(6) experience refunds, adjustments or dividends;

(7) renewability features;

(8) all appropriate expense factors;

(9) interest;

(10) experimental nature of the coverage;

(11) policy reserves;

(12) mix of business by risk classification; and

(13) product features such as long elimination periods, high deductibles and high maximum limits.

B. Issuers of a life insurance policy that funds long-term care benefits are exempted from the requirements of Subsection A of 13.10.15.32 NMAC if they comply with the requirements of 13.10.15.35 NMAC.

[1-1-99; 13.10.15.32 NMAC - Rn & A, 13 NMAC 10.15.30, 1-1-04]

13.10.15.33 PREMIUM RATE SCHEDULE INCREASES:

A. This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2004.

(2) For certificates issued on or after the effective date of this amended rule under a group policy as defined in Paragraph (1) of Subsection C of Section 59A-23A-4 NMSA 1978, which policy was in force at the time this amended rule became effective,

the provisions of this section shall apply on the policy anniversary following July 1, 2004.

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the superintendent at least thirty (30) days prior to the notice to the policyholders and shall include:

(1) Information required by 13.10.15.20 NMAC;

(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing iss in compliance with the provisions of this section.

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the methods and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale. Annual values for the five (5) years preceeding the three (3) years following the valuation date shall be provided separately. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase. The projections shall demonstrate compliance with Subsection C of this section. For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and in the event the superintendent determines that offsets exist, the insurer shall use appropriate net projected experience.

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates.

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for benefits attributable to benefits, unless sufficient justification is provided to the superintendent; and

(5) Sufficient information for review and approval of the premium rate schedule increase by the superintendent.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times fifty-eight percent (58%);

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) of this paragraph on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in Subsection A of 13.10.14.24 NMAC. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review by the superintendent updated projections, as defined in Subparagraph (a) of Paragraph (3) of

Subsection B of this section, annually for the next three (3) years and include a comparison of actual results to projected values. The superintendent may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the superintendent.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium rate schedule, lifetime projections, as defined in Subparagraph (a) of Paragraph (3) of Subsection B of this section, shall be filed for review by the superintendent every five (5) years following the end of the required period in Subsection D of this section. For group insurance policies that meet the conditions of Subsection K of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the superintendent.

F. The following applies:

(1) If the superintendent has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C of this section, the superintendent may require the insurer to implement any of the following:

(a) premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

(2) In determining whether the actual experience adequately matches projected experience, consideration should be given to Subparagraph (e) of Paragraph (3) of Subsection B of this section, if applicable.

G. If a majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to superintendent approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate the appropriate administration and claims processing have been implemented or are in effect; otherwise the superintendent may impose the conditions in subsection H; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C of this section had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been

used in the calculations described in Subparagraphs (a) and (c) of Paragraph (1) of Subsection C of this section.

H. Further considerations:

(1) For a rate increase filing that meets the following criteria, the superintendent shall review, for all policies included in the filing, the projected lapse rates during the twelve (12) months following each rate increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(2) In the event significant adverse lapsation has occurred, is anticipated in the filings or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the superintendent may determine that a rate spiral exists. Following the determination that a rate spiral exists, the superintendent may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall (i) be subject to the approval of the superintendent, (ii) be based on actuarially sound principles, but not be based on attained age, and (iii) provide that maximum benefits under any new policy accepted by the insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lessor of: (i) the maximum rate increase determined based on combined experience, and (ii) the maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the superintendent determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the superintendent may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following provisions:

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I of this section shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection E of 13.10.15.7 NMAC, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides for insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(a) Section 59A-20-31 NMSA 1978;

(b) Section 59A-20-33 NMSA 1978; and

(c) 13.9.3.17 NMAC.

(3) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by 13.9.15 NMAC, Life Insurance Illustrations;

(b) Disclosure requirements in 13.9.12 NMAC, Annuity and Deposit Fund Disclosure; and

(c) Disclosure requirements in 13.9.3 NMAC, Variable Annuity Contracts.

(4) An actuarial memorandum is filed with the superintendent that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on age of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning

a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H of this section shall not apply to group insurance policies as defined in Paragraph (1) of Subsection C of Section 59A-23A-4 NMSA 1978 where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

[13.10.15.33 NMAC - N, 1-1-04]

13.10.15.34 FILING REQUIREMENTS:

A. An insurer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the superintendent in accordance with filing requirements and procedures prescribed in Chapter 59A, Articles 18, 44, 46 and 47 NMSA 1978. Policies and certificates of a master policy issued as a result of solicitations of individuals by agents, or through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies for the purpose of this section.

B. An insurer shall not use or change premium rates for a long-term care policy or certificate unless the rating schedule and supporting documentation have been filed with and approved by the Superintendent in accordance with the filing requirements and procedures of this rule and Chapter 59A, Articles 18, 44, 46 and 47 NMSA 1978 in a form acceptable to the Superintendent.

C. An insurer or a similar organization offering group long-term care insurance to a resident of this state pursuant to Section 59A-23A-5 NMSA 1978 shall file with the Superintendent evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

[1-1-99; 13.10.15.34 NMAC - Rn, 13 NMAC 10.15.31, 1-1-04]

13.10.15.35 EXEMPTION FROM LOSS RATIO REQUIREMENTS:

Issuers of a life insurance policy that funds long-term care benefits entirely by accelerating the death benefit are exempted from 13.10.15.32 NMAC if they provide to the Superintendent:

A. a statement that the interest credited to determine cash value accumulations, including long-term care, if any, are guaranteed to be not less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy.

B. a statement that the life insurance policy meets the requirements of the standard non-forfeiture law, Section 59A-20-31NMSA 1978.

C. a statement that the life insurance policy reserves are set based upon Section 59A-8-5 NMSA 1978.

D. a statement that the policy meets the disclosure requirements of this rule and Section 59A-23A NMSA 1978.

E. a statement that any policy illustration used meets the requirements of rules adopted by the superintendent.

F. an actuarial memorandum which shall include:

(1) a description of the basis on which the long-term care rates were determined;

(2) a description of the basis for the reserves;

(3) a summary of the type of policy benefits, renewability, general marketing method and limits on ages of issuance;

(4) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium, dollars per policy and dollars per unit of benefits, if any;

(5) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; and

(6) the estimated average annual premium per policy and the average issue age;

G. a statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

H. a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy both for active lives and those in long-term care claim status.

I. a certification by an actuary who is a member of the American Academy of Actuaries that the information contained in the memorandum is proper to the best of the actuary's knowledge and judgment.

[1-1-99; 13.10.15.35 NMAC - Rn, 13 NMAC 10.15.32, 1-1-04]

13.10.15.36 FILING REQUIREMENTS FOR ADVERTISING:

A. Every issuer shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Superintendent for review or approval by the Superintendent as required under Section 59A-23A-11 NMSA 1978. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

B. The Superintendent may exempt from these requirements any advertising form or material when, in the Superintendent's opinion, this requirement may not be reasonably applied.

[1-1-99; 13.10.15.36 NMAC - Rn, 13 NMAC 10.15.33, 1-1-04]

13.10.15.37 STANDARDS FOR MARKETING:

Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

A. establish marketing procedures and agent training requirements to assure that:

(1) any marketing activities, including any comparison of policies by its agents or other producers will be fair and accurate; and .

(2) excessive insurance is not sold or issued;

B. display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and the policy the following: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations;"

C. provide copies of the disclosure forms required by Subsection C of 13.10.15.20 NMAC to the applicant;

D. inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance;

E. establish auditable procedures for verifying compliance with this section;

F. if the Superintendent approves a senior insurance counseling program for New Mexico, provide written notice at solicitation to the prospective policyholder and certificate holder that such a program is available and the name, address and telephone number of the program;

G. use the terms noncancelable or level premium for long-term care health insurance policies and certificates only when the policy or certificate conforms to Subsection C of 13.10.15.9 NMAC; and

H. provide an explanation of contingent benefit upon lapse provided for in Subsection B of 13.10.15.43 NMAC.

[1-1-99; 13.10.15.37 NMAC - Rn & A, 13 NMAC 10.15.34, 1-1-04]

13.10.15.38 PROHIBITED MARKETING PRACTICES:

In addition to the practices prohibited in Chapter 59A, Article 16 NMSA 1978, the following acts and practices are prohibited

A. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

B. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether

explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

C. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

[1-1-99; 13.10.15.38 NMAC - Rn, 13 NMAC 10.15.35, 1-1-04]

13.10.15.39 ASSOCIATIONS:

A. The primary responsibility of an association endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

B. The insurer shall file with the Superintendent the following material:

(1) the policy and certificate as required herein,

(2) a corresponding outline of coverage,

(3) the premium rates as required herein, and

(4) all advertisements requested by the Superintendent.

C. The association shall disclose in any long-term care insurance solicitation:

(1) the specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members, and

(2) a brief description of the process under which such policies and the insurer issuing such policies were selected.

D. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose such fact to its members.

E. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve such insurance policies as well as the compensation arrangements made with the insurer.

F. The association shall also:

(1) at the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update such examination thereafter in the event of material change;

(2) actively monitor the marketing efforts of the insurer and its agents; and

(3) review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding such policies or certificates.

G. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the Superintendent the information required by this rule.

H. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements of this section.

I. Failure to comply with the filing and certification requirements of 13.10.15.36 through 10.13.15.39 NMAC constitutes an unfair trade practice in violation of Chapter 59A, Article 16 NMSA 1978.

[1-1-99; 13.10.15.39 NMAC - Rn, 13 NMAC 10.15.36, 1-1-04]

13.10.15.40 SUITABILITY:

This section shall not apply to life insurance policies that accelerate benefits for long-term care.

A. Every issuer shall:

(1) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the Superintendent.

B. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

C. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

D. The issuer shall provide the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" at the same time as the personal worksheet is provided to the applicant. The form shall be in the format contained in 13.10.15.51 NMAC, in not less than twelve (12) point type.

E. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to proved the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to 13.10.15.49 NMAC. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

F. The issuer shall report annually to the Superintendent the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

[1-1-99; 13.10.15.40 NMAC - Rn, 13 NMAC 10.15.37, 1-1-04]

13.10.15.41 REQUIREMENTS FOR LONG-TERM CARE INSURANCE PERSONAL WORKSHEETS:

A. To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(1) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(3) the values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

B. The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Subsection A of of this section. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in 13.10.15.50 NMAC, in

not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Superintendent.

C. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

D. No issuer or agent may sell or disseminate outside the company or any information obtained through the personal worksheet in in 13.10.15.50 NMAC.

[1-1-99; 13.10.15.41 NMAC - Rn, 13 NMAC 10.15.38, 1-1-04]

13.10.15.42 PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES:

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

[1-1-99; 13.10.15.42 NMAC - Rn, 13 NMAC 10.15.39, 1-1-04]

13.10.15.43 NONFORFEITURE BENEFIT REQUIREMENT:

This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

A. Offer required. No policy or certificate may be delivered or issued for delivery in this state unless a policy or certificate providing for nonforfeiture benefits to the defaulting or lapsing policyholder or certificate holder has been offered to the applicant.

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility requirements, benefit triggers and benefit length that are the same as coverage offered without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Subsection C of this section.

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(3) If the offer required to be made pursuant to this subsection is rejected, the insurer shall provide the contingent benefit upon lapse described in Subsection B of this section.

B. Contingent benefit upon lapse.

(1) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Paragraph (2) of this subsection based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the increased premium. Unless otherwise required, policyholders shall be notified at least sixty (60) days prior to the due date of the premium reflecting the rate increase.

(2) Triggers for a substantial premium increase:

ISSUE AGE	**PERCENT INCREASE OVER INITIAL PREMIUM**
29 and under	200%
30-34	**190%**
35-39	**170%**
40-44	**150%**
45-49	**130%**
50-54	**110%**
55-59	**90%**
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%

69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(3) On or before the effective date of a substantial premium increase as defined in Paragraph (1) of Subsection B of this section, the insurer shall:

(a) offer to reduce the policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(b) offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection C of this section. This option may be elected at any time during the 120-day period referenced in Subsection A of this section; and

(c) notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced Paragraph (1) of Subsection B of this section shall be deemed to be the election of the offer to convert in Subparagraph (b) of Paragraph (3) of Subsection B of this section.

(4) To determine whether contingent benefit upon lapse provisions are triggered under Paragraph (1) of Subsection B of this section, a replacing insurer that purchased or otherwise assumed a block of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

C. Nonforfeiture benefits. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases with increasing age:

(a) at least one percent (1%) plus the scheduled percentage increase in benefits per year prior to age fifty (50); and

(b) at least three percent (3%) plus the scheduled percentage increase in benefits per year beyond age fifty(50).

(2) For purposes of this subsection, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3) of Subsection B of this section.

(3) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits and premiums waived. Except as provided in Paragraph (1) of Subsection C of this section, benefits paid during premium paying status will not reduce the standard nonforfeiture credit. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that

duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Paragraph (1) of Subsection C of this section.

(4) Where more than one individual is covered under an individual policy or group certificate, the method of allocation of the nonforfeiture credit to each of the individuals shall be based on:

(a) the ratio of the premium that would have been paid had the individual purchased coverage separately to the total premium that would have been paid for all individuals assuming each had purchased coverage separately; or

(b) any reasonable actuarial method, provided such method has been described in the policy form filing.

(5) The nonforfeiture benefit and the contingent benefit upon lapse shall begin not later than the end of the third year following the policy or certificate issue date.

(6) Notwithstanding Paragraph (5) of Subsection B of this section, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(a) the end of the tenth year following the policy or certificate issue date; or

(b) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(7) For policies or certificates issued on limited payment plans, nonforfeiture benefits shall begin not later than the first year following the policy or certificate issue date for limited pay periods shorter than 10 years. Nonforfeiture benefits for plans with limited pay periods less than 20 years but at least 10 years shall begin not later than the second year.

(8) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(9) No nonforfeiture option may include the offering of a cash surrender benefit or a loan value

D. General provisions.

(1) All benefits paid by the insurer while the policy or certificate is in premium paying status and in paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

(2) There shall be no difference in the minimum nonforfeiture benefits required by this section for group and individual policies.

(3) The requirements of this section apply to all long-term care insurance policies issued on or after January 1, 1998.

(4) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the lifetime loss ratio requirements of 13.10.15.32 NMAC treating the policy as a whole.

[1-1-99; 13.10.15.43 NMAC - Rn & A, 13 NMAC 10.15.40, 1-1-04]

13.10.15.44 STANDARDS FOR BENEFIT TRIGGERS:

The requirements of this section apply to all long-term care insurance policies issued on or after January 1, 1999.

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

B. Activities of daily living.

(1) Activities of daily living shall include at least the following as defined in 13.10.15.8 NMAC and in the policy:

(a) bathing;

(b) continence;

(c) dressing;

(d) eating;

(e) toileting; and

(f) transferring.

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) of Subsection B of this section as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B of this section.

D. For purposes of this section the determination of a deficiency shall not be more restrictive than:

(1) requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

F. Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

[1-1-99; A, 1-1-99; 13.10.15.44 NMAC - Rn, 13 NMAC 10.15.41, 1-1-04]

13.10.15.45 CONTENTS OF OUTLINE OF COVERAGE:

A. The outline of coverage shall be a free-standing document, using no smaller than ten point type.

B. The outline of coverage shall contain no material of an advertising nature.

C. Text which is capitalized or underscored in the standard format for outline of coverage provided in 13.10.15.46 NMAC may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

D. Use of the text and sequence of text of the standard format for outline of coverage provided in 13.10.15.46 NMAC is mandatory, unless otherwise specifically indicated.

[1-1-99; 13.10.15.45 NMAC - Rn, 13 NMAC 10.15.42, 1-1-04]

13.10.15.46 STANDARD FORMAT FOR OUTLINE OF COVERAGE:

[Company Name] [Address City & State]

[Telephone Number]

LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. TYPE OF POLICY. This policy is [an individual policy of insurance] [a group policy which was issued in the (indicate jurisdiction in which group policy was issued)].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY][CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of the [POLICY][CERTIFICATE]. This [POLICY][CERTIFICATE] is not intended to be a federally tax-qulified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Benefits received under this [POLICY][CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

A. [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions

i. Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy,[certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

ii. [Policies and certificates that are noncancelable shall contain the following statement] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

B. [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

C. [Describe waiver of premium provisions or state that there are not such provisions;]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has the right to change the premium, and if a right exists, describe clearly and voncisely each circumstance under which thepremium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

A. [Provide a brief description of the right to return free look provision of the policy.]

B. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the insurance company.

A. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

B. [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

A. [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

B. [Institutional benefits, by skill level.]

C. [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

10. LIMITATIONS AND EXCLUSIONS. Describe:

A. Preexisting conditions;

B. Non-eligible facilities/provider;

C. Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

D. Exclusions/exceptions;

E. Limitations.

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (8) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH

YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following

A. That the benefit level will not increase over time;

B. Any automatic benefit adjustment provisions;

C. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

D. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

E And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

A. State the total annual premium for the policy;

B. If the premium varies with an applicants choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

14. ADDITIONAL FEATURES.

A. Indicate if medical underwriting is used;

B. Describe other important features.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IS YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

[1-1-99; 13.10.15.46 NMAC - Rn & A, 13 NMAC 10.15.43, 1-1-04]

13.10.15.47 REQUIREMENT TO DELIVER SHOPPER'S GUIDE:

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Superintendent, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide must be sent with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the shopper's guide, but shall furnish the policy summary required by Section 59A-23A-6 NMSA 1978.

[1-1-99; 13.10.15.47 NMAC - Rn, 13 NMAC 10.15.44, 1-1-04]

13.10.15.48 PENALTIES:

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

[1-1-99; 13.10.15.48 NMAC - Rn, 13 NMAC 10.15.45, 1-1-04]

13.10.15.49 APPENDIX A:

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF NEW MEXICO FOR THE REPORTING YEAR [ ]

Company Name:_____

Address: _____

_____

Phone Number:_____

Due: March 1 annually

INSTRUCTIONS

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form	Policy and Certificate Number	Name of Insured	Date of Policy Issuance	Date(s) Claim(s) Submitted	Date of Rescission

Detailed reason for rescission:

_____

_____

_____

_____

_____

Signature

_____

Name and Title (please type)

_____

Date

[1-1-99; 13.10.15.49 NMAC - Rn, 13 NMAC 10.15.46, 1-1-04]

13.10.15.50 APPENDIX B:

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long term care insurance can be expensive, and is not appropriate for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the insurance company decide if you should buy this policy.

Premium Information

Policy Form Number(s)_____

The premium for the coverage you are considering will be [$_____ per month, or $____per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable):_____

The Company's Right to Increase Premiums:_____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).]

Questions Related to Your Income

How will you pay each years' premiums?

___ From My Income ___ From My Savings\Investments ___ My Family will Pay

[Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

What is your annual income? (check one)

___ Under $10,000 ___ $10-20,000 ___ $20-30,000 ___ $30-50,000 ___ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

___ No change ___ Increase ___ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ____ yes ____ no

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

___ From My Income ___ From My Savings\Investments ___ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What elimination period are you considering? Number of days _____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period?

___ From My Income ___ From My Savings\Investments ___ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)

___ Under $20,000 ___ $20-30,000 ___ $30-50,000 ___ Over $50,000

How do you expect your assets to change over the next ten years?

___ Stay about the same ___ Increase ___ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

___ The answers to the questions above describe my financial situation.

or

___ I choose not to complete this information.

___ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium rate increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and the potential for premium rate increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed:_____ Date: _____

(Applicant)

[___ I explained to the applicant the importance of completing this information.

Signed:_____
Date:_____

(Agent)

Agent's printed name _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.]

Signed:_____
Date:_____

(Applicant)

The company may contact you to verify your answers.

[1-1-99; 13.10.15.50 NMAC - Rn & A, 13 NMAC 10.15.47, 1-1-04]

13.10.15.51 APPENDIX C:

THINGS YOU SHOULD KNOW BEFORE YOU BUY: LONG-TERM CARE INSURANCE

Long-term Care Insurance A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare Medicare does **not** pay for most long-term care.

Medicaid Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid. Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services. When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets. Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide Make sure the insurance company or agent gives you a copy of a book called National Association of Insurance Commissioners" "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

[1-1-99; 13.10.15.51 NMAC - Rn, 13 NMAC 10.15.48, 1-1-04]

13.10.15.52 APPENDIX D:

LONG-TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]

Your recent application for long-term care insurance included a personal worksheet which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

___ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

___ **No**, I have decided not to buy a policy at this time.

Signed: _____
Applicant

Date: _____

[1-1-99; 13.10.15.52 NMAC - Rn, 13 NMAC 10.15.49, 1-1-04]

13.10.15.53 APPENDIX E

POTENTIAL RATE INCREASE DISCLOSURE FORM

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurer shall provide all of the following information to the applicant:

Long-term care Insurance

Potential rate Increase Disclosure Form

1. **[Premium Rate][Premium Rate Schedules]:** [Premium Rate][Premium Rate Schedules] that [is][are] applicable to you and that will be in effect until a request is made and approved for an increase [is][are] [on the application][$_____]

2. **The [premium][premium rate schedule] for this policy [will be shown on the schedule page of][will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (fill in the blank):_____.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise a least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This optionis available for purchase for additioonal premium.)

- Exercise your contingent nonforfeiture rights* (This option may be available if you do not purchase a separate nonforfeiture option.)

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount,

will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $ 1,000 annual premium for 10 years, so you have paid a total of $ 10,000 in premium.
- In the eleventh year, you received a rate increase of 50%, or $ 500 for a new annual premium of $ 1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $ 10,000 (provided you have at least $ 10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture

Cumulative Premium Increase over Initial Premium

That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from the date of original issue. It does NOT represent a one-time increase)

ISSUE AGE	PERCENT INCREASE OVER INITIAL PREMIUM
29 and under	200%
30-34	**190%**
35-39	**170%**
40-44	**150%**
45-49	**130%**
50-54	**110%**
55-59	**90%**
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%

73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[13.10.15.53 NMAC - N, 1-1-04]

PART 16: PROVIDER GRIEVANCES

13.10.16.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.10.16.1 NMAC - Rp, 13.10.16.1 NMAC, 01/01/2023]

13.10.16.2 SCOPE:

A. This rule applies to every:

(1) health insurance carrier, as defined in Paragraph (2) of Subsection C of Section 59A-16-21.2 NMSA 1978;

(2) vision and dental plans that use a provider network; and

(3) multiple employer welfare arrangement (individually a "carrier" and collectively "carriers").

B. A carrier is not subject to this rule with respect to any "health benefits plan" or "plan" as defined in Paragraph (1) of Subsection C of Section 59A-16-21.2 NMSA 1978, which only provides "excepted benefits," as this term is defined in Subsection B of Section 59A-23G-2 NMSA 1978.

[13.10.16.2 NMAC - Rp, 13.10.16.2 NMAC, 01/01/2023]

13.10.16.3 STATUTORY AUTHORITY:

Sections 59A-16-21.1, 59A-23-14, 59A-46-54, 59A-47-49 and 59A-57-6 NMSA 1978.

[13.10.16.3 NMAC - Rp, 13.10.16.3 NMAC, 01/01/2023]

13.10.16.4 DURATION:

Permanent.

[13.10.16.4 NMAC - Rp, 13.10.16.4 NMAC, 01/01/2023]

13.10.16.5 EFFECTIVE DATE:

January 1, 2023, unless a later date is cited at the end of a section.

[13.10.16.5 NMAC - Rp, 13.10.16.5 NMAC, 01/01/2023]

13.10.16.6 OBJECTIVE:

The purpose of this rule is to mandate provider grievance processes that are fair, efficient and compliant with all applicable state and federal laws, and to specify practices and procedures for external OSI review of provider grievance appeals.

[13.10.16.6 NMAC - Rp, 13.10.16.6 NMAC, 01/01/2023]

13.10.16.7 DEFINITIONS:

A. Terms used in this rule are as defined in Section 59A-22B-2 NMSA 1978 and in 13.10.29 NMAC.

B. For the purposes of this rule, the subsequent term is supplemented and superseded as follows; **"Termination"** means the discontinuance of a provider's employment, contractual relationship or other business relationship with, and initiated by, a carrier.

[13.10.16.7 NMAC - Rp, 13.10.16.7 NMAC, 01/01/2023]

13.10.16.8 GENERAL RULES:

A carrier shall adopt and implement a provider grievance plan that complies with this rule. This rule does not preclude a carrier and provider from addressing or resolving a concern through any other process agreed on between them, but no such alternative process shall preclude a provider from presenting a grievance through a process that complies with this rule.

A. Allowed grievances. At a minimum, a carrier's provider grievance plan shall allow a provider to present any concern regarding:

(1) credentialing deadlines;

(2) claim payment amount or timing;

(3) claim submission requirements or compliance;

(4) network adequacy, including participation determinations based on network composition;

(5) network composition including provider qualifications;

(6) utilization management practices;

(7) provider contract construction or compliance;

(8) patient care standards or access to care;

(9) surprise billing reimbursement amount, rate or timing;

(10) termination;

(11) operation of the plan including compliance with any law enforceable by the superintendent, or of any directive of the superintendent; or

(12) Discrimination.

B. Timeline to file. A provider grievance plan shall allow a provider at least 90 days from the incident that is the subject of the grievance, to file a grievance.

C. Filing procedures and response. A provider grievance plan shall allow a provider to submit a written grievance electronically or manually. A carrier shall send a written acknowledgment of the grievance to the provider within five days of its receipt of the grievance using the provider's preferred communication method.

D. Point of contact. A provider grievance plan may require the submission of a complaint to a designated contact, as specified in the carrier's provider manual which shall identify the designated contact by name or position and provide a valid mailing address, phone number, and email address for the designated point of contact.

E. Request for supplemental information. A provider grievance plan may allow a carrier to request supplemental information pertinent to the resolution of a grievance from the provider. Any such request shall be made within 10 days of the carrier's receipt of a grievance, and shall require the provider to submit the requested supplemental information within the next 10 days.

F. Review panel. A provider grievance plan shall, at a minimum, require a carrier to form a review panel comprised of multiple members, at least one of whom is in a position of authority over the carrier operations that are the subject of a grievance. The review panel shall be responsible for reviewing and deciding the provider's grievance. If the grievance raises a quality-of-care concern the panel must include a New Mexico-licensed medical professional who practices in the general area of concern. A New Mexico-licensed physician shall be included on a review panel considering complex quality-of-care concerns. No person with a conflict of interest shall participate in a decision to resolve a grievance. Employment with the carrier, standing alone, does not present a conflict of interest.

G. Response. A provider grievance plan shall require a carrier to deliver a written response, to a grievance using the provider's preferred method of communication within 45 days of the later of receipt of the grievance, receipt of supplemental information requested to resolve the grievance, or the due date for submission of any requested supplemental information. The response shall include:

(1) the name(s), title(s), and qualification(s) of each person who participated in the grievance decision;

(2) a statement of issue(s) decided and of the ultimate decision(s);

(3) a clear and complete explanation of the rationale for the decision and a summary of the evidence relied upon to support the decision;

(4) a summary of any proposed remedial action; and

(5) information on the provider's appeal rights.

H. Extension of deadlines. If confirmed in a documented communication a carrier and provider may agree to extend any deadline imposed by this rule or a provider grievance plan.

I. Presentation of evidence. A provider grievance plan shall include reasonable procedures by which a provider may present oral or documentary evidence to the assigned grievance panel.

J. Bundled or group grievances. A provider grievance plan shall allow a provider to submit multiple related grievances simultaneously provided the grievances are not unduly duplicative or repetitive, and for a group of providers to assert a single grievance on behalf of multiple providers.

K. Non-participating providers. A carrier's provider grievance plan shall allow a non-participating provider to submit a grievance described in Paragraphs (1), (2), (4), (5), (6), (9) or (12) of Subsection A of this section. The grievance must assert and explain that the carrier's act or practice directly impacted the non-participating provider or a patient of that provider.

[13.10.16.8 NMAC - Rp, 13.10.16.8 NMAC, 01/01/2023]

13.10.16.9 PROVIDER TERMINATION:

For a grievance that concerns a termination a provider grievance plan shall also comply with this section.

A. Terminations for cause. If a termination for cause, the provider grievance plan shall provide a fair hearing process that provides these minimum rights and protections:

(1) the right of the provider to appear in person at a hearing before the deciding panel;

(2) the right of the provider to present testimonial or documentary evidence at the hearing;

(3) the right of the provider to call witnesses, and cross-examine any witness;

(4) the right of the provider to be represented by an attorney or by any other person of the provider's choice;

(5) the right to an expedited hearing within 14 days of the termination in those instances where the carrier has not provided advance written notice of termination and the termination could result in imminent and significant harm to a covered person;

(6) a written decision within 20 days after the hearing, contemporaneously delivered via the provider's preferred method of communication; and

(7) if a group of providers is terminated for cause, each provider in the group shall have an individual right to a hearing. However, if any one of the providers in the group submits a grievance relating to the termination the carrier shall provide each similarly situated provider in the group with a notice of hearing, and each provider who receives such notice shall be bound by the carrier's determination subject to any appeal rights.

B. Other terminations. If a termination is not for cause, the provider grievance plan shall require the carrier to furnish the provider written notice at least 60 days before the effective date of termination. Such notice shall:

(1) be communicated in writing via the format preferred by the provider; and

(2) contain an explanation of the termination.

[13.10.16.9 NMAC - Rp, 13.10.16.9 NMAC, 01/01/2023]

13.10.16.10 APPEALS:

At the request of a provider, the superintendent shall conduct an external review of a provider grievance as authorized by this section.

A. Types of grievances subject to appeal. The superintendent shall only review a provider grievance that pertains to:

(1) an alleged violation of a law enforceable by the superintendent;

(2) alleged noncompliance with an order of the superintendent; or

(3) a termination based on a provider's alleged failure to comply with a law or order enforceable by the superintendent.

B. Disposition. In the disposition of an appeal, the superintendent may only impose a remedy, penalty, or corrective action authorized by the Insurance Code.

C. Exhaustion of internal remedies required. The superintendent shall not review a provider grievance appeal unless the provider has exhausted the carrier's internal grievance process.

D. Timeline for filing appeal. A provider appeal of a grievance shall be filed no later than 30 days after the provider receives a response to the grievance, or the deadline for the response, whichever is earlier.

E. Appeal content. The superintendent shall not review a provider grievance appeal that does not contain the following information:

(1) the provider's name, license number, address, daytime telephone number, email address, and any relevant claim number(s);

(2) the name and phone number of the carrier;

(3) certification that the grievance did not pertain to Medicaid or Medicare coverage, excluding Medicare supplement;

(4) a copy of the carrier's written disposition of the grievance, or certification by the provider that the carrier did not issue a written disposition within the time allowed by law;

(5) the date the provider received the carrier's written disposition of the grievance, or the date by which the carrier was required to provide a written disposition if no disposition was received; and

(6) a clear and concise statement of the issue on appeal, and the remedy requested on appeal.

F. Additional documentation. Within 45 days of receipt of a provider grievance appeal, the superintendent shall determine whether the appeal is authorized by this section and otherwise reviewable. The superintendent may request supplemental information from the provider or carrier to so determine. The time between any such request and the delivery of the requested information by the superintendent shall be excluded from the 45-day deadline imposed by this section.

(1) If the superintendent determines that an appeal is not authorized or reviewable, the superintendent shall issue an order dismissing the appeal and stating the reason for dismissal.

(2) If the superintendent determines that an appeal is authorized and reviewable, the superintendent shall schedule either a formal or an informal hearing pursuant to the superintendent's rules, as appropriate to the issues, facts and circumstances presented in the appeal. The order setting the hearing shall authorize a designated hearing officer to take or authorize any action authorized by law to resolve the appeal.

G. Settlement. The superintendent may order the parties to an appeal to participate in formal or informal settlement discussions focused on resolving the issue on appeal. If all parties to an appeal consent, the assigned hearing officer may facilitate the settlement discussions without being disqualified from issuing a recommended decision on appeal.

H. Waiver. Upon an express finding of good cause, the superintendent may waive any deadline, format or process requirement imposed by this section.

[13.10.16.10 NMAC - Rp, 13.10.16.10 NMAC, 01/01/2023]

13.10.16.11 RETALIATORY ACTION PROHIBITED:

No person shall be subject to retaliatory action by a carrier for submitting or supporting a grievance or appeal.

[13.10.16.11 NMAC - N, 01/01/2023]

13.10.16.12 PROVIDER MANUAL:

A carrier's provider manual shall include a clear statement of a provider's right to grieve, the internal grievance process, the right of appeal and the appeal process. The carrier shall publish its provider grievance plan on a website accessible to any provider.

[13.10.16.12 NMAC - N, 01/01/2023]

13.10.16.13 REPORTING AND COMPLIANCE:

A. Provider grievance plan publication and changes. No carrier shall publish a provider grievance plan., or any amendment of a provider grievance plan., that has not been reviewed and approved by the superintendent. A provider grievance plan shall be deemed approved if the superintendent fails to expressly approve, disapprove, or object to the provider grievance plan within 60 days from submission.

B. Submission of provider grievance plan. In conjunction with the provider contract certificate, a carrier shall submit a provider grievance plan for the superintendent's review and approval. At a minimum, the provider grievance plan shall include:

(1) a description of the procedures used by the carrier to receive, review, and respond to a provider grievance;

(2) the criteria and process the carrier uses to select the persons responsible for reviewing and responding to a provider grievance;

(3) the procedures by which the carrier's governing body is informed of provider grievances and the carrier's responses; and

(4) the title of staff responsible for implementation and oversight of the provider grievance process.

C. Grievance log. A carrier shall maintain a detailed log of provider grievances and their resolutions for a period of no less than five years. The carrier shall make the log available to the superintendent upon request.

[13.10.16.13 NMAC - N, 01/01/2023]

13.10.16.14 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.16.14 NMAC – N, 01/01/2023]

PART 17: GRIEVANCE PROCEDURES

13.10.17.1 ISSUING AGENCY:

Office of Superintendent of Insurance (OSI), Managed Health Care Bureau (MHCB).

[13.10.17.1 NMAC - Rp, 13.10.17.1 NMAC, 1/1/17]

13.10.17.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer or administer health benefits plans, including health benefits plans:

(1) with a point-of-service option that allows subscribers to obtain health care services out-of-network;

(2) provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act (Sections 13-7-1 through 13-7-11 NMSA 1978); and

(3) utilizing a preferred provider network, as defined under Section 59A-22A-3 NMSA 1978.

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

(1) only short-term travel, accident-only, specified disease or other limited benefits; or

(2) credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit; or

(3) self-funded plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

C. Conflicts. For purpose of this rule, if any provision in this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care or 13.10.16 NMAC, Provider Grievances, the provisions in this rule shall apply.

[13.10.17.2 NMAC - Rp, 13.10.17.2 NMAC, 1/1/17]

13.10.17.3 STATUTORY AUTHORITY:

Sections 59A-1-16, 59A-2-8, 59A-2-9, 59A-15-16, 59A-16-3, 59A-16-11, 59A-16-12, 59A-16-12.1, 59A-16-20, 59A-16-22, 59A-19-4, 59A-19-6, 59A-22A-7, 59A-46-10, 59A-46-11, 59A-57-2, 59A-57-4, and 59A-57-5 NMSA 1978.

[13.10.17.3 NMAC - Rp, 13.10.17.3 NMAC, 1/1/17]

13.10.17.4 DURATION:

Permanent.

[13.10.17.4 NMAC - Rp, 13.10.17.4 NMAC, 1/1/17]

13.10.17.5 EFFECTIVE DATE:

January 1, 2017, unless a later date is cited at the end of a section.

[13.10.17.5 NMAC - Rp, 13.10.17.5 NMAC, 1/1/17]

13.10.17.6 OBJECTIVE:

The purpose of this rule is to establish procedures for filing and processing adverse determination grievances and administrative grievances regarding actions taken or inaction by a health care insurer.

[13.10.17.6 NMAC - Rp, 13.10.17.6 NMAC, 1/1/17]

13.10.17.7 DEFINITIONS:

As used in this rule:

A. "Administrative decision" means a decision made by a health care insurer regarding any aspect of a health benefits plan other than an adverse determination, including but not limited to:

(1) administrative practices of the health care insurer that affect the availability, delivery, or quality of health care services;

(2) claims payment, handling or reimbursement for health care services, including but not limited to complaints concerning co-payments, co-insurance and deductibles; and

(3) terminations of coverage.

B. "Administrative grievance" means an oral or written complaint submitted by or on behalf of a covered person regarding an administrative decision.

C. "Adverse determination" means any of the following:

(1) any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time);

(2) a denial, reduction, or termination of, or a failure to make full or partial payment for a benefit including any such denial, reduction, termination, or failure to make payments, that is based on a determination of a covered person's eligibility to participate in a health benefits plan; or

(3) a denial, reduction or termination of, or a failure to make full or partial payment for a benefit resulting from the application of any utilization review; or

(4) failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, or investigational or not medically necessary or appropriate.

D. "Adverse determination grievance" means an oral or written complaint submitted by or on behalf of a covered person regarding an adverse determination.

E. "Certification" means a determination by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for determining medical necessity, appropriateness, health care setting, level of care and effectiveness, and the requested health care service is therefore approved.

F. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state in the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

G. "Co-insurance" is a cost-sharing plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid; co-insurance rates may differ for different types of services.

H. "Co-payment" is a cost-sharing plan that requires an insured person to pay a fixed dollar amount when a medical service is received or when purchasing medicine

after the deductible amount, with the health care insurer paying the balance; there may be different co-payments for different types of service.

I. "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan.

J. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

K. "Culturally and linguistically appropriate manner of notice" means:

(1) Notice that meets the following requirements:

(a) the health care insurer must provide oral language services (such as the telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and reviews (including IRO reviews and external reviews) in any applicable non-English language;

(b) the health care insurer must provide, upon request, a notice in any applicable non-English language; and

(c) the health care insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care insurer.

(2) For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health human services (HHS); the counties that meet this 10 percent standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually.

L. "Day or Days" shall be interpreted as follows, unless otherwise specified:

(1) 1-5 days means only working days and excludes weekends and state holidays; and

(2) 6 days or more means calendar days, including weekends and holidays.

M. "Deductible" means a fixed dollar amount that the covered person may be required to pay during the benefit period before the health care insurer begins payment for covered benefits; plans may have both individual and family deductibles and separate deductibles for specific services.

N. "Expedited review" means a review with a shortened timeline, as described in sections 13.10.17.14 NMAC, 13.10.17.16 NMAC, 13.10.17.21 NMAC, 13.10.17.22 NMAC, and 13.10.17.24 NMAC, which is required in urgent care situations or when the grievant is receiving an on-going course of treatment which the health care insurer seeks to reduce or terminate.

O. "External review" means the external review conducted pursuant to this rule by the superintendent or by an IRO appointed by the superintendent, depending on the circumstances.

P. "Final adverse determination" means an adverse determination that has been upheld by a health care insurer at the conclusion of the internal review process.

Q. "Grievance" means an oral or written complaint submitted by or on behalf of a covered person regarding either an adverse determination or an administrative decision.

R. "Grievant" means a covered person or that person's authorized representative, provider or other health care professional with knowledge of the covered person's medical condition, acting on behalf of and with the covered person's consent.

S. "Health benefits plan" means a health plan or a policy, contract, certificate or agreement offered or issued by a health care insurer or plan administrator to provide, deliver, arrange for, pay for or reimburse the costs of health care services, including a traditional fee-for-service health benefits plan and coverage provided by, through or on behalf of an entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act.

T. "Health care insurer" means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, non-profit health benefits plan, fraternal benefit society, vision plan or pre-paid dental plan.

U. "Health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

V. "Health care services" means services, supplies and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

W. "Hearing officer, independent co-hearing officer (ICO)" means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in external review hearings.

X. "Independent review organization (IRO)" means an entity that is appointed by the superintendent to conduct independent external reviews of adverse determinations and final adverse determinations pursuant to this rule; and which renders an independent and impartial decision.

Y. "Initial determination" means a formal written disposition by a health care insurer affecting a covered person's rights to benefits, including full or partial denial of a claim or request for coverage or its initial administrative decision.

Z. "Managed health care bureau (MHCB)" means the managed health care bureau within the office of the superintendent of insurance.

AA. "Medical necessity or medically necessary" means health care services determined by a provider, in consultation with the health care insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the health care insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis, or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury or disease.

BB. "Office of the superintendent of insurance (OSI)" means the office of the superintendent or its staff.

CC. "Post-service claim" means a claim submitted to a health care insurer by or on behalf of a covered person after health care services have been provided to the covered person.

DD. "Prior authorization" (also called pre-certification) means a pre-service determination made by a health care insurer regarding a member's eligibility for services, medical necessity, benefit coverage, location or appropriateness of services, pursuant to the terms of the health care plan.

EE. "Prospective review" means utilization review conducted prior to provision of health care services in accordance with a health care insurer's requirement that the services be approved in advance.

FF."Provider" means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of their license.

GG. "Rescission of coverage" means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

(1) the cancellation or discontinuance of coverage has only a prospective effect; or

(2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

(3) the cancellation or discontinuance of coverage is initiated by the covered person or the covered person's authorized representative and the employer or health care insurer did not, directly or indirectly, take action to influence the covered person's decision or otherwise retaliate against, interfere with, coerce, threaten or intimidate the covered person; or

(4) the cancellation or discontinuance is initiated by the health insurance exchange.

HH. "Retrospective review" means utilization review that is not conducted prior to provision of health care services.

II. "Summary of benefits" means the written materials required by Section 59A-57-4 NMSA 1978 to be given to the grievant by the health care insurer or group contract holder.

JJ. "Superintendent" means the superintendent of insurance, or the office of the superintendent of insurance.

KK. "Termination of coverage" means the cancellation or non-renewal of coverage provided by a health care insurer to a grievant, but does not include a voluntary termination by a grievant, termination initiated by the health insurance exchange, or termination of a health benefits plan that does not contain a renewal provision.

LL. "Traditional fee-for-service indemnity benefit" means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage covered person to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies, or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

MM. "Uniform standards" means all generally accepted practice guidelines, evidence-based practice guidelines, or practice guidelines developed by the federal government, or national and professional medical societies, boards and associations; and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the health care insurer consistent with the federal, national and

professional practice guidelines that are used by a health care insurer in determining whether to certify or deny a requested health care service.

NN. **"Urgent care situation"** means a situation in which the decision regarding certification of coverage shall be expedited because:

(1) the life or health of a covered person would otherwise be jeopardized;

(2) the covered person's ability to regain maximum function would otherwise be jeopardized;

(3) the physician with knowledge of the covered person's medical condition **reasonably** requests an expedited decision;

(4) in the opinion of the physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

(5) the medical exigencies of the case require an expedited decision, or

(6) the covered person's claim otherwise involves urgent care.

OO. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

[13.10.17.7 NMAC - Rp, 13.10.17.7 NMAC, 1/1/17]

13.10.17.8 COMPUTATION OF TIME:

Whenever this rule requires that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within three days after the date it was mailed.

[13.10.17.8 NMAC - Rp, 13.10.17.8 NMAC, 1/1/17]

13.10.17.9 GENERAL REQUIREMENTS REGARDING GRIEVANCE PROCEDURES:

A. Written grievance procedures required. Every health care insurer shall establish and maintain separate written procedures that comply with this rule to provide for the internal review of adverse determination grievances and administrative grievances.

B. Divisible grievance. If a grievance contains clearly divisible administrative and adverse determination issues, then the health care insurer shall initiate separate

complaints for each issue with an explanation of the health care insurer's actions contained in one acknowledgment letter.

C. Assistance to grievants. In those instances, where a grievant requests or expresses interest in pursuing a grievance, the health care insurer shall assist the grievant to complete all the forms required to pursue internal review and shall advise grievant that the MHCB is available for assistance.

D. Retaliatory action prohibited. No person shall be subject to retaliatory action by the health care insurer for any reason related to a grievance.

[13.10.17.9 NMAC - Rp, 13.10.17.9 NMAC, 1/1/17]

13.10.17.10 INFORMATION ABOUT GRIEVANCE PROCEDURES:

A. For covered persons/grievants. A health care insurer shall:

(1) include a clear and concise summary of the grievance procedures, both internal and external, in boldface type in all handbooks or evidences of coverage, issued to covered persons, along with a link to the full version of the grievance procedures, as found on the OSI website;

(2) when the health care insurer makes either an initial or final adverse determination or an administrative decision, provide the following to a covered person, that person's authorized representative or a provider acting on behalf of a covered person:

(a) a concise written summary of its grievance procedures;

(b) a copy of the applicable grievance forms;

(c) a link to the full version of the grievance procedures, as found on the OSI website; and

(d) a toll-free telephone number, facsimile number, e-mail and mailing addresses of the health care insurer's consumer assistance office and for the MHCB.

(3) notify covered person that a representative of the health care insurer and the MHCB are available upon request to assist covered person with grievance procedures by including such information and a toll-free telephone number for obtaining such assistance in the enrollment materials and summary of benefits issued to covered person;

(4) make available on its website or upon request, consumer education brochures and materials developed and approved by the superintendent in consultation with the health care insurer;

(5) provide notice to covered person in a culturally and linguistically appropriate manner as defined in Subsection H of 13.10.17.7 NMAC;

(6) provide continued coverage for an approved on-going course of treatment pending the final determination on review;

(7) not reduce or terminate an approved on-going course of treatment without first notifying the grievant sufficiently in advance of the reduction or termination to allow a covered person to request a review and obtain a final determination on review of the proposed reduction or termination; and

(8) allow covered person in urgent care situations and those receiving an on-going course of treatment that the health care insurer seeks to reduce or terminate to proceed with an expedited IRO review at the same time as the internal review process.

B. For providers. A health care insurer shall inform all providers of the grievance procedures and shall make all necessary forms available upon request, including consumer education brochures and materials developed or approved by the superintendent for distribution. These items may be provided in paper format or electronically.

C. Special needs. Information about grievance procedures must be provided in accordance with the Americans with Disabilities Act, 42 U.S.C. Sections 12101, *et seq.*; the Patient Protection and Affordable Care Act of 2010, P.L. 111-152 as codified in the U.S.C.; and 13.10.13 NMAC, and MHCB, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity.

[13.10.17.10 NMAC - N, 13.10.17.10 NMAC, 1/1/17]

13.10.17.11 [RESERVED]

[13.10.17.11 NMAC - Rp, 13.10.17.15 NMAC, 1/1/2017; Repealed 01/01/2022]

13.10.17.12 NOTICE OF INITIAL DETERMINATION:

The notices required in Subsections A and B, of this section shall be provided to the covered person, the covered person's authorized representative, if applicable, and to a provider or other health care professional with knowledge of the covered person's medical condition.

A. Adverse determination.

(1) If an adverse determination is based on a determination that the requested service is experimental, investigational or not medically necessary, clearly and completely explain why the requested health care service is not medically

necessary or is experimental or investigational; a statement that the health care service is not medically necessary, is experimental, or is investigational will not be sufficient.

(2) If an adverse determination is based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan; a statement that the requested health care service is not covered by the health benefits plan will not be sufficient.

(3) If the service has already been provided, then include the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(4) Include a description of the health care insurer's standard that was used in denying the claim.

(5) Provide information stating that a request for review of an adverse determination must be filed with the health care insurer within 180 days.

(6) If the adverse determination involves an urgent care situation, provide information that an expedited IRO review to be conducted at the same time as an expedited internal review may be requested.

(7) Describe the procedures and provide all necessary grievance forms for requesting internal review of the decision.

B. Administrative decision.

(1) If the decision involves claims payment, handling or reimbursement for health care services, identify the provisions of the plan that were relied upon in making the decision, including cost-sharing provisions such as co-payments, co-insurance and deductibles.

(2) If the decision involves termination of coverage, identify the provisions of the plan that were relied upon in making the determination.

(3) If the service has already been provided, then include the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(4) Provide information that a request for an internal review of an administrative decision must be filed with the health care insurer within 180 days.

(5) Describe the procedures and provide all necessary grievance forms for requesting internal review of the decision.

[13.10.17.12 NMAC - Rp, 13.10.17.16 NMAC, 1/1/2017; A and Rn, 01/01/2022]

13.10.17.13 PRELIMINARY DETERMINATION OF GRIEVANCE:

Upon receipt of a grievance, a health care insurer shall first determine the type of grievance at hand.

A. If the grievance seeks review of an adverse determination, it is an adverse determination grievance and the health care insurer shall review the grievance in accordance with its procedures for adverse determination grievances and the requirements of 13.10.17.14 NMAC through 13.10.17.26 NMAC 1978.

B. If the grievance is not based on an adverse determination, it is an administrative grievance and the health care insurer shall reconsider the decision in accordance with its procedures for administrative grievances and the requirements of 13.10.17.27 NMAC through 13.10.17.33 NMAC.

[13.10.17.13 NMAC - N, 1/1/17]

13.10.17.14 INTERNAL FIRST LEVEL REVIEW OF ADVERSE DETERMINATIONS:

A. Right to internal review. Every grievant who is dissatisfied with an adverse determination shall have the right to request internal review of the adverse determination by the health care insurer within 180 days of the date of the adverse determination. Nothing in this rule precludes the health care insurer and grievant from resolving a request prior to completion of the internal review.

B. Acknowledgement of request. Upon receipt of a request for first level internal review of an adverse determination, the health care insurer shall date and time stamp the request, and within three days after receipt send the grievant an acknowledgment that the request has been received. The acknowledgment shall contain the name, address and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the grievance.

C. Full and fair internal review. To ensure that a grievant receives a full and fair internal review, the health care insurer must:

(1) allow the grievant to review the claim file;

(2) allow the grievant to present evidence and submit evidence, including but not limited to written comments, documents, records and other materials relating to the request for benefits;

(3) as soon as possible but no less than five days in advance of the date of the internal review of adverse benefit determination, provide the grievant, free of charge, with:

(a) copies of all documents, policies, guidance, statements, records and other information relevant to the request for benefits; and

(b) all evidence or rationale, considered, relied upon, or generated by the health care insurer.

(4) allow the grievant a reasonable opportunity to respond before the adverse determination is reviewed and if the evidence or rationale is not provided to the grievant in time for the grievant to have a reasonable opportunity to respond, provide additional time at the grievant's request in order for the grievant to prepare a response.

D. Conflict of interest. The health care insurer must ensure that all claims and internal reviews are handled in a manner designed to ensure the independence and impartiality of the person(s) involved in making the decisions in such a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or a medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

E. Utilization review. In the case of an adverse determination involving utilization review, the health care insurer shall designate one or more appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer(s) shall not have been involved in the initial adverse determination. If more than one clinical peer is involved in the review, a majority of the individuals reviewing the adverse determination shall be health care professionals who have appropriate expertise.

F. Timeframe for internal reviews of adverse determinations. Upon receipt of a request for internal review of an adverse determination, the health care insurer shall conduct either a standard or expedited internal review, as appropriate.

(1) Expedited internal review. Whenever a request involves an urgent care situation, a health care insurer shall complete an expedited internal review as required by the medical exigencies of the case, but in no case later than 72 hours from the time the internal review request was received.

(2) Standard internal review. In all cases that do not require expedited review, both the standard first level internal review and, if requested, the internal panel's review, as described in 13.10.17.16 NMAC, shall be completed within 30 days after receipt of a request for internal review conducted prior to service and within 60 days after receipt of a request involving a post-service claim.

(a) The timeframe for completing an internal panel review may be extended, at the grievant's request, to afford the grievant a reasonable opportunity to respond to any new or additional rationale or evidence provided to the grievant by the health care insurer during the internal review process.

(b) The health care insurer shall not unreasonably deny a request by the grievant to postpone the internal panel review for up to 30 days.

(c) The timeframe for completing both internal reviews shall be extended during the period of any such postponement.

(d) The health care insurer shall have three days after concluding the postponed internal review to issue its determination.

G. Additional requirements for expedited internal review of an adverse determination.

(1) In an expedited review, all information required to be exchanged shall be transmitted between the health care insurer and the grievant by the most expedient method available.

(2) If an expedited review is conducted during a patient's hospital stay or approved course of treatment, health care services shall be continued without cost (except for applicable co-payments, co-insurance and deductibles) to the grievant until the health care insurer makes a final decision and notifies the grievant.

(3) A health care insurer shall not conduct an expedited review of an adverse determination made after health care services have been provided to a grievant.

H. Failure to comply with deadline. If the health care insurer fails to comply with the deadline for completion of an internal review, unless such deadline is postponed by the grievant, the requested health care service shall be deemed approved, provided that the requested health care service reasonably appears to be a covered benefit under the applicable health benefits plan.

I. New Mexico Health Care Purchasing Act. For grievants who are covered under the New Mexico Health Care Purchasing Act, the health care insurer must provide both a first level review and a review by a panel.

[13.10.17.14 NMAC - Rp, 13.10.17.17 NMAC, 1/1/17]

13.10.17.15 NOTICE FOLLOWING FIRST LEVEL INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Notice requirements. The health care insurer shall notify the grievant and provider of the decision within 24 hours by telephone and in writing by mail or electronic

communication sent within one day after the initial attempt to provide telephonic notice, unless earlier notice is required by the medical exigencies of the case.

B. Contents of notice. If the initial decision denying certification is upheld in whole or in part, then the health care insurer's notice shall include the following:

(1) the name, title and qualifying credentials of the person who provided the review;

(2) a statement of the reviewer's understanding of the nature of the grievance;

(3) a description of the evidence relied on by the reviewer in reaching a decision;

(4) if an adverse determination is upheld based on a determination that the requested service is experimental, investigational or not medically necessary, then:

(a) clearly and completely explain why the requested health care service is not medically necessary, is experimental or investigational; a statement that the health care service is not medically necessary, is experimental or investigational will not be sufficient; and

(b) include a citation to the uniform standards relevant to the grievant's medical condition and an explanation of whether each standard supported or did not support the determination that the requested service is experimental, investigational, or is not medically necessary.

(5) if an adverse determination is upheld based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan; a statement that the requested health care service is not covered by the health benefits plan will not be sufficient;

(6) if the service has already been provided, then include the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(7) notice that the grievant may request either:

(a) an internal panel review within five days; or

(b) an external review within four months.

(8) if the adverse determination involves an urgent care situation, advise that the grievant may immediately request an expedited IRO external review;

(9) if the grievant is covered by the New Mexico Health Care Purchasing Act, then advise the grievant that an internal panel review is required before the grievance will be reviewed by the grievant's specific review board and only then may the grievant request an external review; and

(10) describe the procedures and provide all necessary grievance forms to the grievant for requesting an internal panel review, for requesting an external review, or for requesting an expedited review.

C. Information for requesting an external review. Notice of the grievant's right to request an external review shall include the address and telephone number of the MHCB, a description of all procedures and time deadlines necessary to pursue an external review, copies of all forms required to initiate an external review and the following notice:

> "*We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed, at no cost to you, by an impartial Independent Review Organization (IRO) who has no association with us and is appointed by the Office of Superintendent of Insurance (OSI). If our decision involved making a judgment as to the medical necessity, experimental nature or investigational nature of the requested service, or the appropriateness, health care setting, or level of care, then the IRO review will be performed by one or more health care professionals. You may also request an external review by OSI for rescissions or for adverse determinations that do not involve medical judgment. For more information contact OSI by electronic mail at mhcb.grievance@state.nm.us; by telephone at (505) 827-4601; or toll- free at 1-(855)-427-5674. You may also visit the OSI website at http://www.osi.state.nm.us for more information.*"

D. Grievance discontinued. If the grievant informs the health care insurer by telephone that the grievant does not wish to pursue the grievance, then the health care insurer's notice shall include confirmation of the grievant's decision not to pursue the matter further.

E. Grievant's decision unknown. If the health care insurer is unable to contact the grievant by telephone within one day of the decision to uphold the adverse determination, the health care insurer's written notice shall include a self-addressed stamped envelope and response form which asks whether the grievant wishes to request either an internal panel review or an external review. The form shall provide check boxes as follows:

Do you want to appeal the decision?

☐ No

☐ Yes (If yes, then please select one of the following:)

☐ *Internal panel review requested*

☐ *External review requested*

F. Extending the timeframe for requesting a standard review. If the grievant does not make an immediate decision to pursue the grievance, or the grievant has requested additional time to supply supporting documents or information, or postponement pursuant to Subsection F of 13.10.17.14 NMAC, the timeframe shall be extended to include the additional time if requested by the grievant.

[13.10.17.15 NMAC - N, 1/1/17]

13.10.17.16 INTERNAL PANEL REVIEW OF ADVERSE DETERMINATIONS:

A. Applicability of internal panel review.

(1) A health care insurer that offers managed health care plans shall establish a panel review process for its managed health care plans to give those grievants who are dissatisfied with the internal review decision the option to request a panel review, at which the grievant has the right to appear in person before a panel of designated representatives of the health care insurer.

(2) This section also applies to persons covered under the New Mexico Health Care Purchasing Act (public employees and retirees, public school employees and retirees only).

B. Acknowledgment of request. Upon receipt of a request for internal panel review of an adverse determination, the health care insurer shall date and time stamp the request and:

(1) for a standard internal panel review, within three working days after receipt of the request, send the grievant an acknowledgment that the request has been received; or

(2) for an expedited internal panel review, acknowledge the request telephonically or by electronic communication; and

(3) the acknowledgment shall:

(a) contain the name, address and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the grievance;

(b) specify the date, time and location for the internal panel review meeting and provide a toll-free number for the grievant to participate telephonically;

(c) include the grievant's rights as set forth below; and

(d) inform the grievant if the health care insurer will be represented by an attorney.

C. Grievant's rights. The health care insurer shall notify the grievant of the grievant's right to:

(1) request the opportunity to appear in person or telephonically before an internal review panel comprised of the health care insurer's designated representatives;

(2) present the grievant's case to the internal review panel orally or in writing;

(3) submit written comments, documents, records, and other material relating to the request for benefits for the internal review panel to consider when conducting the review both before and, if applicable, at the review panel's meeting;

(4) if applicable, ask questions of any representative of the health care insurer or health care professional on the internal review panel;

(5) be assisted or represented by an individual of the grievant's choice, including legal representation at the grievant's expense;

(6) hire a specialist to participate in the internal panel review at the grievant's expense, but such specialist may not participate in making the decision; and

(7) request a postponement of the internal panel review for up to 30 days.

D. Conduct of the internal panel review.

(1) Upon receipt of a grievant's request for an internal panel review, the health care insurer shall appoint a panel to review the request.

(a) The health care insurer shall select representatives of the health care insurer and if the adverse determination was based on a determination that the requested service is not a medical necessity, is experimental or investigational, or is considered not a covered benefit, one or more qualified health care professionals shall serve on the internal review panel. At least one of the health care professionals selected shall be a clinical peer that practices in a specialty that would typically manage the case that is the subject of the grievance or be mutually agreed upon by the grievant and the health care insurer.

(b) A panel shall be comprised of individuals who have no financial interest in the outcome of the review and who were not involved in the initial determination or the first internal review decision, except that an individual who was involved in the first

internal review decision may appear before the panel to present information or answer questions.

(2) In conducting the review, the internal review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the grievant, without regard to whether the information was submitted or considered in reaching the initial determination or the first internal review decision.

(3) The internal review panel shall have the legal authority to bind the health care insurer to the panel's decision.

(4) If the initial adverse determination was based on a lack of coverage, the internal review panel shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified. If the internal review panel finds that the requested health care benefit is not covered by the health benefits plan, the panel shall issue its final adverse determination in accordance with this rule.

(5) If the initial adverse determination was based on a determination that the requested service is experimental, investigational or not a medical necessity, the internal review panel shall render an opinion, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.

(6) Internal review panel members must be physically present or attend the panel by video or telephone conferencing to participate in the decision.

E. Information to grievant. No fewer than three days prior to the internal panel review, the health care insurer shall provide to the grievant copies of all documents that will be considered in reviewing the grievant's request for benefits, including, if applicable:

(1) the grievant's pertinent medical records;

(2) the treating provider's recommendation;

(3) relevant sections of the grievant's health benefits plan;

(4) the health care insurer's notice of adverse determination;

(5) uniform standards relevant to the grievant's medical condition that shall be used by the internal panel in reviewing the adverse determination;

(6) questions sent to or reports received from any medical consultants retained by the health care insurer; and

(7) all other evidence or documentation relevant to reviewing the adverse determination.

F. Request for postponement. The health care insurer shall not unreasonably deny a request for postponement of the internal panel review for up to 30 days made by the grievant. The timeframes for completing the internal panel review shall be extended during the period of any postponement.

G. Additional requirements for expedited internal panel review of an adverse determination.

(1) In an expedited review, all information required to be exchanged by Section E. of 13.10.17.16 NMAC shall be transmitted between the health care insurer and the grievant by the most expedient method available.

(2) If an expedited review is conducted during a grievant's hospital stay or approved on-going course of treatment, health care services shall be continued without cost (except for applicable co-payments, co-insurance and deductibles) to the grievant until the health care insurer makes a final decision and notifies the grievant.

(3) A health care insurer shall not conduct an expedited internal panel review of post-service claims.

[13.10.17.16 NMAC - Rp, 13.10.17.20 NMAC, 1/1/17]

13.10.17.17 NOTICE OF INTERNAL PANEL REVIEW DECISION:

A. Notice requirements. The health care insurer shall notify the grievant and provider of the internal panel's decision within 24 hours by telephone and in writing by mail or electronic communication sent within one day after the initial attempt to provide telephonic notice, unless earlier notice is required by the medical exigencies of the case.

B. Contents of notice. If the initial decision denying certification is upheld in whole or in part, then the panel's written notice shall contain:

(1) the names, titles and qualifying credentials of the persons on the internal review panel;

(2) a statement of the internal review panel's understanding of the nature of the grievance and all pertinent facts;

(3) a description of the evidence relied on by the internal review panel in reaching its decision;

(4) if an adverse determination is upheld based on a determination that the requested service is experimental, investigational or not medically necessary, then:

(a) clearly and completely explain why the requested health care service is not medically necessary, is experimental or investigational; a statement that the health care service is not medically necessary, is experimental or investigational will not be sufficient; and

(b) include a citation to the uniform standards relevant to the grievant's medical condition and an explanation of whether each supported or did not support the decision regarding a determination that the requested service is experimental, investigational, or medically necessary.

(5) if an adverse determination is upheld based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan; a statement that the requested health care service is not covered by the health benefits plan will not be sufficient;

(6) if the service has already been provided, then include the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(7) if the grievant is covered by the New Mexico Health Care Purchasing Act, then advise the grievant of the grievant's right to request review from and in the manner designated by an entity authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act and that the entity must review the grievant's request before grievant can request an external review;

(8) if the adverse determination involved medical judgment, including a determination based on medical necessity, appropriateness, health care setting, level of care, effectiveness or that the requested health care service is experimental or investigational, notice of the grievant's right to request external review by an IRO within four months, including the address and telephone number of the MHCB, a description of all procedures necessary to pursue an IRO external review, copies of any forms required to initiate an IRO external review; or

(9) if the adverse determination did not involve medical judgment, notice of the grievant's right to request external review by the superintendent and copies of any forms required to initiate an external review by the superintendent.

C. Information for requesting an external review. Notice of the grievant's right to request an external review shall include the address and telephone number of the MHCB, a description of all procedures and time deadlines necessary to pursue an

external review, copies of all forms required to initiate an external review and the following language:

> "*We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed, at no cost to you, by an impartial Independent Review Organization (IRO) who has no association with us and is appointed by the Office of Superintendent of Insurance (OSI). If our decision involved making a judgment as to the medical necessity, the experimental nature or the investigational nature of the requested service, or the appropriateness, health care setting, or level of care, then the IRO review will be performed by one or more health care professionals. You may also request an external review by OSI for rescission or adverse determinations that do not involve medical judgment. For more information contact OSI by electronic mail at mhcb.grievance@state.nm.us; by telephone at (505) 827-4601; or toll- free at 1-(855)-427-5674. You may also visit the OSI website at http://www.osi.state.nm.us for more information.*"

D. Grievance discontinued. If the grievant informs the health care insurer by telephone that the grievant does not wish to pursue the grievance, the health care insurer's notice shall include written confirmation of the grievant's decision not to pursue the matter further.

E. Grievant's decision unknown. If the health care insurer is unable to contact the grievant by telephone within one day of the panel's decision to uphold the adverse determination, the health care insurer's written notice shall include all information necessary to request an external review.

[13.10.17.17 NMAC - Rp, 13.10.17.22 NMAC, 1/1/17]

13.10.17.18 ADDITIONAL REVIEW BY ENTITIES SUBJECT TO THE NEW MEXICO HEALTH CARE PURCHASING ACT:

A. Applicability. This section applies only to entities and grievants subject to the New Mexico Health Care Purchasing Act (public employees and retirees, public school employees and retirees only).

B. Eligibility for review. A grievant who remains dissatisfied with the decision of the health care insurer after the completion of the internal panel review must have their claim reviewed in accordance with any review process established by the entity providing their health care benefits pursuant to the New Mexico Health Care Purchasing Act.

C. Decision to uphold. If the health care insurer has upheld the initial adverse determination to deny the requested health care service at both the first level internal review and the internal panel review, the health care insurer shall notify the grievant that

their grievance must be reviewed by their specific review board before their grievance may be eligible for an IRO review, as defined by their policy. The health care insurer shall ascertain whether the grievant wishes to pursue the grievance before the specific review board.

(1) If the grievant does not wish to pursue the grievance, the health care insurer shall include confirmation of the grievant's decision not to pursue the matter further with the written notification of the health care insurer's decision as described in Subsection B of 13.10.17.17 NMAC.

(2) If the health care insurer is unable to contact the grievant by telephone within one day of the panel's decision to uphold the adverse determination, the health care insurer shall send a written inquiry, as described in Subsection D of 13.10.17.17 NMAC.

(3) If the grievant responds affirmatively to the telephone or written inquiry the matter will proceed to a review by the grievant's specific review board, according to the procedures contained in the grievant's policy handbook.

D. Extending the timeframe for review. If the grievant does not make an immediate decision to pursue the grievance, the grievant has requested additional time to supply supporting documents or information, or has asked for postponement, the timeframe shall be extended to include the additional time required by the grievant.

E. Notice following review by the specific review board.

(1) Certification. Upon receipt of notice from grievant's specific review board that the requested benefit shall be certified, the health care insurer shall provide coverage in accordance to the review board's decision.

(2) Adverse determination upheld. Upon receipt of notice that grievant's specific review board upholds the decision denying certification, then MHCB shall contact the grievant to determine whether grievant wishes to request an external review. If the MHCB is unable to contact the grievant by telephone within 24 hours, then MHCB will attempt to contact the grievant and the provider in writing by mail or electronically on the following day.

[13.10.17.18 NMAC - N, 1/1/17]

13.10.17.19 IRO REVIEW OF AN ADVERSE DETERMINATION:

A. Right to external IRO review. Every grievant who is dissatisfied with an adverse determination following internal review of a grievance that involves medical judgment, including a determination based on medical necessity, appropriateness, health care setting, level of care, effectiveness or that the requested health care service is experimental, investigational or unproven for a particular medical condition may request

an external review by an impartial IRO appointed by the superintendent at no cost to the grievant.

B. Exhaustion of internal review process. The superintendent may require the grievant to exhaust any required grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for IRO review.

C. Deemed exhaustion. If exhaustion of internal reviews is required prior to IRO review, exhaustion is unnecessary and the internal reviews process will be deemed exhausted if:

(1) the health care insurer waives the exhaustion requirement;

(2) the health care insurer is considered to have exhausted the internal review process by failing to comply with the requirements of the internal review process; or

(3) the grievant simultaneously requests an expedited internal review and an expedited IRO review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection C of 13.10.17.19 NMAC, the internal review process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an on-going, good faith exchange of information between the health care insurer and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer, as determined by the superintendent.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal review process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of 13.10.17.19 NMAC, the grievant has the right to re-submit and pursue a request for review of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the health care insurer shall provide the grievant with notice of the opportunity to re-submit and pursue the internal review of the claim. Time periods for re-filing the claim shall begin to run upon grievant's receipt of such notice.

E. IRO fees. The health care insurer against which a request for external review has been filed shall be responsible for paying the fees of the IRO. The health care insurer shall remit payment to the IRO within 30 days after its receipt of the invoice.

(1) The superintendent shall determine the reasonable compensation for IROs and shall publish a schedule of IRO compensation by bulletin.

(2) Upon completion of an external review, the IRO shall submit its invoice directly to the health care insurer.

F. In reaching a decision, the assigned IRO is not bound by any decisions or conclusions reached during the health care insurer's utilization review process or the health care insurer's internal grievance process.

G. Nothing in this rule shall preclude the health care insurer and grievant from resolving the matter prior to completion of the IRO review.

H. A grievant may not file a subsequent request for external review by an IRO involving the same adverse determination for which the grievant has already received an external IRO review under this rule.

[13.10.17.19 NMAC - Rp, 13.10.17.24 NMAC, 1/1/17]

13.10.17.20 QUALIFICATIONS OF IROs AND APPROVAL BY SUPERINTENDENT:

A. Superintendent's list. The superintendent shall compile and maintain a list of approved IROs.

B. IRO Requirements. To be considered for placement on the list of approved IROs, an IRO shall:

(1) be accredited by a nationally recognized private accrediting entity;

(2) meet the requirements of this rule; and

(3) have quality assurance mechanisms that ensure that clinical reviewers assigned to conduct the external review are qualified and impartial physicians or other appropriate health care providers who;

(**a)** have expertise in the treatment of grievant's medical condition;

(b) hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized medical specialty board in the area(s) appropriate to the subject of the IRO review; and

(c) have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise substantial questions about the clinical reviewer's physical, mental or professional competence or moral character.

(4) have written policies and procedures that ensure:

(a) all reviews are conducted within the timeframe specified by this rule and required notices are provided in a timely manner;

(b) the selection of qualified and impartial physicians or other appropriate health care professionals to act as clinical reviewers based on the requirements of specific cases and that the IRO employs or contracts with an adequate number of clinical reviewers to meet this objective;

(c) the confidentiality of medical and treatment records and clinical review criteria; and

(d) that any person employed by or under contract with the IRO adheres to the requirements of this rule.

(5) maintain a toll-free telephone service to receive information 24 hours a day, seven days per week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours.

C. Applicants for the IRO list. An applicant requesting placement on the list of approved IROs shall submit for the superintendent's review:

(1) an IRO application form available on the OSI website;

(2) all documentation and information requested on the application, including proof of being accredited by a nationally recognized private accrediting entity;

(3) any applicable application fee pursuant to § 59A-6-1 (BB); and

(4) completion of a memorandum of understanding, to be supplied by OSI.

D. Termination of IRO. The superintendent shall, in the superintendent's sole discretion, terminate the approval of an IRO if the superintendent determines that the IRO has lost its accreditation or no longer satisfies the minimum requirements for approval.

E. Conflict of interest by an IRO.

(1) An IRO may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health care insurer, a national, state or local trade association of health care insurers, or a national, state or local trade association of health care providers.

(2) Neither an IRO appointed to conduct the independent review nor any clinical reviewer assigned by an IRO to conduct a review may have a material, professional, familial or financial conflict of interest with:

(a) the health care insurer that is the subject of the IRO review;

(b) an officer, director, manager or management employee of the health care insurer that is the subject of the IRO review;

(c) the health benefits plan;

(d) the plan administrator, plan fiduciaries or plan employees;

(e) the grievant or the grievant's representative;

(f) the grievant's health care provider(s) or the provider's medical group, who is recommending the service or treatment that is the subject of the review;

(g) the health care provider's medical group or independent practice association;

(h) a health care facility where the service would be provided; or

(i) the developer, manufacturer, distributor, or supplier of the principal drug, device, procedure or other service that is the subject of the appeal.

F. Written procedures. An IRO shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this rule.

G. Availability of records. An IRO shall keep and maintain written or electronic records and make available upon request by OSI, any record received or reviewed during an IRO review for a period of six years following the review.

H. IRO's report to OSI. An IRO shall keep and maintain written or electronic records of all IRO reviews it has conducted under this rule and make available to OSI every calendar year on January 15, a report that is organized by health care insurer and which includes:

(1) the total number of reviews conducted;

(2) the number of reviews resolved; and of those resolved, the number resolved upholding the adverse determination or final adverse determination of the health care insurer;

(3) the total number resolved reversing the adverse determination or final adverse determination of the health care insurer;

(4) the average length of time for the review;

(5) a summary of the types of coverages or cases for which the review was sought, as provided in the format required by the superintendent;

(6) the number of reviews that were terminated as a result of a reconsideration by the health care insurer of its adverse determination after the receipt of additional information from the grievant; and

(7) any other information the superintendent may request or require.

I. Contracts with health care insurers. Nothing in this rule precludes or shall be interpreted to preclude a health care insurer from contracting with an approved IRO to conduct peer or federal external reviews.

[13.10.17.20 NMAC - Rp, 13.10.17.23 NMAC, 1/1/17]

13.10.17.21 INITIATING AN IRO REVIEW OF AN ADVERSE DETERMINATION:

A. Expedited IRO review. If required by the medical exigencies of the case, a grievant or provider may telephonically request an expedited review by an IRO by calling the MHCB at (505) 827-4601 or 1-(855)-427-5674. A signed medical release must also be provided.

B. Standard IRO review. To initiate an IRO review, a grievant must file a written request for an IRO review within four months from receipt of the written notice of the final internal review decision unless extended by the superintendent for good cause shown. The request shall be:

(1) mailed to the superintendent, attn: managed health care bureau - external review request, office of superintendent of insurance, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689; or

(2) e-mailed to mhcb.grievance@state.nm.us, subject: external review request; or

(3) faxed to the superintendent, attn: managed health care bureau - external review request at (505) 827-4734; or

(4) completed on-line with an OSI complaint form available at http://www.osi.state.nm.us/.

C. Duty to re-direct request. Any request for external review sent to the health care insurer instead of to OSI shall be forwarded to the OSI by the health care insurer within three days after receipt.

D. Documents required to be filed by the grievant. The grievant shall file the request for IRO review on the forms provided to the grievant by the health care insurer, OSI, or an entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, and shall also file:

(1) a copy of the notice(s) of all prior review decisions; and

(2) a fully executed release form authorizing the IRO or the superintendent to obtain any necessary medical records from the health care insurer or any other relevant provider.

[13.10.17.21 NMAC - Rp, 13.10.17.18 NMAC, 1/1/17]

13.10.17.22 TIMEFRAMES AND PROCESSES FOR IRO REVIEW:

A. Type of IRO review. The IRO shall conduct either a standard or expedited review of the adverse determination, as required by the medical exigencies of the case.

(1) The IRO shall complete an expedited external review and provide notice of its decision to the grievant, the provider, the health care insurer, and the superintendent as required by the medical exigencies of the case as soon as possible, but in no case later than 72 hours after appointment by the superintendent. If notice of the IRO's decision is initially provided by telephone, written notice of the decision shall be provided within 48 hours after the telephone notification.

(2) The IRO shall complete a standard external review and provide written notice of its decision to the grievant, the provider, the health care insurer and the superintendent within 20 days after appointment by the superintendent.

B. Expedited IRO review, timeframe and process.

(1) In cases involving an urgent care claim, the superintendent shall immediately upon receipt of a request for an expedited IRO review send the grievant an acknowledgment that the request has been received and send a copy of the request to the health insurer.

(2) Within 24 hours or the time limit set by the superintendent following receipt of a request for an expedited IRO review from the superintendent, the health care insurer shall complete a preliminary review of the matter to determine whether the

request is eligible for IRO review, and shall report immediately to OSI upon completion of the preliminary review, as follows:

(a) the grievant is or was a covered person in the health benefit plan at the time the health care service was requested;

(b) the health care service that is the subject of the request for IRO review reasonably appears to be a covered benefit under the grievant's health benefit plan, but for a determination by the health care insurer that the requested service is not covered because it is experimental, investigational, or not medically necessary; and

(c) the grievant has or is not required to exhaust the health carrier's internal grievance process.

(3) If the request is not complete, the health care insurer shall inform the grievant, provider and the superintendent telephonically and electronically and include in the notice what information or materials are needed to make the request complete.

(4) If the request is not eligible for IRO review, the health care insurer shall inform the grievant, provider and the superintendent telephonically and electronically and include in the notice the reasons for ineligibility and a statement that the health care insurer's determination of ineligibility may be appealed to the superintendent.

(5) MHCB will confirm or obtain from the grievant all information and forms required to process an expedited IRO review, including the signed release form.

(6) Upon receipt of the health care insurer's notice that a request is complete and eligible for IRO review and the confirmation from MHCB, the superintendent will immediately randomly assign an IRO from the superintendent's list of approved IROs to conduct an expedited review, and shall:

(a) notify the health care insurer of the name of the assigned IRO; and

(b) notify the grievant and the provider of the name of the assigned IRO, that the health care insurer will provide to the IRO all of the documents and information considered in making the adverse determination, and that the grievant and provider may provide additional information.

(7) The superintendent may determine that a request is eligible for an expedited IRO review notwithstanding a health care insurer's initial determination that the request is incomplete or ineligible. In making an eligibility determination, the superintendent's decision shall be made in accordance with the terms of the grievant's health benefit plan.

(8) MHCB will immediately provide to the assigned IRO and to the health care insurer all information and forms obtained from the grievant, including a signed release form.

(9) Within 24 hours from the date of the notice from the superintendent that the IRO has been appointed, the grievant or the provider may also submit additional documentation or information to the IRO; the IRO shall immediately forward any documentation or information received from the grievant to the health care insurer.

(10) Upon receipt of the superintendent's notice that an IRO has been appointed, the health care insurer shall within 24 hours provide to the assigned IRO, any information considered in making the adverse determination, including, but not limited to:

(a) the summary of benefits;

(b) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;

(c) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;

(d) uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and

(e) any other documents, records, and information relevant to the adverse determination and the internal review decision(s).

(11) Failure by the health care insurer to provide the documents and information required by this rule within the time specified shall not delay the conduct of the IRO external review. If the health care insurer fails to provide the documents and information within the time specified, the assigned IRO may terminate the review and make a decision to reverse the adverse determination.

C. Standard IRO review, timeframe and process.

(1) Within one day after the date of receipt of a request for an IRO review, the superintendent shall send the grievant an acknowledgment that the request has been received and send a copy of the request to the health insurer.

(2) Within five days following the receipt of the IRO review request from the superintendent, the health insurer shall complete a preliminary review of the request to determine whether the request is eligible for IRO review, as follows:

(a) the grievant is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(b) the health care service that is the subject of the request for IRO review reasonably appears to be a covered service under the grievant's health benefit plan, but for a determination by the health care insurer that the requested health care service is not covered because it is experimental, investigational, or not medically necessary;

(c) for experimental or investigational adverse determinations, the grievant's treating physician certified, in writing, that one of the following applies:

(i) standard health care services or treatments have not been effective in improving the condition of the grievant;

(ii) standard health care services or treatments are not medically appropriate for the grievant;

(iii) there is no available standard health care service or treatment covered by the health benefits plan that is more beneficial than the recommended or requested health care service or treatment;

(iv) the health care service or treatment requested is likely to be more beneficial to the grievant, in the physician's opinion, than any available standard health care services or treatments; or

(v) the grievant's treating physician, who is licensed, board certified or board eligible to practice in the area of medicine appropriate to treat the grievant's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the grievant than any available standard health care services or treatments.

(d) the grievant has exhausted or is not required to exhaust the health care insurer's internal grievance process; and

(e) the grievant has provided all the information and forms required to process an IRO review, including the signed release form.

(3) Upon completion of the preliminary review, the health care insurer shall notify the superintendent and grievant in writing within one day whether:

(a) the request is complete; and

(b) the request is eligible for IRO review.

(4) If the request:

(a) is not complete, the health care insurer shall inform the grievant and the superintendent in writing and include in the notice what information or material are needed to make the request complete; or

(b) is not eligible for an IRO review, the health care insurer shall inform the grievant and the superintendent in writing and include in the notice the reasons for its ineligibility.

(5) The notice of initial determination shall include a statement informing the grievant that a health care insurer's initial determination of ineligibility for IRO review may be appealed to the superintendent.

(6) The superintendent may determine that a request is eligible for an IRO review notwithstanding a health care insurer's initial determination that the request is ineligible and require that it be referred to an IRO. In making an eligibility determination, the superintendent's decision shall be made in accordance with the terms of the grievant's health benefit plan.

(6) Even after the superintendent assigns a grievance to an IRO for review, the MHCB may attempt to resolve the grievance between the health care insurer and the grievant. If the matter is successfully resolved, OSI will immediately notify the IRO to terminate work.

D. Assignment of IRO by superintendent.

(1) Within one day of receipt of a notice that the health care insurer has determined a request is eligible for an IRO review, the superintendent shall:

(a) randomly assign an IRO from the superintendent's list of approved IROs to conduct the review;

(b) notify the health care insurer of the name of the assigned IRO;

(c) notify the grievant in writing that the request is eligible for an IRO external review, the name of the assigned IRO, and that the health care insurer will provide all of the documents and information considered by the health care insurer in making the adverse determination; and

(d) notify the grievant that the grievant may submit in writing to the assigned IRO within five days following the date of receipt of the notice, any additional information that the IRO shall consider when conducting the review. The IRO is not required to, but may, accept and consider additional information submitted after five days.

(2) If the adverse determination is based on a determination that the requested service is experimental, investigational, or not medically necessary, then the superintendent shall direct the IRO to utilize a panel of appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed.

(3) Within one day after the receipt of the notice of assignment by the superintendent to conduct the external review, the assigned IRO shall select one clinical reviewer or for experimental or investigational adverse determinations, three clinical reviewers to conduct the external review.

(4) Within five days following the notice of the assigned IRO, the health care insurer shall provide to the assigned IRO all documents and any information considered in making the adverse determination, including, but not limited to:

(a) the summary of benefits;

(b) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;

(c) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;

(d) uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and

(e) any other documents, records, and information relevant to the adverse determination and the internal review decision(s).

(5) Failure by the health care insurer to provide the documents and information required by this rule within the time specified shall not delay the conduct of the external review. If the health care insurer fails to provide the documents and information within the time specified, the assigned IRO may terminate the review and make a decision to reverse the adverse determination. Within one day after making such a decision, the IRO shall notify the grievant, the provider, the health care insurer, and the superintendent.

(6) If the grievant provides additional supporting documents or information to the IRO:

(a) The IRO shall send any information received from grievant to the health care insurer within one day.

(b) Upon receipt of such information, the health care insurer may reconsider its adverse determination.

(7) If, upon such review, the health care insurer reverses its prior decision, it shall within one day provide written notification of its decision to the grievant, the provider, the assigned IRO and the superintendent.

(a) If the health care insurer reverses its prior decision, the assigned IRO shall terminate its review upon receipt of the notice from the health care insurer.

(b) Upon reversing its prior decision, the health care insurer shall approve coverage for the health care service subject to any applicable cost sharing including co-payments, co-insurance and deductible amounts for which the grievant is responsible.

(c) The health care insurer shall compensate the IRO according to the published fee schedule whenever the IRO review is terminated prior to completion.

[13.10.17.22 NMAC - Rp, 13.10.17.27 NMAC, 1/1/17]

13.10.17.23 THE FINAL DECISION OF THE IRO AND GRIEVANT'S RIGHT TO HEARING AFTER FINAL IRO DECISION:

A. Independent decision. In reaching its decision, the IRO is not bound by the prior decision of the health care insurer. In addition to the documents and information provided to the IRO by the health care insurer and the grievant and to the extent such documents are available, each reviewer shall consider the following in reaching its decision:

(1) the grievant's medical records;

(2) the attending health care professional's recommendation;

(3) consulting reports from appropriate health care professionals and other documents submitted by the health care insurer, the grievant, or the treating health care professional;

(4) the terms of coverage under the applicable health benefit plan to ensure that the IRO's decision is not contrary to the terms of coverage;

(5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) any applicable clinical review criteria and policies developed and used by the health care insurer; and

(7) the opinion of the IRO's clinical reviewer(s) after considering the information received.

B. Opinion of clinical reviewer. Each clinical reviewer selected shall provide an opinion to the assigned IRO as to whether the recommended or requested health care service should be covered as follows:

(1) for a standard external review, each clinical reviewer shall provide a written opinion to the IRO within the time constraints set by this rule;

(2) for an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the IRO as expeditiously as the covered person's medical condition or circumstances requires. If the opinion is provided orally, each clinical reviewer shall provide a written opinion to the IRO within 48 hours after providing the oral opinion; and

(3) each clinical reviewer's written opinion shall include the following information:

(a) a description of the covered person's medical condition;

(b) whether there is sufficient evidence to demonstrate that the requested health care service is more likely than not to be more beneficial to the covered person than any available standard health care services and that the adverse risks of the requested health care service would not be substantially increased over those of available standard health care services;

(c) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(d) a description and analysis of any evidence-based standards;

(e) the reviewer's rationale for the opinion; and

(f) whether the recommended or requested health care service has been approved by the federal food and drug administration, if applicable, for the condition.

C. Decision of the IRO. Based upon the opinion of each clinical reviewer, the IRO shall issue notice of its decision in the manner set forth in this rule.

(1) If a majority of clinical reviewers recommend that the requested health care service should be covered, the IRO shall reverse the health care insurer's adverse determination.

(2) If a majority of clinical reviewers recommend that the requested health care service should not be covered, the IRO shall uphold the health care insurer's adverse determination.

D. Content of IRO's notice. Notice of the IRO's decision shall be sent to the grievant, the provider, the health care insurer, and the superintendent and shall include:

(1) a general description of the reason for the request for external review;

(2) the date the IRO was appointed;

(3) the date the review by the IRO was completed;

(4) the principal reason(s) for its decision, including any applicable evidence-based standards that were the basis for the decision;

(5) reference to the evidence or documentation that was considered in reaching the decisions;

(6) the rationale for the decision; and

(7) the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for each reviewer's recommendation.

E. Binding decision. The decision of the IRO is binding upon the health care insurer except to the extent that the health care insurer may pursue other remedies under applicable state and federal law. The decision is also binding upon the grievant except to the extent that the grievant may pursue other remedies under applicable state and federal law, including the grievant's right to appeal to the superintendent for a hearing.

(**1)** This requirement that the decision is binding shall not preclude the health care insurer from making payment on the claim or otherwise providing benefits at any time, including after an IRO's decision or following an external review by the superintendent that denies the claim or otherwise fails to require such payment or benefits.

(**2)** Upon receipt of a decision by an IRO reversing an adverse determination, the health care insurer shall approve coverage for the health care service for which the IRO review was conducted, subject to any applicable co-payment, co-insurance and deductible amounts for which the grievant is responsible without delay, regardless of whether the health care insurer intends to seek judicial review of the external review decision and unless or until there is a final judicial decision otherwise.

[13.10.17.23 NMAC - Rp, 13.10.17.30 NMAC, 1/1/17]

13.10.17.24 SUPERINTENDENT'S HEARING PROCEDURES FOR ADVERSE DETERMINATIONS:

A. Grievant's rights.

(1) Following the IRO's decision, the MHCB shall notify the grievant that if the grievant is dissatisfied with the IRO's decision, the grievant may request a hearing from the superintendent within 20 days of the IRO decision. MHCB will provide the grievant with all forms necessary to request a hearing by the superintendent.

(2) Any grievant whose adverse determination grievance involved a rescission of coverage or did not involve medical judgment may request a hearing by the superintendent within four months of receiving the health care insurer's internal decision. The health care insurer will provide the grievant will all forms necessary to request a hearing by the superintendent.

B. Review of request for hearing. Upon receipt of a request for a hearing, the superintendent will review the request and may grant a hearing if the following criteria are met:

(1) the grievant has exhausted the internal review process or is not required to exhaust the internal review process and, if applicable, the external IRO review process;

(2) the grievant has timely requested review by the superintendent;

(3) the grievant has provided a signed release and all forms and documents required to process the request, and

(4) the health care service that is the subject of the request reasonably appears to be a covered benefit under the applicable health benefits plan.

C. Request incomplete. If the request for an external hearing is incomplete, MHCB staff shall immediately notify the grievant and request that the grievant submit the information required to complete the request for external review within a specified period of time. If the grievant fails to provide the required information within the specified time, the request will be deemed to not meet the criteria prescribed by this rule.

D. Request does not meet criteria. If the request for an external hearing does not meet the criteria prescribed by this rule, MHCB staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request does not meet the criteria for external hearing and is thereby denied.

E. Request meets criteria. If the request for external review is complete and meets the criteria prescribed by this rule, MHCB staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request meets the criteria for external review and that an informal hearing pursuant to Section 59A-4-18 NMSA 1978 and this rule has been set to consider the request. Prior to the

hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with Section 12-8-10 NMSA 1978.

F. Notice of hearing. For an expedited review, the notice of hearing shall be given to the grievant, the provider and the health care insurer telephonically. For a standard review, notice of the hearing shall be provided telephonically, and in writing by mail or electronically no less than 10 days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be considered and shall advise the parties of their respective rights. The superintendent shall not unreasonably deny a request for postponement of the hearing made by the grievant or the health care insurer. If the grievant wishes to supply supporting documents or information subsequent to the filing of the request for a hearing with the superintendent, the timeframes for the hearing shall be extended up to 90 days from the receipt of the request or until the grievant submits all supporting documents, whichever occurs first.

G. Timeframe for completion of hearing. The superintendent shall complete the review within the following timeframes:

(1) an expedited review shall be completed no later than 72 hours after receipt of the complete request, or as required by the exigencies of the matter under review; and

(2) a standard review shall be completed within 45 days after receipt of the complete request.

H. Conduct of hearing. The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at OSI's expense.

(1) Co-hearing officers. The superintendent may designate two ICOs who shall be licensed health care professionals and who shall maintain independence and impartiality in the process. If the superintendent designates two ICOs, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

(2) Powers. The superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The superintendent or attorney hearing officer may:

(a) require the production of additional records, documents and writings relevant to the subject of the grievance;

(b) exclude any irrelevant, immaterial or unduly repetitious evidence; and

(c) if the grievant or health care insurer fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

(3) Staff participation. Staff may attend the hearing, ask questions and otherwise solicit evidence from the parties, but shall not be present during deliberations among the superintendent or his designated hearing officer, and any ICOs.

(4) Testimony. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine the grievant, the health care insurer and other witnesses.

(5) Hearing recorded. The hearing shall be stenographically recorded at OSI's expense.

(6) Rights of parties. Both the grievant and the health care insurer have the right to:

(a) attend the hearing; the health care insurer shall designate a person to attend on its behalf, and the grievant may designate a person to attend on grievant's behalf if the grievant chooses not to attend personally;

(b) be assisted or represented by an attorney or other person;

(c) call, examine and cross-examine witnesses; and

(d) submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing, and require that the information be submitted to the health care insurer and the MHCB staff.

(7) Stipulation. The grievant and the health care insurer shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions and conclusions made in the course and scope of the external review.

I. New Mexico health care plan representative. If a grievant is insured pursuant to the New Mexico Health Care Purchasing Act and the grievant requests a hearing, if a representative from the self-insured plan is not present at any pre-hearing conference or at the hearing required by OSI, the health care insurer will be deemed to speak on behalf of the self-insured plan.

[13.10.17.24 NMAC - N, 1/1/17]

13.10.17.25 INDEPENDENT CO-HEARING OFFICERS (ICOS):

A. Identification of ICOs. The superintendent shall provide for maintenance of a list of licensed professionals qualified to serve as ICOs. The superintendent shall select appropriate professional societies, organizations or associations to identify licensed health care and other professionals who are willing to serve as ICOs in external reviews who maintain independence and impartiality of the process.

B. Disclosure of interests. Prior to accepting designation as an ICO, each potential ICO shall provide to the superintendent a list identifying all health care insurers and providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to the grievant, or to the health care insurer, or providers involved in a particular external review.

C. Compensation of ICOs.

(1) Compensation schedule. The superintendent shall determine reasonable compensation for health care and other professionals who are appointed as ICOs for external grievance reviews and shall annually publish a schedule of ICO compensation in a bulletin.

(2) Statement of ICO compensation. Upon completion of an external review, the attorney and co-hearing officers shall each complete a statement of ICO compensation form prescribed by the superintendent; detailing the amount of time spent participating in the external review, and submit it to the superintendent for approval. The superintendent shall send the approved statement of ICO compensation to the grievant's health care insurer.

(3) Direct payment to ICOs. Within 30 days of receipt of the statement of ICO compensation, the grievant's health care insurer shall remit the approved compensation directly to the ICO.

(4) No compensation with early settlement. If the parties provide written notice of a settlement up to three days prior to the date set for external review hearing, compensation will be unavailable to the hearing officers or ICOs.

D. Record retention. The hearing officer and ICOs must maintain written records for a period of three years and make them available upon request to the state.

[13.10.17.25 NMAC - Rp, 13.10.17.32 NMAC, 1/1/17]

13.10.17.26 SUPERINTENDENT'S DECISION ON EXTERNAL REVIEW OF ADVERSE DETERMINATION:

A. Deliberation. At the close of the hearing, the hearing officers shall review and consider the entire record and prepare findings of fact, conclusions of law and a recommended decision within 30 days for a standard review. Any hearing officers may submit a supplementary or dissenting opinion to the recommended decision.

B. Order. Within 10 days after receiving the recommendation of the ICOs, the superintendent will issue an appropriate order. If the order requires action on the part of the health care insurer, the order shall specify the timeframe for compliance:

(1) The order shall be binding on the grievant and health care insurer and shall state that the grievant and the health care insurer have the right to judicial review pursuant to Section 59A-4-20 NMSA 1978 and that state and federal law may provide other remedies.

(2) Neither the grievant nor the health care insurer may file a subsequent request for external review of the same adverse determination that was the subject of the superintendent's order.

[13.10.17.26 NMAC - Rp, 13.10.17.33 NMAC, 1/1/17]

13.10.17.27 INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES:

A. Request for internal review of administrative decision. Any covered person dissatisfied with an administrative decision, action or inaction of a health care insurer, including termination of coverage, has the right to request internal review of an administrative decision orally or in writing within 180 days after receiving the administrative decision.

B. Acknowledgement of grievance. Within three days after receipt of an administrative grievance, the health care insurer shall send the grievant a written acknowledgment that it has received the administrative grievance. The acknowledgment shall contain the name, address and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the administrative grievance.

C. Initial review. The initial review shall:

(1) be conducted by a health care insurer representative authorized to take corrective action on the administrative grievance; and

(2) allow the grievant to present any information pertinent to the administrative grievance.

D. Time for decision. The health care insurer shall mail a written decision to the grievant within 30 days of receipt of the administrative grievance.

E. Contents of notice of decision. The written decision shall contain:

(1) the name, title and qualifications of the person conducting the initial review;

(2) a statement of the reviewer's understanding of the nature of the administrative grievance and all pertinent facts;

(3) a clear and complete explanation of the rationale for the reviewer's decision;

(4) identification of the health benefits plan provisions relied upon in reaching the decision;

(5) reference to evidence or documentation considered by the reviewer in making the decision;

(6) a statement that the initial decision will be binding unless the grievant submits a request for reconsideration within 20 days after receipt of the initial decision; and

(7) a description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms.

[13.10.17.27 NMAC - Rp, 13.10.17.35 NMAC, 1/1/17]

13.10.17.28 RECONSIDERATION OF INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Reconsideration committee. Upon receipt of a request for reconsideration, the health care insurer shall appoint a reconsideration committee consisting of two or more representatives of the health care insurer who did not participate in the initial decision and who are authorized to take corrective action on the grievance.

B. Hearing. The reconsideration committee shall schedule and hold a hearing within 15 days after receipt of a request for reconsideration. The hearing shall be held during regular business hours at a location reasonably accessible to the grievant, and the health care insurer shall offer the grievant the opportunity to communicate with the committee at the health care insurer's expense by conference call, video conferencing or other appropriate technology. The health care insurer shall not unreasonably deny a request for postponement of the hearing for up to 30 days made by a grievant.

C. Notice. The health care insurer shall notify the grievant in writing of the hearing date, time and place at least five days in advance. The notice shall advise the grievant of the rights specified in Subsection E of 13.10.17.28 NMAC. If the health care insurer will have an attorney represent its interests, the notice shall advise the grievant that the

health care insurer will be represented by an attorney and that the grievant may wish to obtain legal representation at grievant's own expense.

D. Information to grievant. No fewer than three days prior to the hearing, the health care insurer shall provide to the grievant all documents and information that the reconsideration committee will rely on in reviewing the case.

E. Rights of grievant. A grievant has the right to:

(1) attend the reconsideration committee hearing;

(2) present the grievant's case to the reconsideration committee;

(3) submit supporting material both before and at the reconsideration committee hearing;

(4) ask questions of any reconsideration committee member; and

(5) be assisted or represented by a person of their choice.

[13.10.17.28 NMAC - Rp, 13.10.17.36 NMAC, 1/1/17]

13.10.17.29 DECISION OF RECONSIDERATION COMMITTEE:

A. Committee Decision.

(1) Denial of payment of post-service claim in whole or in part. If the initial administrative decision involved a failure to make payment in whole or in part for a post-service claim for a covered benefit, the reconsideration committee shall review the claim to determine whether the claim was paid in accordance with the terms of the health benefits plan.

(2) Rescission. If the initial administrative decision involved rescission, the reconsideration committee shall review the request to determine whether the grievant or a person seeking coverage on behalf of the grievant performed an act, practice or omission that constitutes fraud, or made an intentional misrepresentation of material fact, as prohibited by the terms of the health benefits plan.

B. Written decision. The health care insurer shall mail a written decision to the grievant within seven days after the reconsideration committee hearing.

C. Contents. The written decision shall include:

(1) the names, titles and qualifications of the persons on the reconsideration committee;

(2) the reconsideration committee's statement of the issues involved in the administrative grievance;

(3) a clear and complete explanation of the rationale for the reconsideration committee's decision;

(4) the health benefits plan provision(s) relied on in reaching the decision;

(5) references to the evidence or documentation relied on in reaching the decision;

(6) a statement that the initial decision will be binding unless the grievant submits a request for external review by the superintendent within 20 days after receipt of the reconsideration decision;

(7) if applicable, notice of the grievant's right to request review from and in the manner designated by the entity that is providing the health benefits plan to the grievant pursuant to the New Mexico Health Care Purchasing Act; and

(8) a description of the procedures and deadlines for requesting external review by the superintendent, including any necessary forms; the notice shall contain the toll-free telephone number and address of the superintendent's office.

[13.10.17.29 NMAC - Rp, 13.10.17.37 NMAC, 1/1/17]

13.10.17.30 EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES BY SUPERINTENDENT:

A. Right to external review and scope. Every grievant who is dissatisfied with the results of the internal review and reconsideration committee hearing of an administrative decision shall have the right to request external review by the superintendent.

B. Exhaustion of remedies. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer or an entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

C. Deemed exhaustion. If exhaustion of internal reviews is required prior to external review, exhaustion must be unnecessary and the internal reviews process will be deemed exhausted if:

(1) the health care insurer waives the exhaustion requirement; or

(2) the health care insurer is considered to have exhausted the internal reviews process by failing to comply with the requirements of the internal reviews process.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection C of 13.10.17.30 NMAC, the internal claims and reviews process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not cause, and are not likely to cause prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an on-going, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and reviews process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of 13.10.17.30 NMAC, the grievant has the right to re-submit and pursue the internal review of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the health care insurer shall provide the grievant with notice of the opportunity to re-submit and pursue the internal review of the claim. Time periods for re-filing the claim shall begin to run upon grievant's receipt of such notice.

[13.10.17.30 NMAC - Rp, 13.10.17.38 NMAC, 1/1/17]

13.10.17.31 REQUIREMENTS FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Deadline for filing request. To initiate an external review, a grievant must file a written request for external review with the superintendent within 20 days after receipt of the written notice of the reconsideration committee's decision. The grievant shall file the request for external review on the forms provided by the health care insurer, and submitted as follows:

(1) mailed to the superintendent, attn: managed health care bureau - external review request, office of superintendent of insurance, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689;

(2) e-mailed to mhcb.grievance@state.nm.us, subject: external review request;

(3) faxed to the superintendent, attn: managed health care bureau - external review request at (505) 827-4734; or

(4) completed on-line using an OSI complaint form available on website of the OSI.

B. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

C. Extending timeframes for external review. If grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

[13.10.17.31 NMAC - Rp, 13.10.17.39 NMAC, 1/1/17]

13.10.17.32 ACKNOWLEDGEMENT OF REQUEST FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE BY SUPERINTEDENT:

A. Acknowledgement. Upon receipt of a completed request for external review, the superintendent shall immediately send:

(1) the grievant an acknowledgment that the request has been received; and

(2) the health care insurer a copy of the request for external review along with all documents submitted by or on behalf of the grievant with the request.

B. Items provided by health care insurer. Upon receipt of the copy of the request for external review, the health care insurer shall provide to the superintendent and the grievant by any available expeditious method within five days all necessary documents and information considered in arriving at the administrative grievance decision and reconsideration committee's decision. The health care insurer may also provide any documents or information it determines are necessary to respond to additional documents or information that have been provided by or on behalf of the grievant.

[13.10.17.32 NMAC - Rp, 13.10.17.40 NMAC, 1/1/17]

13.10.17.33 REVIEW OF ADMINISTRATIVE GRIEVANCE BY SUPERINTENDENT:

The superintendent shall review the documents submitted by the health care insurer and the grievant, and may conduct an investigation, or inquiry, or consult with the grievant, and the health care insurer, as appropriate. The superintendent shall issue a written decision on the administrative grievance within 45 days after receipt of the complete request for external review.

[13.10.17.33 NMAC - Rp, 13.10.17.41 NMAC, 1/1/17]

13.10.17.34 CONFIDENTIALITY OF A GRIEVANT'S RECORDS AND MEDICAL INFORMATION:

A. Confidentiality. Health care insurers, the superintendent, ICOs, IROs and their reviewers, and all others who acquire access to identifiable medical records and information of grievants when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

B. Procedures required. The superintendent, IROs, and health care insurers shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of grievants that are submitted as part of any grievance.

[13.10.17.34 NMAC - Rp, 13.10.17.11 NMAC, 1/1/17]

13.10.17.35 RECORD OF GRIEVANCES:

A. Record required. The health care insurer shall maintain a grievance register to record all grievances received and handled during the calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the superintendent.

B. Contents. For each grievance received, the grievance register shall:

(1) assign a grievance number;

(2) indicate whether the grievance is an adverse determination or administrative grievance, or a combination of both;

(3) state the date, and for an expedited review, the time the grievance was received;

(4) state the name and address of the grievant, if different from the covered person for whom the grievance was made;

(5) identify by name and member number the covered person making the grievance or for whom the grievance was made;

(6) indicate whether the grievant's coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, the medicaid program, or a commercial health care insurer;

(7) identify the health insurance policy number and the group if the policy is a group policy;

(8) identify the individual employee of the health care insurer to whom the grievance was made;

(9) describe the grievance;

(10) for adverse determination grievances, indicate whether the grievance received was an expedited or a standard review;

(11) indicate at what level the grievance was resolved and what the actual outcome was; and

(12) state the date the grievance was resolved and the date the grievant was notified of the outcome.

C. Annual report. Health care insurers shall annually submit to the superintendent a compilation of data extracted from the grievance register on or before March 1. The specific data to be submitted will be listed in the MHCB's section of the website of the OSI.

D. Retention. The health care insurer shall maintain such records for at least six years.

E. Submittal. The health care insurer shall submit information regarding all grievances involving quality of care issues to the health care insurer's continuous quality improvement committee and to the superintendent; and shall document the qualifications and background of the continuous quality improvement committee members.

F. Examination. The health care insurer shall make such record available for examination upon request and provide such documents free of charge to a grievant, or to state or federal agency officials subject to any applicable federal or state patient confidentiality laws regarding disclosure of personally identifiable health information.

[13.10.17.34 NMAC - Rp, 13.10.17.12 NMAC, 1/1/17]

PART 18: MINIMUM COVERAGE FOR TOBACCO CESSATION TREATMENT

13.10.18.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[13.10.18.1 NMAC - N, 3/1/04]

13.10.18.2 SCOPE:

This rule applies to policies, plans, contracts and certificates that offer maternity benefits delivered or issued for delivery or renewed, extended or amended pursuant to the New Mexico insurance code in this state by any person, insurer, health maintenance

organization, fraternal benefit society, nonprofit health care plan, medical insurance pool or health insurance alliance transacting health insurance or providing health care services.

[13.10.18.2 NMAC - N, 3/1/04]

13.10.18.3 STATUTORY AUTHORITY:

59A-2-9.4, 59A-22-44, 59A-23-4, 59A-23B-3, 59A-46-45 and 59A-47-33 NMSA 1978.

[13.10.18.3 NMAC - N, 3/1/04]

13.10.18.4 DURATION:

Permanent.

[13.10.18.4 NMAC - N, 3/1/04]

13.10.18.5 EFFECTIVE DATE:

March 1, 2004 unless a later date is cited at the end of a section.

[13.10.18.5 NMAC - N, 3/1/04]

13.10.18.6 OBJECTIVE:

The objective of this rule is to define minimum coverage for tobacco cessation treatment.

[13.10.18.6 NMAC - N, 3/1/04]

13.10.18.7 DEFINITIONS:

A. The following terms have the meanings given in the cited article or section of the New Mexico Statutes Annotated 1978:

(1) Fraternal Benefit Society, Section 59A-44-1 NMSA 1978;

(2) Health Insurance Alliance, Section 59A-56-3 NMSA 1978;

(3) Health Maintenance Organization, Section 59A-46-2 NMSA 1978;

(4) Insurer, Section 59A-1-8 NMSA 1978;

(5) Insurance Code, Section 59A-1-1 NMSA 1978;

(6) Nonprofit Health Care Plan, Chapter 59A, Article 47 NMSA 1978;

(7) New Mexico Medical Insurance Pool, Chapter 59A, Article 54 NMSA 1978.

B. The following terms have the meanings given here.

(1) Maternity benefits means coverage for prenatal, intrapartum, perinatal or postpartum care.

(2) Pharmacotherapy means intervention with United States food and drug administration approved first-line drugs available by prescription only to assist cessation of tobacco use or smoking.

(3) Tobacco means cigarettes (including roll-your own or handmade cigarettes), bidis, kreteks, cigars (including little cigars, cigarillos, regular cigars, premium cigars, cheroots, chuttas, and dhumti), pipe, smokeless tobacco (including snuff, chewing tobacco and bettle nut), and novel tobacco products, such as *eclipse*, *accord* or other low-smoke cigarettes.

(4) Cessation counseling means a program, including individual, group, or proactive telephone quit line, that:

(a) is designed to build positive behavior change practices and provides counseling at a minimum on establishment of reasons for quitting tobacco use, understanding nicotine addiction, various techniques for quitting tobacco use and remaining tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow-up;

(b) operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education materials and method for verifying enrollee attendance;

(c) employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and

(d) uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

[13.10.18.7 NMAC - N, 3/1/04]

13.10.18.8 REQUIRED MINIMUM COVERAGE FOR TOBACCO CESSATION TREATMENT:

A. All policies, plans, contracts and certificates that offer maternity benefits shall include at least the following tobacco cessation treatment benefits, which may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan, contract or certificate.

(1) Diagnostic services: Diagnostic services necessary to identify tobacco use, use-related conditions and dependence.

(2) Pharmacotherapy: Two 90-day courses of pharmacotherapy per calendar year.

(3) Cessation counseling: A choice of cessation counseling of up to 90 minutes total provider contact time or two multi-session group programs per calendar year.

B. Initiation of any course of pharmacotherapy or cessation counseling shall constitute an entire course of pharamacotherapy or cessation counseling even if an individual discontinues or fails to complete the course.

[13.10.18.8 NMAC - N, 3/1/04]

PART 19: PRESCRIPTION DRUG INFORMATION CARDS

13.10.19.1 ISSUING AGENCY:

Public Regulation Commission, Insurance Division.

[13.10.19.1 NMAC - N, 12-30-03]

13.10.19.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer, or administer health benefit plans in New Mexico, except as otherwise provided in the act.

B. Conflicts. For purposes of this rule, if any provision of this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care, the provisions of this rule shall apply.

[13.10.19.2 NMAC - N, 12-30-03]

13.10.19.3 STATUTORY AUTHORITY:

NMSA 1978 Section 59A-59-1 et seq.

[13.10.19.3 NMAC - N, 12-30-03]

13.10.19.4 DURATION:

Permanent.

[13.10.19.4 NMAC - N, 12-30-03]

13.10.19.5 EFFECTIVE DATE:

December 30, 2003, unless a later date is cited at the end of a section.

[13.10.19.5 NMAC - N, 12-30-03]

13.10.19.6 OBJECTIVE:

The purpose of this rule is to implement the Prescription Drug Uniform Information Card Act.

[13.10.19.6 NMAC - N, 12-30-03]

13.10.19.7 DEFINITIONS:

Act means the Prescription Drug Uniform Information Card Act, NMSA 1978 Sections 59A-59-1 et seq.

[13.10.19.7 NMAC - N, 12-30-03]

13.10.19.8 CONTENT AND FORMAT:

A. Format. Prescription drug identification cards shall be printed in Times New Roman, font size 8. The information on the front of the card shall be left justified; the information on the back of the card shall be centered at the bottom of the card.

B. Additional information. A health care insurer may add other information to a prescription drug identification card as long as the additional information does not reduce the readability of the required information.

C. Prior approval required. A health care insurer shall submit to the superintendent by March 1, 2004 a schematic showing the contents and format of both sides of the card it proposes to use. A health care insurer shall not issue prescription drug information cards, or cards for health insurance coverage that includes prescription drug coverage, until the superintendent approves the contents and format of the card.

[13.10.19.8 NMAC - N, 12-30-03]

13.10.19.9 IMPLEMENTATION:

A. Plan required. A health care insurer shall submit to the superintendent by March 1, 2004 an implementation plan detailing how and when the health care insurer will meet the requirements of the act and this rule. At a minimum, the plan shall indicate when the health care insurer plans to finalize the design of the card, when the health care insurer plans to commence issuing approved cards, and how the health care insurer plans to have all necessary cards issued by July 1, 2005.

B. Timeframe. A health care insurer shall issue prescription drug information cards that meet the requirements of the act and this rule with new policies or renewed policies issued after the superintendent has approved the content and format of the card, or as requested by the cardholder, but no later than July 1, 2005.

[13.10.19.9 NMAC - N, 12-30-03]

13.10.19.10 PENALTIES FOR NONCOMPLIANCE:

The superintendent may impose penalties in accordance with NMSA 1978 Section 59A-1-18 for failure to comply with the requirements of the act and this rule.

[13.10.19.10 NMAC - N, 12-30-03]

PART 20: SMALL EMPLOYER HEALTH CARE COVERAGE [EXPIRED]

[This part expired July 1, 2010]

PART 21: HEALTH CARE SERVICES AND PROVIDER CREDENTIALING REQUIRED FOR HMOs

13.10.21.1 ISSUING AGENCY:

Public Regulation Commission, Insurance Division.

[13.10.21.1 NMAC - N, 09/01/2009]

13.10.21.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer, or administer health care coverage pursuant to the health maintenance organization (HMO) laws of the state of New Mexico:

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

(1) only short-term travel, accident-only, student health, specified disease, or other limited benefits; or

(2) credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit, including a stand-alone dental benefit plan, whether indemnity, PPO, or non-profit plan.

C. Conflicts. For purposes of this rule, if any provision in this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care, 13.10.16 NMAC, Provider Grievances, or 13.10.17 NMAC Grievance Procedures Rule, the provisions in this rule shall apply.

[13.10.21.2 NMAC - N, 09/01/2009]

13.10.21.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-15-16, 59A-16-13.1, 59A-22- 41.1, 59A-22-43, 59A-46-2, 59A-46-4, 59A-46-7, 59A-46-23, 59A-46-30, 59A-46-35, 59A-46-36, 59A-46-38.2, 59A-46-38.4, 59A-46-38.5, 59A-46-39, 59A-46-41, 59A-46-41.1, 59A-46-42, 59A-46-42.2, 59A-46-43, 59A-46-43.2, 59A-46-44, 59A-46-45, 59A-46-46, 59A-46-48, 59A-46-49, 59A-57-4, and 59A-57-6 NMSA 1978.

[13.10.21.3 NMAC - N, 09/01/2009]

13.10.21.4 DURATION:

Permanent.

[13.10.21.4 NMAC - N, 09/01/2009]

13.10.21.5 EFFECTIVE DATE:

September 1, 2009, unless a later date is cited at the end of a section.

[13.10.21.5 NMAC - N, 09/01/2009]

13.10.21.6 OBJECTIVE:

The purpose of this rule is to clarify what is meant by a basic health care plan, for the purposes of certification of a health care plan as a health maintenance organization (HMO), pursuant to the requirements of Section 59A-46-2 NMSA 1978.

[13.10.21.6 NMAC - N, 09/01/2009]

13.10.21.7 DEFINITIONS:

In addition to the following, this rule is subject to the definitions found in 13.10.17 NMAC and to the definitions in 59A-46-2 NMSA 1978 and 59A-46-7 NMSA 1978.

A. "Credentialing" means the process of obtaining and verifying information about a health professional and evaluating that health professional when that health professional applies to become a participating provider with an HMO.

B. "Credentialing intermediary" means a person to whom an HMO has delegated credentialing or recredentialing authority and responsibility.

C. "Health maintenance organization (HMO)" means any person who undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for covered person responsibility for copayments or deductibles.

D. "Health care professional" means physicians, dentists, registered nurses, licensed practical nurses, podiatrists, optometrists, chiropractic physicians, physician assistants, nurse anesthetists, certified nurse practitioners, certified nurse-midwives, registered lay midwives, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists, doctors of oriental medicine, and other professionals engaged in the delivery of health care services who are licensed to practice in New Mexico, are certified, and are practicing under the authority of an HMO.

E. "Primary care practitioner" means physicians, other health care professionals such as doctors of oriental medicine, chiropractic physicians, nurse practitioners, physician assistants, or certified nurse midwives who may provide primary care, provided that the health care practitioner: 1) is acting within his or her scope of practice as defined under the relevant state licensing law; 2) meets the HMO eligibility criteria for health care practitioners who provide primary care; and 3) agrees to participate and to comply with the health care insurers or HMO care coordination and referral policies.

F. "Quality assurance plan" means the internal ongoing quality assurance program of an HMO to monitor and evaluate the HMO's health care services, including its system for credentialing health professionals applying to become a participating provider with an HMO or otherwise providing services to the HMO's covered persons.

G. "Uniform credentialing forms" means the version current at the time of the application or re-application process of forms used either by the hospital services corporation (HSC) or council for affordable quality healthcare universal credentialing datasource (CAQH), including any revisions thereto and as developed and updated from time to time, and including electronic versions of such forms.

H. "Women's health care practitioner" means obstetricians-gynecologists, family practitioners, general practitioners, certified nurse midwives, other physicians specializing in women's health, and physician assistants or nurse practitioners specializing in women's health. An HMO may also make registered lay midwives available to female covered persons for prenatal care and delivery. The HMO may assure that those providers who seek to provide self-referral women's services who are not obstetricians-gynecologists or who are not practicing under the supervision of

obstetricians-gynecologists have the requisite background, training, and experience to properly examine and treat self-referred female covered persons.

I. "Written notification" as between the MHCP and providers means a writing delivered through standard U.S. postal service, or through other written means if agreed upon by the parties as effective alternative methods of communication for the intended purpose, including but not limited to personal delivery service, facsimile delivery, or electronic mail.

[13.10.21.7 NMAC - N, 09/01/2009]

13.10.21.8 HMO BASIC HEALTH CARE SERVICES:

A health care insurer offering basic health care services through an HMO shall provide or shall arrange for the following medically necessary basic health care services for its covered persons.

A. An HMO may not provide or arrange to provide basic health care services if such services:

(1) do not include all the basic health services set forth in this section; or

(2) are limited as to time or cost except as prescribed in this section, subject to lifetime policy maximums.

B. Outpatient medical services: Outpatient medical services shall include those hospital services that can reasonably be provided on an ambulatory basis, and those preventive, medically necessary, and diagnostic and treatment procedures that are prescribed by a covered person's primary care or attending health care professional. Such services may be provided at a hospital, a physician's office, any other appropriate licensed facility, or at any other appropriate facility if the health care professional delivering the services is licensed to practice, is certified, and is practicing under authority of the health care insurer or HMO, a medical group, an independent practice association or other authority authorized by applicable New Mexico law.

C. Inpatient hospital services: Inpatient hospital services shall include, but not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by the covered person's primary care practitioner or treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary.

D. Emergency and urgent care services: Emergency and urgent care services shall include:

(1) acute medical care that is available twenty-four hours per day, seven days per week, so as not to jeopardize a covered person's health status if such services were not received immediately; such medical care shall include ambulance or other emergency transportation; in addition, acute medical care shall include, where appropriate, transportation and indemnity payments or service agreements for out-of-service area or out-of-network coverage in cases where the covered person cannot reasonably access in-network services or facilities; and

(2) coverage for trauma services at any designated level I, level II, or other appropriately designated trauma center according to established emergency medical services triage and transportation protocols; coverage for trauma services and all other emergency services shall continue at least until the covered person is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending physician or health care professional in consultation with the HMO; if the health care insurer or HMO requests transfer to a hospital participating in its provider network, the patient must be stabilized and the transfer effected in accordance with federal law. See 42 CFR 489.20 and 42 CFR 489.24;

(3) reimbursement for emergency care and emergency transportation shall not be denied by the health care insurer or HMO when the covered person, who in good faith and who possesses average knowledge of health and medicine, seeks medical care for what reasonably appears to the covered person to be an acute condition that requires immediate medical attention, even if the patient's condition is subsequently determined to be non-emergent;

(4) in determining whether care is reimbursable as emergency care, the MHCP shall take the following factors into consideration:

(a) a reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment;

(b) the time of day the care was provided;

(c) the presenting symptoms; and

(d) any circumstances which precluded use of the HMO's established procedures for obtaining emergency care;

(5) reimbursement for emergency care shall not be denied in those instances when the covered person is referred to emergency care by the covered person's primary care practitioner or by the HMO;

(6) no prior authorization shall be required for emergency care. In addition, appropriate out-of-network emergency care shall be provided to a covered person

without additional cost; whether out-of-network emergency care is appropriate shall be determined by the standards of Paragraph (4) of Subsection D of 13.10.21.8 NMAC.

E. Short-term rehabilitation services and physical therapy: Short-term rehabilitation services and physical therapy shall be provided in those instances where the covered person's primary care practitioner or other appropriate treating health care professional determines that such services and therapy can be expected to result in the significant improvement of a covered person's physical condition within a period of two months. Such services may be extended beyond the two month period upon recommendation by the primary care practitioner in consultation with the HMO.

F. Diagnostic services: Diagnostic services shall include diagnostic laboratory services, diagnostic and therapeutic radiological services, and other services in support of comprehensive basic health care services.

G. Other mandated benefits: Any and all mandated benefits pursuant to federal or state law that apply to HMOs which become effective following promulgation of this rule, and the following:

(1) dental services:

(a) when determined to be medically necessary by a participating provider in connection with the following: accidental injury to sound natural teeth, the jaw bones, or surrounding tissues; the correction of a non-dental physiological condition which has resulted in a severe functional impairment; or the treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(b) general anesthesia and hospitalization, pursuant to Section 59A-46-48 NMSA 1978;

(2) reconstructive surgery: surgery from which an improvement in physiologic function could reasonably be expected, when ordered by a covered person's primary care practitioner or treating health care professional and performed for the correction of functional disorders resulting from accidental injury or from congenital defects or disease;

(3) diabetes care: for insulin-using individuals, non-insulin-using individuals and those with elevated blood glucose levels induced by pregnancy, coverage pursuant to Section 59A-46-43 NMSA 1978;

(4) medical diets: for genetic inborn errors of metabolism, medical diets pursuant to Section 59A-46-43.2 NMSA 1978;

(5) craniomandibular and temporomandibular joint disorders: for surgical and nonsurgical treatment of temporomandibular joint disorders and craniomandibular

disorders, subject to the same conditions, limitations, prior review and referral procedures as are applicable to treatment of any other joint in the body, pursuant to Section 59A-16-13.1 NMSA 1978;

(6) cancer clinical trials: routine patient care costs incurred as a result of the patient's participation in a phase II, III or IV cancer clinical trial, pursuant to Section 59A-22-43 NMSA.

H. Children's health care: Children's health care shall include, but not be limited to:

(1) childhood immunizations, pursuant to Section 59A-46-38.2 NMSA 1978;

(2) vision and hearing testing for persons through age 17 to determine the need for vision and hearing corrections;

(3) well-child care from birth in accordance with recommendations of the American academy of pediatrics;

(4) prenatal care, including medically necessary nutritional supplements prescribed by the expectant mother's obstetrician-gynecologist, or other health care professional from whom the expectant mother is receiving prenatal care, if maternity coverage is provided by the HMO;

(5) availability of educational materials or consultation from providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of tobacco use, nutrition and diet recommendations, exercise plans, and, as deemed appropriate by the primary care practitioner or as requested by the parents or legal guardian, educational information on alcohol and substance abuse, sexually-transmitted diseases, and contraception;

(6) hearing aid coverage, pursuant to Section 59A-46-38.5 NMSA 1978; and

(7) circumcision for newborn males, pursuant to Section 59A-46-38.4 NMSA 1978.

I. Women's health care: Women's health care coverage shall be included in all HMOs, and shall include, at a minimum, the following:

(1) mammograms, pursuant to Section 59A-46-41 NMSA 1978;

(2) cytologic and human papillomavirus screening, pursuant to Section 59A-46-42 NMSA 1978;

(3) osteoporosis services, defined as diagnosis, treatment, and appropriate management of osteoporosis when such services are determined to be medically necessary by a covered person's primary care practitioner in consultation with the HMO;

(4) alpha-fetoprotein IV screening, pursuant to Section 59A-46-46 NMSA 1978;

(5) limitation on visits: an HMO may limit the number of visits to designated women's health care providers by female covered persons, provided that it allows:

(a) at least one routine annual well-visit per female covered person; and

(b) follow-up treatment within sixty days following a well-visit for treatment of a condition diagnosed during a well-visit.

J. HMOs providing maternity coverage: If an HMO provides maternity benefits, the coverage shall include:

(1) medically necessary prenatal, intrapartum, and perinatal care;

(2) smoking cessation treatment, pursuant to Section 59A-46-45 NMSA 1978; and 13.10.18.8 NMAC;

(3) maternity transport, pursuant to Section 59A-46-39 NMSA 1978; and

(4) minimum hospital stays and postpartum care, pursuant to federal law and 13.10.2 NMAC.

K. HMOs providing mastectomy coverage: Each HMO which provides mastectomy coverage shall also cover mammography for screening and diagnostic purposes, prosthetic devices, and reconstructive surgery, as mandated by federal or state laws.

L. Direct access to women's health care practitioners: A female covered person whose primary care practitioner is not a women's health care practitioner shall have direct and timely access to an in-network, participating women's health care practitioner for women's health care coverage, as defined at Subsection I of 13.10.21.7 NMAC. Direct access shall also be offered by an HMO that offers additional obstetric and gynecological services beyond those required under this rule, or that offers maternity coverage.

(1) Disclosure. Each managed health care plan shall disclose to covered persons in clear, accurate language, the right of female covered persons age 13 and over of direct access to an in-network, participating women's health care practitioner of her choice. The information shall include, at a minimum, any specific women's health

care services excluded from coverage, and shall include reference to the HMO's right to limit coverage to medically necessary and appropriate women's health care services.

(2) Co-payments. No HMO shall impose additional copayments, co-insurance, or deductibles for female covered persons' direct access to in-network, participating women's health care providers when acting as a PCP.

(3) Choice to become a PCP. Nothing in this section requires any women's health care provider to enter into a contract with an HMO whereby he or she must act as a primary care practitioner (PCP) rather than as a referral specialist.

(4) Criteria for PCP acceptance. An HMO's criteria for accepting women's health care providers as PCPs must be the same as the criteria utilized by the HMO for other specialists seeking to act as PCPs.

(5) Procedure for direct access. Any female covered person age 13 or older shall have direct access to women's health care by:

(a) including qualified women's health care providers as primary care practitioners (PCPs), which means that the women's health care provider has met the HMO's general eligibility criteria for a specialist seeking PCP status, and agrees with the HMO to comply with its coordination and referral policies;

(b) allowing female covered persons to select a qualified women's health care practitioner as their PCP; and

(c) allowing female covered persons who have not chosen a women's health care provider as their PCP to self-refer, without requiring prior authorization or pre-approval from the plan or their PCP, to an in-network, participating women's health care practitioner for women's health care and, if offered as a covered benefit under the plan, for maternity care and additional obstetric and gynecological services, subject to the following:

(i) self-referrals shall be limited to those services defined by the published recommendations of the American college of obstetrics and gynecology;

(ii) the HMO may require the women's health care practitioner to discuss with the female covered person's PCP any services or treatment the women's health care practitioner recommends for the covered person.

(iii) the women's health care practitioner must comply with the HMO's coordination and referral policies.

M. Health promotion program: Each HMO that provides coverage for comprehensive basic health care services in this state shall provide a preventative health services program and shall make the following services available to a covered

person only in those instances where the covered person's primary care practitioner determines that such services are medically necessary:

(1) periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level, in accordance with recommendations of the U.S. preventive services task force;

(2) periodic glaucoma eye tests for all persons 35 years of age or older, in accordance with recommendations of the U.S. preventive services task force;

(3) periodic stool examinations for the presence of blood for all persons 50 years of age or older, in accordance with recommendations of the U.S. preventive services task force;

(4) colorectal cancer screening, in accordance with the recommendations of the U.S. preventive services task force, pursuant to Section 59A-46-48 NMSA 1978;

(5) immunizations for all adults, as recommended by the CDC advisory committee for immunization practice;

(6) for all persons 20 years of age or older and as deemed medically necessary by a primary care practitioner, an annual consultation with a health professional to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat-belts in motor vehicles, and other preventative health care practices;

(7) other preventative health services shall include, under a covered person's primary care practitioner's supervision:

(a) reasonable physical and behavioral health appraisal examinations and laboratory and radiological tests on a periodic basis when medically necessary;

(b) voluntary family planning services; and

(c) diagnosis and medically indicated treatments for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery.

[13.10.21.8 NMAC - Rp, 13.10.13.9 NMAC, 09/01/2009]

13.10.21.9 UNIFORM PROVIDER CREDENTIALING FOR HEALTH MAINTENANCE ORGANIZATIONS (HMOs):

A. Delegation of credential verification activities: Whenever an HMO delegates credential verification activities to a contracting entity, whether a credentialing intermediary or subcontractor, the HMO shall review and approve the contracting entity's credential verification program before contracting and shall require that the entity comply with all applicable requirements of this regulation. The HMO shall monitor the contracting entity's credential certification activities. The HMO shall implement oversight mechanisms, including (a) reviewing the contracting entity's credential verification plans, policies, procedures, forms, and adherence to verification procedures, (b) requiring the contract entity to submit an updated list of health professionals no less frequently than quarterly, and (c) conducting an evaluation of the contracting entity's credential verification program at least every two years. The HMO's monitoring activities should at least meet the verification procedures and standards as defined by the national committee for quality assurance (NCQA).

B. Credential verification program: In order to assure accessibility and availability of services, each HMO shall establish a program in accordance with this regulation that verifies that its network providers are credentialed before the HMO lists those providers in the HMO's provider directory, handbooks, or other marketing or member materials. The credential verification program established by each HMO shall provide for an identifiable person or persons to be responsible for all credential verification activities, which person or persons shall be capable of carrying out that responsibility.

C. Written credential verification plan: Each HMO shall develop and adopt a written credentialing plan that contains policies and procedures to support the credentialing verification program. The plan shall include the purpose, goals and objectives of the credential verification program; and the roles of those persons responsible for the credential verification program.

D. Use of uniform credentialing forms required: Beginning September 1, 2009, an HMO shall not use any health professional credentialing application form other than uniform HSC or CAQH credentialing or re-credentialing forms. Should the superintendent determine that these forms no longer represent industry standards, the superintendent will issue a bulletin advising of alternative forms to be used to satisfy this requirement. The uniform credentialing or re-credentialing forms may be used in electronic or paper format, as determined by the HMO. An HMO shall not require an applicant to submit information not required by the uniform credentialing or re-credentialing forms. An exception is made for health professionals who: (a) are subject to credentialing under the HMO's internal policy; (b) practice outside of New Mexico; and (c) prefer to use the credentialing forms required by their respective states. In such circumstances, the HMO and its delegated entity, if any, may accept those forms.

E. Verification of credentials: Each HMO shall maintain a process to assess and verify the qualifications of health professionals applying to become participating providers with the HMO within 45 calendar days of receipt of a completed uniform credentialing form. Each HMO's process for verifying credentials shall take into account and make allowance for the time required to request and obtain primary source

verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials, and shall make allowance for the scheduling of a final decision by a credentialing committee, if the HMO's credentialing program requires such review.

(1) Within 45 calendar days after receipt of a completed application and all supporting documents, the HMO shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 45th calendar day after receipt of the application, the HMO has not received all of the information or verifications it requires from third parties, or date-sensitive information has expired, the HMO shall issue a written notification, through standard mail, fax, electronic mail or other agreed-upon writing, to the applicant either closing the application and detailing the HMO's attempts to obtain the information or verification, or pending the application and detailing the HMO's attempts to obtain the information and verifications. If the application is held, the HMO shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and telephone number of a credentialing staff person who will serve as a contact person for the applicant.

(2) Within 10 working days after receipt of an incomplete application, the HMO shall notify the applicant in writing of all missing or incomplete information or supporting documents.

(a) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as the contact person for the applicant.

(b) Within 45 calendar days after receipt of all of the missing or incomplete information or documents, the HMO shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with Subsection E of this section.

(c) If the missing information or documents have not been received within 45 calendar days after initial receipt of the application or if date-sensitive information has expired, the HMO shall close the application or delay final review, pending receipt of the necessary information. The HMO shall provide written notification to the applicant of the closed or pending status of the application and, where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as the contact person for the applicant.

(3) If an HMO elects not to include an applicant in its network, for reasons that do not require review of the application, the HMO shall provide written notice to the applicant of that determination within 10 working days after receipt of the application.

(4) Nothing in this regulation shall require an HMO to include a health professional in its network or prevent an HMO from conducting a complete review and verification of an applicant's credentials, including an assessment of the applicant's office, before agreeing to include the applicant in its network.

(5) Nothing in this regulation shall be deemed to supersede any provision of a contract between an HMO and a health professional participating as a provider in the HMO's network.

(6) HMOs must notify a provider at least 120 days in advance of all items necessary to complete recredentialing. The HMO must complete the recredentialing process within 45 days of receipt of the provider's complete recredentialing application and all supporting documents.

F. Health professional files: Each HMO shall maintain centralized files, either paper or electronic, on each health professional making application to be a participating provider in the HMO's network. Each file shall include documentation of compliance with this regulation.

G. Records and examinations: Each HMO shall maintain all records related to credential verification in a manner that the HMO deems to be adequate for a period of six years and shall make such records available to the superintendent on request.

H. Accreditation by nationally recognized accrediting entity: Nothing in this section shall prohibit an HMO from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where an HMO seeks to meet the requirements of this section through accreditation by a private accrediting entity, the HMO shall submit to the division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the HMO has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the HMO and upon which accreditation of the HMO was based. An HMO accredited by the private accrediting entity that has submitted all of the requisite information to the division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the HMO obtained accreditation is recognized and approved by the superintendent.

[13.10.21.9 NMAC - N, 09/01/2009]

13.10.21.10 PENALTIES:

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of

this rule may be imposed against a health care insurer by the superintendent in accordance with Sections 59A-1-18, 59A-46-25, and 59A-57-11 NMSA 1978.

[13.10.21.10 NMAC - Rp, 13.10.13.32 NMAC, 09/01/2009]

13.10.21.11 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.21.11 NMAC - Rp, 13.10.13.33 NMAC, 09/01/2009]

PART 22: MANAGED HEALTH CARE PLAN COMPLIANCE

13.10.22.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Division of Insurance, Post Office Box 1269, Santa Fe, New Mexico 87504-1269.

[13.10.22.1 NMAC - Rp, 13.10.13.1 NMAC, 09/01/2009]

13.10.22.2 SCOPE:

This rule applies to health care insurers that are required to obtain a certificate of authority or licensure in this state and which provide, offer, or administer managed health care plans. This rule relates to and should be read in conjunction with 13.10.13, 13.10.16, 13.10.17, 13.10.21 and 13.10.23 NMAC.

[13.10.22.2 NMAC - Rp, 13.10.13.2 NMAC, 09/01/2009]

13.10.22.3 STATUTORY AUTHORITY:

Sections 59A-1-18, 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-15-16, 59A-16-12, 59A-16-12.1, 59A-16-13, 59A-16-22, 59A-18-17, 59A-18-27.1, 59A-22-32, 59A-22-32.1, 59A-22A-4, 59A-22A-5, 59A-23-4, 59A-44-34, 59A-44-41, 59A-46-7, 59A-46-9, 59A-46-10, 59A-46-11, 59A-46-23, 59A-46-25, 59A-46-27, 59A-46-30, 59A-46-35, 59A-46-36, 59A-47-27, 59A-47-29, 59A-47-33, 59A-57-2, 59A-57-4, 59A-57-5, 59A-57-6, 59A-57-8, and 59A-57-11 NMSA 1978.

[13.10.22.3 NMAC - Rp, 13.10.13.3 NMAC, 09/01/2009]

13.10.22.4 DURATION:

Permanent.

[13.10.22.4 NMAC - Rp, 13.10.13.4 NMAC, 09/01/2009]

13.10.22.5 EFFECTIVE DATE:

September 1, 2009, unless a later date is cited at the end of a section.

[13.10.22.5 NMAC - Rp, 13.10.13.5 NMAC, 09/01/2009]

13.10.22.6 OBJECTIVE:

The purpose of this rule is to ensure the availability, accessibility, and quality of health care services provided by health care insurers through managed health care plans, and to regulate trade practices in the insurance business and related businesses by prohibiting unfair or deceptive acts or practices.

[13.10.22.6 NMAC - Rp, 13.10.13.6 NMAC, 09/01/2009]

13.10.22.7 DEFINITIONS:

In addition to the following, this rule is subject to the definitions found in the Grievance Procedures Rule, 13.10.17 NMAC.

A. "Claim" means:

(1) any request by an insured for indemnification by a MHCP; and

(2) any direct services provided to an individual.

B. "Direct services" means:

(1) services rendered to an individual by a health insurer or a health care professional, facility or other provider;

(2) case management, disease management, health education and promotion, preventive services, quality incentive payments to providers or individuals; and

(3) any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act.

C. "Earned premium" means paid premiums for the year plus uncollected premiums minus premiums paid in advance.

D. "**Health care facility**" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or

treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

E. "**Health care insurer**" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, prepaid dental plan, a multiple employer welfare arrangement or any other person providing a plan of health insurance or a managed health care plan subject to state insurance law and regulation.

F. "Health care professional" means a physician or other health care professional, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

G. "**Health care services**" means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

H. "Incurred claims" means paid-on-incurred claims for the year, plus a reserve for claims incurred but not yet paid, plus the change in any other reserve held, plus expenses incurred during the year.

I. "Incurred health care expenses" means health care coverage that is provided by a health maintenance organization, as defined in Article 46 of the New Mexico Insurance Code, on a service rather than reimbursement basis.

J. "Loss Ratio" means incurred claims or incurred health care expenses to earned premiums.

K. "**Managed health care plan (MHCP or plan)**" means a policy, contract, certificate or agreement offered or issued by a health care insurer, provider service network, or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services, except as otherwise provided in this subsection. A MHCP either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health care insurer, provider service network, or plan administrator. Effective immediately, a MHCP does not include a traditional fee-for-service indemnity health benefit plan or a health benefit plan that covers only short-term travel, accident-only, limited benefit, an indemnity, PPO dental or non-profit dental benefit plan, student health plan, or specified disease policies. For purposes of this section, "plan administrator" shall include and apply to an HMO or other health care insurer not required to be licensed under Section 59A-12A-2 NMSA 1978, but which is acting as a "plan administrator" as defined under the act." A MHCP includes a health benefits plan as defined under NMSA 1978 Section 59A-22A-3(D) as "the health

insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available."

L. "Premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitation payments, recoveries from third parties or other insurers, interest and administrative fees received and claim payments made by:

(1) an administrator or third party administrator pursuant to Chapter 59A, Article 12A NMSA 1978;

(2) a health maintenance organization;

(3) a nonprofit health care plan; or

(4) an insurer.

M. "Small group health insurance market" means plans offered to small employers pursuant to Article 23C of the New Mexico Insurance Code.

N. "Usual, customary and reasonable rate" means health care services, medical supplies and payment rates for health care services provided by a health care practitioner at or near the median rate paid for similar health care services within a surrounding geographic area where the charges were incurred. Surrounding geographic area may be determined by the type of service and access to that service in the geographic area.

[13.10.22.6 NMAC - Rp, 13.10.13.6 NMAC, 09/01/2009]

13.10.22.8 ACCESS TO HEALTH CARE SERVICES:

A. Provider network adequacy: Each health care insurer through its MHCP shall maintain and have available an adequate network of licensed primary care practitioners (PCPs) to provide comprehensive basic health care services to its enrolled population at all times. Those MHCPs currently doing business in New Mexico shall submit to the superintendent for approval an access plan addressing all of the criteria of this section. A MHCP new to this state shall submit a preliminary access plan to the division as part of its application for licensure. A MHCP new to this state shall file a follow-up access plan with the superintendent within six months after it obtains a certificate of authority. The superintendent shall approve or reject an access plan submitted by a MHCP within 45 days after the access plan is submitted to the division. In considering whether to approve or reject an access plan, the superintendent shall determine whether the MHCP meets all of the following criteria; however, the superintendent may make reasonable exceptions to the criteria on a case by case basis when the MHCP demonstrates the need for such exceptions.

(1) Whether, in population areas of 50,000 or more residents, two PCPs are available within no more than 20 miles or 20 minutes average driving time for 90 percent of the enrolled population, or, in population areas of less than 50,000, whether two PCPs are available in any county or service area within no more than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population. For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made sufficient PCPs available given the number of residents in the county or service area and given the community's standard of care.

(2) Whether the MHCP has a sufficient number of PCPs to meet the primary care needs of the enrolled population, using, as guidelines for calculation, the following criteria: 1) that each covered person will have four primary care visits annually, averaging a total of one hour; 2) that each PCP will see an average of four patients per hour; and 3) that one full-time equivalent PCP will be available for every 1,500 covered persons.

(3) Whether the MHCP demonstrates that the projected PCP network is sufficient to meet the primary care needs of adult, pediatric, and obstetric-gynecological patients. Each MHCP should show the adequacy of PCP availability by verifying that the PCPs committed to provide sufficient time for new patients so that projected clinic hour needs of the projected enrollment by service area are met.

(4) Whether the MHCP provides reasonable and reliable access for its covered persons to qualified health care professionals in those specialties that are covered by the MHCP. In developing its access plan, the MHCP should: 1) demonstrate that a sufficient number of licensed medical specialists are available to covered persons for specialty care when referral to such care is determined to be medically necessary by the PCP or other treating health care professional in consultation with the MHCP; and 2) attempt to provide at least one licensed medical specialist in those specialties that are generally available in the geographic area served, taking into consideration the urban or rural nature of the service area, the geographic location of each covered person, and the type of specialty care needed by the covered person population. A MHCP shall not restrict PCPs, in consultation with the MHCP, from referring covered persons to providers outside the network, even when geographically distant from the covered person's residence, when access to such treatment by such provider is medically necessary and no other provider can provide comparable treatment in-network or on a more cost-effective basis.

(5) Whether the MHCP has contracts, or other arrangements acceptable to the superintendent, with institutional providers - so that: 1) the need for services covered by the MHCP is satisfied; 2) the medical needs of covered persons are met 24 hours per day, seven days per week; and 3) the institutional services are geographically accessible to covered persons. In its access plan, the MHCP should demonstrate that in population areas of 50,000 or more residents, at least one licensed acute care hospital providing, at a minimum, licensed medical-surgical, emergency medical, pediatric, obstetrical, and critical care services is available no greater than 30 miles or 30 minutes

average driving time for 90 percent of the enrolled population within the service area, and, in population areas of less than 50,000, that the acute care hospital is available no greater than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population within the service area. For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made at least one licensed acute care hospital available given the number of residents in the county or service area and given the community's standard of care.

(6) Whether a sufficient number of health care professionals, such as registered and licensed practical nurses, are available to covered persons to ensure the delivery of covered health care services.

(7) Whether the MHCP has made surgical facilities including acute care hospitals for major surgery, hospitals for minor surgical procedures, licensed ambulatory surgical facilities, and medicare eligible surgical practices reasonably available, given the population of the service area and the institutional facilities available in or around the service area.

(8) Whether the MHCP has a policy assuring access to tertiary and specialized services as evidenced by contract or other agreement acceptable to the superintendent. In its access plan, the MHCP should describe the geographic location of and covered persons' accessibility to the following such services:

(a) at least one hospital providing regional perinatal services, if maternity coverage is offered as a health care service;

(b) a hospital offering tertiary pediatric services;

(c) a hospital offering diagnostic cardiac catheterization services;

(d) inpatient psychiatric services for adults and children, if provided as a covered health care service; and

(e) a residential substance abuse treatment center, if provided as a covered health care service.

(9) Whether the MHCP has a policy assuring access to the specialized services listed below, as evidenced by contract or other agreement acceptable to the superintendent. The MHCP should demonstrate in its access plan the geographic location of and covered persons' accessibility to the following such services:

(a) a therapeutic radiation provider;

(b) magnetic resonance imaging center;

(c) diagnostic radiology provider, including x-ray, ultrasound, and CAT scan; and

(d) a licensed renal dialysis center.

(10) Whether the MHCP has at least one licensed home health care professional available to serve each service area where 3,000 or more covered persons reside, if home health care is provided as a covered health care service.

B. Appointment waiting times: Each MHCP shall demonstrate that the network will meet the following criteria:

(1) emergencies shall be triaged through the PCP or by a hospital emergency room through medical screening or evaluation;

(2) urgent care shall be available within 48 hours of notification to the PCP or MHCP, or sooner as required by the medical exigencies of the case;

(3) for both emergent and urgent care, the MHCP shall ensure 7 day, 24 hour access to triage services, and that each PCP will have back-up coverage by another provider;

(4) the MHCP shall have an adequate number of PCPs with admitting privileges at one or more participating hospitals within the MHCP's service area so that necessary hospital admissions are made on a timely basis consistent with generally accepted practice parameters;

(5) routine appointments shall be scheduled as soon as is practicable given the medical needs of the covered person and the nature of the health care professional's medical practice;

(6) routine physical exams shall be scheduled within 4 months;

(7) in all instances of scheduling, the MHCP or its participating health care professionals shall have guidelines to assess when an appointment should be scheduled based on the type of health care service to be provided; upon request, the MHCP shall make such guidelines available to covered persons;

(8) all appointments shall be scheduled either during normal business hours or after hours (if applicable), depending upon the individual patient's needs and in accordance with the individual physician's scheduling practice.

C. Referrals: The MHCP shall implement a system that ensures routine referrals are made to other participating health care professionals.

(1) A covered person shall not be held liable for payment of services if the MHCP health care professional mistakenly makes a referral to a non-participating health care professional, unless the MHCP has notified the covered person in writing concerning the use of non-participating health care professionals and informed the covered person that the MHCP will not be responsible for future payment to the non-participating health care professionals.

(2) The MHCP shall bear the burden of showing that the covered person has been adequately informed by specific written notice of the MHCP's future refusal to pay for future care provided by the identified non-participating health care professional.

(3) The MHCP shall ensure that a covered person is not precluded from obtaining a referral from the covered person's PCP to a specialist or other health care professional that is within the MHCP's network, if the referral is reasonable.

D. Provider lists: A MHCP must provide a list of all providers to subscribers, enrollees, covered persons or prospective enrollees upon request.

(1) The list shall include specialty health care professionals and other health care professionals providing health care services, and shall specify the locations, including addresses, of such providers.

(2) The list shall identify those health care professionals who are not currently accepting new patients.

(3) The information shall be made available and upon request be provided to enrollees in the evidence of coverage.

(4) Information should be provided through toll-free phones and electronic means, as specified in 13.10.23.7 NMAC.

(5) MHCPS are encouraged to facilitate a covered person's ability to obtain a second opinion from a participating health care professional regarding the covered person's request for a second opinion from, or referral to, a non-participating health care professional.

E. Out-of-network services: In the event medically necessary covered services are not reasonably available through participating health care professionals, the MHCP shall provide in the contract terms that the MHCP and the PCP or other participating health care professional shall refer a covered person to a non-participating health care professional and shall fully reimburse the non-participating health care professional at the usual, customary, and reasonable rate or at an agreed upon rate. The contract must further state that before a MHCP may deny such a referral to a non-participating physician or health care professional, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested.

F. Specialty care: Referrals to participating or non-participating specialty health care professionals must be accessible to covered persons on a timely and appropriate basis in accordance with generally accepted medical guidelines.

(1) If the MHCP requires covered persons to obtain prior authorization before referral to specialty care, the MHCP must provide covered persons the following information in the evidence of coverage:

(a) procedures a covered person must follow to obtain prior authorization for specialty referrals, including whether a covered person's PCP, the MHCP's medical director, or a committee must first authorize the specialty referral;

(b) the necessity, if any, of repeating prior authorization if the specialist care is to be ongoing; and

(c) procedures to obtain a second medical opinion.

(d) if a PCP referral is required under the MHCP, the MHCP must inform PCPs of their responsibility to provide written referrals; of any specific procedures that must be followed in providing such referrals; and that the PCP must refer patients to those participating health care professionals who are qualified to address the covered person's health care needs as determined by the PCP in consultation with the MHCP.

(2) The MHCP shall make determinations on requests for referrals in accordance with Subsection D of 13.10.13.19 NMAC.

(3) Covered persons denied referral to specialty care may initiate a grievance through the MHCP's grievance procedures pursuant to 13.10.17 NMAC.

G. Ongoing specialty care: If, in the best medical judgment of the covered person's PCP, the covered person's health condition requires ongoing specialty care, such as for chronic illnesses requiring medical supervision beyond the capability or training of the PCP, the PCP may, after consultation with the specialist and the MHCP, refer the covered person to the appropriate specialist for ongoing care as the severity of the condition warrants.

(1) The ultimate determination, however, of whether the covered person should have ongoing care from the specialist shall remain with the PCP.

(2) In such cases, neither the PCP nor the covered person will be required to obtain a prior authorization from the MHCP for subsequent specialist visits.

(3) The MHCP may review such referrals to specialist care on an annual basis to determine whether ongoing specialist care continues to be medically necessary. In conducting such a review, the MHCP shall consult with the covered

person's primary care physician and the specialist to whom the covered person has been referred.

(4) Nothing in Subsection G of 13.10.22.8 NMAC prohibits a MHCP from requiring that covered persons receive ongoing specialist care from those specialists who are considered "participating health care professionals" by the MHCP, unless there are no participating specialists of the type required to manage the patient's condition. In such instances, the MHCP shall make indemnity or other payment arrangements for the patient's care, and covered persons will not be assessed higher or additional co-payments as a result of such arrangements.

(5) A MHCP must allow qualified health care professionals who are specialists to act as PCPs for patients with chronic medical conditions of sufficient severity to require primary coordination of care by a specialist as determined by the covered person, the covered person's current treating health care professional, the covered person's PCP if different than the treating health care professional, and the MHCP, provided that:

(a) the specialist offers all basic health care services that are required of them by the MHCP; and

(b) the specialist meets the MHCP's eligibility criteria for health care professionals who provide primary care.

H. Out of state providers: A MHCP is encouraged to enter into contracts or other arrangements with out of state providers in order to meet the access requirements of this rule.

I. Access to non-allopathic health care services: In order to maximize covered persons' access to all types of health care services, the division affirmatively encourages each health care insurer or MHCP to enter into appropriate contracts with qualified health care professionals, including but not limited to, doctors of oriental medicine, chiropractic physicians, nurse practitioners, physician assistants, or certified nurse midwives to provide both allopathic and non-allopathic health care services.

J. Reliance on nationally recognized accreditation standards to meet access standards: If the MHCP utilizes an open network pursuant to NMSA 1978, Section 59A-22A-5, then in lieu of the provisions of 13.10.22.8 NMAC, Subsections A-I, the MHCP shall present to the superintendent written verification either that the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission/URAC (URAC) determined that the MHCP has achieved one of the two highest ratings for all factors regarding availability of health care professionals and accessibility of services, under contemporaneous NCQA or URAC standards.

(1) In lieu of the above, the plan shall present evidence to the superintendent that it would achieve these ratings if evaluated by the NCQA or URAC, in addition to member survey results.

(2) Plans shall also take into account that the division will utilize the standards described in Subsections D, H and I of 13.10.22.8 NMAC, and the "medical necessity" and "usual, customary, and reasonable rate" standards found in Subsection E of 13.10.22.8 NMAC.

[13.10.22.8 NMAC - Rp, 13.10.13.11 NMAC, 09/01/2009]

13.10.22.9 UTILIZATION MANAGEMENT:

A. Utilization management program: The health care insurer through its MHCP shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care services. The program shall be under the direction of a medical director responsible for the medical services provided by the MHCP in New Mexico and who is a licensed physician in New Mexico, and shall be based on a written plan that is reviewed at least annually. At a minimum, the plan shall identify the following:

(1) scope of utilization management activities;

(2) procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services;

(3) mechanisms to detect underutilization and overutilization;

(4) clinical review criteria and protocols used in decision-making;

(5) mechanisms to ensure consistent application of review criteria and uniform decisions;

(6) development of outcome and process measures for evaluating the utilization management program; and

(7) a mechanism to evaluate member and provider satisfaction with the complaint and appeals systems set forth at 13.10.17 NMAC; such evaluation shall be coordinated with the performance monitoring activities conducted pursuant to the continuous quality improvement program to include care coordination between utilization management, case management and disease management services as set forth in 13.10.22.10 NMAC.

B. Utilization management determinations shall be based on written clinical criteria and protocols developed with involvement from practicing physicians and other health professionals and providers within the MHCP's net network. These criteria and protocols

shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to affected providers and covered persons. The MHCP shall have the burden of showing that information requested by affected providers or covered persons is in fact proprietary. Nothing in this section shall be construed to prevent a MHCP from incorporating into its clinical protocols criteria from outside sources.

C. Utilization management staff availability:

(1) A registered professional nurse or physician shall be immediately available by telephone seven days a week, 24 hours a day, to render utilization management determinations for providers.

(2) The MHCP shall provide all covered persons and providers with a toll-free telephone number by which to contact utilization management staff on at least a five-day, 40 hours a week basis. The MHCP may provide a separate telephone number for covered persons and for providers.

(3) All covered persons must have immediate telephone access seven days a week, 24 hours a day, to their primary care physician or the physician's authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician on the utilization management staff must be available to respond to inquiries concerning emergency or urgent care.

D. Utilization management determinations:

(1) All determinations to authorize an admission, service, procedure or extension of stay shall be rendered by either a physician, registered professional nurse, or other qualified health professional.

(2) All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician, either after application of uniform criteria established by the plan in consultation with specialists acting within the scope of their license or after consultation with specialists acting within the scope of their license. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the MHCP's New Mexico covered persons. Such determinations shall be made in accordance with clinical and medically necessary criteria developed pursuant to Subsection A of 13.10.22.9 NMAC and the evidence of coverage.

(3) All determinations shall be made on a timely basis as required by the exigencies of the situation and in accordance with sound medical principles, which, in any event, shall not exceed 24 hours for emergency care and seven days for all other determinations. If the MHCP is unable to complete a referral within ten days due to unforeseen circumstances, the MHCP shall inform the covered person in writing about the reasons for the delay and when a decision may be expected.

(4) A MHCP may not retroactively deny reimbursement for a covered service provided to a covered person by a provider who relied upon the verbal or written authorization of the MHCP or its agents prior to providing the service to the covered person, except in those cases where there was material misrepresentation or fraud. Retroactive reimbursement for a covered service shall not be denied when the covered person provides authorization information, such as a MHCP referral number, directly to the provider, except in those cases where there was material misrepresentation or fraud.

(5) An enrollee must receive a written notice of all determinations to deny coverage or authorization for health care services, which shall contain the reasons why coverage or authorization was denied, and which shall be subject to review in accordance with the specific grievance procedures outlined in 13.10.17 NMAC. The written notice shall advise the covered person that review of the MHCP's denial of coverage or authorization is available. In addition, the notice shall describe the procedures necessary for commencing an internal review as outlined in 13.10.17 NMAC.

E. Accreditation by nationally recognized accrediting entity. Nothing in this section shall prohibit a MHCP from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where a MHCP seeks to meet the requirements of this section through accreditation by a private accrediting entity, the MHCP shall submit to the division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the MHCP has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the MHCP and upon which accreditation of the MHCP was based. A MHCP accredited by the private accrediting entity that has submitted all of the requisite information to the division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the MHCP obtained accreditation is recognized and approved by the superintendent.

[13.10.22.9 NMAC - Rp, 13.10.13.19 NMAC, 09/01/2009]

13.10.22.10 CONTINUOUS QUALITY IMPROVEMENT:

A. Under the direction of a medical director or his or her designated physician, the MHCP shall have a system-wide continuous quality improvement program to monitor the quality and appropriateness of care and services provided to covered persons. This program shall be based on a written plan which is reviewed at least annually and revised as necessary. The plan shall describe at least:

(1) the scope and purpose of the program;

(2) the organizational structure of quality improvement activities;

(3) duties and responsibilities of the medical director and/or designated physician responsible for continuous quality improvement activities;

(4) contractual arrangements, where appropriate, for delegation of quality improvement activities;

(5) confidentiality policies and procedures;

(6) specification of standards of care, criteria and procedures for the assessment of the quality of services provided and the adequacy and appropriateness of health care resources utilized;

(7) a system of ongoing evaluation activities, including individual case reviews as well as pattern analysis;

(8) a system of focused evaluation activities, particularly for frequently performed and/or highly specialized procedures;

(9) a system for monitoring random covered person satisfaction and network provider's response and feedback on MHCP operations;

(10) a system for verification of providers' credentials, recertification, performance reviews and for obtaining information about any disciplinary action against a provider available from any state licensing board applicable to the provider;

(11) the procedures for conducting peer review activities, which shall include providers within the same discipline and area of clinical practice;

(12) a system for evaluation of the effectiveness of the continuous quality improvement program to include care coordination between utilization management, case management and disease management services.

B. The board of directors or other management body of the MHCP shall be kept apprised of continuous quality improvement activities and be provided at least annually with regular written reports from the program delineating quality improvements, performance measures used and their results, and demonstrated improvements in clinical and service quality.

C. There shall be a multidisciplinary continuous quality improvement committee responsible for the implementation and operations of the program. The structure of the committee shall include representation from the medical, nursing and administrative staff, with substantial involvement of the medical director of the MHCP.

D. The program shall monitor the availability, accessibility, continuity and quality of care on an ongoing basis. Indicators for evaluating the quality of health care services provided by all participating providers shall be identified and established and may include:

(1) a mechanism for monitoring patient appointment and triage procedures, discharge planning services, linkage between all modes and levels of care and appropriateness of specific diagnostic and therapeutic procedures, as selected by the continuous quality improvement program;

(2) a mechanism for evaluating all providers of care that is supplemental to each provider's quality improvement system;

(3) a system to monitor provider and covered person access to utilization management services, including, at a minimum, waiting times to respond to phone requests for service authorization, covered person urgent care inquiries, and other services required by this rule.

E. The MHCP shall follow up on findings from the program to assure that effective corrective actions have been taken, including, at a minimum, policy revisions, procedural changes and implementation of educational activities for covered persons and providers.

F. Continuous quality improvement activities shall be coordinated with other performance monitoring activities including utilization management, risk management, and monitoring of covered person and provider complaints.

G. The MHCP shall maintain documentation of the quality improvement program in a confidential manner. This documentation shall be available to the superintendent, shall be submitted as part of the health care insurer's annual report to the superintendent, and shall include:

(1) minutes of quality improvement committee meetings;

(2) records of evaluation activities, performance measures, quality indicators and corrective plans and their results or outcomes.

H. External quality audit:

(1) Upon request by the superintendent, each MHCP shall have an external quality audit conducted by an IQRO approved by the division, and shall submit proof to the superintendent that such an audit and report has been completed.

(2) The report must describe in detail the MHCP's conformance to performance standards established by the IQRO, other national standard-setting bodies for MHCPs, and the standards set out in this rule. The report shall also describe in detail

any corrective actions proposed and/or undertaken and approved by the IQRO. The report shall be submitted to the division within 60 days of its receipt in final form by the MHCP.

(3) The superintendent may grant a MHCP a deferral of the above requirement for an external quality audit for a 12-month period if it is in the initial three years of start-up operations.

I. Performance and outcome measures.

(1) The division may develop a performance and outcome measurement system for monitoring the quality of care provided to MHCP covered persons. The data collected through this system may be used by the division to:

(a) assist MHCPs and their providers in quality improvement efforts;

(b) provide the division with information on the performance of MHCPs for regulatory oversight;

(c) support efforts to inform consumers about MHCP performance;

(d) promote the standardization of data reporting by MHCPs and providers; and for

(e) any other purpose consistent with the policies and provisions of this rule and the Insurance Code.

(2) The performance and outcome measures may include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction. To minimize costs to health care insurers, MHCPs, providers, and the division, performance measures will incorporate, when possible, data routinely collected or available to the division from other sources. Data for these performance measures may include but not be limited to the following:

(a) indicator data collected by MHCPs from chart reviews and administrative data bases;

(b) satisfaction surveys of covered persons;

(c) provider surveys;

(d) all reports submitted by MHCPs to the superintendent as required by this rule;

(e) data collected by the division for administrative, epidemiological and other purposes, such as the state cancer registry, vital records, and hospital records.

(3) MHCPs shall submit such performance and outcome data as the division may request from time to time.

(4) The division shall provide each MHCP an opportunity to comment on the compilation and interpretation of the data before its release to consumers.

(5) The division may conduct or arrange for periodic satisfaction surveys of covered persons. Upon request by the superintendent, the MHCP shall provide the division with the mailing list of covered persons to be used to select samples of the MHCP's membership for the surveys. Upon request by the superintendent, the MHCP shall also provide the division with a mailing list of former covered persons who are no longer covered by the MHCP, which the division may use to select samples of the MHCP's former covered persons for surveys.

(6) The division shall ensure the confidentiality of patient specific information.

(7) The division shall take all necessary measures to reduce duplicative reporting of information to state agencies. Any performance and outcome measurement system developed by the division shall not be duplicative of the health information system created by the Health Information System Act, Chapter 24, Article 14A NMSA 1978, and implemented by the New Mexico health policy commission.

(8) In developing a performance and outcome measurement system, the division shall take into consideration data reporting standards of nationally recognized accrediting entities, such as, for example, the health plan employer data and information set (HEDIS), and shall attempt to avoid duplication of such reporting standards, so that a MHCP may, where possible, submit the same data to the division that the MHCP submits to a private accrediting entity.

J. Accreditation by nationally recognized accrediting entity: Nothing in this section shall prohibit a MHCP from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where a MHCP seeks to meet the requirements of this section through accreditation by a private accrediting entity, the MHCP shall submit to the division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the MHCP has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the MHCP and upon which accreditation of the MHCP was based. A MHCP accredited by the private accrediting entity that has submitted all of the requisite information to the division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the MHCP obtained accreditation is recognized and approved by the superintendent.

[13.10.22.10 NMAC - Rp, 13.10.13.20 NMAC, 09/01/2009]

13.10.22.11 CULTURAL AND LINGUISTIC DIVERSITY:

The MHCP must ensure that information and services are available in languages other than English, that services are provided in a manner that takes into account cultural aspects of the covered person population, and that accommodations are provided for covered persons with disabilities. Each MHCP shall develop, implement, and maintain a plan that reasonably addresses the cultural and linguistic diversity of its covered person population.

A. MHCPs that have not already done so and are currently doing business in New Mexico shall submit to the superintendent for approval a plan of how the MHCP will address the cultural and linguistic diversity of its covered person population. At a minimum, the plan shall address:

(1) how the MHCP will identify the language needs of covered persons;

(2) measures to be taken to ensure access for limited-English-proficient (LEP) covered persons in both administrative and health care encounters with the plan and its providers;

(3) steps the MHCP will take to ensure availability of adequate interpretation services within its network, which shall include a description of specific contracts or other arrangements for interpretation and identification of interpreters for the deaf;

(4) whether interpreting services are available to covered persons on a 24-hour basis for emergency care;

(5) whether linguistic and cultural needs are explicitly addressed in the MHCP's continuous quality improvement program;

(6) how the MHCP will conduct outreach to ensure that covered persons with particular cultural and linguistic needs are identified by the MHCP and made aware of the services available to them to address their needs;

(7) any guidelines or training regarding cultural and linguistic needs of covered persons that the MHCP will utilize with its own staff and providers within its network;

(8) the extent to which the MHCP contracts with community clinics and other local providers that offer linguistic and culturally appropriate services to covered persons in their areas; and

(9) physical accessibility to persons with disabilities of MHCP information and administrative services as well as the provider network.

B. A MHCP new to this state shall submit a plan for addressing cultural and linguistic diversity to the superintendent as part of its application for licensure. The plan shall address all of the factors listed Subsection A of 13.10.22.11 NMAC.

C. The superintendent shall approve or reject a plan submitted by a MHCP within 45 days after the plan is submitted to the superintendent. If the superintendent rejects a plan submitted by a MHCP, the superintendent shall state in writing in a letter addressed to the MHCP the specific grounds for rejection.

[13.10.22.11 NMAC - Rp, 13.10.13.29 NMAC, 09/01/2009]

13.10.22.12 CONTRACTS WITH PROVIDERS IN THE STATE OF NEW MEXICO:

This section shall apply only to health care professionals practicing in and health care facilities located in the state of New Mexico.

A. A health care insurer shall, either directly or indirectly, enter into contracts with participating professionals and health care facilities through which health care services are provided on a recurring basis to its covered persons. The health care insurer shall file an annual certificate with the superintendent certifying that all health care professional contracts and contracts with health care facilities located in the state of New Mexico through which health care services are being provided on a recurring basis meet the criteria of this section.

B. Each contract shall contain a description of the specific health care services for which the health care professional or health care facility will be responsible, including any limitations or conditions on such services.

C. Each contract shall contain the specific hold harmless provision specifying protection of covered persons set forth as follows: "Health care professional/health care facility agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall health care professional/health care facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, covered person, or person acting on behalf of the covered person, for health care services provided pursuant to this agreement. This does not prohibit health care professional/health care facility from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

D. Each contract shall contain a provision clearly stating the rights and responsibilities of the MHCP, and of the contracted health care professionals and health care facilities, with respect to administrative policies and programs, including, but not limited to, payment systems, utilization review, quality assessment and improvement

programs, credentialing, confidentiality requirements, and any applicable federal or state programs.

E. Each contract shall contain a provision regarding the availability and confidentiality of those health records maintained by health care professionals and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the medical necessity and appropriateness of health care services provided to covered persons. The provision shall include terms requiring the health care professional or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of covered persons, and requiring the health care professional or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records.

F. Each contract shall provide that contractual rights and responsibilities may not be assigned or delegated by the provider without the prior written consent of the contracting MHCP.

G. Each contract shall contain a provision requiring the health care professional or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the health care professional or health care facility to notify the health care insurer or MHCP not more than ten days after the provider's receipt of notice of any reduction or cancellation of such coverage.

H. Each contract shall require the health care professional or health care facility to observe, protect, and promote the rights of covered persons as patients.

I. Each contract shall require the health care professional or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, gender, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the health care professional or health care facility appropriately does not render services due to limitations arising from the health care professional's or health care facility's lack of training, experience, or skill, or due to licensing restrictions. Each contract shall require the health care insurer or MHCP to provide interpreters for limited English proficient (LEP) individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Such interpretive services will be made available to provider's office at no cost to the provider.

J. Each contract shall contain a provision detailing the specifics of any obligation on the health care professional or health care facility to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week.

K. Each contract shall set forth procedures for the resolution of disputes arising out of the contract.

L. Each contract shall state that the hold harmless provision required by Subsection C of 13.10.22.12 NMAC shall survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health care insurer or MHCP.

M. Each contract shall provide that those terms used in the contract and that are defined by New Mexico statutes and division regulations will be used in the contract in a manner consistent with any definitions contained in said laws or regulations.

N. A health care insurer or MHCP is prohibited from including the following provisions in any of its contracts with health care professionals or health care facilities:

(1) offer an inducement, financial or otherwise, to provide less than medically necessary services to a covered person;

(2) penalize a health care professional or health care facility that assists a covered person to seek a reconsideration of the health care insurer's or MHCP's decision to deny or limit benefits to the covered person;

(3) prohibit a participating health care professional from discussing treatment options with covered persons irrespective of the health care insurer's or MHCP's position on treatment options, or from advocating on behalf of a patient or patients within the utilization review or grievance processes established by the MHCP or a person contracting with the health care insurer or MHCP;

(4) prohibit a participating health care professional from using disparaging language or making disparaging comments when referring to the health care insurer or MHCP; or

O. Each contract shall provide that a MHCP failing to pay a health care professional or failing to pay a covered person for out of pocket covered expenses within forty-five days after a clean claim has been received by the MHCP shall be liable for the amount due and unpaid with interest on that amount at the rate of one and one half times the rate established by a bulletin entered by the superintendent in January of each calendar year. For the purposes of this section, "clean claim" means a manually or electronically submitted claim that contains all the required data elements necessary for accurate adjudication without the need for additional information from outside of the MHCP's system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by the MHCP, or particular circumstances requiring special treatment that prevents timely payment from being made by the MHCP.

P. Except for the access requirements contained in 13.10.22.8 NMAC, nothing contained in this rule should be construed to either prohibit or limit a health care insurer from entering into contracts with qualified health care professionals other than allopathic

physicians to provide primary care to covered persons, provided that the health care professional is acting within his or her scope of practice as defined under the relevant state licensing law.

Q. A health care insurer shall not, based upon a national policy of the insurer, uniformly reject contract terms that may be requested by New Mexico providers.

R. Retroactive adjustments by a health care insurer or MHCP for overpayment must be made within 18 months absent health care professional miscoding, claim submission error, suspected fraud and abuse; or retroactive adjustments required by other federal or state agencies.

[13.10.22.12 NMAC - Rp, 13.10.13.25 NMAC, 09/01/2009]

13.10.22.13 ADMINISTRATIVE COSTS AND BENEFIT DISCLOSURES:

A. Yearly reporting required: On a yearly basis, on or before April 15, each MHCP shall provide the superintendent with a loss ratio for individual contracts and a separate calculation for plans offered in the small group health insurance market by the MHCP. The superintendent may require that the information be prepared on a form supplied by the division.

B. Calculation of the ratio: Calculation of the loss ratio shall be based on the average of a plan's previous three years' experience. The superintendent shall apply or alter this calculation in a manner consistent with New Mexico law.

(1) If the plan has been in existence for less than three years, than the ratio shall be based on a two year past plan experience, with a statement as to the length of plan experience.

(2) If the plan has been in existence for less than two years, than the ratio shall be based on a one year past plan experience, with a statement as to the length of plan experience.

(3) If the plan is new or has been in existence less than one year, then the MHCP shall report to the superintendent a loss ratio for a similar plan with an explanation as to why that plan can be used as an estimated loss ratio for the new plan.

(4) The superintendent shall state on any materials distributed to the public the bases for the loss ratios.

(5) The superintendent shall provide notice to brokers, agents, and solicitors engaged in the sale of managed health care plans regarding the availability and use of the loss ratios for MHCPs.

(6) The superintendent may in the future require in addition to the ratio calculations, that each MHCP provide the division with sample premium costs for various plan designs, to be used by the superintendent as a guide to purchasing managed health care products in the state.

[13.10.22.13 NMAC - N, 09/01/2009]

13.10.22.14 PENALTIES:

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurer by the superintendent in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.

[13.10.22.14 NMAC - Rp, 13.10.13.32 NMAC, 09/01/2009]

13.10.22.15 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.22.15 NMAC - Rp, 13.10.13.33 NMAC, 09/01/2009]

PART 23: MANAGED HEALTH CARE PLAN CONTRACTING

13.10.23.1 ISSUING AGENCY:

Public Regulation Commission, Insurance Division.

[13.10.23.1 NMAC - N, 09/01/2009]

13.10.23.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer, or administer managed health care plans subject to the Insurance Code of the state of New Mexico:

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

(1) only short-term travel, accident-only, student health, specified disease, or other limited benefits; or

(2) credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit.

C. Conflicts. This rule relates to and should be read in conjunction with 13.10.13, 13.10.16, 13.10.17, 13.10.21 and 13.10.23 NMAC. If any provision in this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care-Benefits, 13.10.16 NMAC, Provider Grievances, or 13.10.17. NMAC Grievance Procedures Rule, the provisions in this rule shall apply.

[13.10.23.2 NMAC - N, 09/01/2009]

13.10.23.3 STATUTORY AUTHORITY: Sections 59A-1-18, 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-59A-15-16, 59A-16-4, 59A-16-5, 59A-16-11, 59A-16-12, 59A-16-12.1, 59A-16-13, 59A-16-15, 59A-16-16, 59A-16-17, 59A-18-16, 59A-19-4, 59A-19-5, 59A-19-6, 59A-23E-15, 59A-44-34, 59A-44-41, 59A-46-7, 59A-46-8, 59A-46-23, 59A-46-25, 59A-46-27, 59A-46-30, 59A-46-32, 59A-46-34, 59A-47-33, 59A-47-34, 59A-57-2, 59A-57-4, 59A-57-6, and 59A-57-11, NMSA 1978.

[13.10.23.3 NMAC - N, 09/01/2009]

13.10.23.4 DURATION: Permanent.

[13.10.23.4 NMAC - N, 09/01/2009]

13.10.23.5 EFFECTIVE DATE: September 1, 2009, unless a later date is cited at the end of a section.

[13.10.23.5 NMAC - N, 09/01/2009]

13.10.23.6 OBJECTIVE: The purpose of this rule is to clarify contracting between both the health care insurer and enrollees and health care providers under managed health care plans.

[13.10.23.6 NMAC - N, 09/01/2009]

13.10.23.7 DEFINITIONS:

A. In addition to the following, this rule is subject to the definitions found in Managed Health Care - Benefits, 13.10.13 NMAC.

B. "Medical record" means all information maintained by a health care provider relating to the past, present or future physical or mental health of a patient, and for other provision of health care to a patient. This information includes, but is not limited to, the health care provider's notes, reports and summaries, and x-rays and laboratory and other diagnostic test results. A patient's complete medical record includes information generated and maintained by the health care provider, as well as information provided

to the health care provider by the patient, by any another health care provider who has consulted with or treated the patient, and other information acquired by the health care provider about the patient in connection with the provision of health care to the patient. A medical record does not include medical billing, insurance forms or correspondence and communication related thereto.

[13.10.23.7 NMAC - N, 09/01/2009]

13.10.23.8 INFORMATION PROVIDED TO COVERED PERSONS AND READABILITY OF MANAGED HEALTH CARE PLAN CONTRACTS:

A. Evidence of coverage: At the time of enrollment, each managed health care plan (MHCP) shall provide each covered person with information on how to access and obtain an evidence of coverage. Upon request at any time after enrollment, the covered person shall be provided with the evidence of coverage. Each evidence of coverage offered to covered persons, and prospective covered persons shall state in clear, accurate, and conspicuous language, in not less than 10 point font, written such that it can be easily understood by the average covered person, and so that it comports with the requirements of the "Policy Language Simplification Law," Chapter 59A, Article 19 NMSA 1978, the following information:

(1) the name of the health care insurer and managed health care plan and its principal place of business, including its address and telephone number;

(2) definitions for words that have meanings other than common general usage;

(3) for an HMO, a description of the HMO's service area;

(4) a complete list or description of the comprehensive basic health care services, urgent health care services, emergency health care services, and, if applicable, supplemental health care services available within the MHCP's service or geographical area, and any other benefits to which the covered person is entitled under the particular plan;

(5) an explanation of how participation in the managed health care plan may affect the potential covered person's choice of physician, hospital, or other health care provider;

(6) eligibility requirements for coverage, including a statement of conditions on eligibility for benefits;

(7) conditions of cancellation, which shall include a statement that if a covered person believes coverage was canceled due to health status or health care requirements, race, gender, age, or sexual orientation, he may appeal termination to the superintendent;

(8) the name, address, and toll-free telephone number of the superintendent;

(9) a statement that a copy of the evidence of coverage will be provided upon request if the covered person is unable to obtain a copy of the contract from the covered person's employer or other contract holder;

(10) conditions for renewal and reinstatement;

(11) any procedures for filing claims;

(12) in bold typeface, or through an equally or more effective means, highlight any and all exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including deductibles or copayments, or co-insurance; when presented on the plan's website or through other internet means, this information may be highlighted with movement, color, pop-up material, and other devices;

(13) any other requirements or procedures necessary for covered persons to obtain particular health care services, such as additional copayments, prior authorizations, second opinions, and consultations with or referrals to specialists, physicians, or other providers other than the primary care physician;

(14) the covered person's personal financial obligation for non-covered health care services;

(15) a clear and complete summary of where, and in what manner, information is available regarding how a covered person obtains services, including emergency and out-of-area services;

(16) a toll-free telephone number and a web-based or other electronic methods through which the covered person may contact the MHCP for additional information on obtaining health care services or for other inquiries regarding the plan, including benefit information and plan requirements;

(17) for all contracts, a list of relevant copayments and all other out of pocket expenses paid by the covered person;

(18) for individual and conversion contracts, the contractual periodic prepayment or premium, which may be contained in a separate insert and the total of payment for health services and the indemnity or services benefits, if any, which the covered person is obligated to pay;

(19) a description of the MHCP's grievance procedures and method for resolving covered person complaints, including a description of the appeals process available if the MHCP limits or excludes coverage of a treatment or procedure, the address and telephone number to which grievances are to be directed, and a statement

identifying the superintendent as an external source with whom grievances may be filed, including the division of insurance contact information, as provided at Paragraph (2) of Subsection A of 13.10.17.24 NMAC, so that the covered person may submit the complaint;

(20) if the MHCP provides prescription drug coverage, the evidence of coverage must convey in clear and concise language:

(a) whether participating providers are restricted to prescribing drugs from a drug formulary;

(b) whether or not brand-name products or specialty drugs require a higher copayment;

(c) the extent, if at all, to which an enrollee will be reimbursed for costs of a drug that is not on the plan's formulary;

(d) how covered persons may obtain, upon request, a complete list of drugs covered by the plan or listed on the MHCP's drug formulary; and

(e) any exclusions or limitations for coverage of "experimental," "investigational," or "specialty" drugs and definitions of "experimental," "investigational," and "specialty" as those terms are used by the MHCP, and in accordance with this chapter;

(21) a list of providers which contains all of the information listed in Subsection D of 13.10.22.8 NMAC, and shall include a statement, if applicable, that providers may be deleted or added within the coverage year;

(22) a statement regarding whether or not participating providers must comply with any specified numbers, targeted averages, or maximum durations of patient visits; and if so, a description of the specific requirements;

(23) a statement reflecting that a covered person will not be liable to a provider for any sums owed to the provider by the MHCP;

(24) language reflecting that the enrollee may be liable for sums owed to a non-contracting provider, except when an enrollee or covered person is mistakenly referred to a non-participating provider by a MHCP provider as discussed in Subsection C of 13.10.22.8 NMAC; and

(25) a statement explaining the covered person's rights and responsibilities as required by 13.10.13.8 NMAC.

B. Toll-free number: The toll-free telephone number referred to in Paragraph (16) of Subsection A of this section shall:

(1) be answered twenty-four (24) hours a day, seven days a week, so that covered persons who need assistance may obtain answers to their questions;

(2) be equipped so that covered persons with non-medical benefit information questions may leave a voice-mail message for the MHCP that the administrative office of the MHCP will answer before 5:00 p.m. on the next business day;

(3) be included on a covered person membership card issued by the MHCP.

C. Electronic communications: MHCPs shall provide web-based or other electronic methods to inform interested covered persons with benefit information and other health care information in accordance with state and federal privacy regulations.

D. Bi-annual updates of provider lists: For MHCPs that require covered persons to select a primary care physician, the MHCP shall provide covered persons with written bi-annual notices of any deletions or additions to the list of primary care physicians in their area, and shall make more recent updated lists available to enrollees or covered persons upon request. The bi-annual notices may be included in other written materials that are sent to covered persons.

E. Current provider lists: The MHCP shall use a current list of providers, including health professionals and facilities, when soliciting individuals or groups for enrollment in the MHCP.

F. Provider information: Upon request of a covered person or prospective covered person, the MHCP shall provide information on participating providers, including their education, training, applicable certification, and any sub-specialty.

G. Termination of provider status:

(1) When an HMO terminates or suspends any contract with a participating provider, the HMO shall notify, in writing, affected covered persons who are current patients of or, where applicable, assigned to the provider, within 30 days. The notice to covered persons shall advise them of their right to continue receiving care from the provider as set forth in 13.10.23.13 NMAC. Current patients are covered persons who have a claim with the HMO related to the provider's services within the past year, or who have received a pre-authorization prior to termination to use the provider's services at a future time.

(2) The HMO shall assist such affected covered persons in locating and transferring to another similarly qualified provider.

(3) A covered person may not be held financially liable for services received from the provider in good faith between the effective date of the suspension or termination and the receipt of notice provided to the covered person, if the covered person has not received comparable notice during this time from the provider.

H. Notice of plan changes: Before issuing any increase in premiums in an individual contract, a MHCP shall provide a 60 day written notice to affected subscribers in the manner the MHCP customarily provides such notice. The MHCP shall also provide in the same manner a 60 day written notice for plan design or plan benefit changes, other than enhanced benefits, in an individual contract. All notices pursuant to this section shall state the reasons for the changes.

I. Disclosure of utilization review procedures: Each MHCP currently doing business in this state shall disclose to the superintendent and to its contracting providers the process by which the MHCP authorizes or denies health care services rendered by its providers pursuant to the benefits covered by the plan. Any MHCP claiming that such information is proprietary has the burden of showing to the superintendent that the information requested is in fact proprietary. Health care insurers planning to offer a new MHCP in this state must disclose such information to the superintendent prior to when the health care insurer solicits individuals or groups for enrollment in the MHCP. In addition, each MHCP shall make available such information to covered persons and prospective covered persons upon request.

J. Upon request of covered persons and prospective covered persons, the MHCP shall provide copies of its quality assurance plans and patterns of its utilization of services that the MHCP routinely tracks. A MHCP may provide such information through such nationally recognized reporting data bases, such as, for example, the health plan employer data and information set (HEDIS).

[13.10.23.8 NMAC - Rp, 13.10.13.14 NMAC, 09/01/2009]

13.10.23.9 TERMINATION OF COVERAGE:

A. A MHCP shall not cancel the coverage of an enrollee except for "good cause," which, for the purposes of this section means:

(1) failure of the enrollee or subscriber to pay the premiums and other applicable charges for coverage;

(2) material failure to abide by the rules, and/or policies and procedures of the MHCP;

(3) fraud or material misrepresentation affecting coverage;

(4) a reason for cancellation or failure to renew which the superintendent determines is not objectionable.

B. Notwithstanding Subsection A of 13.10.23.8 NMAC, a MHCP shall not cancel an enrollee's coverage for non-payment of copayments if such a cancellation would constitute abandonment of a covered person who is hospitalized and is receiving treatment for a life threatening condition. In addition, a MHCP shall not cancel an

enrollee's coverage due to a covered person's refusal to follow a prescribed course of treatment.

C. Before an enrollee's coverage may be terminated by the MHCP, the MHCP must provide written notice of at least 30 calendar days to the enrollee. Notification of cancellation of enrollment must:

(1) be in writing and dated;

(2) state the reason(s) for cancellation, with specific reference to the clause of the MHCP contract giving rise to the right of cancellation;

(3) state that an enrollee cannot be canceled because of health status, need for health care services, race, gender, age, or sexual orientation of covered persons under enrollee's contract;

(4) state that an enrollee who alleges that an enrollment has been canceled or not renewed because of the enrollee's or covered person's health status, need for health care services, race, gender, age, or sexual orientation may request review of the cancellation by the superintendent as set forth in 13.10.17 NMAC;

(5) state that in the event of cancellation by either the enrollee or MHCP, except in the case of fraud or deception in the use of services or facilities of the MHCP or knowingly permitting such fraud or deception by another, the MHCP shall, within 30 calendar days, return to the enrollee or subscriber the pro rata portion of the money paid to the MHCP which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due the MHCP; provided, however, that the superintendent may approve other reasonable reimbursement practices;

(6) state the date on which the cancellation becomes effective;

(7) state that receipt by the MHCP of the proper prepaid or periodic payment, including all past due amounts, after cancellation of the contract for nonpayment shall reinstate the contract as though it had never been canceled if such payment is received on or before the due date of the succeeding prepaid or periodic payment; provided, however, that the contract may specify one or more of the following methods by which the MHCP may avoid such reinstatement:

(a) in the notice of cancellation, the MHCP notifies the enrollee that if payment is not received within 15 days of issuance of the notice of cancellation, a new application is required and the conditions under which a new contract will be issued or whether the original contract will be reinstated;

(b) if such payment is received more than 15 calendar days after issuance of the notice of cancellation, the MHCP refunds the payment within 20 business days; or

(c) if such payment is received more than 15 calendar days after issuance of the notice of cancellation, the MHCP issues to the enrollee, within 20 business days of receipt of such payment, a new contract accompanied by a written notice clearly stating the ways in which the new contract differs from the canceled contract, including any difference in benefits or coverage;

(8) state that the MHCP is prohibited from increasing the amount paid by the enrollee, except after a period of at least 30 calendar days from either: 1) the postage paid mailing to the enrollee at the enrollee's address of record with the MHCP; or 2) actual hand delivery to the enrollee of written notice of such proposed increase; and

(9) state that the MHCP is prohibited from decreasing the benefits stated in the contract in any manner, except after a period of at least 30 calendar days from either: 1) the postage paid mailing to the enrollee at the enrollee's address of record with the MHCP; or 2) actual hand delivery to the enrollee of written notice of such proposed change(s).

D. In the event that the MHCP cancels or refuses to renew a managed health care plan contract, or enrollment under the contract, the MHCP shall mail a notice of the cancellation to the enrollee at the enrollee's address of record with the MHCP. However, in the event that the MHCP cancels or refuses to renew a group contract, the MHCP need not mail a notice of cancellation to each enrollee covered by the group plan if:

(1) the plan contract requires the group contract holder to mail promptly any such notice to each enrollee;

(2) the MHCP mails or hand delivers a notice of cancellation to the group contract holder designated in the plan contract, and the MHCP gives a written reminder to the group contract holder of its obligation under the contract; and

(3) the MHCP demonstrates that the group contract holder promptly provided proof to the MHCP of the mailing of a legible true copy of the notice of cancellation to each enrollee at the enrollee's current address and the date the mailing occurred.

E. Each MHCP contract shall provide a notice of cancellation, pursuant to Paragraph (3) of Subsection C of 13.10.23.8 NMAC and will not be effective any sooner than 30 calendar days after the notice is mailed to the enrollee.

F. The terms "cancellation" and "failure to renew," for the purposes of this section do not include a voluntary termination by an enrollee or the termination of a plan or contract which does not contain a renewal provision.

[13.10.23.9 NMAC - Rp, 13.10.13.17 NMAC, 09/01/2009]

13.10.23.10 MEDICAL RECORDS:

A. Transfer of medical records. Each health care insurer shall develop and implement a policy for the transfer of medical records of a covered person whenever the following occur:

(1) change of physician or other health care professional;

(2) disenrollment of enrollee from the managed health care plan; or

(3) other circumstances where requests by covered persons or former covered persons is reasonable.

B. Confidentiality of medical records.

(1) Any data or information pertaining to the diagnosis, treatment, or health of any covered person obtained from the covered person, from any provider, or from any other source, shall be held in confidence as otherwise required or permitted by New Mexico or federal law.

(2) The data or information shall not be disclosed to any person except: 1) to the extent that it may be necessary to carry out the purposes of this rule; 2) upon the express consent of the covered person; 3) pursuant to state or court order for the production of evidence or the discovery thereof; 4) in the event of claim or litigation between a covered person and the health care insurer wherein such data or information is pertinent; or 5) where otherwise required or permitted by New Mexico or federal law.

(3) A health care insurer shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health care insurer is entitled to claim.

C. Maintenance of medical records.

(1) Any medical records directly maintained by the health care insurer shall be organized in a uniform format applicable to all medical records.

(2) The health care insurer shall have policies governing the contents of medical records including maintenance of records by electronic means.

D. Copies of medical records.

(1) Covered persons or their legally authorized representatives shall have a right to inspect and obtain a copy of their medical records maintained by the health care insurer.

(2) Charges for copies of medical records must be based upon actual costs not to exceed the prevailing community market rates. For photocopying, the cost shall be twenty-five cents ($.25) per page or less.

E. Protection of medical records. Medical records maintained by health care insurers shall be protected by health care insurers against loss, destruction, or unauthorized use, and shall be retained for at least 10 years or until the covered person reaches age 21 years, whichever is longer.

F. Destruction of medical records. Destruction of medical records must be such that confidentiality is maintained. Records must be destroyed by shredding, incinerating (where permitted) or by other method of permanent destruction, including purging of medical records from a computer hard disk, server hard disk or other media or disk in accordance with current practices for data deletion. A log must be kept of all charts destroyed, including the patient's name and date of record destruction.

[13.10.23.10 NMAC - Rp, 13.10.13.21 NMAC, 09/01/2009]

13.10.23.11 NONDISCRIMINATION BY HEALTH CARE INSURERS:

A. Guaranteed renewability:

(1) In addition to the guaranteed renewability provisions pertaining to individuals, pursuant to NMSA 1978, Section 59A-23E-19, and under group health plans, pursuant to NMSA 1978, Section 59A-23E-14, health care insurers through managed health care plans are prohibited from establishing rules for continued eligibility of any individual to continue to participate in a health plan based on any of the following:

(a) gender, race, color, national origin, ancestry, religion or marital status;

(b) sexual orientation;

(c) age or the age of any contracting party, or person reasonably expected to benefit from any such contract as a covered person;

(d) health status related factors, and

(e) filing of a grievance or utilization management appeal as permitted by this rule.

(2) Health status related factors include:

(a) medical condition, including both physical and mental illnesses and disability;

(b) claims experience and frequency of use of health care services;

(c) medical history;

(d) genetic information;

(e) evidence of insurability, including conditions arising out of acts of domestic violence.

B. Contract terms and premiums:

(1) A health care insurer issuing a managed health care plan shall comply with the adjusted community rating requirements as to individuals, pursuant to NMSA 1978, Section 59A-18-13.1, and as to small group employers, pursuant to NMSA 1978, Section 59A-23C-5.1.

(2) A health care insurer issuing a managed health care plan is allowed to apply premium, price or charge differentials based on a wellness program to promote health or prevent disease in a managed health care plan, in compliance with 26 CFR Part 54, 29 CFR Part 2590 and 45 CFR Part 146.

C. Providers nondiscrimination: In addition to the provisions of NMSA 1978, Section 59A-57-6, a health care insurer issuing a managed health care plan shall not discriminate against providers on the basis of religion, race, color, national origin, age, sex, marital status, disability, or sexual orientation. Selection of participating providers shall be primarily based on, but not limited to, cost and availability of covered services and the quality of services performed by the providers.

D. Genetic information and testing prohibition:

(1) In determining insurability and in processing an application for coverage for health care services under a managed health care plan, health care insurers are prohibited from: 1) requiring an individual seeking coverage to submit to genetic screening or testing; 2) taking into consideration, other than in accordance with this section, the results of genetic screening or testing; 3) making any inquiry to determine the results of genetic screening or testing; or 4) making a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(2) In developing and asking questions regarding medical histories of applicants for coverage under an individual or group managed health care plan, contract, policy, or agreement, no health care insurer shall ask for the results of any genetic screening or testing or ask questions designed to ascertain the results of any genetic screening or testing.

(3) No health care insurer shall cancel or refuse to issue or renew coverage for health care services based on the result of genetic screening or testing or the use of genetic services.

(4) No health care insurer shall deliver, issue for delivery, or renew an individual or group managed health care plan, contract, policy, or agreement in this state that limits benefits based on the results of genetic screening or testing.

(5) A health care insurer may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.

[13.10.23.11 NMAC - Rp, 13.10.13.22 NMAC, 09/01/2009]

13.10.23.12 DECEPTIVE HEALTH CARE INSURER OR MANAGED HEALTH CARE PLAN NAME:

A. A health care insurer or managed health care plan shall not use a deceptive name.

B. A name will be considered deceptive if it unreasonably suggests:

(1) the quality of care provided by the health care insurer or managed health care plan;

(2) that full benefits are provided for health care or a specialized area of health care;

(3) that the cost of benefits to enrollees of the MHCP is lower than the cost of similar benefits purchased elsewhere; and

(4) in any such case where the express or implied representation contained in the name is demonstrably untrue or is not supported by substantial evidence at all times while such name is used by the health care insurer or MHCP.

C. Nothing in this section limits or restricts the superintendent from determining that a health care insurer or MHCP or solicitor firm name is deceptive for reasons other than those stated herein.

D. A change of a health maintenance organization plan name is a "substantial modification" of the HMO for purposes of Section 59A-46-3D NMSA 1978.

[13.10.23.12 NMAC - Rp, 13.10.13.23 NMAC, 09/01/2009]

13.10.23.13 ADVERTISING AND SOLICITATION:

A. Deceptive advertising prohibited. No health care insurer may cause or knowingly permit the use of advertising or solicitation that is untrue or misleading, or may cause or knowingly permit any form of summary of benefits or evidence of coverage which is deceptive.

B. Approval required. All materials, including, but not limited to, solicitation documents and texts of media advertising to be employed by the health care insurer for the purpose of personally soliciting individual or group enrollees shall be submitted, in a

form as prescribed by Section 59A-46-5 NMSA 1978 and 13.10.4.18 NMAC, to the superintendent prior to the health care insurer's use of such materials. If such material has not been disapproved by the superintendent within 30 days of its receipt, it shall be deemed approved until such time the superintendent issues a specific disapproval in writing.

C. Information to be included in solicitation. Any solicitation document employed by the health care insurer for the purpose of soliciting individual or group enrollees shall provide a link, contact or other information which would allow the consumer to find the following:

(1) all information necessary to enable a consumer of reasonable understanding, not possessing special knowledge regarding health care coverage, to make an informed choice as to whether or not to enroll with the health care insurer or in the MHCP;

(2) a specific description of the health care services available;

(3) a current list of providers, including health care professionals and facilities; and

(4) the obligations, including financial obligations, required of enrollees who join the MHCP.

D. Deceptive description of benefits. A summary of benefits or evidence of coverage is deceptive if the document taken as a whole, and with consideration given to typography and format, would cause a reasonable person, not possessing special knowledge regarding health care coverage, to expect benefits, services, charges, or other advantages which the MHCP does not provide to covered persons.

E. Inducements prohibited.

(1) No health care insurer shall use monetary or other valuable consideration, engage in misleading or deceptive practices, or make untrue, misleading, or deceptive representations to applicants in order to induce enrollment.

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

(3) Inducements do not include incentives specified or provided for in the MHCP contract given to covered persons and to promote the delivery of preventive care or other health improvement activities, which include "value added services" described in 8.305.17.9 NMAC.

F. Filing of public advertising. Texts of all media promotional advertising used by the health care insurer solely for the purpose of public advertising shall be filed with the superintendent no later than fifteen (15) days prior to when it first appears in the print, television, electronic, radio, or other medium.

G. Retraction. Any health care insurer that makes untrue or misleading statements may be required by the superintendent to publish a correction or retraction of the untrue or misleading statements in the same medium and with the same prominence in which the original untrue or misleading statements were published or broadcasted.

H. Language used in contracts and advertisements.

(1) All MHCP contracts or forms shall be in English.

(2) If the negotiation by a health care insurer with a subscriber, enrollee or covered person leading up to the effectuation of a MHCP contract is conducted in a language other than English, the health care insurer shall supply to the subscriber, enrollee or covered person a written translation of the contract in the negotiated language, with a verification which certifies that the translation is true, accurate and complete, and accurately reflects the substance of the contract, pursuant to Section 59A-19-6 NMSA 1978. The written translation and verification shall be affixed to and shall become a part of the contract or form. Any such translation and verification shall be provided to the superintendent as part of the filing of the MHCP contract or form. No translation of a MHCP contract form shall be approved by the superintendent unless the translation accurately reflects the substance of the MHCP contract form.

(3) The text of all advertisements by a health care insurer, if printed or broadcast in a language other than English, shall also be available in English and shall be provided to the superintendent upon request.

[13.10.23.13 NMAC - Rp, 13.10.13.26 NMAC, 09/01/2009]

13.10.23.14 CONTINUATION AND TRANSITION OF TREATMENT:

Each health care insurer shall offer continuation and transition of treatment to covered persons in compliance with the Insurance Code and applicable rules.

A. If a covered person's health care provider leaves the MHCP's network of providers, the MHCP shall permit the covered person to continue an ongoing course of treatment with the provider for a transitional period.

B. For all covered persons except those addressed Subsection C of 13.10.23.14 NMAC, the transitional period shall continue for a time that is sufficient to permit coordinated transition planning consistent with the patient's condition and needs relating to continuity of case, and, in any event, shall not be not less than thirty days.

C. If a covered person has entered the third trimester of pregnancy at the time of the provider's disaffiliation, and the MHCP offers maternity coverage, the transitional period shall include the provision of post-partum care directly related to the delivery.

D. The MHCP will not be required to permit the covered person to continue treatment with the current provider if the provider's disaffiliation with the MHCP was for reasons related to medical competence or professional behavior.

E. For transitional periods exceeding thirty days, the MHCP shall authorize continued care as provided in this section only if the health care provider agrees:

(1) to accept reimbursement from the MHCP at the rates applicable prior to the start of the transitional period as payment in full;

(2) to adhere to the MHCP's quality assurance requirements and to provide to the MHCP necessary medical information related to such care; and

(3) to otherwise adhere to the MHCP's policies and procedures, including but not limited to procedures regarding referrals, pre-authorization and treatment planning approved by the MHCP.

F. If upon the effective date of enrollment a new covered person's health care provider is not a member of the MHCP's provider network, the MHCP shall permit the covered person to continue an ongoing course of treatment with the covered person's current health care provider for a transitional period of time.

G. For covered persons in an ongoing course of treatment, the transitional period shall be sufficient to permit coordinated transition planning consistent with the patient's condition and needs relating to continuity of care, and, in any event, shall not be less than thirty days.

H. If a covered person has entered the third trimester of pregnancy at the effective date of enrollment, and the MHCP offers maternity coverage, the transitional period shall include the provision of post-partum care directly related to the delivery.

I. While a covered person is under the care of a provider outside the MHCP's network pursuant to this section, the covered person may receive care from other providers outside the network as ordered by the treating health care professional in consultation with the MHCP. The MHCP shall be obligated to authorize such care and to pay for such services only if the provider furnishing the care to the covered person agrees to accept the conditions described in this section.

[13.10.23.14 NMAC - Rp, 13.10.13.28 NMAC, 09/01/2009]

13.10.23.15 PENALTIES:

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurer by the superintendent in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.

[13.10.23.15 NMAC - Rp, 13.10.13.32 NMAC, 09/01/2009]

13.10.23.16 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.23.16 NMAC - Rp, 13.10.13.33 NMAC, 09/01/2009]

PART 24: GENETIC INFORMATION NONDISCRIMINATION - MEDICARE SUPPLEMENT PLANS

13.10.24.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[13.10.24.1 NMAC - N/E, 05/26/09]

13.10.24.2 SCOPE:

This rule applies to all insurers issuing or delivering in the state of New Mexico medicare supplement policies, certificates or contracts with policy years beginning on or after May 21, 2009.

[13.10.24.2 NMAC - N/E, 05/26/09]

13.10.24.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-24A-1 et seq. NMSA 1978.

[13.10.24.3 NMAC - N/E, 05/26/09]

13.10.24.4 DURATION:

Permanent.

[13.10.24.4 NMAC - N/E, 05/26/09]

13.10.24.5 EFFECTIVE DATE:

May 26, 2009, unless a later date is cited at the end of a section.

[13.10.24.5 NMAC - N/E, 05/26/09]

13.10.24.6 OBJECTIVE:

The purpose of this rule is to provide for nondiscrimination based on genetic information in the issuance and pricing of medicare supplement policies or certificates of coverage, and to generally prohibit insurers' requests for genetic testing except for limited use in determining payment for treatment and for genetic testing when used as part of certain scientific research using human subjects.

[13.10.24.6 NMAC - N/E, 05/26/09]

13.10.24.7 DEFINITIONS:

As used in this rule:

A. "certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy;

B. "family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual;

C. "genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual; such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual; any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member; the term "genetic information" does not include information about the sex or age of any individual;

D. "genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education;

E. "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes; the term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological

condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved;

F. "issuer of a medicare supplement policy or certificate" includes insurance companies, fraternal benefit societies, nonprofit health care plans, health maintenance organizations and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates, and includes a third-party administrator, or other person acting for or on behalf of such issuer;

G. "medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

H. "medicare supplement policy" means a group or individual policy of insurance or a subscriber contract other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare; "medicare supplement policy" does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D, or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act;

I. "secretary" means the secretary of the United States department of health and human services;

J. "underwriting purposes" means:

(1) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(2) the computation of premium or contribution amounts under the policy;

(3) the application of any pre-existing condition exclusion under the policy; and

(4) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

[13.10.24.7 NMAC - N/E, 05/26/09]

13.10.24.8 NONDISCLOSURE REQUIREMENTS AND EXCEPTIONS:

A. An issuer of a medicare supplement policy or certificate:

(1) shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

(2) shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

B. Nothing in Subsection A of 13.10.24.8 NMAC shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(1) denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(2) increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

C. An issuer of a medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

D. Subsection C of 13.10.24.8 NMAC shall not be construed to preclude an issuer of a medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment.

(1) Payment shall be defined as for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection A of 13.10.24.8 NMAC.

(2) An issuer of a medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose of this subsection.

E. Notwithstanding Subsection C of 13.10.24.8 NMAC, an issuer of a medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) the request is made pursuant to research that complies with part 46 of title 45, code of federal regulations (CFR), or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

(2) the issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that compliance with the request is voluntary, and non-compliance will have no effect on enrollment status or premium or contribution amounts;

(3) the genetic information collected or acquired under this subsection shall not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

(4) the issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted; and

(5) the issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

F. An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

G. An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

H. If an issuer of a medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection G of 13.10.24.8 NMAC if such request, requirement, or purchase is not in violation of Subsection F of 13.10.24.8 NMAC.

[13.10.24.8 NMAC - N/E, 05/26/09]

13.10.24.9 PENALTIES:

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the insurance code, a penalty for any material violation of this rule may be imposed against a health care insurer by the superintendent in accordance with Sections 59A-1-18 NMSA 1978.

[13.10.24.9 NMAC - N/E, 05/26/09]

13.10.24.10 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the

remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.24.10 NMAC - N/E, 05/26/09]

PART 25: MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

13.10.25.1 ISSUING AGENCY:

Office of Superintendent of Insurance.

[13.10.25.1 NMAC - Rp, 13.10.25.1 NMAC, 1/1/2019]

13.10.25.2 SCOPE:

A. Except as otherwise specifically provided in Sections 10, 19, 20, 23 and 28 of 13.10.25 NMAC this regulation shall apply to:

(1) All Medicare Supplement policies delivered or issued for delivery in this state before or after the effective date of this regulation; and

(2) All certificates issued under group Medicare Supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations

[13.10.25.2 NMAC - Rp, 13.10.25.2 NMAC, 1/1/2019]

13.10.25.3 STATUTORY AUTHORITY:

Section 59A-2-9, Subsection D of Section 59A-18-12, Subsection B of Section 59A-18-13, Paragraph (4) of Subsection A of Section 59A-23-3 and Section 59A-24A-1 et seq. NMSA 1978.

[13.10.25.3 NMAC - Rp, 13.10.25.3 NMAC, 1/1/2019]

13.10.25.4 DURATION:

Permanent.

[13.10.25.4 NMAC - Rp, 13.10.25.4 NMAC, 1/1/2019]

13.10.25.5 OBJECTIVE:

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare Supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

[13.10.25.5 NMAC - Rp, 13.10.25.5 NMAC, 1/1/2019]

13.10.25.6 EFFECTIVE DATE:

January 1, 2019, unless a later date is cited at the end of a section.

[13.10.25.6 NMAC - Rp, 13.10.25.6 NMAC, 1/1/2019]

13.10.25.7 DEFINITIONS:

For purposes of this regulation:

A. "1990 Standardized Medicare Supplement benefit plan," "1990 standardized benefit plan" or **"1990 Plan"** means a group or individual policy of Medicare Supplement insurance issued on or after July 1, 1992 with an effective date prior to June 1, 2010 and includes Medicare Supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

B. "2010 Standardized Medicare Supplement benefit plan," "2010 standardized benefit plan" or **"2010 plan"** means a group or individual policy of Medicare Supplement insurance issued on or after June 1, 2010.

C. "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, administration of drugs that are normally self-administered, and changing bandages or other dressings.

D. "Applicant" means:

(1) In the case of an individual Medicare Supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare Supplement policy, the proposed certificate holder.

E. "At-home recovery visit" means the period of a visit required to provide at-home-recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24 hour period of services provided by a care provider is one visit.

F. "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

G. "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide, nurse provided through a licensed home health care agency, referred by a licensed referral agency or by a licensed nurses' registry.

H. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare Supplement policy.

I. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

J. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

K. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

L. "Creditable coverage";

(1) means with respect to an individual, coverage of the individual provided under any of the following:

(a) a group health plan;

(b) health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), 42 U.S.C. 1396, et seq., other than coverage consisting solely of benefits under section 1928;

(e) Chapter 55 of Title 10 U.S.C. (*Civilian Health and Medical Program of the Uniformed Services* – CHAMPUS, TRICARE);

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool;

(h) a health plan offered under Chapter 89 of Title 5 U.S.C. (*Federal Employees Health Benefits Program*);

(i) a public health plan as defined in federal regulation; and

(j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e));

(2) shall not include one or more, or any combination of, the following:

(a) coverage only for accident or disability income insurance, or any combination thereof;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics; and

(h) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(3) shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) limited scope dental or vision benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) such other similar, limited benefits as are specified in federal regulations;

(4) shall not include the following benefits if offered as independent, non-coordinated benefits:

(a) coverage only for a specified disease or illness; and

(b) hospital indemnity or other fixed indemnity insurance; and

(5) shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) Medicare Supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1));

(b) coverage supplemental to the coverage provided under Chapter 55 of Title 10, U.S.C.; and

(c) similar supplemental coverage provided to coverage under a group health plan.

M. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

N. "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

O. "Insolvency" exists as to:

(1) any organization, when it is unable to meet its obligations as they mature;

(2) a stock insurer or other stock corporation, when its assets are in amount less than its liabilities, exclusive of paid-in capital stock;

(3) a mutual, reciprocal, or foreign Lloyds insurer, when its assets are in amount less than its liabilities exclusive of the minimum paid-in basic capital required under Section 59A-5-16 NMSA 1978 for its authority to transact insurance; or

(4) a domestic Lloyds insurer, nonprofit health care plan, prepaid dental care plan, motor club, or other corporation other than any referred to in Paragraph (1) of (2) of this subsection, when its assets are in amount less than its liabilities, exclusive of surplus, guaranty fund or deposit required to be maintained under the Insurance Code for its authority to transact insurance in this state.

P. "Issuer" includes insurance companies, fraternal benefit societies, nonprofit health care plans, health maintenance organizations and any other entity offering, delivering, issuing Medicare Supplement policies or certificates for delivery in this state.

Q. "Medicare" has the meaning set forth in Subsection F of 13.10.25.8 NMAC.

R. "Medicare Advantage plan" or previously "**Medicare+Choice"** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

(1) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

S. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

T. "Medicare Select policy" or **"Medicare Select certificate"** mean respectively a Medicare Supplement policy or certificate that contains restricted network provisions.

U. "Medicare Supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of a nonprofit health care plan or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare Supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act (42 U.S.C. §1395l(a)(1)(A)).

V. "NAIC" means the national association of insurance commissioners.

W. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

X. "Pre-standardized Medicare Supplement benefit plan," "Pre-standardized benefit plan" or **"Pre- standardized plan"** means a group or individual policy of Medicare Supplement insurance issued prior to July 1, 1992.

Y. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

Z. "Restricted network provision," means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

AA. "Secretary" means the secretary of the United States department of health and human services.

BB. "SERFF" means the NAIC's system for electronic rate and form filing.

CC. "Service area" means the geographic area approved by the superintendent within which an issuer is authorized to offer a Medicare Select policy.

DD. "Superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

[13.10.25.7 NMAC - Rp, 13.10.25.7 NMAC, 1/1/2019]

13.10.25.8 POLICY DEFINITIONS AND TERMS:

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

A. "Accident," "accidental injury," or **"accidental means"** shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit period" or **"Medicare benefit period"** shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or **"skilled nursing facility"** shall not be defined more restrictively than as defined in the Medicare program.

D. "Health care expenses" means, for purposes of 13.10.25.20 NMAC, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended," or "Title I, Part I of Public Law 89-97, as enacted by the eighty-ninth congress of the United States of America and popularly known as the *Health Insurance for the Aged Act*, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Part A and Medicare Part B, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following:

(1) "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

(2) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

[13.10.25.8 NMAC - Rp, 13.10.25.8 NMAC, 1/1/2019]

13.10.25.9 PROHIBITED POLICY PROVISIONS:

A. Except for permitted preexisting condition clauses as described in Paragraph (1) of Subsection A of 13.10.25.10 NMAC, Paragraph (1) of Subsection A of 13.10.25.11 NMAC, and Paragraph (1) of Subsection A of 13.10.25.13 NMAC, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare Supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare Supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D. Outpatient prescription drugs:

(1) Subject to Paragraphs (4) of Subsection A and Subsection B of 13.10.25.10 NMAC and Paragraphs (4) of Subsection A and Subsection B of 13.10.25.11 NMAC, a Medicare Supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

(2) A Medicare Supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare Supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D at the option of the policyholder unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Medicare Part D plan and;

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

[13.10.25.9 NMAC - Rp, 13.10.25.9 NMAC, 1/1/2019]

13.10.25.10 MINIMUM BENEFIT STANDARDS FOR PRE-STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992:

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General standards. The following standards apply to Medicare Supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) Preexisting conditions. A Medicare Supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) Losses from sickness. A Medicare Supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) Cost sharing. A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) Cancellation and termination. A "non-cancellable," "guaranteed renewable" or "non-cancellable and guaranteed renewable" Medicare Supplement policy shall not:

(a) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) be cancelled or non-renewed by the issuer solely on the grounds of deterioration of health.

B. Renewal and continuation of coverage for policies or certificates.

(1) Cancellation by issuer. Except as authorized by the superintendent, an issuer shall neither cancel nor non-renew a Medicare Supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(2) Termination by group. If a group Medicare Supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (4) of this subsection, the issuer shall offer certificate holders an individual Medicare Supplement policy. The issuer shall offer the certificate holder at least the following choices:

(a) an individual Medicare Supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare Supplement policy; and

(b) an individual Medicare Supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection D of 13.10.25.13 NMAC.

(3) Group membership termination. If membership in a group is terminated, the issuer shall:

(a) offer the certificate holder the conversion opportunities described in Paragraph (2) of this subsection; or

(b) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) Replacement. If a group Medicare Supplement policy is replaced by another group Medicare Supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5) Coverage of continuous loss. Termination of a Medicare Supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(6) Elimination of drug benefit. If a Medicare Supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

C. Minimum Benefit Standards. Medicare Supplement insurance policies shall consist of the following:

(1) Medicare Part A coinsurance after day 60. Coverage of eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Medicare Part A hospitalization inpatient deductible. Coverage of either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Medicare Part A reserve lifetime days daily charges. Coverage of eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Medicare Part A uncovered hospitalization coverage. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Medicare Part A blood. Coverage for or the reasonable cost (as per 42 U.S.C. §1395x(v)) of the first three pints of blood (or equivalent quantities of packed red

blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Medicare Part B;

(6) Medicare Part B cost sharing. Coverage of the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, subject to a maximum calendar year out-of- pocket amount equal to the Medicare Part B deductible; and

(7) Medicare Part B blood. Effective January 1, 1990, coverage for the reasonable cost (as per 42 U.S.C. §1395x(v)) of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Medicare Part A, subject to the Medicare deductible amount.

[13.10.25.10 NMAC - Rp, 13.10.25.10 NMAC, 1/1/2019]

13.10.25.11 BENEFIT STANDARDS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER JULY 1, 1992 AND PRIOR TO JUNE 1, 2010:

The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992 and with an effective date prior to June 1, 2010. For policies issued with an effective date after June 1, 2010, refer to Section 13.10.25.13 NMAC.

A. General Standards. The following standards apply to 1990 Benefit Standardized Plan policies and certificates and are in addition to all other requirements of this regulation.

(1) Preexisting conditions. Refer to Paragraph (1) of Subsection A of 13.10.25.10 NMAC.

(2) Loss from sickness. Refer to Paragraph (2) of Subsection A of 13.10.25.10 NMAC.

(3) Cost sharing. Refer to Paragraph (3) of Subsection A of 13.10.25.10 NMAC. An increase in premium shall not be effective without 60 days-notice to the policyholder.

(4) Termination of spousal coverage. No Medicare Supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

B. Renewal and continuation of coverage for policies or certificates. Each Medicare Supplement policy shall be guaranteed renewable.

(1) Cancellation for health status. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(2) Cancellation by issuer. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) Termination by group. If the Medicare Supplement policy is terminated by the group policyholder and is not replaced as provided under Paragraph (5) of this subsection, the issuer shall offer certificate holders an individual Medicare Supplement policy which (at the option of the certificate holder):

(a) provides for continuation of the benefits contained in the group policy, or

(b) provides for benefits that otherwise meet the requirements of this subsection.

(4) Group membership termination. If an individual is a certificate holder in a group Medicare Supplement policy and the individual terminates membership in the group, the issuer shall

(a) offer the certificate holder the conversion opportunity described in Paragraph (3) of this subsection, or

(b) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) Replacement. Refer to Paragraph (4) of Subsection B of 13.10.25.10 NMAC.

(6) Coverage of continuous loss. Refer to Paragraph (5) of Subsection B of 13.10.25.10 NMAC.

(7) Elimination of drug benefit. Refer to Paragraph (6) of Subsection B of 13.10.25.10 NMAC.

C. Coordination with Medical Assistance under Title XIX of the Social Security Act.

(1) Temporary suspension. A Medicare Supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security

Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(2) Reinstitution. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Suspension - other coverage. Each Medicare Supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss.

(4) Reinstitution of coverage. Reinstitution of coverages as described in Paragraphs (2) and (3) of this subsection:

(a) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(b) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare Supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(3) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

D. Policy exchanges. If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans to exchange during a specified period from the policyholder's 1990 Standardized Benefit Plan (as described in 13.10.25.12 NMAC) to a 2010 Standardized Benefit Plan (as described in 13.10.25.14 NMAC), the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the superintendent if the insured replaces a 1990 Standardized Benefit Plan policy or certificate with a 2010 Standardized Benefit Plan policy or certificate of identical rate structure and basis, using the insured's identical rating characteristics and classification. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The issuer must file the proposed method electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978.

(2) The rating class of the new policy or certificate shall be the class of the replaced coverage.

(3) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized Benefit Plan policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six months to any added benefits contained in the new 2010 Standardized Benefit Plan policy or certificate not contained in the exchanged policy.

(4) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

E. Standards for basic (core) benefits common to benefit plans A to J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement insurance benefit plans in addition to the basic core package, but not in lieu of it.

(1) Medicare Part A coinsurance after day 60. Coverage of eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Medicare Part A reserve lifetime days coinsurance. Coverage of Medicare Part A –eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Medicare Part A uncovered hospitalization coverage. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one-hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an

additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Medicare Part A and Medicare Part B blood. Coverage under Medicare Part A and Medicare Part B for the reasonable cost (as per 42 U.S.C. §1395x(v)) of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Medicare Part B cost sharing. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

F. Standards for additional benefits. The following additional benefits shall be included in Medicare Part B for Plan B through Plan J only as provided by 13.10.25.12 NMAC:

(1) Medicare Part A deductible. Coverage for one-hundred percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled nursing facility care. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B deductible. Coverage of one-hundred percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty percent of the Medicare Part B excess charges. Coverage for eighty percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Medicare Part B charge.

(5) One-hundred percent of the Medicare Part B excess charges. Coverage for one-hundred percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Medicare Part B charge.

(6) Basic outpatient prescription drug benefit. Coverage for fifty percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare Supplement policy effective after December 31, 2005.

(7) Extended outpatient prescription drug benefit. Coverage for fifty percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare Supplement policy effective after December 31, 2005.

(8) Medically necessary emergency care in a foreign country. Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive medical care benefit.

(a) Coverage for the following preventive health services not covered by Medicare:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) of this subparagraph and patient education to address preventive health care measures; and

(ii) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(b) Reimbursement shall be for the actual charges up to one-hundred percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in *American Medical Association Current Procedural Terminology* (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-home recovery benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) Coverage requirements and limitations.

(i) At-home recovery services provided must be primarily services that assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(b) Coverage is limited to:

(i) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(ii) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(iii) $1,600 per calendar year;

(iv) seven visits in any one week;

(v) care furnished on a visiting basis in the insured's home;

(vi) **s**ervices provided by a care provider as defined in Subsection E of 13.10.25.7 NMAC;

(vii) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and

(viii) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) home care visits paid for by Medicare or other government programs; and

(ii) care provided by family members, unpaid volunteers or providers who are not care providers.

G. Standards for Plans K and L.

(1) Plan K. Standardized Medicare Supplement benefit Plan K shall consist of the following:

(a) Medicare Part A coinsurance after day 60. Refer to Paragraph (1) of Subsection E of 13.10.25.11 NMAC;

(b) Medicare Part A coinsurance reserves. Refer to Paragraph (2) of Subsection E of 13.10.25.11 NMAC;

(c) Medicare Part A hospital inpatient coverage. Refer to Paragraph (3) of Subsection E of 13.10.25.11 NMAC;

(d) Medicare Part A deductible. Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;

(e) Skilled nursing facility care. Coverage for fifty percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;

(f) Hospice care. Coverage for fifty percent of cost sharing for all Medicare Part A -eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;

(g) Blood. Coverage for fifty percent, under Medicare Part A or Medicare Part B, of the reasonable cost (as per 42 U.S.C. §1395x(v)) of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;

(h) Medicare Part B cost sharing. Except for coverage provided in Subparagraph (i) of this paragraph, coverage for fifty percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;

(i) Medicare Part B preventive services. Coverage of one-hundred percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Medicare Part B deductible; and

(j) Cost sharing – out-of-pocket limitation. Coverage of one-hundred percent of all cost sharing under Medicare Part A and Medicare Part B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Part A and Medicare Part B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Plan L. Standardized Medicare Supplement benefit Plan L shall consist of the following:

(a) the benefits described in Subparagraphs (a), (b) (c) and (i) of Paragraph (1) of this subsection;

(b) the benefit described in Subparagraphs (d) (e), (f), (g), and (h) of Paragraph (1) of this subsection, but substituting seventy-five percent for fifty percent; and

(c) the benefit described in Subparagraph (j) of Paragraph (1), but substituting $2000 for $4000.

[13.10.25.11 NMAC - Rp, 13.10.25.11 NMAC, 1/1/2019; A/E 1/1/2019; A, 4/23/2019]

13.10.25.12 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JULY 1, 1992 AND PRIOR TO JUNE 1, 2010:

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Subsection E of 13.10.25.11 NMAC.

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Subsection G of this section and in 13.10.25.16 NMAC.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit *Plans A* through *L* listed in this section and conform to the definitions in 13.10.25.7 NMAC. Each benefit shall be structured in accordance with the format provided in Subsection B, C or D of 13.10.25.11 NMAC and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C of this section, other designations to the extent permitted by law.

E. Make-up of benefit plans:

(1) Plan A. Standardized Medicare Supplement benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans, as defined in Subsection E of 13.10.25.11 NMAC.

(2) Plan B. Standardized Medicare Supplement benefit Plan B shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible as defined in Paragraph (1) of Subsection F of 13.10.25.11 NMAC.

(3) Plan C. Standardized Medicare Supplement benefit Plan C shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (2), (3) and (8) respectively of Subsection F of 13.10.25.11 NMAC.

(4) Plan D. Standardized Medicare Supplement benefit Plan D shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Paragraphs (1), (2), (8) and (10) respectively of Subsection F of 13.10.25.11. NMAC.

(5) Plan E. Standardized Medicare Supplement benefit Plan E shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Paragraphs (1), (2), (8) and (9) respectively of Subsection F of 13.10.25.11. NMAC.

(6) Plan F. Standardized Medicare Supplement benefit Plan F shall include only the following: The core benefit as defined Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, the skilled nursing facility care, the Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (2), (3), (5) and (8) respectively of Subsection F of 13.10.25.11 NMAC.

(7) High deductible Plan F. Standardized Medicare Supplement benefit High Deductible Plan F shall include only the following: one-hundred percent of covered expenses following the payment of the annual High Deductible Plan F deductible. The covered expenses include the core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (2), (3), (5) and (8) respectively of Subsection F of 13.10.25.11 NMAC. The annual High Deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement Plan F policy, and shall be in addition to any other specific benefit deductibles. The annual High Deductible Plan F deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the *Consumer Price Index* for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Plan G. Standardized Medicare Supplement benefit Plan G shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign

country, and the at-home recovery benefit as defined in Paragraphs (1), (2), (4), (8) and (10) respectively of Subsection F of 13.10.25.11 NMAC.

(9) Plan H. Standardized Medicare Supplement benefit Plan H shall consist of only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (2), (6), and (8) respectively of Subsection F of 13.10.25.11 NMAC. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(10) Plan I. Standardized Medicare Supplement benefit Plan I shall consist of only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, one-hundred percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Paragraphs (1), (2), (5), (6), (8) and (10) respectively of Subsection F of 13.10.25.11 NMAC. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(11) Plan J. Standardized Medicare Supplement benefit Plan J shall consist of only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Paragraphs (1), (2), (3), (5), (7), (8), (9) and (10) respectively of Subsection F of 13.10.25.11 NMAC. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(12) High deductible Plan J. Standardized Medicare Supplement benefit High Deductible Plan J shall consist of only the following: one-hundred percent of covered expenses following the payment of the annual High Deductible Plan J deductible. The covered expenses include the core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Paragraphs (1), (2), (3), (5), (7), (8), (9) and (10) respectively of Subsection F of 13.10.25.11 NMAC. The annual High Deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement Plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the *Consumer Price Index* for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest

multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(13) Plan K and Plan L. Make-up of two Medicare Supplement plans mandated by the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA):

(a) Plan K. Standardized Medicare Supplement benefit Plan K shall consist of only those benefits described in Paragraph (1) of Subsection G of 13.10.25.11 NMAC.

(b) Plan L. Standardized Medicare Supplement benefit Plan L shall consist of only those benefits described in Paragraph (2) of Subsection G of 13.10.25.11 NMAC.

F. New or innovative benefits: An issuer may, with the prior approval of the superintendent, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare Supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare Supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

[13.10.25.12 NMAC - Rp, 13.10.25.12 NMAC, 1/1/2019]

13.10.25.13 BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010:

The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare Supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare Supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare Supplement policies and certificates issued with an effective date of coverage before June 1, 2010 remain subject to the requirements of 13.10.25.11 NMAC.

A. General standards. The following standards apply to 2010 Standardized Benefit Plan policies and certificates and are in addition to all other requirements of this regulation.

(1) Preexisting conditions. Refer to Paragraph (1) of Subsection A of 13.10.25.11 NMAC.

(2) Losses from sickness. Refer to Paragraph (2) of Subsection A of 13.10.25.11 NMAC.

(3) Cost sharing. Refer to Paragraph (3) of Subsection A of 13.10.25.11 NMAC.

(4) Termination of spousal coverage. Refer to Paragraph (4) of Subsection A of 13.10.25.11 NMAC.

B. Renewal and continuation of coverage for policies or certificates. Each Medicare Supplement policy shall be guaranteed renewable.

(1) Cancellation for health status. Refer to Paragraph (1) of Subsection B of 13.10.25.11 NMAC.

(2) Cancellation by issuer. Refer to Paragraph (2) of Subsection B of 13.10.25.11 NMAC.

(3) Termination by group. Refer to Paragraph (3) of Subsection B of 13.10.25.11 NMAC.

(4) Group membership termination. Refer to Paragraph (4) of Subsection B of 13.10.25.11 NMAC.

(5) Replacement. Refer to Paragraph (5) of Subsection B of 13.10.25.11 NMAC.

(6) Coverage of continuous loss. Refer to Paragraph (6) of Subsection B of 13.10.25.11 NMAC.

C. Coordination with medical assistance under Title XIX of the Social Security Act.

Refer to Subsection C of 13.10.25.11 NMAC.

D. Standards for basic (core) benefits common to Medicare Supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M and N: Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement insurance benefit plans in addition to the basic core package, but not in lieu of it.

(1) Medicare Part A coinsurance after day 60. Refer to Paragraph (1) of Subsection E of 13.10.25.11 NMAC;

(2) Medicare Part A reserve lifetime days coinsurance. Refer to Paragraph (2) of Subsection E of 13.10.25.11 NMAC;

(3) Medicare Part A uncovered hospitalization coverage. Refer to Paragraph (3) of Subsection E of 13.10.25.11 NMAC;

(4) Medicare Part A and Medicare Part B blood. Refer to Paragraph (4) of Subsection E of 13.10.25.11 NMAC;

(5) Medicare Part B cost sharing. Refer to Paragraph (5) of Subsection E of 13.10.25.11 NMAC; and

(6) Hospice care cost sharing. Coverage of cost sharing for all Medicare Part A-eligible hospice care and respite care expenses.

E. Standards for additional benefits: The following additional benefits shall be included in Medicare Supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by 13.10.25.14 NMAC.

(1) Medicare Part A deductible, one-hundred percent. Refer to Paragraph (1) of Subsection F of 13.10.25.11 NMAC;

(2) Medicare Part A deductible, fifty percent. Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled nursing facility care. Refer to Paragraph (2) of Subsection F of 13.10.25.11 NMAC.

(4) Medicare Part B deductible. Refer to Paragraph (3) of Subsection F of 13.10.25.11 NMAC;

(5) One-hundred percent of the Medicare Part B excess charges. Refer to Paragraph (5) of Subsection F of 13.10.25.11 NMAC; and

(6) Medically necessary emergency care in a foreign country. Refer to Paragraph (8) of Subsection F of 13.10.25.11 NMAC.

F. Standards for Plans K and L.

(1) Plan K. Plan K as mandated by the *Medicare Prescription Drug, Improvement and Modernization Act of 2003,* shall include only the following:

(a) Medicare Part A coinsurance after day 60. Refer to Subparagraph (a) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(b) Medicare Part A hospital coinsurance, 91st through 150th days. Refer to Subparagraph (b) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(c) Medicare Part A hospitalization after lifetime reserve days are exhausted. Refer to Subparagraph (c) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(d) Medicare Part A deductible. Refer to Subparagraph (d) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC

(e) Skilled nursing facility care. Refer to Subparagraph (e) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(f) Hospice Care. Refer to Subparagraph (f) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(g) Blood. Refer to Subparagraph (g) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(h) Medicare Part B Cost sharing. Refer to Subparagraph (h) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(i) Medicare Part B preventive services. Refer to Subparagraph (i) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(j) Cost sharing after out-of-pocket limits. Refer to Subparagraph (j) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC.

(2) Plan L. Plan L as mandated by the *Medicare Prescription Drug Improvement and Modernization Act of 2003*, shall include only the following:

(a) The benefits described in Subparagraphs (a), (b), (c) and (i) of the preceding paragraph;

(b) The benefit described in Subparagraphs (d), (e), (f), (g) and (h) of the preceding paragraph, but substituting seventy-five percent for fifty percent; and

(c) The benefit described in Subparagraph (j) of the preceding paragraph, but substituting $2000 for $4000.

[13.10.25.13 NMAC - Rp, 13.10.25.13 NMAC, 1/1/2019]

13.10.25.14 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010:

The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare Supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare Supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of 13.10.25.12 NMAC.

A. Benefit requirements:

(1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in Subsection D of 13.10.25.13 NMAC of this regulation.

(2) If an issuer makes available any of the additional benefits described in Subsection E of 13.10.25.13 NMAC, or offers standardized benefit Plans K or L (as described in Paragraphs (8) and (9) of Subsection E of this section), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Paragraph (1) of this subsection, a policy form or certificate form containing either standardized benefit Plan C (as described in Paragraph (3) of Subsection of E of this section) or standardized benefit Plan F (as described in Paragraph (5) of Subsection E of this section).

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Subsection F of this section and 13.10.25.16 NMAC.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in 13.10.25.7 NMAC. Each benefit shall be structured in accordance with the format provided in Subsections D and E of 13.10.25.13 NMAC; or, in the case of Plans K or L, in Paragraphs (8) and (9) of Subsection E of this section and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

E. Make-up of 2010 standardized benefit plans:

(1) Plan A. Standardized Medicare Supplement Benefit Plan A shall include only the following: The basic (core) benefits as defined in Subsection D of 13.10.25.13 NMAC.

(2) Plan B. Standardized Medicare Supplement Benefit Plan B shall include only the following: The basic (core) benefit as defined in Subsection d of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible as defined in Paragraph (1) of Subsection E of 13.10.25.13 NMAC.

(3) Plan C. Standardized Medicare Supplement Benefit Plan C shall include only the following: The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, one-hundred percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3), (4), and (6) respectively of Subsection E of 13.10.25.13 NMAC.

(4) Plan D. Standardized Medicare Supplement Benefit Plan D shall include only the following: The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Paragraphs (1), (3) and (6) respectively of Subsection E of 13.10.25.13 NMAC.

(5) Plan F. Standardized Medicare Supplement Benefit Plan F shall include only the following: The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, the skilled nursing facility care, one-hundred percent of the Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3), (4), (5) and (6) respectively of Subsection E of 13.10.25.13 NMAC.

(6) High Deductible Plan F. Standardized Medicare Supplement Benefit Plan F with High Deductible shall include only the following: one-hundred percent of covered expenses following the payment of the annual deductible set forth in Subparagraph (b) of this paragraph.

(a) The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, one-hundred percent of the Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3), (4), (5) and (6) respectively of Subsection E of 13.10.25.13 NMAC.

(b) The annual deductible in Plan F with High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7) Plan G. Standardized Medicare Supplement Benefit Plan G shall include only the following: The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3), (5) and (6) respectively of Subsection E of 13.10.25.13 NMAC. Effective January 1, 2020, the standardized benefit plans described in Paragraph (4) of Subsection A of 13.10.25.15 NMAC (Redesignated Plan G With High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Plan K. Standardized Medicare Supplement Benefit Plan K shall consist of only those benefits described in Paragraph (1) of Subsection F of 13.10.25.13 NMAC.

(9) Plan L. Standardized Medicare Supplement Benefit Plan L shall consist of only those benefits described in Paragraph (2) of Subsection F of 13.10.25.13 NMAC.

(10) Plan M. Standardized Medicare Supplement Benefit Plan M shall include only the following: The basic (core) benefit as defined in Subsection B of 13.10.25.13 NMAC, plus fifty percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs (2), (3) and (6) of Subsection C of 13.10.25.13 NMAC, respectively.

(11) Plan N. Standardized Medicare Supplement Benefit Plan N shall include only the following: The basic (core) benefit as defined in Subsection B of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3) and (6) Subsection C of 13.10.25.13 NMAC, respectively, with co-payments in the following amounts:

(a) the lesser of $20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

(b) the lesser of $50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

F. New or innovative benefits: An issuer may, with the prior approval of the superintendent, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare Supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare Supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative

benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

[13.10.25.14 NMAC - Rp, 13.10.25.14 NMAC, 1/1/2019]

13.10.25.15 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020:

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) requires the following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare Supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare Supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of 13.10.25.11 NMAC.

A. Benefit Requirements. The standards and requirements of 13.10.25.14 NMAC shall apply to all Medicare Supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare Supplement Benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Paragraph (3) of Subsection E of 13.10.25.14 NMAC but shall not provide coverage for one-hundred percent or any portion of the Medicare Part B deductible.

(2) Standardized Medicare Supplement Benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Paragraph (5) of Subsection E of 13.10.25.14 NMAC but shall not provide coverage for one-hundred percent or any portion of the Medicare Part B deductible.

(3) Standardized Medicare Supplement Benefit Plan F with High Deductible is redesignated as Plan G with High Deductible and shall provide the benefits contained in Paragraph (6) of Subsection E of 13.10.25.14 NMAC but shall not provide coverage for one-hundred percent or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(4) Standardized Medicare Supplement Benefit Plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(5) The reference to Plans C or F contained in Paragraph (2) of Subsection A of 13.10.25.14 NMAC is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to certain individuals. This section, applies to only individuals who are newly eligible for Medicare on or after January 1, 2020:

(1) by reason of attaining age 65 on or after January 1, 2020; or

(2) by reason of entitlement to benefits under Medicare Part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

C. Guaranteed issue for eligible persons. For purposes of Subsection E of 13.10.25.18 NMAC, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare Supplement policy Plans C or F including Plan F with High Deductible) shall be deemed to be a reference to Medicare Supplement Plans D or G (including Plan G with High Deductible), respectively that meet the requirements of this Subsection A of this section.

D. Offer of redesignated plans to individuals other than newly eligible. On or after January 1, 2020, the standardized benefit plans described in Paragraph (4) of Subsection A of this section may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Subsection E of 13.10.25.14 NMAC of this regulation.

[13.10.25.15 NMAC - Rp, 13.10.25.15 NMAC, 1/1/2019]

13.10.25.16 MEDICARE SELECT POLICIES AND CERTIFICATES:

A. Applicability.

(1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. Authorization. The superintendent may authorize a Medicare Select issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the *Omnibus Budget Reconciliation Act (OBRA) of 1990* if the superintendent finds that the issuer has satisfied all of the requirements of this regulation.

C. Approval required. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the superintendent.

D. Filing of plan of operation. A Medicare Select issuer shall file a proposed plan of operation with the superintendent in accordance with the requirements set forth in 13.10.30 NMAC, "Network Access Plans, Network Adequacy and Provider Directories." The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available 24 hours per day and seven days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) the formal organizational structure;

(b) the written criteria for selection, retention and removal of network providers; and

(c) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection I of this section.

(7) Any other information requested by the superintendent.

E. Plan updates.

(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the superintendent prior to implementing the changes. Changes shall be considered approved by the superintendent after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the superintendent at least quarterly.

F. Payment of non-network providers.

(1) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non- network providers if:

(a) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or condition; and

(b) it is not reasonable to obtain services through a network provider.

(2) A Medicare Select policy or certificate shall not restrict payment for covered services that are not available through network providers.

G. Required disclosures. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) other Medicare Supplement policies or certificates offered by the issuer; and

(b) other Medicare Select policies or certificates;

(2) a description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the insured's rights to purchase any other Medicare Supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the Medicare Select issuer's quality assurance program and grievance procedure.

H. Signed acknowledgment. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

I. Complaint and grievance procedure. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the insureds. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the insured describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 1 to the superintendent regarding its grievance procedure. The report shall be in a format prescribed by the superintendent and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

J. Alternate policies. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare Supplement policy or certificate otherwise offered by the issuer.

K. Offering non-network policies.

(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare Supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(2) For the purposes of this subsection, a Medicare Supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.

L. Continuation of coverage. Medicare select policies and certificates shall provide for continuation of coverage in the event the secretary determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare Supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare Supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means

coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

M. Data calls. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purpose of evaluating the Medicare Select Program.

[13.10.25.16 NMAC - Rp, 13.10.25.16 NMAC, 1/1/2019]

13.10.25.17 OPEN ENROLLMENT:

A. Plan availability. An issuer shall not deny or condition the issuance or effectiveness of any Medicare Supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare Supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B. Period of creditable coverage.

(1) If an applicant qualifies under Subsection A of this section and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A of this section and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

C. Exclusion of benefits. Except as provided in Subsection B of this section and 13.10.25.18 NMAC and 13.10.25.29 NMAC, Subsection A of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

[13.10.25.17 NMAC - Rp, 13.10.25.17 NMAC, 1/1/2019]

13.10.25.18 GUARANTEED ISSUE FOR ELIGIBLE PERSONS:

A. Guaranteed issue.

(1) Eligibility. Eligible persons, as defined in the *Balanced Budget Act of 1997*, are those individuals described in Subsection B of this section who seek to enroll under the policy during the period specified in Subsection C of this section, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare Supplement policy.

(2) Discrimination, denial and exclusion. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare Supplement policy described in Subsection E of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare Supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare Supplement policy.

B. Eligible persons. An eligible person is an individual described in any of the following paragraphs:

(1) Employee welfare benefit plan. The individual is enrolled under an employee welfare benefit plan, as defined in 29 U.S.C. Section 1002, that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all of such supplemental health benefits to the individual;

(2) Medicare Advantage or PACE. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a *Program of All-Inclusive Care for the Elderly* (PACE) provider under Section 1894 of the Social Security Act (42 U.S.C. §1395eee), and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) the certification of the organization or plan has been terminated;

(b) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (42 U.S.C. §1395w-21(g)(3)(B), where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(d) the individual demonstrates, in accordance with guidelines established by the secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) the individual meets such other exceptional conditions as the secretary may provide.

(3) Eligible organization.

(a) The individual is enrolled with:

(i) an eligible organization under a contract under Section 1876 of the Social Security Act (42 U.S.C. §1395mm, Medicare cost);

(ii) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) an organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (42 U.S.C. §1395l(a)(1)(A), health care prepayment plan); or

(iv) an organization under a Medicare Select policy; and

(b) the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph (2) of this subsection.

(4) Enrollment ceases. The individual is enrolled under a Medicare Supplement policy and the enrollment ceases because:

(a) of the insolvency of the issuer or bankruptcy of the non-issuer organization or of other involuntary termination of coverage or enrollment under the policy;

(b) the issuer of the policy substantially violated a material provision of the policy; or

(c) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) Termination of enrollment with Medicare Advantage.

(a) the individual was enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the Social Security Act (42 U.S.C. §1395mm, Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act (42 U.S.C. §1395eee) or a Medicare Select policy; and

(b) the subsequent enrollment under Subparagraph (a) of this paragraph is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act, 42 U.S.C. §1395w-21(e));

(6) Disenrollment with Medicare Advantage. The individual, upon first becoming eligible for benefits under Medicare Part A at age 65, enrolls in a Medicare Advantage plan under Medicare Part C, or with a PACE provider under Section 1894 of the Social Security Act (42 U.S.C. §1395eee), and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment; or

(7) Duplicate drug plan enrollment. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Medicare Part D, was enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph (4) of Subsection E of this section.

C. Guaranteed issue time periods.

(1) In the case of an individual described in Paragraph (1) of Subsection B of this section, the guaranteed issue period begins on the later of:

(a) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or

(b) the date that the applicable coverage terminates or ceases, and ends 63 days thereafter.

(2) In the case of an individual described in Paragraphs (2), (3), (5) or (6) of Subsection B of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in Subparagraph (a) of Paragraph (4) of Subsection B of this section, the guaranteed issue period begins on the earlier of:

(a) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and

(b) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in Paragraph (2), (5) or (6) or Subparagraphs (b) of (c) of Paragraph (4) of Subsection B of this section, who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in Paragraph (7) of Subsection B of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act (42 U.S.C. §1395ss(v)(2)(B)) from the Medicare Supplement issuer during the 60 day period immediately preceding the initial Medicare Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in Subsection B of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

D. Extended Medigap access for interrupted trial periods.

(1) In the case of an individual described in Paragraph (5) of Subsection B of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subparagraph (a) of Paragraph (5) of Subsection B of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Paragraph (5) of Subsection B of this section;

(2) In the case of an individual described in Paragraph (6) of Subsection B of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Paragraph (6) of Subsection B of

this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described Paragraph (6) of Subsection B of this section; and

(3) For purposes of Paragraph (5) and (6) of Subsections B of this section, no enrollment of an individual with an organization or provider described in Subparagraph (a) of Paragraph (5) of Subsection B of this section, or with a plan or in a program described in Paragraph (6) of Subsection B of this section, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to which eligible persons are entitled. The Medicare Supplement policy to which eligible persons are entitled under:

(1) Paragraphs (1), (2), (3) and (4) of Subsection B of this section is a Medicare Supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2) Subject to Subparagraph (b) of Paragraph (5) of Subsection B of this section is the same Medicare Supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (1) of this section and after December 31, 2005, if the individual was most recently enrolled in a Medicare Supplement policy with an outpatient prescription drug benefit, a Medicare Supplement policy described in this paragraph is:

(a) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(b) at the election of the policyholder, a Plan A, B, C, F (including F with a high deductible), K or L that is offered by any issuer.

(3) Paragraph (6) of Subsection B of this section shall include any Medicare Supplement policy offered by any issuer.

(4) Paragraph (7) of Subsection B of this section is a Medicare Supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare Supplement policy with outpatient prescription drug coverage.

F. Notification provisions.

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare Supplement policies under Subsection A of this section. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare Supplement policies under Subsection A of this section. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

[13.10.25.18 NMAC - Rp, 13.10.25.18 NMAC, 1/1/2019]

13.10.25.19 STANDARDS FOR CLAIMS PAYMENT:

A. An issuer shall comply with section 1882(c)(3) of the Social Security Act (42 U.S.C. §1395ss(c)(3), as enacted by section 4081(b)(2)(C) of the *Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987*, Pub. L. No. 100-203) by:

(1) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A of this section shall be certified

on the Medicare Supplement insurance experience reporting form.

[13.10.25.19 NMAC - Rp, 13.10.25.19 NMAC, 1/1/2019]

13.10.25.20 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM:

A. Loss ratio standards.

(1) Return of premiums.

(a) A Medicare Supplement policy form or certificate form shall not be delivered unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, i.e., are guaranteed, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies;

(b) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) home office and overhead costs;

(ii) advertising costs;

(iii) commissions and other acquisition costs;

(iv) taxes;

(v) capital costs;

(vi) administrative costs; and

(vii) claims processing costs.

(2) Rate filings. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage, i.e., are guaranteed, can be expected to meet the appropriate loss ratio standards.

(3) Solicited policies. For purposes of applying Paragraph (1) of this subsection and Paragraph (3) of Subsection C of 13.10.25.21 NMAC only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be group policies.

(4) Combining experience. For policies issued prior to July 1, 1992, expected claims in relation to premiums shall meet:

(a) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) The appropriate loss ratio requirement from items (i) and (ii) of Subparagraph (a) of Paragraph (1) of this subsection when combined with actual experience beginning with July 1, 1992 to date; and

(c) The appropriate loss ratio requirement from items (i) and (ii) of Subparagraph (a) of Paragraph (1) of this subsection over the entire future period for which the rates are computed to provide coverage, i.e., are guaranteed.

B. Refund or credit calculation.

(1) Filing Appendix A. Pursuant to Subsection A of 13.10.26.31 NMAC, for each type in a standard Medicare Supplement benefit plan, the issuer shall collect and file with the superintendent by May 31 of each year the data contained in the applicable reporting form contained in Appendix A as provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

(2) Refund calculation. If on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare Supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) Calculation of older policies. For the purposes of this section, policies or certificates issued prior to July 1, 1992, the issuer shall make the refund or credit

calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1996. The first report shall be due by May 31, 1998.

(4) Refund interest and distribution. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for thirteen-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of premium rates. An issuer of Medicare Supplement policies and certificates issued before or after July 1, 1992, shall annually file its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the superintendent electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed, i.e., are guaranteed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare Supplement policies or certificates in this state shall file for approval electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978:

(1) Premium adjustments.

(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare Supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare Supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the superintendent, the superintendent may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Eliminating duplications. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare Supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare Supplement benefits provided by the policy or certificate.

D. Public hearings. The superintendent may, at the superintendent's discretion, conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after July 1, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the superintendent.

[13.10.25.20 NMAC - Rp, 13.10.25.20 NMAC, 1/1/2019]

13.10.25.21 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES:

A. Filing policies and certificates. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed and approved electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978.

B. Filing riders and amendments. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* only with the superintendent in the state in which the policy or certificate was issued.

C. Filing rate change requests. An issuer shall not use or change premium rates for a Medicare Supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed and approved electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978.

D. Restrictions on number of forms filed.

(1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each combination of type and series for each standard Medicare Supplement benefit plan.

(2) An issuer may offer, with the approval of the superintendent, up to four additional policy forms or certificate forms of the same type for the same standard Medicare Supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this subsection, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy; "series" means the separate sets of 1990, 2010, and 2020 Standardized Medicare Supplement Benefit Plans defined in Sections 13.10.25.12, 13.10.25.14, and 13.10.25.15 NMAC respectively.

E. Availability of approved forms.

(1) Except as provided in Subparagraph (a) of this paragraph, an issuer shall continue to make available for purchase any policy form or certificate form issued after July 1, 1992, that has been approved by the superintendent, unless constrained by law from doing so. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the superintendent in writing its decision at least 60 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the superintendent, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) of this paragraph shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare Supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the superintendent of the discontinuance. The period of discontinuance may be reduced if the superintendent determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare Supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) of this subsection.

F. Combining experience for refund calculation.

(1) Except as provided in Paragraph (2) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare Supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 13.10.25.20 NMAC.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

G. An issuer shall not present for filing or approval a rate structure for its Medicare Supplement policies or certificates issued after the effective date of the amendment of this regulation based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

[13.10.25.21 NMAC - Rp, 13.10.25.21 NMAC, 1/1/2019]

13.10.25.22 PERMITTED COMPENSATION ARRANGEMENTS:

A. First year. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare Supplement policy or certificate only if the first year commission or other first year compensation is no more than two-hundred percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. Subsequent years. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

C. Replacement policies. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. Compensation defined. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

[13.10.25.22 NMAC - Rp, 13.10.25.22 NMAC, 1/1/2019]

13.10.25.23 REQUIRED DISCLOSURE PROVISIONS:

A. General rules.

(1) Renewal or continuation. Medicare Supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Riders or endorsements. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare Supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare Supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare Supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Payment standards. Medicare Supplement policies or certificates issued or delivered after July 1, 1992 shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) Disclosure of preexisting condition limitations. If a Medicare Supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Return and refund period. Medicare Supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded within 30 days after its return if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Delivery of guide.

(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the NAIC and

Center for Medicare and Medicaid Services (CMS) and in a type size no smaller than 12 point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare Supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application and acknowledgement of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.

(1) Benefit changes. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare Supplement insurance policies or certificates in a format acceptable to the superintendent. The notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare Supplement policy or certificate, and

(b) inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) Required format. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) No solicitation. The notices shall not contain or be accompanied by any solicitation.

C. MMA notice requirements. Issuers shall comply with any notice requirements of the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*.

D. Outline of coverage requirements.

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare Supplement policy or certificate is issued on a basis which would require

revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12 point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

[Insert "Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010" provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and will return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:] - Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:] [insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph must not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as listed below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017. An issuer may use additional benefit plan designations on these charts pursuant to Subsection D of 13.10.25.14 NMAC.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the superintendent.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare Supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

[Use the Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2020 provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan A (Part A) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan A (Part B) chart, chart notes and associated values provided in the Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651, as adopted in 2017.]

PARTS A & B

[Use the Plan A (Parts A& B) chart, chart notes and associated values provided in the Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651, as adopted in 2017.]

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan B (Part A) charts, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan B (Part B) charts, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan B (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan C (Part A) charts, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan C (Part B) charts, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan C (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan C chart, chart notes and associated values for Other Benefits – Not Covered by Medicare provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan D (Part A) chart, chart notes, and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan D (Part B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan D (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan D chart, chart notes and associated values for Other Benefits – Not Covered by Medicare provided in the *Model Regulation To Implement the NAIC*

Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651, as adopted in 2017.]

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan F or High Deductible Plan F (Part A) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan F or High Deductible Plan F (Part B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan F or High Deductible Plan F (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan F or High Deductible Plan F chart and associated values for Other Benefits – not covered by Medicare provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan G or High Deductible Plan G (Part A) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan G or High Deductible Plan G (Part B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan G or High Deductible Plan G (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan G or High Deductible Plan G chart, chart notes and associated values for Other Benefits – not covered by Medicare provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN K

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan K (Part A) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan K (Part B) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan K (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN L

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan L (Part A) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan L (Part B) chart. chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

PARTS A & B

[Use the Plan L (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan M (Part A) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan L (Part B) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

PARTS A & B

[Use the Plan M (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan M chart, chart notes and associated values for Other Benefits – not covered by Medicare provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan N (Part A) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan N (Part B) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan N (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan N chart, chart notes and associated values for Other Benefits – not covered by Medicare provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

E. Notice Regarding Policies or Certificates Which are not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare Supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 et seq.), disability income policy; or other policy identified in Subsection B of 13.10.25.3 NMAC, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare Supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

> "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the company."

(2) Pursuant to Subsection B of 13.10.25.31 NMAC, applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph (1) of Subsection D of this section shall be disclosed, using the applicable statement in Appendix C as provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

[13.10.25.23 NMAC - Rp, 13.10.25.23 NMAC, 1/1/2019]

13.10.25.24 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE:

A. Statements and questions. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare Supplement, Medicare Advantage, Medicaid

coverage, or another health insurance policy or certificate in force or whether a Medicare Supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

1. You do not need more than one Medicare Supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified

Medicare Beneficiary (QMB) and a Specified Low- Income Medicare Beneficiary (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

1. **(a)** Did you turn age 65 in the last 6 months?

Yes_____ No _____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes_____ No _____

(c) If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes_____ No _____

If yes,

(a) Will Medicaid pay your premiums for this Medicare Supplement policy?

Yes_____ No _____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes_____ No _____

3. **(a)** If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END: blank.

START /__/___ END /__/_

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

Yes_____ No _____

(c) Was this your first time in this type of Medicare plan?

Yes_____ No _____

(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

Yes_____ No _____

4. **(a)** Do you have another Medicare Supplement policy in force?

Yes_____ No _____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy?

Yes_____ No _____

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes_____ No _____

(a) If so, with what company and what kind of policy?

_____
_____

_____
_____

_____
_____

(b) What are your dates of coverage under the other policy?

START /__/ END /__/____

(If you are still covered under the other policy, leave "END" blank.)

B. Other policies sold to this applicant. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five years that are no longer in force.

C. Signed form. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Replacement notice. Upon determining that a sale will involve replacement of Medicare Supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare Supplement policy or certificate, a notice regarding replacement of Medicare Supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare Supplement coverage.

E. Format for notice. The notice required by the preceding Subsection for an issuer shall be provided in substantially the following form in no less than 12 point type:

NOTICE TO APPLICANT REGARDING REPLACMENT

OF MEDICARE SUPPLEMENT INSURANCE

OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will

provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____ Other. (please specify)

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph must not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature

_____

(Date)

*Signature not required for direct response sales.

F. Paragraph (2) of the replacement notice (applicable to preexisting conditions) must be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

[13.10.25.24 NMAC - Rp, 13.10.25.24 NMAC, 1/1/2019]

13.10.25.25 FILING REQUIREMENTS FOR ADVERTISING:

An issuer shall provide a copy of any Medicare Supplement advertisement intended for use in this state whether through written, radio or television medium to the superintendent for review and approval electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978. Advertisements must comply with the requirements set forth in 13.10.4 NMAC.

[13.10.25.25 NMAC - Rp, 13.10.25.25 NMAC, 1/1/2019]

13.10.25.26 STANDARDS FOR MARKETING:

A. Issuer's procedures. An issuer, directly or through its producers, shall:

(1) establish marketing procedures to assure that any comparison of policies by its

agents or other producers will be fair and accurate;

(2) establish marketing procedures to assure excessive insurance is not sold or issued;

(3) display prominently by type, stamp or other appropriate means, on the first page

of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses"

(4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare Supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

(5) establish auditable procedures for verifying compliance with this Subsection A of this section.

B. Unfair trade practices prohibited. In addition to the practices prohibited in Section 59A-16-1 et seq. NMSA 1978 and Section 57-12-1 et seq. NMSA 1978 and accompanying regulations, the following acts and practices are prohibited:

(1) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(2) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. Use of terms. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

[13.10.25.26 NMAC - Rp, 13.10.25.26 NMAC, 1/1/2019]

13.10.25.27 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE:

A. Agent's responsibility. In recommending the purchase or replacement of any Medicare Supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Duplicate policies prohibited. Any sale of a Medicare Supplement policy or certificate that will provide an individual more than one Medicare Supplement policy or certificate is prohibited.

C. Duplicate Part C prohibited. An issuer shall not issue a Medicare Supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

[13.10.25.27 NMAC - Rp, 13.10.25.27 NMAC, 1/1/2019]

13.10.25.28 REPORTING OF MULTIPLE POLICIES:

A. Appendix B due date. On or before March 1 of each year, an issuer shall report to the superintendent the following information for every individual resident of this state for which the issuer has in force more than one Medicare Supplement policy or certificate using the form referenced in Subsection B of 13.10.26.31 NMAC:

(1) policy and certificate number; and

(2) date of issuance.

B. Report organization. The items set forth in Subsection A of this section must be grouped by individual policyholder.

[13.10.25.28 NMAC - Rp, 13.10.25.28 NMAC, 1/1/2019]

13.10.25.29 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES:

A. If a Medicare Supplement policy or certificate replaces another Medicare Supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare Supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare Supplement policy or certificate replaces another Medicare Supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

13.10.25.30 PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING:

This Section applies to all policies with policy years beginning on or after May 21, 2009.

A. Use of genetic testing – exclusion and discrimination. An issuer of a Medicare Supplement policy or certificate;

(1) Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

(2) Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

B. Use of disease or disorder in setting group premium rates. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

(1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

C. Request for genetic testing prohibited. An issuer of a Medicare Supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

D. Permitting use of genetic testing. Subsection C of this section shall not be construed to preclude an issuer of a Medicare Supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the *Health Insurance Portability and Accountability Act of 1996*, as may be revised from time to time) and consistent with Subsection A.

E. For purposes of carrying out Subsection D of this section, an issuer of a Medicare Supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C of this section, an issuer of a Medicare Supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with part 46 of title 45,

Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the

legal guardian of such child, to whom the request is made that:

(a) compliance with the request is voluntary; and

(b) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

G. An issuer of a Medicare Supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

H. An issuer of a Medicare Supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

I. If an issuer of a Medicare Supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H of this section if such request, requirement, or purchase is not in violation of Subsection G of this section.

J. For the purposes of this section only:

(1) "Issuer of a Medicare Supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research, which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" means,

(a) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(b) The computation of premium or contribution amounts under the policy;

(c) The application of any pre-existing condition exclusion under the policy; and

(d) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

[13.10.25.30 NMAC - Rp, 13.10.25.30 NMAC, 1/1/2019]

13.10.25.31 SEPARABILITY:

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

[13.10.25.31 NMAC - Rp, 13.10.25.31 NMAC, 1/1/2019]

13.10.26.32 APPENDICES:

A. Appendix A - medicare supplement refund calculation form. For the required *Medicare Supplement Refund Calculation Form* for each calendar year, use the form so named and instructions provided in Appendix A of the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017, except that on line 7, in place of "(see worksheet for Ratio 1)" use "(sixty-five percent for Individual, seventy-five percent for Group)".

B. Appendix B - form for reporting medicare supplement policies. Use the *Form For Reporting Medicare Supplement Policies* provided in Appendix B of the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651,* as adopted in 2017.

C. Appendix C - disclosure statements.

(1) Instructions for use of the disclosure statements for health insurance policies sold to Medicare beneficiaries that duplicate Medicare.

(a) Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

(b) All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

(c) State and federal law prohibits insurers from selling a Medicare Supplement policy to a person that already has a Medicare Supplement policy except as a replacement policy.

(d) Property/casualty and life insurance policies are not considered health insurance.

(e) Disability income policies are not considered to provide benefits that duplicate Medicare.

(f) Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

(g) The federal law does not preempt state laws that are more stringent than the federal requirements.

(h) The federal law does not preempt existing state form filing requirements.

(i) Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

(2) For the required disclosure statements refer to the various options that are provided in Appendix C of the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

[13.10.25.32 NMAC - Rp, 13.10.25.32 NMAC, 1/1/2019]

PART 26: REGISTRATION OF PRIVATE HEALTH INSURANCE COOPERATIVES

13.10.26.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[13.10.26.1 NMAC - N, 10-15-12]

13.10.26.2 SCOPE:

This rule applies to private health insurance cooperatives established under Chapter 59A, Article 23 NMSA 1978.

[13.10.26.2 NMAC - N, 10-15-12]

13.10.26.3 STATUTORY AUTHORITY: Sections 59A-2-9 and 59A-23-3 NMSA 1978.

[13.10.26.3 NMAC - N, 10-15-12]

13.10.26.4 DURATION:

Permanent.

[13.10.26.4 NMAC - N, 10-15-12]

13.10.26.5 EFFECTIVE DATE:

October 15, 2012, unless a later date is cited at the end of a section.

[13.10.26.5 NMAC - N, 10-15-12]

13.10.26.6 OBJECTIVE:

To establish minimum registration requirements for private health insurance cooperatives.

[13.10.26.6 NMAC - N, 10-15-12]

13.10.26.7 DEFINITIONS:

A. "Private health insurance cooperative" means a nonprofit corporation formed to arrange for health benefit plan coverage with insurance carriers for its participating member large or small employers.

B. "Carrier" means carrier as defined in Section 59A-23-11.Q (1) NMSA 1978.

C. "Large employer" means a large employer as defined in Section 59A-23-11.Q (2) NMSA 1978.

D. "Small employer" means a small employer as defined in as defined in Section 59A-23-11.Q (3) NMSA 1978.

[13.10.26.7 NMAC - N, 10-15-12]

13.10.26.8 REGISTRATION REQUIREMENTS:

A. Any private health insurance cooperative operating in New Mexico shall register with the agent licensing bureau of the insurance division of the New Mexico public regulation commission prior to commencing operations.

B. All business entities should be aware that other licensing and registration requirements for corporations and partnerships may exist. Corporations may contact the corporations bureau of the New Mexico public regulation commission at (505) 827-4387

to determine the applicable requirements and to register. Partnerships may contact the secretary of state's office (505) 827-3600 to determine the applicable requirements and to register.

C. The registration process with the agent licensing bureau of the insurance division shall include verification that the private health insurance cooperative:

(1) has provided:

(a) name;

(b) New Mexico public regulation commission corporations number;

(c) New Mexico address as registered;

(d) New Mexico city of registration;

(e) state and zip code of registration;

(f) sufficient evidence that the entity is in good standing with the secretary of state (if the date is not identical to the current date, then the agent licensing bureau shall notify the private health insurance cooperative that it may not negotiate contracts until its good standing is re-established);

(g) member-employer names, addresses, cities of registration, states, zip codes, and New Mexico tax I.D. numbers; and

(h) the private health insurance cooperative's employee names and addresses;

(2) has not been formed by, nor has as a member, a carrier, pursuant to the prohibition in Chapter 59A, Article 23 NMSA 1978;

(3) has established procedures under which an applicant for or participant in its group health benefit plan coverage may have a grievance reviewed by an impartial entity, specifically by requiring the carrier to electronically file a non-grandfathered grievance plan with the New Mexico public regulation commission, insurance division, managed health care bureau that shall be subject to and comply with the insurance division's grievance procedures rule pertaining to internal and external grievance review (13.10.17 NMAC);

(4) has developed and implemented a plan to maintain public awareness of the private health insurance cooperative and publicize the eligibility requirements for, and the procedures for enrollment in, its group health benefit plan coverage;

(5) in instances wherein the private health insurance cooperative has made available to its members more than one group health benefit plan, has made each group health benefit available to all employees covered by the cooperative;

(6) ensures that any group health benefit plan provided through the private health insurance cooperative provides coverage for diabetes equipment, supplies and services;

(7) does not self-insure or self-fund any health benefit plan or portion of a plan; and

(8) has contracted only with a carrier that demonstrates that it:

(a) is in good standing with the division;

(b) has the capacity to administer health benefit plans;

(c) is able to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;

(d) is able to conduct utilization management and establish applicable procedures and policies;

(e) is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers;

(f) has a satisfactory grievance procedure that is subject to and shall comply with the insurance division's grievance procedures rule (13.10.17 NMAC) and is able to respond to enrollees' calls, questions and complaints; and

(g) has financial capacity, either through satisfying solvency standards that the superintendent shall set or through appropriate reinsurance or other risk-sharing mechanisms.

[13.10.26.8 NMAC - N, 10-15-12]

13.10.26.9 ANNUAL REQUIRED FILING:

A. Each private health insurance cooperative shall file an annual report for the preceding calendar year with the superintendent on or before March 1 of each year, or within such extension of time as the superintendent for good cause may grant. The report shall be in the form and contain such matters as the superintendent prescribes and shall be verified by at least two officers or two partners of the private health insurance cooperative.

B. The annual report shall include the complete names and addresses of all insurers with which the private health insurance cooperative had an agreement during the preceding fiscal year. If requested in writing by the private health insurance cooperative, the names and addresses of the insureds may be kept confidential by the superintendent.

[13.10.26.9 NMAC - N, 10-15-12]

PART 27: UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATING THE MEDICAL LOSS RATIO

13.10.27.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance.

[13.10.27.1 NMAC - N, 11/30/2012; A, 8/1/2020]

13.10.27.2 SCOPE:

This rule applies to all health care insurers, health maintenance organizations, or health care plans that are required to obtain a certificate of authority or licensure in this state or which provide, offer or administer managed health care plans.

[13.10.27.2 NMAC - N, 11/30/2012]

13.10.27.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-22-50, 59A-23C-10, 59A-46-51 and 59A-47-46 NMSA 1978.

[13.10.27.3 NMAC - N, 11/30/2012; A, 8/1/2020]

13.10.27.4 DURATION:

Permanent.

[13.10.27.4 NMAC - N, 11/30/2012]

13.10.27.5 EFFECTIVE DATE:

November 30, 2012, unless a later date is cited at the end of a section.

[13.10.27.5 NMAC - N, 11/30/2012]

13.10.27.6 OBJECTIVE:

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

[13.10.27.6 NMAC - N, 11/30/2012]

13.10.27.7 DEFINITIONS:

As used in this rule:

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

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

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

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

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

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

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

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

I. "health product lines" means:

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

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

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

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

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

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

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

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

[13.10.27.7 NMAC - N, 11/30/2012; A, 8/1/2020]

13.10.27.8 MINIMUM MEDICAL LOSS RATIOS FOR ALL HEALTH PRODUCT LINES:

A. General requirement. Carriers shall meet the minimum medical loss ratio established, and in the manner calculated, under this rule.

B. Measurement period. Compliance with the minimum medical loss ratio shall be measured over a rolling three-year period. The initial measurement period shall be the years, 2010, 2011 and 2012. Each year thereafter, the subsequent year shall be added to the rolling three-year period and the oldest year shall be removed. For example, the second measurement period shall be 2011, 2012 and 2013.

C. Aggregation. Medical loss ratios shall be calculated on a consolidated level within a state, with experience allocated to state based upon the situs of the contract. Experience of all affiliates shall be accumulated to the following levels:

(1) individually underwritten health policies;

(2) small group policies;

(3) large group policies and all other policies; and

(4) total of all group policies combined.

D. Frequency. Medical loss ratios shall be calculated annually by carriers that issue products through health product lines, beginning in 2013 covering the period 2010 through 2012.

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

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

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

(1) the minimum medical loss ratio level for individually underwritten policies shall be eighty percent;

(2) the minimum medical loss ratio level for small group policies shall be eighty percent;

(3) the minimum medical loss ratio level for large group policies and all other policies shall be eighty-five percent; and

(4) the minimum medical loss ratio level for the total of all group policies shall be eighty-five percent.

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

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

(2) a plan to make the required reimbursements to policyholders.

I. Actions required upon noncompliance with requirements. The plan to make the required reimbursements to policyholders shall provide either prospective premium credits or refunds to each policyholder who was enrolled in the affected segment (i.e., individually underwritten health policies, small group, or all other policies) during the last year of the measurement period and provide that any such refund for a policyholder be reduced by the amount of any rebate owing to the policyholder for a medical loss ratio reporting year pursuant to 45 CFR Part 158 that coincides with such measurement period. The premium credits or refunds shall be reflected in either a one-time payment or premium credit or in multiple payments or premium credits. Any such credits or refunds must be provided no later than the end of December of the year following the applicable measurement period. The deadline for reimbursement may be extended if the premium credits exceed the monthly premiums due by the end of December of the year following the applicable measurement period. Any overage may be applied to succeeding premium payments until the full amount of any refund has been credited. No later than March 31st of the second year following the applicable measurement period the carrier shall demonstrate that the refunds in the required amounts have been made or that premium credits are being applied until such time as the full amount on the refund has been credited. The prospective premium credits or refunds shall be made on a per subscriber basis, unless an alternative basis is approved by the superintendent of insurance and shown separately on the policyholder's monthly (or other frequency) bill. This credit may reflect the family composition of the rating structure used for each policyholder. Any premium credit or refund to policyholders shall be based only upon the medical loss ratios calculated for individually underwritten policies and for the total of all group policies calculated collectively across all group health product lines.

[13.10.27.8 NMAC - N, 11/30/2012; A, 8/1/2020]

13.10.27.9 COMPLIANCE REQUIREMENT FORM:

A. An Insurer shall use an OSI approved form to submit minimum loss ratios.

B. The form shall be posted to the OSI website.

[13.10.27.9 NMAC - N, 11/30/2012; A, 8/1/2020]

PART 28: PROVIDER PAYMENT AND PROVIDER CREDENTIALING REQUIREMENTS

13.10.28.1 ISSUING AGENCY:

Office of Superintendent of Insurance (OSI), Life and Health (L&H)

[13.10.28.1 NMAC - N, 01/01/17]

13.10.28.2 SCOPE:

A. Applicability. This rule applies to all health carriers, including health maintenance organizations, individual health plans, group and blanket plans, provider service networks, non-profit healthcare plans and third-party payers or their agents that provide, offer or administer health benefit plans, including health benefit plans and managed health care plans subject to the insurance laws and regulations of this state. This rule also applies to all health care providers who are licensed to provide health-related services in this state.

B. Timely Payments. This rule addresses the timely payment to providers by health carriers for covered services that have been provided to the carrier's enrollees or covered persons, the credentialing process by which health carriers review and select providers who apply to join carriers' networks, and a dispute resolution process to be utilized by providers and health carriers to resolve differences pertaining to provider credentialing and payment for covered services.

C. Exclusions. This rule does not impose any requirement on health carriers as to which providers must be accepted into health carriers' networks, specify terms of contracts established between health carriers and providers, establish standard reimbursement rates for payment by health carriers to in- or out-of-network providers for services, or interpret terms of any contract established between a health carrier and its enrollees or covered persons.

[13.10.28.2 NMAC - N, 01/01/17]

13.10.28.3 STATUTORY AUTHORITY:

Sections 59A-16-20; 59A-16-21.1, 59A-22-54, 59A-23-14, 59A-46-54, and 59A-47-48 NMSA 1978.

[13.10.28.3 NMAC - N, 01/01/17]

13.10.28.4 DURATION:

Permanent.

[13.10.28.4 NMAC - N, 01/01/17]

13.10.28.5 EFFECTIVE DATE:

January 1, 2017, unless a later date is cited at the end of a section.

[13.10.28.5 NMAC - N, 01/01/17]

13.10.28.6 OBJECTIVE:

The purpose of this rule is to establish a uniform and efficient provider credentialing process and to ensure that providers receive prompt payment from health carriers for clean claims and interest on unpaid claims. This rule also establishes a process for resolving payment-related credentialing disputes between health carriers and providers.

[13.10.28.6 NMAC - N, 01/01/17]

13.10.28.7 DEFINITIONS:

As used in this rule:

A. "Business day" means a consecutive 24-hour period, excluding weekends or holidays.

B. "Claim" means a request from a provider for payment for health care services.

C. "Clean claim" means a manually or electronically submitted claim from an eligible provider that:

(1) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health carrier's system;

(2) is not materially deficient or improper, including lacking substantiating documentation currently required by the health carrier; and

(3) has no particular or unusual circumstances requiring special treatment – such as, but not limited to, coordination of benefits, pre-existing conditions, subrogation, or suspected fraud – that prevents payment from being made by the health carrier within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

D. "Completed credentialing application" means a credentialing application that is free of defects and contains all of the information that, when later supplemented by verifications and documentation gathered by the health carrier during the primary source verification process, is necessary for the health carrier to make a credentialing decision.

E. "Covered benefits" means the specific health services provided under a health benefits plan.

F. "Credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider applies to become a participating provider within a health carrier's network.

G. "Credentialing application" means the application form to be used for the credentialing of providers.

H. "Credentialing intermediary" means a person to whom a health carrier has delegated credentialing or re-credentialing authority and responsibility.

I. "Date of receipt" means the date on which a claim or credentialing application is deemed received, as follows:

(1) for claims and credentialing applications submitted electronically or sent via fax and unless the sender is notified immediately of a transmission error, the date of receipt is the date on which a claim or credentialing application is submitted or, for claims that arrive on a non-business day, the date of the first business day thereafter;

(2) for claims and credentialing applications that are hand delivered, the date of receipt is the date of delivery; or

(3) for claims and credentialing applications submitted through the US mail, the health carrier may select and shall consistently administer one of the following options:

(a) the first business day following the date of actual receipt by a person or organization that has been designated by the health carrier to manage incoming mail;

(b) if no person or organization has been designated to manage incoming mail, then the first business day following the date of actual receipt by the health carrier; or

(c) three business days after the postmark on the claim or application that is submitted through the US mail.

J. "Day" means a calendar day, including weekends, holidays, and any other non-business days.

K. "Electronic claim submission" means a request for payment that is submitted by a provider to a health carrier via an electronic portal or using another on-line form or submission process that complies with state and federal patient privacy protection requirements and links or transmits directly to the health carrier.

L. "Enrollee or covered person" means an individual who is entitled to receive health care benefits provided by a health carrier for covered health-related services, subject to out-of-network costs, deductibles, co-payments, co-insurance deductibles or other cost-sharing provisions provided by the health benefits plan.

M. "Health benefits plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

N. "Health care professional" means an individual engaged in the delivery of health care services that is licensed or authorized to practice in this state.

O. "Health care services" means services, supplies, and procedures for the diagnosis, prevention, treatments, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

P. "Health insurer or health carrier" means an entity subject to the insurance laws and regulations of this state, including a health insurance company, a health carrier, a health maintenance organization, a hospital and health service corporation, a provider service network, a non-profit health care plan, a third-party, or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefit policies and managed health care plans in this state.

Q. "Manual claim submission" means a request for payment that is submitted by a provider to a health carrier via US mail, fax, e-mail, or hand delivery.

R. "Network" means the group(s) of participating providers who provide services under a network plan or managed health care plan.

S. "Network plan" means a health benefits plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

T. "Participating provider" means a provider, health care professional, or facility who under express contract with a health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving

payment directly or indirectly from the health carrier, subject to co-payments, co-insurance deductibles, or other cost-sharing provisions.

U. "Provider" means a physician, hospital or other health care professional licensed or otherwise authorized to furnish health care services in this state.

V. "Practice group" means an incorporation or other legal collaboration of providers who work together sharing responsibility for providing care, liability and resources.

W. "Provisional acceptance" means a provider that is treated by a health carrier as a participating provider for a period of up to one-year, based on the results of credentialing.

X. "Standard reimbursement rate" means the usual, customary and reasonable reimbursement rate paid to providers for health care services that is at or near the median rate paid for similar health care services within the surrounding geographic area where the charges were incurred.

Y. "Superintendent" means the superintendent of insurance, acting on behalf of the office of the superintendent, or anyone acting in an official capacity on the superintendent's behalf.

Z. "Uniform credentialing forms" means the version current at the time of the application or re-application process of forms used by the hospital services corporation (HSC), the counsel for affordable quality healthcare datasource (CAQH), or another form as approved by the superintendent provided that the form is used only for the credentialing of facility and ancillary providers, or other credentialing forms as specified by a bulletin posted on the OSI website, including any revisions thereto and as developed and updated from time to time and including electronic versions of such forms.

AA. "Verification or verification supporting statement" means documentation confirming the information submitted by an applicant for credentialing by a specifically named entity or by a regional, national, or general data depository providing primary source verification, including but not limited to a college, university, medical school, teaching hospital, specialty certification board, health care facility or institution, state licensing board, federal agency or department, professional liability insurer, or the national practitioner data bank.

[13.10.28.7 NMAC - N, 01/01/17]

13.10.28.8 CLAIM SUBMISSION AND CODING CHANGES:

A. General.

(1) Health carriers shall comply with both the provisions of this section and with the provisions of 13.10.12 NMAC, which provides for standardization of health claim forms.

(2) Claims information, including claim status information shall be subject to state and federal patient privacy protection laws.

(3) A health carrier that has entered into a contract with one or more intermediaries to conduct provider credentialing or provide payments to providers shall require the intermediary to indicate the name of the intermediary and the name of the health carrier for which it is conducting the work when contacting a provider on behalf of the health carrier.

B. Electronic submission.

(1) Health carriers shall make available to participating providers a process and procedure for submitting claims electronically.

(2) Health carriers shall make available to participating providers a process and procedure for electronically making coding changes for claims after submission.

(3) Claims that are transmitted electronically are deemed to be received by the health carrier on the date of receipt unless the provider receives immediate notice of a transmission error.

(4) When a claim is submitted electronically and the health carrier subsequently determines that there is an error or omission with the submission that will delay or prevent payment to the participating provider, the health carrier shall make a good faith effort to notify the participating provider by fax, electronic, or other written communication within 30 days following the date of receipt.

(5) Any notification from a health carrier to a provider that there is an error or omission in a claim submission must contain a specific statement regarding all information sought to rectify the error or omission. The carrier shall make a good faith effort to convey all of the errors or omissions to the provider at one time. A pattern of repetitive requests for the same information from a health carrier to a provider is a violation of Article 16 of the Insurance Code, as defined at §59A-16-20.

C. Manual submission.

(1) Health carriers shall make standard forms available to providers for submitting claims manually via US mail, fax, e-mail, or hand delivery.

(2) Health carriers shall make standard forms available to providers for manual coding changes to be submitted via US mail, fax, e-mail, or hand delivery.

(3) Claims that are submitted via US mail are deemed to be received by the health carrier on the date of receipt. Claims that are transmitted via fax, E-mail or hand delivery are deemed to be received by the health carrier on the date of receipt unless the provider receives immediate notice of a transmission error.

(4) When a claim is submitted manually and the health carrier subsequently determines that there is an error or omission with the submission that will delay or prevent payment to the provider, the health carrier shall make a good faith effort to notify the participating provider in writing within 45 days following the date of receipt.

(5) Any notification from a health carrier to a provider that there is an error or omission in a claim submission must contain a specific statement regarding all information sought to rectify the error or omission. The carrier shall make a good faith effort to convey all of the errors or omissions to the provider at one time. A pattern of repetitive requests for the same information from a health carrier to a provider is violation of Article 16 of the Insurance Code, as defined at §59A-16-20.

D. Access to Claims Status Information.

(1) Health carriers shall provide an electronic means whereby participating providers can access claim information within three business days of the date of receipt for electronic claims and within 10 business days of the date of receipt for manual claims.

(2) The information that is available to the provider shall indicate the status of the request for payment, including, but not limited to the following:

(a) date of receipt;

(b) identifying claim information, which may include enrollee/covered persons identifiers, date(s) of service, and appropriate coding, as required by the health carrier and agreed to by the provider;

(c) whether the claim is pending or if it has been accepted or rejected for payment;

(d) if the claim is pending, whether the health carrier has requested additional information from the provider to complete processing of the claim;

(e) if the claim has been accepted, the payment amount that has been approved; and

(f) a clear explanation of the circumstances if the claim has been found to involve particular or unusual circumstances that require special treatment and that are likely to delay payment.

[13.10.28.8 NMAC - N, 01/01/17]

13.10.28.9 PAYMENT OF CLAIMS, OVERDUE CLAIMS AND CALCULATION OF INTEREST:

A. Payment of claims - timeliness.

(1) Claim payment. Health carriers shall promptly pay providers upon receipt of clean claims for uncontested covered health care services that the provider has supplied.

(2) Timeliness. The health carrier shall reimburse the eligible provider within 30 days of the date of receipt if the clean claim has been submitted electronically or within 45 days of the date of receipt if the clean claim has been submitted manually.

(3) Prompt payment. For purposes of prompt payment, a claim shall be deemed to have been "paid" upon one of the following:

(a) a check is mailed by the health carrier or its intermediary to the provider; or

(b) an electronic transfer of funds is made by the health carrier or its intermediary to the provider.

(4) Reimbursement rate. The health carrier shall make payment to the provider based on the standard reimbursement rate as specified within the contractual agreement, or as otherwise agreed upon between the health carrier and the provider.

(5) Multi-claim payments. A single payment made to a provider can serve as payment for multiple claims, but must clearly identify each claim and the amount of the claim that has been satisfied by the payment. If non-claim payments to a provider are included in a multi-claim payment, the nature of those payments must also be clearly identified.

B. Interest on unpaid clean claims. A health carrier shall pay interest as set forth in Subsection D of 13.10.28.9 NMAC on the amount of any clean claim that has not been paid within the time specified in Subsection A of 13.10.28.9 NMAC.

C. Pending claims.

(1) Questionable liability and special treatment claims.

(a) If, upon receipt of a claim, a health carrier is unable to determine liability for, or otherwise refuses to pay a claim or a portion of a claim of an eligible provider within the time specified in Subsection A of 13.10.28.9 NMAC, the health carrier shall make a good faith effort to notify the eligible provider electronically, in writing, or by

another method, as agreed between the health carrier and provider, within 30 days of the date of receipt of the claim if submitted electronically and within 45 days of the date of receipt of the claim if submitted manually.

(b) If, upon receipt of a claim, a health carrier determines that a claim or a portion of a claim requires special treatment due to particular or unusual circumstances that will delay payment beyond the time specified in Subsection A of 13.10.28.9 NMAC, the health carrier shall make a good faith effort to notify the eligible provider electronically, in writing, or by another method, as agreed between the health carrier and provider, within 30 days of the date of receipt of the claim if submitted electronically and within 45 days of the date of receipt of the claim if submitted manually.

(2) Notification of pending claims. The notification required by Subsection C of 13.10.28.9 NMAC, shall:

(a) specify the reason(s) why the health carrier is refusing to pay the claim, has determined it is not liable for the claim, or shall specify what information is required to determine liability for the claim;

(b) clearly indicate if only certain charges associated with a claim are contested; and

(c) shall be repeated by the health carrier at least monthly until the matter is resolved.

(3) Uncontested portion of pending claims. The timely payment requirement described in Section A of 13.10.28.9 NMAC applies to any uncontested portion of a contested claim.

(4) Liability resolved. The date on which liability or special treatment issues are resolved for a pending claim is the date that the claim becomes a clean claim and shall initiate the timely payment requirement described in Subsection A of 13.10.28.9 NMAC.

D. Overdue payments, calculation of interest.

(1) When payment is not made by the health carrier to the provider within the time specified in Subsection A of 13.10.28.9 NMAC and there is no question of liability or special treatment as described in Subsection C of 13.10.28.9 NMAC or questions of liability or special treatment have been resolved, interest shall be calculated and paid to the provider, on the unpaid portion of the claim as follows:

(a) For any full or partial month, beginning on the 31st day after the claim has been submitted electronically and on the 46th day for claims submitted manually, the health carrier shall calculate and pay interest in the amount of one and one-half percent for each full or partial month. For purposes of this section, any 30-day period is the

equivalent of one month, excepting that a calendar year shall only be equal to 12 months; and

(b) Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The health carrier shall not be required to pay any interest calculated to be less than two dollars ($2.00). The interest shall be paid within 30 days of the payment of the claim. Interest can be paid on the same check or electronic transfer as the claim payment or on a separate check or electronic transfer. If the health carrier combines interest payments for more than one late clean claim, the check or electronic transfer shall include information identifying each claim covered by the check or electronic transfer and the specific amount of interest being paid for each claim.

(2) When a claim that involves a question of liability or special treatment is ultimately resolved in favor of the provider and is not paid within 30 or 45 days of becoming an electronic or manual clean claim, respectively, the health carrier shall pay all of the interest due on the unpaid claim, to be calculated as described in Paragraph (1) of Subsection D of 13.10.28.9 NMAC.

[13.10.28.9 NMAC - N, 01/01/17]

13.10.28.10 GENERAL PROVIDER CREDENTIALING:

The provisions of this section apply equally to initial credentialing applications and applications for re-credentialing.

A. Credential verification program.

(1) In order to ensure accessibility and availability of services, each health carrier shall establish a program in accordance with this regulation that verifies that its participating providers are credentialed before the health carrier accepts a provider into its network and lists a provider in the health carrier's provider directory, handbooks, or other marketing or member materials.

(2) The credential verification program established by each health carrier shall provide for an identifiable person(s) to be responsible for all credential verification activities, which person(s) shall be capable of carrying out that responsibility.

(3) A health carrier is not obligated to approve all applications for credentialing and may deny any application based on existing network adequacy, issues with an application, failure by provider to provide a complete credentialing application, or another reason.

(4) No contract between a health carrier and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

B. Delegation of credential verification activities.

(1) Whenever a health carrier delegates credential verification activities to a contracting entity, whether a credentialing intermediary or subcontractor, the health carrier shall review and approve the contracting entity's credential verification program before contracting and shall require that the entity comply with all applicable requirements of this regulation.

(2) The health carrier shall monitor the contracting entity's credential certification activities.

(3) The health carrier shall implement oversight mechanisms, including:

(a) reviewing the contracting entity's credential verification plans, policies, procedures, forms, and adherence to verification procedures; and

(b) conducting an evaluation of the contracting entity's credential verification program at least every two years.

(4) The health carrier's monitoring activities should at least meet the verification procedures and standards as defined by the national committee for quality assistance (NCQA).

C. Written credential verification plan.

(1) Each health carrier shall develop and adopt a written credentialing plan that contains policies and procedures to support the credentialing verification program.

(2) Each health carrier's written credential verification plan shall:

(a) include the purpose, goals, and objectives of the credential verification program;

(b) include written criteria and procedures for initial enrollment, renewal, restrictions, and termination of providers;

(c) be provided to the superintendent upon request;

(d) provide an organized system to manage and protect confidentiality of credentialing files and records; and

(e) require that records and documents relating to provider credentialing be retained for at least six years.

(3) Each health carrier's credentialing verification plan shall include a process to assess and verify the qualifications of providers applying to become participating

providers within 45 calendar days of receipt of a provider's request for credentialing or a provider's completed uniform credentialing form, whichever is earlier. The plan shall allow for the following to take place within this 45 calendar days:

(a) time required to obtain the completed uniform credentialing form in electronic format, if necessary;

(b) time to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials;

(c) a final decision by a credentialing committee if the health carrier's plan requires such review; and

(d) time to notify the provider of the health carrier's decision.

D. Reporting requirements. Each health carrier shall submit a report to the superintendent regarding its credentialing process for the prior two-year period beginning December 31, 2018, and on December 31 for all even numbered years thereafter, or as otherwise directed by the superintendent. The report shall include the following:

(1) the number of applications made to the plan for each type of provider;

(2) the number of applications approved by the plan for each type of provider;

(3) the number of applications rejected by the plan for each type of provider;

(4) the number of providers terminated for reasons of quality; and

(5) the amount of time taken to review and reach a determination on an application.

E. Use of uniform credentialing forms required:

(1) Beginning January 1, 2017, a health carrier shall not use any provider credentialing application form other than uniform credentialing forms, as that term is defined in 13.10.28.7 NMAC.

(2) Should the superintendent determine that these forms no longer represent industry standards; the superintendent will issue a bulletin advising of alternative credentialing forms to be used to satisfy this requirement.

(3) A health carrier or its credentialing or re-credentialing intermediary shall make uniform credentialing application forms available to any health care provider that seeks to be credentialed or re-credentialed by that health carrier or its credentialing

intermediary and also accept uniform credentialing applications electronically or through electronic transfer upon the request of any provider.

(4) An exception to Paragraph (1) of Subsection E of 13.10.28.10 NMAC is made for providers who:

(a) are licensed and also practice outside of New Mexico; and

(b) prefer to use the credentialing forms required by their respective states. In such circumstances, the health carrier and its delegated entity, if any, may accept those forms.

F. Required information. A health carrier shall not require an applicant to submit information not required by the uniform credentialing or re-credentialing forms other than information or documentation that is reasonably related to information on the application.

G. Accreditation by nationally recognized accrediting entity.

(1) Nothing in this section shall require a health carrier to violate or fail to meet a standard or requirement of a nationally recognized accrediting entity.

(2) A health carrier may seek a waiver of these requirements from the superintendent by submitting accreditation by a nationally recognized entity as evidence of compliance with the requirements of this section.

(3) In those instances where a health carrier seeks to meet the requirements of this section through accreditation by a private accrediting entity, the health carrier shall submit to the superintendent the following information:

(a) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule;

(b) documentation from the private accrediting entity showing that the health carrier has been accredited by the entity; and

(c) a summary of the data and information that was presented to the private accrediting entity by the health carrier and upon which accreditation of the health carrier was based.

(4) A health carrier accredited by the private accrediting entity that has submitted all of the requisite information to the superintendent may then be determined by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the health carrier obtained accreditation is recognized and approved by the superintendent.

[13.10.28.10 NMAC - N, 01/01/17]

13.10.28.11 TIMELY CREDENTIALING DECISIONS:

A. Initiation of credentialing process. The credentialing process may be initiated by a provider, who either:

(1) provides a completed uniform credentialing form directly to the health carrier; or

(2) notifies the health carrier that the provider is requesting credentialing by the health carrier, that the provider's completed uniform credentialing form is in electronic format and is available to the health carrier for access via the credentialing form's website or on-line database, and that the health carrier is requested to obtain the provider's completed uniform credentialing form.

B. Initial verification upon receipt.

(1) Upon receiving a provider's request for credentialing or a provider's completed credentialing form, a health carrier or a health carrier's agent shall review the application to verify that the application includes all necessary information and documentation that is reasonably related to the information in the application. The health carrier may initially attempt to obtain additional or missing information by informal means including but not limited to fax, telephone, or e-mail.

(2) A health carrier or a health carrier's agent shall notify the applicant by US certified mail within 10 days of receipt that the request for credentialing has been received, but that if the application is incomplete that the 45-day time period set forth in Subsection C of 13.10.28.11 NMAC shall not commence until the applicant provides all requested information or documentation.

(3) Any request for additional information that has not been met through an informal exchange and remains outstanding at the end of the initial 10-day review period shall also be sent to the provider via the same or separate certified mail within 10 business days of receipt of the application, to include:

(a) a complete and detailed description of all of the information or supporting documentation that is reasonably related to information in the application that the insurer requires to approve or reject the credentialing application; and

(b) the name, address, e-mail, and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process; and

(c) notice that if an application remains incomplete and the applicant has been unresponsive to requests for information beyond 45 days, then the health carrier

may deny the application for failure to respond and notify the applicant that the application is denied.

C. Timely decision.

(1) Within 45 calendar days of the date of receipt of a request for credentialing, the health carrier or the health carrier's agent shall:

(a) assess and verify the qualifications of a provider applying to become a participating provider; and

(b) review the application and determine whether to approve or deny the credentialing application.

(2) The health carrier may:

(a) approve the provider for the health carrier's network for a period of up to three years;

(b) provisionally accept the provider for the health carrier's network for a period of one-year, or the maximum duration up to one-year as allowed by the health carrier's accreditation organization; or

(c) deny the provider for the health carrier's network.

(3) The health carrier's decision must be issued to the provider in writing by US mail at the

physical or mailing address listed in the application, and by e-mail if an e-mail address has been provided.

D. Timing for re-credentialing.

(1) If the credentialing application is approved, re-credentialing verification may not be required more frequently than every three years.

(2) If the application is approved provisionally, then re-credentialing shall be required annually or at the conclusion of the shorter period if required by a health carrier's accreditation organization and approved by the superintendent.

(3) Nothing in this section shall be construed to require a health carrier to credential or provisionally credential any provider.

(4) Nothing in this section shall be construed to prevent a health carrier from terminating its participation agreement with a provider for cause at any time; regardless of time remaining before re-credentialing is due.

(5) Except as may otherwise be required by a health carrier's accreditation organization a health carrier may not require a participating provider to be re-credentialed based on:

(a) a change in the provider's federal tax identification number;

(b) a change in the federal tax identification number of a provider's employer; or

(c) a change in the provider's employer, if the new employer:

(i) is a participating provider; or

(ii) also employs other participating providers.

(6) A health carrier may require that a participating provider or the provider's employer give written notice to the health carrier of a change in the provider's or the provider's employer's federal tax identification number not less than 45 calendar days before the effective date of the change.

E. Accreditation by nationally recognized accrediting entity.

(1) A health carrier may seek a waiver of these credentialing requirements from the superintendent by submitting accreditation by a nationally recognized entity as evidence of compliance with the requirements of this section.

(2) In those instances where a health carrier seeks to meet the requirements of this section through accreditation by a private accrediting entity, the health carrier shall submit to the superintendent the following information:

(a) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule;

(b) documentation from the private accrediting entity showing that the health carrier has been accredited by the entity; and

(c) a summary of the data and information that was presented to the private accrediting entity by the health carrier and upon which accreditation of the health carrier was based.

(3) The superintendent will determine whether a health carrier that has been accredited by a private accrediting entity and has submitted all of the requisite information has met the requirements of the relevant provisions of this section where comparable standards exist.

[13.10.28.11 NMAC - N, 01/01/17]

13.10.28.12 REIMBURSEMENT BY HEALTH CARRIER UPON DELAY IN CREDENTIALING PROCESS:

A. Terms for reimbursement. A health carrier shall reimburse a provider, subject to co-payments, co-insurance, deductibles, or other cost-sharing provisions, for any clean claims for covered services, provided that:

(1) the date of service is more than 45 calendar days after the date the provider requested credentialing from the health carrier and either the provider supplied a completed uniform credentialing application or made the completed uniform credentialing application available for electronic access by the health carrier, including submission of any supporting documentation that the health carrier requested in writing during the initial 10-day review period;

(2) the health carrier has approved, or has failed to approve or deny the applicant's completed uniform credentialing application within the timeframe established pursuant to Subsection C of 13.10.28.11 NMAC;

(3) the provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and

(4) the provider has professional liability insurance or is covered under the Medical Malpractice Act.

B. Sole practitioner. A provider who, at the time services were rendered has been approved by a health carrier for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was not in a practice or group that has contracted with the health carrier to provide services at specified rates of reimbursement, shall be paid by the health carrier in accordance with the carrier's standard reimbursement rate or at an agreed upon rate.

C. Provider group reimbursement. A provider who, at the time services were rendered, has been approved by a health carrier for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was in a provider group that has contracted with the health carrier to provide services at specified rates of reimbursement, shall be paid by the carrier in accordance with the terms of the provider group contract.

D. Reimbursement period. A health carrier shall reimburse a provider pursuant to Subsections A, B, and C of 13.10.28.12 NMAC until the earlier of the following occurs:

(1) the health carrier denies the provider's credentialing application;

(2) the health carrier approves the provider's credentialing application and the provider and health carrier enter a contract to replace a previously agreed upon rate, or

(3) the passage of three years from the date the insurer received the provider's completed uniform credentialing application.

[13.10.28.12 NMAC - N, 01/01/17]

13.10.28.13 CREDENTIALING AND PAYMENT DISPUTE RESOLUTION:

A. Internal review process.

(1) Each health carrier shall establish an internal process for resolving disputes regarding payment of claims between the health carrier and providers arising when a credentialing decision is delayed beyond the timeline found in Subsection C of 13.10.28.11 NMAC, the prompt payment deadline described in Paragraph (2) of Subsection A of 13.10.28.9 NMAC has passed, and payment has not been made.

(2) The internal process shall include required notification regarding pending claims and calculation and payment of interest on overdue claims, as described in Subsections C and D of 13.10.28.9 NMAC.

(3) The internal process shall provide for resolution of disputes regarding reimbursement rates as described in 13.10.28.12 NMAC.

(4) At a minimum, the internal review process shall provide for the following:

(a) To initiate a payment dispute, the provider shall contact the health carrier in writing to determine the status of a claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered by the health carrier to be a clean claim.

(b) The health carrier shall respond in writing to a provider's inquiry regarding the status of an unpaid claim within 15 days of receiving the inquiry.

(c) The health carrier's response shall explain its failure or refusal to pay, and the expected date of payment if payment is pending.

(5) The internal review process may provide specific procedures for resolving payment disputes, including by not limited to, the use of medication.

B. Complaint filed with Superintendent.

(1) If the health carrier fails to respond or the provider believes that payment is being denied, delayed, or calculated in error and the matter has not been successfully resolved at the internal level within 45 days, then the provider may file a complaint,

either individually or in batches, with the superintendent using the form found on the OSI website.

(2) Complaints filed with the superintendent shall contain the following information:

(a) the provider's name, identification number, address, daytime telephone number and the claim number;

(b) the date that the provider's request for credentialing was complete;

(c) the name and address of the health carrier;

(d) the name of the patient and employer (if known);

(e) the date(s) of service and the date(s) the claims were submitted to the health carrier;

(f) relevant correspondence between the provider and the health carrier, including requests for additional information from the health carrier;

(g) additional information which the provider believes would be of assistance in the superintendent's review; and

(h) only those excerpts from provider contracts that are minimally necessary to resolve the dispute shall be submitted to the superintendent, who shall maintain the confidentiality of such excerpts to the fullest extent allowed by applicable law.

(3) The complaining provider shall furnish the health carrier with a complete copy of the complaint and submitted documentation concurrently with the provider's submission to the superintendent.

(4) The health carrier shall be afforded 10 business days after the provider's submission to resolve the matter or to submit additional information that the health carrier believes would be of assistance to the superintendent's review.

(5) The superintendent will review the matter, based on documents and other materials that are submitted by the provider and health carrier for this purpose.

(6) The superintendent may issue an order resolving the dispute, with or without a hearing.

(7) If the superintendent determines, at his sole discretion, that a hearing is necessary, then the provider and the health carrier may appear and may elect to be represented by counsel at the hearing.

(8) The superintendent may designate one or more persons to act as hearing officer. The hearing officer shall prepare a recommendation for the superintendent's review.

(9) The superintendent's decision will be issued within 30 days of receiving a payment complaint if no hearing is required or within 30 days of the hearing, if a hearing is held.

(10) The superintendent may order a health carrier to reimburse a provider at the standard reimbursement rate for covered services provided to the health carrier's enrollees, subject to out-of-network costs, deductibles, co-payments, co-insurance or other cost-sharing provisions due from the enrollee.

(11) In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the insurance code, the superintendent may find that violators of the regulations set forth in this section are subject to the standard penalties for material violations of the insurance code, in accordance with sections 59A-1-18 and 59A-46-25 NMSA 1978.

(12) The provisions of this subsection do not prevent the superintendent from investigating a complaint when the provider has failed to contact the health carrier.

[13.10.28.13 NMAC - N, 01/01/17]

13.10.28.14 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.28.14 NMAC - N, 01/01/17]

PART 29: DEFINITIONS

13.10.29.1 ISSUING AGENCY:

Office of Superintendent of Insurance (OSI), Life and Health (L&H).

[13.10.29.1 NMAC - N, 10/01/2018]

13.10.29.2 SCOPE:

This rule applies to all health insurance carriers, including health maintenance organizations, individual health plans, group and blanket health plans, provider service networks and nonprofit healthcare plans that offer or administer health benefits plans,

including health benefits plans and managed health care plans subject to the insurance laws and regulations of this state.

[13.10.29.2 NMAC - N, 10/01/2018]

13.10.29.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-7-3, 59A-18-2, 59A-18-13.2, 59A-18-13.3, 59A-18-16.2, 59A-22-1 et seq., 59A-23-2, 59A-23-3, and 59A-46-1 et seq. NMSA 1978.

[13.10.29.3 NMAC - N, 10/01/2018]

13.10.29.4 DURATION:

Permanent.

[13.10.29.4 NMAC - N, 10/01/2018]

13.10.29.5 EFFECTIVE DATE:

October 1, 2018, unless a later date is cited at the end of a section.

[13.10.29.5 NMAC - N, 10/01/2018]

13.10.29.6 OBJECTIVE:

The purpose of this rule is to standardize the definitions utilized for rules applicable to health insurance carriers as defined by the scope of this rule in 13.10.29.2 NMAC.

[13.10.29.6 NMAC - N, 10/01/2018]

13.10.29.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) "Accrued liability" means liabilities established on the date an injury is sustained or an illness commences.

(2) "Ambulance service" means any transportation service designated and used or intended to be used for the transportation of sick or injured persons.

(3) "Ambulatory surgical center" means a facility where health care providers perform surgeries, including diagnostic and preventive surgeries that do not require hospital admission.

(4) "Appointment waiting time" means the time from the initial request for health care services by a covered person or the covered person's treating provider to the earliest date offered for the appointment for services inclusive of the time for obtaining authorization from the health insurance carrier or completing any other condition or requirement of the carrier or its participating providers.

(5) "Authorized representative of a covered person" means an individual selected and authorized in writing by a covered person to represent the covered person's interests in matters related to the provision of services under a health benefits plan. Health care professionals and health insurance agents and brokers may serve as authorized representatives of covered persons.

(6) "Authorized representative of a health insurance carrier" means an individual or organization that is selected by the insurance company to represent its interests in an aspect of the regulatory or hearing process.

B. Terms beginning with the letter "B":

(1) "Behavioral health services" means assessment, diagnosis, treatment or counseling in the context of a professional relationship to assist an individual or group alleviate behavioral symptoms, conditions or disorders, including mental health diagnoses and substance use disorders, as well as other services to address developmental disability or developmental delay.

(2) "Blanket health insurance" is a form of health insurance covering special groups of not fewer than 10 persons that meets the criteria outlined in Section 59A-23-2 NMSA 1978.

(3) "Business day" means a consecutive 24-hour period, excluding weekends or state holidays.

C. Terms beginning with the letter "C":

(1) "Certificate" means any certificate issued under an individual or group accident and health insurance policy that has been delivered or issued for delivery in this state, regardless of the state in which the policyholder is domiciled.

(2) "Certification of service" means a determination by a health insurance carrier that a health care service requested by a health care professional or covered person has been reviewed and, based upon the information available, is a covered benefit and meets the carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness, and the requested health care service is therefore approved. The certification of service can take place following the health carrier's utilization review process.

(3) "Certified nurse-midwife" means any person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico department of health as a certified nurse-midwife.

(4) "Certified nurse practitioner" means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information are entered on the list of certified nurse practitioners maintained by the board of nursing.

(5) "Claim" means a request from a provider for payment for health care services rendered.

(6) "Clinical peer" means a physician or other health care professional who holds a similar non-restricted license in a state or territory of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

(7) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health insurance carrier to determine the medical necessity and appropriateness of health care services.

(8) "Co-insurance" is a cost-sharing method that requires a covered person to pay a stated percentage of medical or pharmaceutical expenses after the deductible amount, if any, is paid; co-insurance rates may differ for different types of services under the same health benefits plan.

(9) "Copayment" is a cost-sharing method that requires a covered person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the health insurance carrier paying the allowed balance; there may be different copayment amounts for different types of services under the same health benefits plan.

(10) "Continuous quality improvement" means ongoing and systematic efforts to measure, evaluate, and improve a health insurance carrier's processes and procedures in order to continually improve the quality of health care services provided to covered persons.

(11) "Cost-sharing" means a copayment, co-insurance, deductible, or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of the health benefits plan.

(12) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan.

(13) "Covered person" or "enrollee" means a subscriber, policyholder or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

(14) "Credentialing" means the process of obtaining, verifying and evaluating information about a provider when the provider applies to become a participating provider within a health insurance carrier's network.

D. Terms beginning with the letter "D":

(1) "Day" or "Days" shall be interpreted as follows, unless otherwise specified:

(a) one to five days means only working days and excludes weekends and state holidays; and

(b) six or more days means calendar days, including weekends and state holidays.

(2) "Deductible" means a fixed dollar amount that a covered person may be required to pay during a benefit period before the health insurance carrier begins payment for covered benefits; health benefits plans may have both individual and family deductibles and separate deductibles for specific services.

(3) "Designated rating area" means a geographic unit designated by the superintendent and used by insurers to determine health benefits plan premiums.

E. Terms beginning with the letter "E":

(1) "Emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person;

(2) "Enrollee" or "covered person" means a subscriber, policyholder or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

(3) "Essential community provider (ECP)" means a provider as defined in 45 C.F.R. §156.235(c).

(4) "Evidence of coverage (EOC)" means a specific document containing a clear, conspicuous, concise and legible written statement of the essential features and

services covered by a health benefits plan given to the covered person by the health insurance carrier or group contract holder, which may include a separate summary of benefits as defined in Paragraph (7) of Subsection S of this section. The evidence of coverage may serve as a covered person's certificate as defined in Paragraph (1) of Subsection C of this section.

(5) "Exception" or "exclusion" means any provision in a health benefits plan whereby coverage for a specific hazard, condition, or situation is excluded entirely. It is a statement of a risk or risks not assumed by the health insurance carrier under the plan.

(6) "Exchange" means the New Mexico health insurance exchange, composed of an exchange for the individual market and a small business health options program (SHOP) exchange under a single governance and administrative structure. Also known as the health insurance marketplace.

F. Terms beginning with the letter "F":

(1) "Facility" means an entity providing a health care service, including:

(a) a general, specialized, psychiatric or rehabilitation hospital;

(b) an ambulatory surgical center;

(c) a cancer treatment center;

(d) a birth center;

(e) an inpatient, outpatient or residential drug and alcohol treatment center;

(f) a laboratory, diagnostic or other outpatient medical evaluation or testing center;

(g) a health care provider's office or clinic;

(h) an urgent care center; or

(i) any other therapeutic health care setting.

(2) "Federally qualified health center (FQHC)" means an entity as defined in 42 C.F.R. §405.2401.

(3) "FDA" means the United States food and drug administration.

G. Terms beginning with the letter "G": "Group health insurance" means a form of health insurance covering groups of persons, with or without their dependents, and issued upon the criteria outlined in Section 59A-23-3 NMSA 1978.

H. Terms beginning with the letter "H":

(1) "Health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(2) "Health care professional" means a physician or other health care practitioner, including a pharmacist or practitioner of the healing arts, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

(3) "Health care service" means a service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, to the extent covered by the health benefits plan, a physical or behavioral health service.

(4) "Health insurance carrier," "health carrier," "carrier" or "health insurer" means an entity subject to the insurance laws and regulations of this state, including a health insurance company, a health maintenance organization, a hospital and health services corporation, a provider service network, a non-profit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers health benefits plans or managed health care plans in this state.

(5) "Health maintenance organization (HMO)" is as defined in Subsection N of Section 59A-46-2 NMSA 1978.

(6) "Hospital" means a facility offering inpatient services, nursing and overnight care for three or more individuals on a 24-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

I. Terms beginning with the letter "I": "Initial determination" means a formal written disposition by a health insurance carrier affecting a covered person's rights to benefits, including full or partial denial of a claim or request for coverage or its initial administrative decision pursuant to the grievance procedures set forth at 13.10.17 NMAC.

J. Terms beginning with the letter "J": [RESERVED]

K. Terms beginning with the letter "K": [RESERVED]

L. Terms beginning with the letter "L":

(1) "Limitation" means any provision that restricts coverage under a health benefits plan other than an exception, exclusion or reduction.

(2) "Limited benefits plan" means a health benefits plan offered or marketed as supplemental health insurance coverage that pays specified amounts according to a schedule of benefits to defray the costs of care, services or cost-sharing amounts not covered by a major medical plan. "Limited benefits plan" does not include a short-term, limited-duration plan.

M. Terms beginning with the letter "M":

(1) "Major medical plan" or "comprehensive plan" means a health benefits plan, other than a limited benefits plan, that provides fully-insured, expense-based coverage, including a short-term, limited duration plan; a qualified health plan; a managed health care plan; a student health plan or a high-deductible or catastrophic plan.

(2) "Managed care" means a system or technique(s) generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following:

(a) prior, concurrent and retrospective review of the medical necessity and appropriateness of services or site of services;

(b) contracts with selected health care providers;

(c) financial incentives or disincentives for covered persons to use specific providers, services, prescription drugs or service sites;

(d) controlled access to and coordination of health care services by a case manager; and

(e) payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

(3) "Managed health care bureau (MHCB)" means the managed health care bureau within the office of superintendent of insurance.

(4) "Maternity benefits" means covered benefits for prenatal, intrapartum, perinatal or postpartum care.

(5) "Medical necessity" or "medically necessary" means health care services determined by a provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

(a) any applicable generally accepted principles and practices of good medical care;

(b) practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or

(c) any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

(6) "Medical record" means all information maintained by a provider relating to the past, present or future physical or behavioral health of a patient, and for other provision of health care services to a patient. This information includes, but is not limited to the provider's notes, reports and summaries, and x-rays, laboratory, and other diagnostic test results. A patient's complete medical record includes information generated and maintained by the provider, as well as other information provided to the provider by the patient, by any other provider who has consulted with or treated the patient in connection with the provision of health care services to the patient. A medical record does not include the patient's medical billing or health insurance records or forms or communications related thereto.

(7) "Medicare" means Title 18 of the Social Security Amendments of 1965, *"Health Insurance for Aged and Disabled,"* as then constituted or later amended.

(8) "Medicare supplement policy" means a group or individual policy of insurance or a subscriber contract other than a policy issued pursuant to a contract under Section 1876 of the Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1) that is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare; "medicare supplement policy" does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under 42 U.S.C. Section 1833(a)(1)(A) of the Social Security Act.

N. Terms beginning with the letter "N":

(1) "Network" means the group or groups of participating providers who provide health care services under a network plan.

(2) "Network plan" means a health benefits plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person

to use health care providers and facilities managed, owned or under contract with or employed by the health insurance carrier.

(3) "Nonparticipating provider" means a provider who is not a participating provider as defined in Paragraph (1) of Subsection P of this section. Also known as an out-of-network provider or non-contracted provider.

O. Terms beginning with the letter "O": "Obstetrician-gynecologist" means a physician who is eligible to be or who is board certified by the American board of obstetricians and gynecologists or by the American college of osteopathic obstetricians and gynecologists.

P. Terms beginning with the letter "P":

(1) "Participating provider" means a provider who, under an express contract with a health insurance carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment directly or indirectly from the carrier, subject to any cost-sharing required by the health benefits plan. Also known as an in-network provider or contracted provider.

(2) "Physician assistant (PA)" means a skilled person who is a graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of physical assistants, and who is licensed to practice medicine, usually under the supervision of a licensed physician.

(3) "Post-service claim" means a claim submitted to a health insurance carrier by or on behalf of a covered person after health care services have been provided to the covered person.

(4) "Practitioner of the healing arts" means a health care professional as defined in Paragraph (2) of Subsection B of Section 59A-22-32 NMSA 1978.

(5) "Preventive care" means health care services provided for prevention and early detection of disease, illness, injury or other health condition.

(6) "Primary care" means health care services for a range of common physical or behavioral health conditions provided by a physician or non-physician primary care practitioner.

(7) "Primary care practitioner (PCP)" means a health care professional who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to covered persons; who initiates the patient's referral for specialist care and who maintains continuity of patient care. Primary care practitioners include general practitioners, family practice physicians, geriatricians, internists, pediatricians, obstetrician-gynecologists, physician assistants and nurse practitioners. Pursuant to

13.10.21.7 NMAC, other health care professionals may also serve as primary care practitioners.

(8) "Prior authorization" or "pre-certification" means a pre-service determination made by a health insurance carrier regarding a covered person's eligibility for health care services based on medical necessity, health benefits coverage and the appropriateness and site of services pursuant to the terms of the health benefits plan.

(9) "Private health insurance cooperative" means a nonprofit corporation formed to arrange for health benefits coverage with health insurance carriers for its participating members, including large and small employers.

(10) "Product" means a discrete package of health insurance benefits that is offered using a particular network type within a service area.

(11) "Prospective enrollee" means:

(a) in the case of an individual who is a member of a group, an individual eligible for enrollment in a health benefits plan through the group; or

(b) in the case of an individual who is not a member of a group or whose group has not purchased or does not intend to purchase a health benefits plan, an individual who has expressed an interest in purchasing individual plan coverage.

(12) "Prospective review" means utilization review conducted prior to the provision of health care services by the health insurance carrier.

(13) "Provider" means a licensed health care professional, hospital or other facility authorized to furnish health care services.

(14) "Provider group" means an incorporation or other legal association of providers who work together in proximity and share resources for as well liability that may result from the provision of patient care.

Q. Terms beginning with the letter "Q":

(1) "Qualified health plan (QHP)" means a major medical plan that has been reviewed and deemed by the superintendent to provide essential health benefits, follow established limits on cost-sharing, provide "minimum essential coverage" and meet the other requirements of the Affordable Care Act.

(2) "Quality assurance plan" means the ongoing, internal quality assurance program of a health insurance carrier to monitor and evaluate the carrier's health care services, including its system for credentialing health care professionals to become participating providers with a health benefits plan or otherwise provide services to the carrier's covered persons.

R. Terms beginning with "R":

(1) "Reduction" means any provision that reduces the amount of a benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than otherwise would be payable and the reduction has not been used.

(2) "Registered lay midwife" means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

(3) "Retrospective review" means utilization review that is conducted following the provision of health care services.

S. Terms beginning with the letter "S":

(1) "Second opinion" means an opportunity or requirement for a covered person to obtain a clinical evaluation to assess the medical necessity and appropriateness of the initial proposed health service, by a provider other than one who originally recommended or denied it.

(2) "Short-term, limited-duration plan" or "short-term plan" means a nonrenewable major medical plan with a specified duration of not more than three months that is issued only to individuals who have not been enrolled in a plan providing the same or similar nonrenewable coverage from any carrier within the past twelve months and which so states in all advertisements, marketing materials and application and policy forms.

(3) "Specialist" means a physician or non-physician health care professional who:

(a) focuses on a specific area of physical or behavioral health or a specific group of patients; and

(b) has successfully completed required training and is recognized by the state in which the health care professional practices to provide specialty care.

(4) "Specialty care" means advanced, medically necessary care and treatment by a specialist, preferably in coordination with a primary care practitioner or other health care professional, of specific physical or behavioral health conditions or health conditions that may manifest in a particular age group or other subpopulation.

(5) "Stabilize" means to provide physical or behavioral health treatment of a condition as may be necessary to ensure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility or, with respect to an emergency birth with

no complications resulting in a continuing emergency, to deliver the child and the placenta.

(6) "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health benefits plan, or in the case of an individual contract, the person in whose name the contract is issued.

(7) "Summary of benefits" means a summary of the benefits and exclusions required to be given prior to or at the time of enrollment to a prospective subscriber or covered person by the health insurance carrier.

(8) "Superintendent" means the superintendent of insurance, the office of superintendent of insurance (OSI), or employees of OSI acting with the superintendent's authorization.

T. Terms beginning with the letter "T":

(1) "Telemedicine" or "Telehealth" means the use by a health care professional of interactive, simultaneous audio and video or store-and-forward technology using information and telecommunications technologies to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

(2) "Tertiary care facility" means a hospital unit that provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

(3) "Third-party administrator (TPA)" is as defined in Subsection B of Section 59A-12A-2 NMSA 1978.

(4) "Tiered network" means a network that supports a health benefits plan in which there are at least two quantitatively different cost-sharing levels for participating providers who or which furnish the same covered services.

(5) "Traditional fee-for-service indemnity benefit" means a fee-for-service indemnity benefit as defined in Subsection LL of 13.10.17.7 NMAC, as a fee-for-service indemnity benefit, not associated with any financial incentives that encourage covered persons to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

U. Terms beginning with the letter "U":

(1) "Urgent care situation" means a situation in which a prudent layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

(a) the life or health of the covered person would otherwise be jeopardized;

(b) the covered person's ability to regain maximum function would otherwise be jeopardized;

(c) in the opinion of a physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without care or treatment;

(d) the medical exigencies of the case require expedited care; or

(e) the covered person's claim otherwise involves urgent care.

(2) "Utilization review" means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients.

V. Terms beginning with the letter "V": [RESERVED]

W. Terms beginning with the letter "W": [RESERVED]

X. Terms beginning with the letter "X": [RESERVED]

Y. Terms beginning with the letter "Y": [RESERVED]

Z. Terms beginning with the letter "Z": [RESERVED]

[13.10.29.7 NMAC - N, 10/01/2018; A, 2/12/2019]

PART 30: PHARMACY BENEFITS MANAGERS

13.10.30.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.10.30.1 NMAC – Rp, 13.10.30.1 NMAC, 3/1/2022]

13.10.30.2 SCOPE:

This rule applies to every pharmacy benefits manager ("PBM") and health insurance carrier subject to the jurisdiction of the office of superintendent of insurance.

[13.10.30.2 NMAC – Rp, 13.10.30.2 NMAC, 3/1/2022]

13.10.30.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978 and Subsection C of Section 59A-61-3 NMSA 1978.

[13.10.30.3 NMAC – Rp, 13.10.30.3 NMAC, 3/1/2022]

13.10.30.4 DURATION:

Permanent.

[13.10.30.4 NMAC – Rp, 13.10.30.4 NMAC, 3/1/2022]

13.10.30.5 EFFECTIVE DATE:

March 1, 2022, unless a later date is cited at the end of a section.

[13.10.30.5 NMAC – Rp, 13.10.30.5 NMAC, 3/1/2022]

13.10.30.6 OBJECTIVE:

This rule establishes operating standards, licensing, reporting and record retention requirements for PBMs to implement and promote the objectives and policies of the Pharmacy Benefits Manager Regulation Act, Chapter 59A, Article 61 NMSA 1978.

[13.10.30.6 NMAC – Rp, 13.10.30.6 NMAC, 3/1/2022]

13.10.30.7 DEFINITIONS:

For purposes of this rule and the Pharmacy Benefits Manager Regulation Act:

A. "Clean claim" has the definition found in Paragraph (1) of Subsection A of Section 59A-16-21.1 NMSA 1978.

B. "Client" means any person with whom a PBM contracts to provide pharmacy benefits management services arising out of or relating to pharmacy operations in New Mexico.

C. "Formulary" is a list of prescription drugs that has been developed by a health insurance carrier or its designee that the carrier or health plan in determining applicable prescription drug coverage and benefit levels.

D. "Health insurance carrier" or "carrier" has the definition found in Paragraph (2) of Subsection C of Section 59A-16-21.2 NMSA 1978.

E. "Health plan" has the definition found in Paragraph (3) of Subsection A of Section 59A-16-21.1 NMSA 1978.

F. "NCPDP" means the national council for prescription drug program.

G. "NDC" means national drug code.

H. "Network pharmacy" means a pharmacy with whom a payor or PBM has contracted to provide pharmacy services to persons with an expectation of receiving payment directly or indirectly from the carrier.

I. "Prescription drug claim administration" is administrative services performed in connection with the processing, adjudicating and auditing of claims relating to pharmacy services.

J. "Similarly situated" refers to a network pharmacy whose PBM contract is subject to the same reimbursement for a claim as a pharmacy whose appeal was granted.

[13.10.30.7 NMAC – Rp, 13.10.30.7 NMAC, 3/1/2022]

13.10.30.8 REQUIREMENTS FOR LICENSURE:

A PBM shall not conduct any operation or provide any service in New Mexico unless it holds a valid PBM license issued by the superintendent.

A. A PBM shall apply for a license by submitting a complete application package on a form, and pursuant to the directions, prescribed by the superintendent. The application package shall include:

(1) The non-refundable filing fee prescribed by Paragraph (1) of Subsection AA of Section 59A-6-1 NMSA 1978 for filing an application for a license.

(2) The name of the legal entity, federal employer identification number ("FEIN"), business address, phone number and state of residency.

(3) The name, business address, phone number and e-mail address of a contact person designated by the PBM to respond to grievances.

(4) The name, business address, phone number and e-mail address of a contact person designated by the PBM to respond to inquiries by the superintendent.

(5) Proof of current authority from the controlling New Mexico regulator to conduct business in New Mexico.

(6) For each partner, managing member, and director, as applicable, the application package shall include a background investigation report through a vendor approved by OSI upon initial application. Changes in leadership shall submit a background investigation report at the time of renewal of license.

(7) For the preceding 10 years, a statement of whether the application has:

(a) been refused a registration, license or certification to act as or provide the services of a PBM or third-party administrator; or

(b) had any registration, license or certification denied, suspended, revoked or non-renewed for any reason by any state or federal entity; and

(c) if either (a) or (b) apply, the PBM shall separately attach the details of each such action, including the date, nature and disposition of the action.

(8) A statement of whether the applicant in the most recent 10 years had a business relationship terminated for any admission, legal finding, or judgement of fraudulent or illegal activities in connection with the administration of a pharmacy benefits plan and a description of each termination.

(9) A list of all New Mexico clients serviced by the PBM.

(10) A list of each regulatory enforcement action against the PBM in any other state for the previous 10 years.

(11) The application shall be shall be signed and verified by an officer, director, managing member, or partner, as applicable, of the PBM.

(12) Any other information that is deemed necessary by the superintendent in evaluating the application to evidence compliance with Chapter 59A, Article 61 NMSA 1978 or the requirements of rules promulgated by the superintendent.

(13) Confidentiality requests by an applicant are governed by the superintendent's bulletin 2022-001 or any superseding bulletin or rule.

(14) The application package, except for the application fee, shall be submitted as directed by the superintendent. After the application has been approved or rejected by the PBM program coordinator, the applicant shall pay the application fee through NIPR. Failure to pay the application fee for a rejected application will preclude licensure or renewal.

B. Review and approval process for initial licensure. Within 30 days of receipt of an application pursuant to Subsection A of this section, the superintendent will review the application and:

(1) if the application is incomplete, notify the applicant in writing that additional information is needed, and allow the applicant 30 days to cure any deficiency in the application.

(2) approve the application and issue a PBM license to the applicant if the superintendent determines that the applicant meets the requirements for licensure; or

(3) deny the application if the superintendent determines that the applicant does not meet the requirements for licensure.

C. Content and scope of license.

(1) Content. A license issued by the superintendent under this rule shall identify the PBM by name and business address; the capacity of the licensee to act as a PBM in New Mexico; and the effective and expiration dates of the license.

(2) Scope. A license issued under this regulation entitles the PBM to act for one or more authorized insurance carriers, health plans, workers' compensation insurers, Medicaid MCO, multiple employer welfare arrangement or government plan or persons that self-insure without being required to obtain a separate license.

D. License renewal. To continue a license a PBM shall submit a renewal application by March 1, of each year pursuant as directed by the superintendent After the application has been approved or rejected by the PBM program coordinator, the applicant shall pay the required application fee through NIPR and shall pay the annual report fee as directed by the superintendent. Failure to pay the application fee will preclude renewal. A renewal application shall include updates to any items required by the initial application for licensure.

E. Review and approval process for renewal of license. Within 60 days of receipt of a renewal license application, the superintendent will review the application and:

(1) if the application is incomplete, notify the applicant in writing that additional information is needed, and allow the applicant 30 days to cure any deficiency in the application.

(2) approve the application and issue a PBM license to the applicant if the superintendent determines that the application meets the requirements for licensure; or

(3) deny the application if the superintendent determines that the applicant does not meet the requirements for licensure. For disapprovals or denials of an

application for renewal the superintendent will notify the applicant of the denial or rejection and state the basis or reason for the denial.

F. Corrective action plan. In lieu of a denial for initial licensure or renewal, the superintendent may require the PBM to submit a plan to cure or correct deficiencies in its application.

[13.10.30.8 – Rp, 13.10.30.8 NMAC, 3/1/2022]

13.10.30.9 PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION ("PSAO") REGISTRATION:

A. Registration required. A PSAO shall not provide any service in New Mexico unless it is registered with the register with the superintendent.

B. A PSAO's registration application shall be submitted on a form provided by the superintendent and shall include:

(1) full business name of PSAO;

(2) name, business address, phone number and e-mail address for primary contact;

(3) name, business address, phone number and e-mail address for contact designated to handle grievances; and

(4) FEIN.

[13.10.30.9 – Rp, 13.10.30.9 NMAC, 3/1/2022]

13.10.30.10 PHARMACY GRIEVANCES:

A. Health plans subject to 13.10.16 NMAC: a pharmacy grievance relating to a PBM who is performing services for a health plan or carrier subject to rule 13.10.16 NMAC shall be governed by that rule.

B. Health plans not subject to 13.10.16 NMAC: A pharmacy with a grievance relating to a PBM who is performing services for health plan or carrier that is not subject to rule 13.10.16 NMAC may file a grievance against the PBM with the superintendent.

(1) A grievance by a pharmacy against a PBM shall be in writing on a form provided by the superintendent.

(2) A pharmacy shall submit a grievance within six months from the date the pharmacy new or should have known of alleged PBM misconduct.

(3) A grievance may allege multiple violations against a single PBM.

(4) A pharmacy shall provide supporting documentation.

(5) The superintendent shall transmit any grievance, including supporting documentation to the e-mail contact designated by the PBM to receive grievance.

(6) The superintendent will specify the documentation necessary to address the grievance.

(7) A PBM shall have 14 business days from receipt of the grievance to respond in writing.

(8) The superintendent may request additional documentation. The PBM shall provide any additional documentation in writing within 14 business days from the date of the superintendent's request.

(9) The superintendent may grant a PBM's request for an extension of time.

(10) The superintendent will send a copy of all submissions received in connection to a grievance to the opposing party.

C. Enforcement: If the superintendent finds probable cause that a PBM violated a law enforceable by the superintendent, the superintendent may issue a notice to show cause, why the superintendent should not take specified enforcement action against the PBM and its principal.

[13.10.30.10 NMAC – Rp, 13.10.30.10 NMAC, 3/1/2022]

13.10.30.11 PAYMENT OF CLAIMS:

Claims for reimbursement by a pharmacy are subject to the clean claims laws.

[13.10.30.11 NMAC – Rp, 13.10.30.11 NMAC, 3/1/2022]

13.10.30.12 MAXIMUM ALLOWABLE COST ("MAC") APPEALS:

A. Submission of appeal. A network pharmacy that disputes a MAC reimbursement amount may submit a MAC appeal, to the PBM within 21 business days after a network pharmacy receives notice of the reimbursement amount. A PSAO may submit a MAC appeal on behalf of a network pharmacy.

B. Appeals mechanism. A PBM shall provide a mechanism for submitting MAC appeals, including the dedicated phone number and electronic mail address or website. The phone number shall be manned at a minimum during the hours of 8:00 a.m. to 5:00

p.m., mountain time. Information about MAC appeals mechanisms shall be prominently displayed in any contract or manual provided by a PBM to a pharmacy.

C. Appeal instructions on website. The PBM's website shall prominently display instructions for submitting a MAC appeal and instructions for seeking assistance in navigating the website. This link shall also be included in the PBM's provider manual.

D. Response to denied appeal(s). The PBM's response to a denied MAC appeal shall include:

(1) the source or sources used, including NDC and name of supplier, to determine pricing for the maximum allowable cost list specific to that provider.

(2) the date of the last MAC list update for the drug which is the subject of the MAC appeal;

(3) documentation evidencing that the drug was available for purchase by a pharmacy in New Mexico at the MAC price from a national or regional wholesaler at the time of claim submission; and

(4) any other information the PBM deems relevant to the MAC appeal.

E. Nonresponse to appeal. The MAC appeal shall be deemed granted if the PBM does not respond within 14 business days of a complete appeal submission or its response does not include the items outlined in Subsection D of 13.10.30.12 NMAC.

F. Notice of granting appeal. If a MAC appeal is granted or deemed granted, a PBM shall:

(1) within one day, notify by email the challenging pharmacy and any similarly situated network pharmacy and their PSAO(s) that a MAC appeal was granted, the NDC of the drug, the MAC price challenged and the updated MAC price; and

(2) permit the appealing pharmacy and any similarly situated pharmacy to resubmit the claim at the updated price.

H. Request for MAC list. A PBM shall provide a MAC list to a network pharmacy or the superintendent within seven business days upon request.

[13.10.30.12 NMAC – Rp, 13.10.30.12 NMAC, 3/1/2022]

13.10.30.13 SUBMISSION OF A MAC APPEAL:

A. Submission requirements. A MAC appeal submission include:

(1) fill date;

(2) BIN number (six digits);

(3) NCPDP (seven digits);

(4) Rx number;

(5) NDC 11 (11 digits);

(6) drug name;

(7) drug strength;

(8) invoice price and net purchase price of drug (whole dollar with two decimal places);

(9) total reimbursement (whole dollar with two decimal places);

(10) reason for review;

(11) any information required by contract; and

(12) notes (optional).

B. No additional information required. A PBM shall not require or request additional information to process a MAC appeal but shall accept and consider any additional information provided in a MAC appeal submission.

[13.10.30.13 NMAC – Rp, 13.10.30.13 NMAC, 3/1/2022]

13.10.30.14 SEARCHABLE ONLINE DATABASE OF DRUG PRICES:

A. Update timeframe. A PBM shall update its MAC list at least once every seven days.

B. Searchable online database required. A PBM shall establish a searchable online database that will allow a network pharmacy to search MAC list prices for a particular drug for as long as the pharmacy has the right to file a MAC appeal or grievance concerning a specific fill. The PBM's provider manual shall include instructions for accessing the price list on the PBM's website. The provider manual shall be transmitted to a newly joined pharmacy within 10 business days from the date of execution of a contract with the PBM. A PBM shall provide an updated version of its provider manual within 30 days of any revisions to all network pharmacies.

C. Search requirements. The database shall be searchable by NDC or drug name, and specific plan identifier.

D. Drug information. The information provided for the drug shall contain:

(1) NDC;

(2) NDC description;

(3) MAC list price; and

(4) effective date.

E. Instructions required. The provider manual shall contain instructions for searching the MAC list and contain instructions for requesting the name of the sources used to determine MAC pricing for the MAC list. A network pharmacy may request the name of the sources through a PBM's website, e-mail, facsimile or letter, if they are not already included in the provider manual. The PBM shall respond with the names of the sources within 10 business days from the date of the request.

F. Website requirements. The PBM's website shall contain a prominent link to request the names of the sources used to establish the MAC price.

G. Accessibility. Upon request a PBM shall provide the superintendent information contained in the database to determine compliance with these rules or to resolve a grievance.

[13.10.30.14 NMAC – Rp, 13.10.30.14 NMAC, 3/1/2022]

13.10.30.15 HISTORICAL MAC LIST DATABASE:

A. Searchable list of drugs. A PBM shall maintain a searchable database containing all MAC list pricing for the preceding five years, but no earlier than January 14, 2021. The database shall be searchable by these criteria:

(1) NDC number;

(2) drug name;

(3) specific health plan; and

(4) removal data.

B. Reason for removal. When a drug is removed from the MAC database, the database shall indicate the reason for its removal.

C. Obsolete drugs. The database shall include obsolete drugs. If a drug is removed because it is obsolete, the database shall indicate the date it became obsolete.

D. List dated. The database shall specifically indicate the date a drug price was updated and posted to the PBM's website.

E. Accessibility. Upon request a PBM shall provide the superintendent information contained in the database for any regulatory or legislative purpose.

[13.10.30.15 NMAC – Rp, 13.10.30.15 NMAC, 3/1/2022]

13.10.30.16 ANNUAL REPORT BY PBM:

A PBM applying for license renewal shall submit an annual report to the superintendent's PBM program coordinator with the license renewal application. The annual report shall contain the items outlined in 13.10.30.8 NMAC. Failure to comply with these requirements shall result in non-renewal of the license. Information submitted in the annual report is considered PBM data received by the superintendent pursuant to a specific request pursuant to 13.10.30.17 NMAC.

[13.10.30.16 NMAC – Rp, 13.10.30.16 NMAC, 3/1/2022]

13.10.30.17 CONFIDENTIALITY AND CONFLICTS:

A. Confidentiality. Any PBM data received by the superintendent in response to a specific request shall be deemed confidential, unless disclosure is required for a regulatory purpose, enforcement, rulemaking, to respond to a legislative request, or is otherwise required by law or directed by court order. Notwithstanding the foregoing, the superintendent may publish aggregated data that cannot be traced to a specific PBM, provided any published data is at least 12 months old.

B. Conflicts. The superintendent shall not share confidential data with a consultant or contractor unless that third-party:

(1) discloses all potential conflicts of interest;

(2) maintains appropriate data safeguards and firewalls; and

(3) executes an agreement prohibiting unauthorized disclosure or use of the confidential data.

[13.10.30.17 NMAC – Rp, 13.10.30.17 NMAC, 3/1/2022]

13.10.30.18 COMPLIANCE REPORTING BY PBM:

PBMs shall submit the following information to determine compliance with New Mexico law according to the schedule provided by the superintendent:

A. Grievance and MAC appeal data. The PBM shall file a log of grievance and MAC appeal data using a form specified by the superintendent.

B. Pharmacy and therapeutics ("P&T") committee data. The PBM shall submit the following information for any P&T Committee:

(1) names of committee members and conflict disclosure statements;

(2) dates and meeting minutes of the P&T committee from the prior plan year; and

(3) statement of the P&T committee's duties responsibilities, and goals.

C. Confidentiality of P&T committee data. P&T committee minutes provided to the superintendent shall be deemed confidential.

[13.10.30.18 NMAC – Rp, 13.10.30.18 NMAC, 3/1/2022]

13.10.30.19 RETALIATION, DISCRIMINATION AND UNFAIR PRACTICES:

A PBM shall not:

A. Retaliate. Retaliate against a pharmacy for invoking its rights under these rules or the Pharmacy Benefits Manager Regulation Act. Selecting a pharmacy that has filed a grievance for audit at a rate disproportionately higher than for other network pharmacies may be considered retaliation.

B. Discriminate. Discriminate against any person or legal entity.

(1) based on any class membership or characteristic protected under any state of federal antidiscrimination law or

(2) that receives discounts on prescription drugs as a result of a state or federal program or law.

C. Unfair trade practice. Engage in or commit any act or practice proscribed by any state or federal unfair practice law.

D. Steer. Induce or attempt to induce, a health plan member to fill a prescription at a pharmacy benefits manager affiliate or transfer a prescription to any pharmacy benefits manager affiliated without an enrollee's express and informed consent.

[13.10.30.19 NMAC – Rp, 13.10.30.19 NMAC, 3/1/2022]

13.10.30.20 EXAMINATION:

A. Examination. Pursuant to the examination powers conferred by the Insurance Code, the superintendent may examine a PBM for compliance with any applicable New Mexico law.

B. Data calls. Pursuant to the oversite and supervision powers conferred by the Insurance Code, the superintendent may issue a data call to a PBM or PSAO.

[13.10.30.20 NMAC – Rp, 13.10.30.20 NMAC, 3/1/2022]

13.10.30.21 MAINTENANCE OF INFORMATION:

Every PBM shall maintain at its principal administrative office for the duration of the written agreement referred to in Section 59A-12A-4 NMSA 1978 and five years thereafter adequate books and records of all contracts and transactions. The superintendent shall have access to such books and records for the purpose of examination, audit and inspection. A PBM may request that certain records be deemed confidential through the process established by OSI. The release of any confidential information shall only be made pursuant to law.

[13.10.30.21 NMAC – Rp, 13.10.30.21 NMAC, 3/1/2022]

13.10.30.22 RULE NONCOMPLIANCE:

Failure to comply with any provision of these rules is a violation of the Insurance Code.

[13.10.30.22 NMAC – Rp, 13.10.30.22 NMAC, 3/1/2022]

PART 31 PRIOR AUTHORIZATION

13.10.31.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

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

13.10.31.2 SCOPE:

These rules apply to every:

A. health insurer as defined in Subsection H of Section 59A-22B-2 NMSA 1978;

B. multiple employer welfare arrangement; and

C. Medicaid managed care organization, that requires prior authorization as a condition to payment for a medical service, pharmaceutical, or medical supply benefit. The subject entities are referred to collectively herein as "carriers" and individually as a "carrier." The requirements of these rules supersede any conflicting provision of any

rule previously adopted by the superintendent, and are superseded by any conflicting provision of federal or state law applicable to a Medicaid managed care organization.

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

13.10.31.3 STATUTORY AUTHORITY:

Section 59A-2-9.8 NMSA 1978, Section 59A-15-20 NMSA 1978; Sections 59A-22B-1 through 59A-22B-5 NMSA 1978; and Sections 59A-57-1 through 59A-57-11 NMSA 1978.

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

13.10.31.4 DURATION:

Permanent.

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

13.10.31.5 OBJECTIVE:

To establish and standardize oversight, reporting, transparency and confidentiality procedures for prior authorization processes.

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

13.10.31.6 EFFECTIVE DATE:

January 1, 2022, unless a later date is cited at the end of a section.

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

13.10.31.7 DEFINITIONS:

Terms used in these rules are as defined in Section 59A-22B-2 NMSA 1978, and in 13.10.29 NMAC, except as supplemented and superseded below.

A. "Benefit" means any medical service, medical service location, medical provider selection, pharmaceutical, or medical supply that is the subject of a prior authorization request.

B. "Utilization review organization" or "URO" means an entity engaged by a carrier to determine medical necessity for covered services. A URO includes a pharmacy benefits manager ("PBM") who determines medical necessity for a carrier's prescription drug coverage.

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

13.10.31.8 GENERAL REQUIREMENTS:

A carrier shall comply with the standard prior authorization processes specified in these rules.

A. Responsibility for requesting prior authorization.

(1) A carrier shall accept a prior authorization request submitted by a provider or by a covered person.

(2) If a covered person directly submits, or attempts to submit, a prior authorization request, the carrier shall provide the covered person all assistance required to properly submit the request, including assistance with obtaining required documentation and information to meet clinical guidelines.

(3) A carrier shall prohibit its participating providers from billing a covered person for a delivered benefit for which prior authorization was required if the provider failed to obtain the required authorization without the covered person's informed and documented consent.

(4) A carrier shall allow non-participating providers to:

(a) request prior authorizations and submit supporting documentation by all submission methods authorized by these rules; and

(b) receive confirmations and tracking numbers as required by these rules.

B. Requests for multiple benefits.

(1) A carrier shall allow a provider to submit a single request for multiple benefits that will be delivered contemporaneously to the same covered person.

(2) If a carrier does not grant prior authorization for all of the benefits in a multiple benefit request, the carrier must clearly state which benefits are approved and which are denied.

(3) A carrier shall permit a provider or covered person to appeal the denial of any benefits regardless of the number of benefits requested at one time.

C. Changes to prior authorization requirements.

(1) After inception of coverage, a carrier shall not expand the list of benefits for which prior authorization is required except when a new covered benefit is added to the plan, when safety or other concerns have arisen with respect to the benefit, when authorized by a state or federal regulatory agency, or as indicated by changes in nationally recognized clinical guidance.

(2) After inception of coverage, a carrier shall notify its network providers before adding a prior authorization requirement.

(3) A carrier may remove a prior authorization requirement at any time. A carrier who removes a prior authorization requirement during a plan year shall notify its network providers of the change as soon as practicable, and no more than 60 days after the requirement is removed.

D. Retroactive denials. A carrier shall not retroactively deny authorization if a provider relied upon a written prior authorization from the carrier received prior to providing the benefit, except in those cases where there was material misrepresentation or fraud by the provider.

E. Retrospective Authorization Requests. A carrier shall establish written policies and guidance for the process and circumstances under which it will consider a retrospective authorization. A carrier's policies shall not unreasonably limit the ability of a provider to request or obtain a retrospective authorization.

F. Mental health parity. A carrier shall not apply more restrictive prior authorization requirements for covered behavioral health services than for covered medical and surgical services.

G. Expiration of prior authorization. A carrier's prior authorization shall expire no sooner than 60 days from the date of approval, unless an earlier expiration is warranted by the clinical criteria. A carrier shall allow a request for the extension of an authorization as supported by the clinical criteria.

H. Reasonable prior authorization requirements. A carrier shall not impose a prior authorization requirement that deters or unreasonably delays the delivery of medically necessary and covered benefits warranted by prevailing standards of care. A carrier shall only require prior authorization for a benefit to the extent reasonably necessary to contain inappropriate or unnecessary costs or implement demonstrably effective medical management services.

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

13.10.31.9 PRIOR AUTHORIZATION SUBMISSION:

A. A carrier shall:

(1) accept prior authorization requests submitted at any time prior to the delivery of service;

(2) accept prior authorization requests telephonically and by facsimile;

(3) offer at least one bi-directional electronic prior authorization portal;

(4) allow a provider to upload in a secure manner the supporting documentation associated with an electronic prior authorization request, subject to reasonable limits on file type and size;

(5) accept and consider any information from a provider that will assist in the review;

(6) require only the information necessary to evaluate the request;

(7) not reject a request solely on the basis of documentation or submission errors that do not prevent substantive review;

(8) ensure that the system it operates for receiving electronic prior authorization requests and supporting documentation satisfies all applicable Health Insurance Portability and Accountability Act ("HIPAA") transaction requirements and operating rules no later than the effective date that such requirements and rules are established;

(9) make its system available for accepting electronic prior authorization requests and supporting documentation 24-hours per day, seven-days per week. Planned maintenance or down time of the system shall be performed during historically low-utilization periods; and

(10) notify providers of planned maintenance or downtime of the system at least 24-hours in advance. A carrier shall notify providers of any unplanned system downtime as soon as practicable.

B. Confirmation of receipt and tracking numbers.

(1) Within one business day of receipt, a carrier shall confirm receipt of a prior authorization request and any supporting documentation to the submitter. The carrier also shall assign a unique tracking number to the request. The tracking number shall identify the request throughout the processing cycle, including after approval or denial.

(2) The confirmation that includes the tracking number shall be communicated by electronic portal, fax or email.

(3) A carrier shall provide the tracking number of a prior authorization request to the covered person upon request.

(4) A carrier may assign other identifiers to a prior authorization request.

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

13.10.31.10 DOCUMENTATION AND TRANSPARENCY:

A. Prior authorization forms.

(1) A carrier shall accept the uniform prior authorization request form(s) developed by the superintendent and found on the superintendent's website at www.osi.state.nm.us.

(2) A carrier may ask the superintendent to approve a non-uniform prior authorization request form. If the superintendent approves the non-uniform request form, the carrier shall prominently publish the form to providers on its website.

B. Document retention. A carrier shall maintain a record of each prior authorization request and its associated documentation. The carrier shall store the records in compliance with all applicable state and federal privacy and security laws and regulations. The record shall be retained for as long as required by federal and state document retention guidelines, laws and regulations.

C. Access to information about services requiring prior authorization.

(1) A carrier shall make available on its member and provider websites a list of all benefits for which a prior authorization is required. The list shall be presented clearly and in readily understandable language appropriate for the intended audience. The list shall be updated at least annually and upon notification to providers of any change.

(2) Prior authorization information presented on the provider website shall include general clinical criteria requirements and shall list supporting documentation that is expected to accompany the prior authorization request. If a prior authorization is denied, the criteria used to deny the request shall be supplied to the provider in full upon request.

(3) Information on benefits requiring prior authorization, associated clinical criteria and supporting documentation may be located in an area(s) of a website(s) that is not accessible to a covered person, including the carrier's prior authorization portal.

(4) A carrier shall provide an on-line search tool for any provider to use to search the list of benefits that require prior authorization.

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

13.10.31.11 AUTO-ADJUDICATION:

A. No later than January 1, 2022, a carrier shall implement a process to auto-adjudicate electronically submitted prior authorization requests.

(1) A carrier shall comply with all statutory timelines applicable to prior authorization review. A list of all statutory prior authorization review timelines is posted on the OSI website.

(2) A carrier may reject for correction an auto-adjudicated prior authorization request for reasons other than medical necessity as long as the rejection is completed within statutory timelines.

(3) A carrier may pend an auto-adjudicated prior authorization request if it requires manual review, as long as the review is completed within statutory timelines.

(4) A carrier shall not automatically deny an auto-adjudicated prior authorization request. A carrier shall only deny a prior authorization request based on a live review.

B. Incomplete information. If a provider fails to supply sufficient information to evaluate a prior authorization request, the carrier shall allow the provider a reasonable amount of time, taking into account the circumstances of the covered person, but not less than 4 hours for expedited requests and two calendar days for standard requests, to provide the specified information.

C. Notice. A carrier shall provide written notice to the provider and covered person of a determination to approve or deny authorization. The Notice shall contain the reasons for a denial.

D. Delegation. A carrier may delegate one or more of the obligations mandated by these rules to a qualified third party, including a URO. A carrier who delegates any obligation mandated by these rules remains responsible for compliance with the delegated obligation.

E. Reporting. At least annually, a carrier shall report to the superintendent data and information about the auto-adjudication process, when and as directed by the superintendent.

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

13.10.31.12 EVALUATION OF PRIOR AUTHORIZATION POLICY AND PROVIDER PERFORMANCE:

A. Applicability. This section of the rule shall only apply to fully-insured commercial coverages regulated by the superintendent.

B. Review of covered benefits that require prior authorizations. Annually, beginning in 2023, a carrier shall review its prior authorization requirements for all covered benefits, except for inpatient admissions to acute-care hospitals, including transfers, in order to assess the continued utility of each requirement.

(1) At a minimum, a carrier's assessment shall consider the following elements:

(a) the approval rate for each covered benefit for which a prior authorization was required;

(b) whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered benefit protects patient safety or generates better health outcomes, or both;

(c) whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered benefit prevents the need for higher cost services;

(d) whether based on demonstrable evidence, including claims and clinical data, the prior authorization requirement of each covered benefit has deterred any reasonable suspicion of insurance fraud, waste, or abuse;

(e) whether, based on demonstrable evidence, including claims, clinical and operational data, and considering both the providers' and the carrier's experience, the costs and other administrative burdens associated with the prior authorization requirement for a covered benefit outweigh the demonstrated benefits of the requirement; and

(f) whether the prior authorization requirement for a covered benefit, based on demonstrable evidence including provider and member grievances, appeals and complaints, and claims and clinical data, contributed to unreasonable or unnecessary delays in treatment or adverse health outcomes for a covered person.

(2) A carrier shall conduct and complete the review by the end of the second quarter of each calendar year, beginning in 2023, and shall evaluate the prior authorizations issued during the prior calendar year.

(3) A carrier shall identify those covered benefits, with the exception of inpatient admissions to acute care hospitals, for which ninety percent of the prior authorization requests for that benefit are approved.

(4) A carrier shall prepare a report of its annual assessment that, at a minimum, contains its findings based on the elements listed above, and identifies any change in prior authorization requirements.

(a) The report shall be submitted to the superintendent no later than October 31, 2023 and no later than September 30th of every year thereafter, beginning in 2024.

(b) The report shall be submitted in the form and manner proscribed by annual guidance issued pursuant to Subsection G of this Section.

(5) A carrier that enters the market in 2023 or later shall conduct its first prior authorization evaluation during its second full calendar year in the market.

(6) If no protection of patient safety or no better health outcomes related to prior authorization of a covered benefit can be shown by the carrier, the prior authorization requirement must be eliminated for 12 months or until the carrier is able to demonstrate additional evidence to support its position.

C. Assessment of prior authorization request outcomes. Beginning in the first quarter of 2023, a carrier shall annually evaluate its network providers' patterns of adherence to the carrier's prior authorization criteria and policies in the preceding calendar year. For the first year, prior authorization requests for admissions to general acute care hospitals, psychiatric hospitals, and rehabilitation hospitals, and durable medical equipment, including oxygen and disposable medical supplies, shall be excluded from this evaluation. The superintendent may include these services in subsequent years pursuant to the annual guidance issued in accordance with Subsection G of this Section.

(1) A carrier shall identify providers who are the most frequent submitters of prior authorizations, and who have a consistent pattern of adherence to prior authorization requirements and criteria as evidenced by prior authorization approval rates of ninety percent or greater (a "high compliance provider").

(2) A carrier shall select no less than thirty percent of its high compliance providers and shall:

(a) enter into an agreement with each selected high-compliance provider on an alternative to the standard requirement to submit a prior authorization request for a discreet service or set of services that otherwise require one (an alternate arrangement); and

(b) the agreement with each provider shall clearly describe the terms of the alternate arrangement, including under what conditions the agreement can be terminated by a carrier or a provider. The agreement shall include how the provider's ordering and prescribing performance during the course of the alternative arrangement will be monitored and evaluated, how results will be communicated, and how the agreement can be extended beyond the base period of the agreement. At a minimum, the agreement will be effective for 12 months.

(3) The high compliance providers selected for alternate arrangements shall be representative of the various eligible types of providers, including specialists, that participate in a carrier's network, and the spectrum of covered benefits.

(4) The first year's alternative arrangements shall go into effect on January 1, 2024, and all subsequent years' agreements shall go into effect on the first day of the year.

(5) After the first year, a carrier shall increase the number of high compliance providers with which it enters into alternate arrangements by at least fifty percent of providers who had alternative arrangements in the first year. If a carrier is not able to increase the number of providers with alternate arrangements by at least fifty percent compared to the prior year, the carrier shall request an exception according to guidance issued by the superintendent. The exception request will be subject to the approval of the superintendent.

(6) After the second year, a carrier shall comply with specific performance requirements identified in guidance issued pursuant to Subsection G of this Section.

(7) A carrier may elect to remove a prior authorization requirement at any time, in accordance with Paragraph (3) of Subsection C of Section 13.10.31.8 NMAC above.

D. Annual Report. A carrier shall, by September 30th of each year, submit a report to the superintendent that:

(1) describes the evaluation process and criteria used to identify high compliance providers;

(2) lists the providers identified, the providers with whom an alternate arrangement was made, and the providers with whom negotiations are ongoing; and

(3) describes, in general, the terms of the alternate arrangements entered into, including the effective dates of the agreement, the services involved, performance evaluation, and communication provisions; and

(4) describes experiences making these alternate arrangements, the results of the alternate arrangements when known, lessons learned, and recommendations to the superintendent.

E. New carriers. A carrier that enters the market in 2023 or later shall conduct its first prior authorization evaluation in its second full calendar year in the market unless the carrier has not met a threshold enrollment of more than 500 members in which case the carrier shall file the first year after it meets that enrollment threshold

F. Data confidentiality and use. Information reported to the superintendent concerning a specific, identifiable, provider shall be deemed confidential pursuant to Subsection B of Section 59A-2-12 NMSA 1978. The superintendent may publish and use any other reported information for any regulatory purpose, including development and promulgation of rules to specify minimum prior authorization incentive and corrective action programs.

G. Guidance. The superintendent shall annually publish guidance for carriers for the upcoming plan year. This guidance shall include, at minimum, procedural reporting requirements, and any specific performance requirements.

[13.10.31.12 NMAC - N, 1/1/2022; A, 1/1/2023]

13.10.31.13 PENALTIES:

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any violation of this rule may be imposed against an insurer in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.

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

13.10.31.14 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

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

PART 32: COVERAGE FOR CONTRACEPTION

13.10.32.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.10.32.1 NMAC - N, 1/01/2021]

13.10.32.2 SCOPE:

A. Applicability. This rule applies to every insurer who issues an individual or group health insurance policy, health care plan or certificate of health insurance that provides a prescription drug benefit for a resident of this state. Herein, each such insurer is referred to as "Insurer."

B. Exceptions. This rule does not apply to:

(1) An excepted benefits plan as defined in Section 59A-23G-2 NMSA 1978.

(2) Medicare supplemental health insurance as defined by Section 1882(g)(1) of the Federal Social Security Act; or

(3) Any coverage supplemental to the coverage provided pursuant to Chapter 55 of Title 10 United States Code Annotated and similar supplemental coverage provided to coverage pursuant to a group health plan.

[13.10.32.2 NMAC - N, 1/01/2021]

13.10.32.3 STATUTORY AUTHORITY:

Sections 59A-22-42, 59A-23.7.14, 59A-46-44 and 59A-47-45.5 NMSA 1978.

[13.10.32.3 NMAC - N, 1/01/2021]

13.10.32.4 DURATION:

Permanent.

[13.10.32.4 NMAC - N, 1/01/2021]

13.10.32.5 OBJECTIVE:

To clarify contraceptive coverage requirements.

[13.10.32.5 NMAC - N, 1/01/2021]

13.10.32.6 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.10.32.6 NMAC - N, 1/01/2021]

13.10.32.7 DEFINITIONS:

A. Unless inconsistent with a term defined in this rule, or the usage of a term in this rule, the definitions in 13.10.29 NMAC apply.

B. "Provider" means, in addition to the definition in Paragraph (13) of Subsection P of 13.10.29.7 NMAC, pharmacists authorized to prescribe hormonal contraception directly to patients pursuant to 16.19.26.14 NMAC.

[13.10.32.7 NMAC - N, 1/01/2021]

13.10.32.8 COVERAGE REQUIREMENTS:

A. Oral contraceptives. An insurer satisfies its obligation to cover a sufficient number and assortment of oral contraceptives to reflect the variety of oral contraceptives approved by the federal food and drug administration only if its plan

covers contraceptive pills of differing hormone combinations at differing strengths that reflect the variety of unique combinations approved by the federal food and drug administration.

B. Immediate Post-Partum Long Acting Reversible Contraception. Included in the description of clinical services covered by this rule is immediate (pre-discharge) post-partum long acting reversible contraception.

C. Six-Month Dispensing. An insurer shall provide coverage and shall reimburse a health care provider or dispensing entity on a per unit basis for dispensing a six-month supply of contraceptives, provided that the contraceptives are prescribed and self-administered. Nothing in this rule shall be construed to require a health care provider to prescribe six months of contraceptives at one time or permit an insurer to limit coverage or impose cost sharing for an alternate method of contraception if an insured changes contraceptive methods before exhausting a previously dispensed supply.

D. Coverage for Prescription Contraceptive Drugs and Devices. An insured, an insured 's designee, or an insured's health care provider may submit a request to an insurer for coverage of a non-covered contraceptive drug or device pursuant to Subsections C and D of Section 59A-22-42 NMSA 1978. Such request shall indicate whether the covered contraceptive drug or device is not available or is medically necessary for the insured . An insurer may require that the request for coverage be in writing. If the insured' s health care provider determines that the use of a non-covered drug or device is medically necessary, the health care provider's determination shall be final.

E. Sexually transmitted infections. An insurer is obligated to provide contraceptives for the prevention of sexually transmitted infections.

F. Confidentiality of services. An insurer shall maintain confidentiality of claims and services pursuant to state and federal law, including the Domestic Abuse Insurance Protection Act, Sections 59A-16B-1 et seq. NMSA 1978.

[13.10.32.8 NMAC - N, 1/01/2021]

13.10.32.9 PROVIDER ACCESS:

A. Access. If an insurer's plan limits coverage of contraceptive services and supplies to in-network providers, the Insurer shall establish and maintain a network for these services and supplies that meets the access and adequacy standards set forth in state and federal network adequacy law.

B. Limited access requirements. If an insurer's plan network lacks a sufficient number or type of participating providers or facilities to provide a particular covered contraceptive service or supply in a timely manner appropriate for the covered person's condition, the insurer shall allow the covered person to obtain the covered service or

supply from a provider or facility within reasonable proximity of the covered person at no greater cost than if the service or supply were obtained from in-network providers and facilities.

[13.10.32.9 NMAC - N, 1/01/2021]

13.10.32.10 COVERAGE FOR CONTRACEPTION WHERE A PRESCRIPTION IS NOT REQUIRED:

A. If a prescription is not required for the purchase of a contraceptive, an insurer shall not charge a member for a purchase at an in-network pharmacy, and shall provide a process for the member to obtain reimbursement for an out-of-network purchase.

B. An insurer's website and evidence of coverage handbook shall clearly explain the process a covered person shall use to submit a claim for reimbursement for the purchase of non-prescription contraception drugs or devices. The reimbursement process is subject to these requirements:

(1) An insurer shall allow a covered person at least 90 days from the date of purchase to submit a request for reimbursement.

(2) An insurer shall reimburse a covered person within 30 days of receipt of a timely and complete reimbursement request submitted electronically, by email, or by fax, and within 45 days of receipt of a timely and complete reimbursement request submitted by U.S. mail.

(a) A reimbursement request that is transmitted electronically, via email, or fax, pursuant to the insurer's instructions, is deemed received by the insurer on the date of receipt, unless the covered person receives notice of a transmission error.

(b) A request for reimbursement is complete if it contains the covered person's name and address, their plan identification number, and a paid receipt explicitly delineating the purchased services or supplies.

(c) An insurer may require a covered person to use a specific claim form for a reimbursement request.

[13.10.32.10 NMAC - N, 1/01/2021]

13.10.32.11 COVERAGE DISPUTES:

A dispute between an insurer and a covered person concerning a request to grant coverage for a contraceptive supply or service shall be processed in accordance with Sections 59A-23-12.1, 59A-47-47.1, 59A-22B-5, 59A-22-42, or 59A-46-52 NMSA 1978, as applicable, or 13.10.17 NMAC.

[13.10.32.11 NMAC - N, 1/01/2021]

13.10.32.12 TRANSPARENCY OF COVERAGE:

A. Forms. An insurer shall provide each covered person with a contraceptive coverage summary that clearly explains the scope of contraceptive coverage and how to access this benefit at least annually. The coverage summary through written materials or links to an insurer's website and a toll free number must include the following information:

(1) whether covered services or supplies are available from in-network and out-of-network providers;

(2) whether there are any limitations on contraceptive services or supplies;

(3) that the coverage required shall not be subject to:

(a) cost sharing for insureds;

(b) utilization review;

(c) prior authorization or step-therapy requirements; or

(d) any other restrictions or delays on the coverage;

(4) if elected by the insurer, that brand-name pharmacy drugs or items are subject to cost sharing when at least one generic or therapeutic equivalent is covered within the same method of contraception without patient cost sharing, unless the insured's health care provider determines that a particular drug or item is medically necessary;

(5) that coverage will be provided for a six-month supply of prescribed and self-administered contraceptives;

(6) a list of the covered contraceptive drugs and devices, as well as clinical services, that are covered without cost-sharing;

(7) a description of the process and forms required to address coverage disputes in Sections 59A23-12.1, 59A-47-47.1, 59A-22B-5, 59A-22-42, or 59A-46-52 NMSA 1978, as applicable, or 13.10.17 NMAC; and

(8) a description of the process and forms related to coverage for contraception where a prescription is not required.

B. Drug formulary requirements. An insurer shall identify on its publicly available drug formulary any cost-sharing free contraceptive drugs and devices.

[13.10.32.12 NMAC - N, 1/01/2021]

13.10.32.13 NONDISCRIMINATION:

An Insurer who is legally obligated to provide contraceptive supplies or services shall do so without discriminating against the covered person on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability. This includes, but is not limited to, providing coverage for of any method of over-the-counter contraception without regard to the sex, or gender identity or expression, of the covered person.

[13.10.32.13 NMAC - N, 1/01/2021]

13.10.32.14 RULES FOR HSA QUALIFYING PLANS:

An insurer who issues a health benefit plan that qualifies as a health savings account ("HSA-qualifying plan") is subject to this rule. A deductible under an HSA-qualifying plan for over-the-the counter contraceptive supplies or services and voluntary male sterilization shall not exceed the minimum amount required to preserve the covered person's ability to claim tax exempt contribution and withdrawals from the covered person's health savings.

[13.10.32.14 NMAC - N, 1/01/2021]

13.10.32.15 PENALTIES:

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any violation of this rule may be imposed against an insurer in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.

[13.10.32.15 NMAC - N, 1/01/2021]

13.10.32.16 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.32.16 NMAC - N, 1/01/2021]

PART 33: SURPRISE BILLING

13.10.33.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance ("OSI").

[13.10.33.1 NMAC - N, 3/01/2021]

13.10.33.2 SCOPE:

These rules apply to every health insurance carrier ("carrier") that provides health coverage under a policy, arrangement, contract or plan described in Section 59A-57A-12 NMSA 1978.

[13.10.33.2 NMAC - N, 3/01/2021]

13.10.33.3 STATUTORY AUTHORITY:

Section 59A-2-9 NMSA 1978, Sections 59A-57A-1 through 59A-57A-13 NMSA 1978 and Section 59A-16-21.3 NMSA 1978.

[13.10.33.3 NMAC - N, 3/01/2021]

13.10.33.4 DURATION:

Permanent.

[13.10.33.4 NMAC - N, 3/01/2021]

13.10.33.5 EFFECTIVE DATE:

March 1, 2021, unless a later date is cited at the end of a section.

[13.10.33.5 NMAC - N, 3/01/2021]

13.10.33.6 OBJECTIVE:

To implement consumer protection, reimbursement, refund, reporting and appeal requirements for the surprise billing protection act.

[13.10.33.6 NMAC - N, 3/01/2021]

13.10.33.7 DEFINITIONS:

For definitions of terms contained in this rule, refer to Section 59A-57A-2 NMSA 1978 and 13.10.29 NMAC.

[13.10.33.7 NMAC - N, 3/01/2021]

13.10.33.8 REFUNDS FOR OVERPAYMENT:

A. Notice of payment and right to a refund. A carrier who reimburses a provider for a surprise bill shall provide the covered person an explanation of benefits ("EOB") showing, at a minimum, the name of the provider, the date of service, the amount billed and the amount paid. As of June 1, 2021, the first page of the EOB shall provide a surprise billing explanation of benefits and rights and contain the following statement in bold and of at least 12 point type:

SURPRISE BILLING – YOU RECENTLY VISITED A PROVIDER WHO IS NOT IN YOUR PLAN'S NETWORK. IF YOU HAVE ALREADY PAID THE PROVIDER MORE THAN YOU OWE, THE PROVIDER OWES YOU A REFUND WITHIN 45 DAYS OF THE DATE THE PROVIDER RECEIVED OUR PAYMENT. IF YOU DO NOT RECEIVE A REFUND WITHIN THAT 45-DAY PERIOD, YOU MAY FILE AN APPEAL WITHIN 180 DAYS AFTER EXPIRATION OF THE 45-DAY PERIOD
AT WWW.OSI.STATE.NM.US OR 1-855-427-5674.

B. Issuance of the EOB. A carrier shall issue the EOB within 15 days of the payment.

C. Payment notice to provider. A carrier who reimburses a surprise bill shall inform the out-of-network provider of the in-network cost-sharing amount owed by the covered person. Any notice of the covered person's cost-sharing responsibility shall refer to New Mexico's surprise billing protections act and the provider rights granted therein.

D. Appeal process. A covered person may appeal a provider's failure to make a timely or complete refund of an excess payment using the surprise billing appeal form on OSI's website.

(1) The appeal must be filed within 180 days after the expiration of the 45-day period in which the provider was required to refund the covered person's excess payment.

(2) The provider shall have 30 days to respond to the appeal in writing.

(a) A provider's failure to timely respond shall result in an order from the superintendent directing the provider to pay the full amount of the claimed refund.

(b) If a provider timely responds to a refund appeal, the superintendent shall resolve the appeal following the rules that govern informal hearings. If the superintendent determines that a provider owed a refund, the superintendent shall order the provider to pay the refund amount with interest pursuant to Section 59A-16-21.1 NMSA 1978.

E. EOB Alternative. A carrier may file with the superintendent, and request approval to use, an alternate form or style of surprise billing EOB. The superintendent

shall approve the alternate EOB if it is at least as likely to convey a member's rights under the Surprise Billing Act as the EOB required by Subsection A of this rule.

[13.10.33.8 NMAC - N, 3/01/2021]

13.10.33.9 COVERED PERSON RIGHTS:

A carrier shall afford a covered person these rights:

A. Out of state care. A carrier shall reimburse a surprise medical bill as required by law regardless of the situs of delivery of the medical care, including medical care rendered out-of-state.

B. Specific consent. For purposes of Subparagraph (b) of Paragraph (1) of Subsection Y of Section 59A-57A-2 NMSA 1978, "specific consent" shall only be valid if the covered person has a meaningful choice between a participating provider and a nonparticipating provider; the covered person was not encouraged or coerced by a network provider or the carrier into selecting the out-of-network provider; and the covered person signs a notice and disclosure statement, at least five days before the service or supply is received, acknowledging that the covered person may be liable for a balance bill and chooses to receive the service or supply.

C. Notice of Rights. A carrier shall provide each covered person with notice of surprise billing protection act rights in the plan's evidence of coverage and as directed by the superintendent in a bulletin.

[13.10.33.9 NMAC - N, 3/01/2021]

13.10.33.10 PROVIDER CLAIM SUBMISSION:

An out-of-network provider shall not bill a covered person for a potential surprise bill without first submitting the bill to the covered person's designated carrier and obtaining a payment or denial.

[13.10.33.10 NMAC - N, 3/01/2021]

13.10.33.11 REPORTS REQUIRED:

A carrier shall annually submit a surprise billing data report using a template provided by the superintendent. The template shall require a carrier to report changes to the percent of claims paid for emergency services. The report shall be filed annually by May 1st of each year and shall contain data from the full prior calendar year.

[13.10.33.11 NMAC - N, 3/01/2021]

13.10.33.12 PROVIDER COMPLAINTS:

A provider may dispute the denial, or reimbursement amount, of a surprise bill pursuant to the applicable procedures in 13.10.16 NMAC.

[13.10.33.12 NMAC - N, 3/01/2021]

13.10.33.13 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.33.13 NMAC - N, 3/01/2021]

PART 34: STANDARDS FOR ACCIDENT ONLY, SPECIFIED DISEASE OF ILLNESS, HOSPITAL INDEMNITY AND RELATED EXCEPTED EXPENSES

13.10.34.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance ("OSI").

[13.10.34.1 NMAC - Rp, 13.10.34.1 NMAC, 07/01/2023]

13.10.34.2 SCOPE:

This section identifies the excepted benefits and excepted benefits products that are subject to this rule, and applicable exceptions.

A. Subject products. This rule applies to these excepted benefits products:

(1) accident only;

(2) specified disease or illness;

(3) hospital indemnity;

(4) other fixed indemnity;

(5) disability income;

(6) supplemental; and

(7) insurance similar to workers' compensation (non-subject worker).

B. Extraterritorial plans. This rule applies to every subject individual, group and blanket contract of insurance, including any certificate, delivered in this state, and to any

subject contract issued to a group located outside of this state, if any covered person resides in this state, except:

(1) a group plan, and certificates of insurance relating to that plan, issued to an out-of-state employer that employs 100 or fewer New Mexico residents at any time during the calendar year; or

(2) a group or blanket plan issued to an out-of-state entity that resides in a state whose laws offer protections that, in the discretion of the superintendent, are equivalent to or more protective than New Mexico law.

C. Grandfathered plans. This rule does not apply to:

(1) An individual or blanket plan issued prior to the effective date of these rules if:

(a) the plan is guaranteed renewable, non-cancellable, or guaranteed renewable through a specified age, or conditionally renewable in the case of disability income plans;

(b) the plan is continually in force without any lapse; and

(c) there are no material changes in the substantive provisions of the plan after the effective date of this rule. An annual rate change that does not exceed ten percent is not considered a material change in the substantive provisions of a grandfathered plan unless the plan was issued with a guaranteed rate.

(2) An employer group, labor union, credit union, or bona fide association, as defined at Subsection A of Section 59A-23G-2 NMSA 1978, if:

(a) the carrier began offering the plan through the employer, labor union, credit union, or association prior to the effective date of this rule;

(b) the plan is continually in force without any lapse;

(c) eligibility for the plan is limited to employees, labor union, credit union, or association members and their dependents;

(d) there are no material changes in the substantive provisions of the plan after the effective date of this rule. An annual rate change that does not exceed ten percent is not considered a material change in the substantive provisions of a grandfathered plan unless the plan was issued with a guaranteed rate. Incremental changes in fixed dollar coverage amounts or benefit limitations consistent with inflation, and changes in plan enrollment of employees and their dependents (whether newly hired or newly enrolled) are also not considered a material change.

D. Self-funded plans. This rule does not apply to a self-funded employer plan.

[13.10.34.2 NMAC - Rp, 13.10.34.2 NMAC, 07/01/2023]

13.10.34.3 STATUTORY AUTHORITY:

Sections 59A-18, 59A-16 and 59A-23G-3 NMSA 1978.

[13.10.34.3 NMAC - Rp, 13.10.34.3 NMAC, 07/01/2023]

13.10.34.4 DURATION:

Permanent.

[13.10.34.4 NMAC – Rp, 13.10.34.4 NMAC, 07/01/2023]

13.10.34.5 EFFECTIVE DATE:

July 1, 2023, unless a later date is cited at the end of a section.

[13.10.34.5 NMAC - Rp, 13.10.34.5 NMAC, 07/01/2023]

13.10.34.6 OBJECTIVE:

The purpose of this rule is to establish regulatory requirements for the subject excepted benefit plans. The rule will standardize and simplify the terms and coverages; facilitate public understanding and comparison of coverage; eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims and require disclosures in the marketing and sale of subject excepted benefit plans.

[13.10.34.6 NMAC - Rp, 13.10.34.6 NMAC, 07/01/2023]

13.10.34.7 DEFINITIONS:

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

A. "Accident only plan" means an insurance agreement that conditions a fixed indemnity benefit on the occurrence of an injurious accident.

B. "Certificate" means a document that extends coverage under a group plan to a group member.

C. "Direct response insurer" means a carrier who does not sell its insurance products through producers.

D. "Disability income plan" means an insurance agreement that provides income protection benefits during a period of disability resulting from either sickness, pregnancy, injury or a combination of these.

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

F. "Hospital indemnity plan" means an insurance agreement that conditions a fixed indemnity benefit on the hospitalization, hospital-based treatment or hospice care of a covered person.

G. "Occupational accident plan" means an accident-only plan that pays a fixed indemnity benefit for injury that results from an occupational accident involving a covered subject worker.

H. "Other fixed indemnity" means a fixed cash benefit payable to a covered person on the occurrence of an event, circumstance or condition, other than or in addition to accident, injury, illness or disability.

I. "Plan" means any individual, group or blanket insurance subject to this rule provided through a standalone policy, certificate, contract or rider.

J. "Non-contributory" means that a covered person pays no premium, membership fee or dues to qualify for coverage or benefits under the plan.

K. "Non-subject worker plan" means an insurance agreement that provides benefits similar to workers' compensation benefits to a self-employed non-subject worker.

L. "Specified disease plan" means an insurance agreement that conditions a fixed indemnity benefit on the occurrence or diagnosis of a specific disease or illness that is either life-threatening or likely to cause a covered person to incur significant financial obligations.

M. "Supplemental plan" means an insurance agreement that provides benefits that supplement coverage under a group major medical, TRICARE or Champus plan.

[13.10.34.7 NMAC - Rp, 13.10.34.7 NMAC, 07/01/2023]

13.10.34.8 GENERALLY APPLICABLE PROVISIONS:

A plan subject to this rule shall comply with these provisions:

A. Probationary periods. A plan shall not include a probationary or waiting period during which no coverage is provided for a covered benefit after the coverage effective

date. A probationary period does not include an eligibility-waiting period during which no premium is paid, or an elimination period for a disability income plan.

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

C. Preexisting conditions. An individual plan, or plan sold through an association or group described in Paragraph (2) or (4) of Subsection A of Section 59A-23-3 NMSA 1978, shall not exclude coverage for a loss due to a preexisting condition unless the application or enrollment form includes a conspicuous notice about the scope and applicability of any such exclusion that will apply in the coverage, and that notice also appears in the plan document issued to the covered person at the start of the free look period.

D. Return of premium. A plan may include a return of premium or cash value benefit if authorized by the superintendent following an evaluation of the potential impact on the carrier's reserves and ability to service policy obligations. Nothing in this rule requires a carrier to seek authorization from the superintendent to return premiums unearned through termination or suspension of coverage, retroactive waiver of premium paid during a medical condition, payment of dividends on participating policies, or experience rating refunds.

E. Exclusions. A plan shall not exclude any type, circumstance or cause of loss that would not otherwise be covered, and the plan exclusions shall not, individually or collectively, unreasonably or deceptively alter the scope of coverage. Subject to the foregoing, a plan may exclude coverage for the following conditions, circumstances and causes of loss:

(1) preexisting conditions;

(2) loss resulting from or contributed to by:

(a) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary to it;

(b) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury within two years of the effective date of coverage;

(c) aviation, other than travel as a fare paying passenger on a commercial carrier; or

(d) incarceration or detention due to illegal activity.

(3) loss for which benefits are provided under Medicare or other governmental program (except Medicaid), a state or federal workers' compensation program, employers liability or occupational disease law, or motor vehicle no-fault law;

(4) participation in an illegal activity;

(5) voluntary intoxication by any legal or illegal drug, including alcohol;

(6) specifically named high-risk physical activities;

(7) international territorial limitations;

(8) occupational injury or disease;

(9) normal pregnancy or childbirth;

(10) foreign travel or residency; or

(11) any other type, circumstance or cause of loss if the carrier satisfies the superintendent that the exclusion promotes a legitimate underwriting or public policy objective or is required to comply with any state or federal law.

F. Contracted providers. A plan shall not condition a benefit or offer an enhanced benefit based on receipt of health care from any specific provider, provider network or facility, or based on the care methodology. A carrier shall not refer to a network or provider arrangement in any plan document or advertisement.

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

H. Arbitration provisions. A plan shall not require a covered person or master policyholder to submit a dispute arising out of or relating to the plan to mediation or arbitration. A covered person or master policyholder may agree to participate in voluntary mediation or arbitration after the submission of a claim for benefits, or after a dispute arises.

I. Legal compliance. A covered person's rights under any plan shall be governed by the terms of the plan approved by the superintendent, and by applicable state and federal law. This rule does not limit the superintendent's authority to approve or disapprove a plan or plan provision as authorized by any other state or federal law.

J. Telemedicine services. A plan that provides a benefit conditioned on a covered person's receipt of a health care service shall provide that benefit if the service is delivered in-person or virtually. No plan may offer a telemedicine only benefit.

K. Discrimination. No carrier or plan shall discriminate in eligibility for coverage or benefits on the basis of sex, sexual orientation, gender, gender identity, race, religion, or national origin. A plan may differentiate on the basis of age in rating and age limits on coverage.

L. Insurance cards. A carrier shall not issue an insurance card or similar proof of coverage to a covered person.

M. Direct reimbursement. A carrier shall pay fixed indemnity benefits directly to a covered person unless the covered person assigns benefits after a covered loss occurs. A coercive assignment is unenforceable.

N. Inducements. Except as authorized by Section 59A-16-17 NMSA 1978, and these rules, a carrier shall not offer or provide monetary or other valuable consideration, engage in misleading or deceptive practices or make untrue, misleading, or deceptive representations in any plan document, advertising or sales presentation to induce enrollment.

O. Military service exclusion or suspension. If a plan contains a military service exclusion or a provision that suspends coverage during military service, the plan shall refund unearned premiums upon receipt of a written request for refund, or upon learning that a covered person has entered military service.

P. Individual noncancellable and guaranteed renewable policies. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual plan shall not provide for termination of coverage of the domestic co-insured solely because of the occurrence of an event specified for termination of coverage of the covered person, other than nonpayment of premium. In addition, the plan shall provide that in the event of the covered person's death, the domestic co-insured of the covered person, if covered under the plan, shall become the policyholder.

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

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

(3) In an individual plan covering domestic co-insureds, the age of the younger of the two shall be used as the basis for meeting the age and durational requirements of the definitions of "non-cancellable" or "guaranteed renewable."

However, this requirement shall not prevent termination of coverage of the older of the two upon attainment of the stated age, so long as the plan may be continued in force as to the younger of the two to the age or for the durational period as specified in the plan.

Q. Dependent child. An individual excepted benefit plan's coverage for a child who is incapable of self-sustaining employment on the date the child would otherwise age out of coverage shall continue if the child depends on the covered person for support and maintenance. The plan may require that within 31 days of the date the company receives proof of the child's incapacity, the covered person may elect to continue the plan in force with respect to the child or insure the child under an approved conversion plan.

R. Continuous loss. A carrier shall not terminate a plan, except for non-payment of premium, during a period of continuous loss that commences during the period of coverage unless expressly limited by the duration of the benefit period, if any, or any maximum benefit limit.

S. Waivers. Where a waiver is required as a condition of plan issuance, renewal or reinstatement, a signed acceptance by the covered person is required. A waiver shall be limited to a specifically named or described disease, physical condition or activity.

T. Termination of coverage. A carrier may terminate a plan only for a reason specified in the agreement delivered to the covered person. A plan may authorize termination for:

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

(2) material breach of a contractual obligation, or a prejudicial failure to satisfy a post-loss condition;

(3) fraud or misrepresentation affecting underwriting;

(4) expiration of term; or

(5) any reason that the superintendent determines is not substantively or procedurally unconscionable.

U. Notice required upon termination of coverage for individual plans. A carrier shall not terminate a plan unless it provides written notice to a covered person 30 days prior to the intended termination date. Notice of termination shall:

(1) be in writing and dated;

(2) state the reason for termination, with specific references to the clauses of the plan that justify the termination;

(3) state that a covered person's plan cannot be terminated because of health status, need for services, race, religion, national origin, gender, gender identity, age (except where allowed by law or rule), or sexual orientation of covered persons under the contract;

(4) state that a covered person who alleges that an enrollment has been terminated or not renewed because of the covered person's health status, need for health care services, race, religion, national origin, gender, gender identity, age or sexual orientation may file a complaint with the superintendent of insurance at www.osi.state.nm.us or 1-855-427-5674; and

(5) state that in the event of termination by either the covered person or the carrier, except in the case of fraud or deception, the carrier shall, within 30 calendar days, return to the covered person or subscriber the portion of the money paid to the carrier that corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any.

V. Notice required upon termination of coverage for group plans. A group plan shall specify that either the carrier or the group master policyholder shall provide notice to the party responsible for providing notice to each group certificate holder of any plan expiration, lapse or termination at least 30 days in advance. Except where the group policyholder or the employer is replacing a group plan with another carrier's plan, a carrier shall not terminate a group plan unless it provides written notice to the party responsible for providing notice to each certificate holder 30 days prior to the certificate holder's intended termination date. The party responsible for providing notice to each certificate holder shall attest that notice was provided 30 days prior to the intended termination date. Notice of termination shall:

(1) be in writing and dated;

(2) state the reason(s) for termination, with specific references to the clauses of the plan that justify the termination; and

(3) state that in the event of termination by either the group policyholder or the carrier, except in the case of fraud or deception, the carrier shall, within 30 calendar days, return to the group policyholder the money paid to the carrier that corresponds to any unexpired period for which payment had been received.

W. Claim form. If a carrier requires submission of a claim form as a condition of payment, the carrier, upon receipt of notice of a claim, shall deliver the form to the covered person. If a carrier does not deliver a claim form within 15 days after notice of a claim, the claimant shall be deemed to have complied with any proof of loss requirement if a written notice of claim contains sufficient detail to determine that a covered loss occurred.

X. Grace periods. A carrier shall grant a premium payment grace period of at least 10 days for a monthly premium plan and at least 31 days for a plan billed less frequently.

Y. Variability. A carrier who offers an individual plan with variable benefit types and levels shall submit for approval the outline of coverage and benefits that illustrates the plan design that would be available to a prospective covered person. A carrier who offers coverage to eligible covered persons under a group plan shall submit for approval an outline of coverage or certificate that corresponds with the plan design ultimately offered to those covered persons. A carrier shall comply with the variability guidance posted on the OSI website, including mapping requirements. Each distinct outline of coverage, or certificate shall be subject to a filing fee as specified in statute.

Z. Treatment trigger. Except as expressly authorized in this rule, no accident only or specified disease plan shall condition a benefit on a covered person's receipt of health care or offer a fee for service benefit.

AA. Portability. A portability or continuation provision in an employer group plan shall not allow a person whose group eligibility ends to continue group coverage for more than nine months. A portability or continuation provision in any other type of group plan shall not allow a covered person to continue coverage for more than three months. In the event of the death of a covered group member, coverage for a domestic co-insured of the decedent insured may continue for two years, until one-year after any minor dependent insured obtains the age of majority, and for one-year after circumstances creating dependency end for any other dependent insured.

BB. Subrogation. A carrier who offers or pays a fixed indemnity benefit shall not claim, assert or pursue subrogation.

CC. Benefit minimums. The superintendent may, after conducting a public hearing, issue an order mandating, or reducing mandated, benefit minimums for any type of subject plan. A non-contributory plan is not subject to any benefit minimum mandated by this rule. Benefit minimums are not applicable to the non-contributory portion of a plan that has both contributory and non-contributory portions.

DD. Value added product or service. A carrier shall not provide or offer a value added product or service in connection with a subject plan if any part of the cost of providing the product or service is included in the plan rates. A carrier who proposes to offer a value added product or service must provide actuarial certification of compliance with this rule.

[13.10.34.8 NMAC - Rp, 13.10.34.8 NMAC, 07/01/2023]

13.10.34.9 ADDITIONAL REQUIREMENTS FOR DISABILITY INCOME PLANS:

A disability income plan is subject to these additional requirements:

A. Benefit reduction. A disability income plan may provide that benefits shall decrease by up to fifty percent if the covered person is or attains the age of 62 during the period of disability.

B. Disability limitation. A disability income plan shall only provide benefits for disability resulting from injury, sickness, pregnancy or combination of these causes.

C. Partial disability. A disability income plan shall consider an individual to be partially disabled if the individual:

(1) is unable to perform one or more but not all of the substantial and material duties or words of similar import, of the individual's employment or existing occupation or work a specified percentage of time, or a specified number of hours, or earn a specified amount of compensation; and

(2) remains engaged in work for wage or profit.

D. Residual disability. A disability income plan shall consider "residual disability" in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation or to the inability to perform all usual business duties for as long as is usually required. A disability income plan that provides for residual disability benefits may require a qualification period, during which the covered person must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," a disability income plan may use "proportionate disability" or other term of similar import that, in the opinion of the superintendent, adequately and fairly describes the benefit.

E. Total disability. A disability income plan shall not define "total disability" more restrictively than a definition requiring that an individual who is totally disabled not be able to perform the duties of any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience; and is not, in fact, engaged in any employment or occupation for wage or profit.

(1) Total disability may be defined in relation to the inability of the insured to perform duties, and may include a reduction in earnings requirement, but may not be based solely on an insured's inability to:

(a) Perform any occupation whatsoever, any occupational duty, or any and every duty of his or her occupation; or

(b) Engage in a training or rehabilitation program.

(2) A disability income plan may require the covered person to have complete inability to perform all of the substantial and material duties of his or her regular occupation, or words of similar import.

(3) If the covered person is not employed at the onset of disability, a disability income plan shall not define total disability more restrictively than the inability to perform three or more activities of daily living, as certified by a physician.

(4) A carrier may require proof of disability or care to be provided by a physician other than the insured of a member of the insured's immediate family.

F. Independent examination. A carrier may require a covered person to undergo an independent examination to evaluate disability as often as reasonably necessary.

G. Elimination period. A disability income plan shall not include an elimination period greater than 30 days in the case of coverage providing a benefit duration of one year or less; 60 days in the case of coverage providing a benefit duration of greater than one year and no more than two years; 90 days in the case of coverage providing a benefit duration of greater than two years and no more than three years; 180 days in the case of coverage providing a benefit duration of greater than three years and no more than five years; or 365 days in all other cases. For purposes of this provision, the benefit duration shall disregard reduced benefit durations based on age. If a plan provides both full and partial disability, only one elimination period is allowed. The requirements of this section do not apply to a short term disability plan.

H. Minimum benefit period. After the elimination period, a disability income plan shall not have a benefit duration of less than three months, or until the disability ends, whichever is less.

I. Recurrent disabilities. Unless a disability income plan provides for a benefit payable to a certain age limit, a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six months.

[13.10.34.9 NMAC - Rp, 13.10.34.9 NMAC, 07/01/2023]

13.10.34.10 ADDITIONAL REQUIREMENTS FOR ACCIDENT-ONLY PLANS:

An accident-only plan is subject to these additional requirements.

A. Plan definitions. An accident-only plan:

(1) shall not define "accident" more narrowly than an injurious event during the coverage period that was unexpected and unintended from the standpoint of the covered person.

(2) shall not define "injury" more narrowly than physical or mental harm that results from an accident, no matter the degree of harm or when it manifests.

B. Coverage requirements. An accidental death benefit in an accident-only plan shall be no less than $5,000 for a named covered person and any domestic co-insured. Dependent coverage for accidental death shall be no less than $2,500 for each dependent. The death benefit amount may vary for each specifically identified life insured under the policy or certificate. A dismemberment benefit shall be at least $2,500 for loss of an arm or leg. The benefit amount for partial dismemberment and loss of a non-limb body part shall be no less than $250 for each covered loss.

C. Basis of compensation. An accident-only plan shall only compensate for losses on a fixed-indemnity basis.

D. Specified accident. Specified accident insurance coverage shall only be sold as blanket coverage pursuant to Section 59A-23-2 NMSA 1978, or as nonrenewable individual coverage with a term not to exceed 30 days. Specified accident coverage shall only be offered in a designated specified accident plan.

E. Occupational accident plan. An occupational accident plan:

(1) shall only be issued to an individual or group member who is a worker engaged in employment subject to New Mexico workers' compensation law protections.

(2) shall only pay benefits conditioned on the covered person sustaining a work-related injury.

(3) shall not coordinate with workers' compensation benefits.

(4) shall include this notice, displayed on a cover page or on the first page of the plan in bold 14-point type:

YOUR PURCHASE OF THIS PLAN DOES NOT RELEASE YOUR EMPLOYER FROM ANY LEGAL DUTY TO PROVIDE WORKERS' COMPENSATION COVERAGE. TO LEARN MORE ABOUT YOUR RIGHTS TO WORKERS' COMPENSATION COVERAGE PLEASE CONTACT:

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION
2410 CENTRE AVE SE
ALBUQUERQUE, NM 87106
505-841-6000
www.workerscomp.nm.gov

THIS PLAN ONLY PROVIDES BENEFITS IF YOU ARE INJURED WHILE ENGAGED IN EMPLOYMENT SUBJECT TO NEW MEXICO WORKERS' COMPENSATION LAWS. IF YOU ARE NOT ENGAGED IN SUCH EMPLOYMENT OR CEASE TO BE

ENGAGED IN SUCH EMPLOYMENT, CONTACT US AT [INSERT NUMBER] AND WE WILL CANCEL THIS PLAN AND REFUND ANY UNEARNED PREMIUM.

(5) shall not reduce or eliminate any benefit because a covered person receives, or is entitled to receive, workers' compensation benefits.

(6) shall not exclude activities or accidents inherent to the covered person's occupation.

(7) shall not require a covered person to waive rights to workers' compensation coverage or benefits.

(8) shall be cancellable at any time.

(9) shall not be conditioned on a covered person receiving workers' compensation benefits.

(10) shall provide benefits for any injury that results during a covered person's work hours at the covered person's work location, subject to any authorized exclusion and to the going-and-coming rule. An injury to a traveling worker shall be covered if the injury results while the worker is traveling for the employer and is being compensated for the travel.

F. Sickness benefit. An accident-only plan shall not offer a benefit for any sickness or disease that is not caused by a covered accident. Sickness or disease benefits shall be limited to illness that arises within 90 days of the accident. Sickness benefits may include coverage for mental health care or nervous disorders that result from an accident.

G. Other Fixed Indemnity Benefits: An accident-only plan may offer other fixed indemnity benefits in compliance with Section 13.10.34.12.

H. Income replacement benefit. An accident-only plan may offer income replacement benefits only for disability resulting from a covered accident.

I. Accidental cause variation. An accident only plan that provides benefits, or benefit amounts, that vary depending on the accident cause, place, time or manner shall prominently set forth in the outline of coverage the circumstances under which different benefits or amounts are payable. A plan that includes accidental cause variation may be deemed a specified accident plan subject to the specified accident provisions of this rule.

J. Exclusion consistency. A carrier shall not suggest or imply that an accident only plan applies to injury that results from an excluded activity.

K. Death and dismemberment. An accident-only plan may offer a death and dismemberment benefit. When accidental death and dismemberment coverage is part of an individual plan, the covered person shall have the option to include all covered persons under the coverage and not just the principal covered person.

L. Delayed loss. Accident-only benefits shall be payable if a covered loss was caused by a covered accident during the period of coverage even if the loss first manifests after the period of coverage, provided notice of loss is provided within five years of the covered accident.

M. Fractures or dislocations. A plan that provides coverage for fractures or dislocations shall provide benefits for full and partial fractures or dislocations.

[13.10.34.10 NMAC - Rp, 13.10.34.10 NMAC, 07/01/2023]

13.10.34.11 ADDITIONAL REQUIREMENTS FOR HOSPITAL INDEMNITY PLANS:

A hospital indemnity plan is subject to these additional requirements.

A. Benefit minimum. A hospital indemnity plan shall pay a minimum lump-sum of no less than $1,500 upon initial confinement. A plan may offer additional lump-sum or daily benefits for additional periods of confinement as defined by the plan, subject to the provisions contained in this rule.

B. Continuous hospital confinement. A hospital indemnity plan shall treat consecutive days of in-hospital service received as an inpatient, and successive inpatient confinement for treatment of the same condition within 30 days of prior discharge, as a single period of confinement. A carrier shall not combine confinements that result from medically distinct causes. A plan may exclude benefits for any calendar day period of confinement that does not result in billed charges by a hospital.

C. Basis of compensation. A hospital indemnity plan shall provide benefits only on a fixed indemnity basis.

D. Hospital indemnity benefit limitations. A hospital indemnity plan shall only offer benefits conditioned on a covered person being hospitalized, or receiving hospice, convalescent or extended care, hospital-treatment related ambulatory surgical center services, ambulance service to or from a covered confinement, hospital-affiliated outpatient services, anesthesia, surgery, emergency care leading to a hospital, convalescent or hospice confinement, lost wages during a period of hospital confinement, or expenses to travel to or from a hospital confinement. These benefits shall not be offered as a separate rider.

E. Confinement defined. A hospital indemnity plan shall define "confinement" as any consecutive 24-hour period during which medical observation or services are provided on a continuous basis in a licensed medical facility, each immediately

successive such period, and any period of time less than 24-hours on the date of discharge from any such confinement.

F. Convalescent or extended care. A plan that provides a benefit conditioned on a covered person receiving convalescent or extended care following hospitalization shall provide such benefits if the admission to the convalescent or extended care facility is within 14-days after discharge from the hospital.

[13.10.34.11 NMAC - Rp, 13.10.34.11 NMAC, 07/01/2023]

13.10.34.12 OTHER FIXED INDEMNITY:

Other fixed indemnity benefits are subject to these additional requirements.

A. Benefits. Other fixed indemnity benefits shall be no less than $50 per triggering event, circumstance or condition. The aggregate amount of all other fixed indemnity benefits offered shall not exceed $10,000.

B. Limitations. A carrier shall not offer or sell a person a plan, or combination of plans, that provide more than ten other fixed indemnity benefits. A carrier shall not sell a plan that includes other fixed indemnity benefits if that would result in the customer having coverage for more than ten other fixed indemnity benefits under one or more plans. An application for a plan that offers other fixed indemnity benefits shall inquire whether a prospective insured has other excepted benefits coverage, and about the number and type of other fixed indemnity benefits covered by a prospective insured's other coverage, if any. A carrier that offers more than five other fixed indemnity benefits must do so in a manner which is not ambiguous, deceptive, or misleading, or which suggests that the package of fixed indemnity benefits is a substitute for or constitutes major medical insurance.

C. Other fixed indemnity benefit types. Unless otherwise limited by this rule, the other fixed indemnity benefits shall be limited to hospitalization, outpatient services, ambulance and other transportation services, behavioral health services, laboratory and imaging services, in-home care, durable medical equipment, home, work or vehicle modifications to accommodate disability, therapy services, treatment-related lost wages, health care related lodging, pet care and daycare services, or cosmetic services relating to a covered accident or illness. Other fixed indemnity benefits may be offered as a stand-alone policy or certificate of insurance or as a rider to an excepted benefit subject plan. A stand-alone other fixed indemnity plan shall include all notices required by this rule at an appropriate reading level which is understandable to a prospective insured.

D. Treatment trigger. Other fixed indemnity benefits may be conditioned upon a covered person receiving medical care given in a medically appropriate location. A carrier shall not condition payment for any such benefit on prior approval of treatment or on medical necessity.

[13.10.34.12 NMAC - Rp, 13.10.34.12 NMAC, 07/01/2023]

13.10.34.13 ADDITIONAL REQUIREMENTS FOR SPECIFIED DISEASE PLANS:

A specified disease plan is subject to these additional requirements.

A. General requirements.

(1) A plan covering a single specified disease or combination of specified diseases shall not be sold or offered for sale other than as a specified disease plan.

(2) A specified disease plan that conditions payment upon a pathological diagnosis shall also provide that if the pathological diagnosis is not medically feasible, a clinical diagnosis will be accepted.

(3) A specified disease plan shall pay a lump-sum upon medical diagnosis of the specified disease, or for any form or variation of a specified disease that is covered by the plan.

(4) An individual specified disease plan shall be guaranteed renewable.

(5) A specified disease plan shall not be sold to a person covered by any Title XIX program (Medicaid, Centennial Care or any similar name). An individual specified disease plan shall contain a statement above the signature line of an individual applicant or covered person attesting that the person seeking to be covered for a specified disease is not covered by Medicaid. The statement may not be combined with any other statement for which the carrier may require the applicant or covered person's signature. For group plans, the carrier shall provide a notice in any enrollment materials of the above prohibition of sale of a specified disease plan to persons covered by Title XIX programs.

(6) Any benefit that is conditioned on repeated care for a specified disease shall begin with the first day of care even if the diagnosis is made at some later date.

(7) A specified disease plan shall provide benefits only on a fixed indemnity basis.

(8) A specified disease plan may offer other fixed indemnity benefits in compliance with 13.10.34.12.

B. Minimum benefits. The following minimum benefits standards apply to all specified disease coverages:

(1) No less than an aggregate amount of $5,000 per triggering diagnosis. The OSI may approve product filings that allow a lower aggregate amount for a variant or subtype of a covered specified disease that requires minimally invasive treatment or are

non-life-threatening. OSI may also approve plan designs for more extensive coverage for dependents.

(2) Dollar benefit limits shall be offered for sale only in even increments of $1,000 unless for dependent extended coverage riders, in which case this extended coverage may be offered for sale only in even increments of $500.

(3) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular variant or subtype of the disease, unless lower aggregate amounts have otherwise been approved under Paragraph (1) of this subsection.

C. Reductions in benefits. A specified disease plan shall not eliminate or reduce benefits based on the occurrence of specified events or attaining a certain age.

D. Overinsurance. No carrier or producer shall offer or sell a specified disease plan, or combination of such plans, that apply to more than eight specified diseases. Except for group specified disease plans offered by an employer, no carrier or producer shall sell a specified disease plan if that would result in the customer having coverage for more than eight specified diseases under plans issued by different carriers. Except for group specified disease plans offered by an employer, a specified disease plan application shall inquire whether a prospective insured has other specified disease coverage, and about the number and type of diseases covered by a prospective insured's other coverage, if any. A specified disease plan may provide benefits for all medically diagnosed and commonly recognized forms or variations of each specified disease or illness without having each variation count against the eight disease limit. A carrier shall not sell to an individual a specified disease plan if such coverage would result in the individual being covered by more than one specified disease plan for the same specified disease.

[13.10.34.13 NMAC - Rp, 13.10.34.13 NMAC, 07/01/2023]

13.10.34.14 ADDITIONAL REQUIREMENTS FOR HOSPICE CARE BENEFITS:

A hospital indemnity plan that provides hospice coverage, separately or in conjunction with other hospital indemnity coverage, is subject to these additional requirements.

A. Scope. The hospice benefit shall apply to care received in a facility or through an in-home program, licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(1) for terminally ill patients whose life expectancy is less than six months;

(2) provided on an inpatient or outpatient basis; and

(3) directed by a physician.

B. Benefits trigger. Hospice benefits shall be payable when the attending physician of the covered person provides a written statement that the covered person has a life expectancy of six months or less, and the person is receiving hospice care as described in this rule.

C. Hospice benefit. A hospice care benefit shall be no less than a lump-sum of $2,500.

[13.10.34.14 NMAC - Rp, 13.10.34.14 NMAC, 07/01/2023]

13.10.34.15 SUPPLEMENTAL PLAN:

A supplemental plan is subject to these additional requirements.

A. Group coverage limitation. A carrier shall only offer or issue a supplemental plan to a person who is covered under a primary group major medical, TRICARE or Champus plan.

B. Plan design. A supplemental plan must be specifically designed to fill gaps in the primary coverage. This requirement is satisfied if the coverage is designed to fill gaps in cost-sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits as defined under section 1302(b) of the Patient Protection and Affordable Care Act in the New Mexico benchmark plan, or the coverage is designed to both fill such gaps in cost-sharing under, and cover such benefits not covered by, the primary coverage.

C. No coordination. A supplemental plan shall not include a coordination-of-benefits provision but may condition payment of benefits on the covered person becoming obligated to pay a cost-sharing obligation under the primary coverage.

D. Indemnity. A supplemental plan shall not offer fixed indemnity benefits.

E. Filing requirement. For each supplemental plan filed with the superintendent, the carrier shall also file a separate document specifically identifying any offered benefits that are not covered by group major medical coverage and are not essential health benefits.

F. Exclusions. A supplemental plan shall include a provision that guarantees the plan will not impose an exclusion that does not appear in the covered person's group major medical plan.

[13.10.34.15 NMAC - Rp, 13.10.34.15 NMAC, 07/01/2023]

13.10.34.16 NON-SUBJECT WORKER PLAN:

A non-subject worker plan is subject to these additional requirements.

A. Eligibility. A non-subject worker plan shall only be offered or sold to a person who is self-employed and not subject to New Mexico workers' compensation law protections. A carrier shall investigate and evaluate the self-employment status of each applicant for an individual non-subject worker plan, and of each person who applies to enroll in a group non-subject worker plan. An attestation of self-employment by an applicant shall not relieve a carrier from these duties. 1099 income, standing alone, is insufficient proof of self-employment.

B. Notice. An application for individual coverage, and an enrollment form for group coverage, shall include this notice, printed in 14-point type:

THE INSURANCE YOU ARE APPLYING FOR IS NOT A MAJOR MEDICAL INSURANCE PLAN. THE INSURANCE YOU ARE APPLYING FOR DOES NOT OFFER ANY BENEFIT FOR MEDICAL CARE YOU REQUIRE FOR AN OFF-WORK INJURY OR ILLNESS.

TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT WWW.BEWELLNM.COM. OR CALL 1-833-862-3935. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, MEDICAID OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

C. Benefit requirements. The benefits provided under a non-subject worker plan are limited to medical expense reimbursement, wage loss replacement and lump-sum payment for permanent or temporary disability (full or partial) sustained by a covered person as a result of an on-the-job injury or occupational disease. A subject plan may provide any combination of such benefits, subject to the benefit levels rule.

D. Benefit levels. The benefits offered under a non-subject worker plan shall be no less than what a covered person would be entitled to receive if that person's self-employment was subject to New Mexico workers' compensation laws. A subject plan may provide lower benefit levels, and omit some such benefits, provided the carrier offers an applicant a plan that would provide workers' compensation equivalent benefits, and the covered person rejects that offer in writing. The rejection document shall include the following attestation printed in 14-point type:

[CARRIER] OFFERED APPLICANT AN INSURANCE PLAN THAT INCLUDED BENEFITS EQUIVALENT TO WHAT APPLICANT WOULD BE ENTITLED TO IF THE APPLICANT'S SELF-EMPLOYMENT WAS SUBJECT TO NEW MEXICO WORKERS' COMPENSATION LAWS. THE MONTHLY PREMIUM FOR THAT COVERAGE WOULD BE [$XX]. APPLICANT ELECTED TO PURCHASE THIS PLAN WHICH PROVIDES LESS COVERAGE THAN WOULD BE AVAILABLE TO A SUBJECT WORKER UNDER THE NEW MEXICO WORKERS COMPENSATION LAWS. THE MONTHLY PREMIUM FOR THIS PLAN IS [$XX]. [CARRIER] OFFERED APPLICANT A CHART SHOWING THE DIFFERENCES BETWEEN THIS PLAN AND THE FULL COVERAGE PLAN AND OFFERED TO EXPLAIN THOSE DIFFERENCES.

I ATTEST THAT THE STATEMENT ABOVE IS TRUE AND CORRECT:

_____
_____

[APPLICANT NAME] DATE

E. Notice to Workers' Compensation Administration. Upon the sale of any non-subject worker plan, the carrier shall file a disclosure notice with the New Mexico Workers' Compensation Administration Employer Compliance Bureau. The notice shall contain the following information:

(1) name of covered person;

(2) covered person's occupation;

(3) name, address, and telephone number of any group sponsor of the plan; and

(4) effective dates of the plan.

[13.10.34.16 NMAC - Rp, 13.10.34.16 NMAC, 07/01/2023]

13.10.34.17 FORM AND RATE FILING AND APPROVAL REQUIRED:

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

B. Prior approval of rates required. A carrier shall not use rates or modified rates for an individual or group plan unless and until such rates are filed with and approved by the superintendent, except for rates for a plan issued to eligible members of an out-of-state group policyholder defined by Paragraph (1) of Subsection A of Section 59A-23-3 NMSA 1978. A carrier shall not offer a group coverage plan to New Mexico residents that are members of a group not defined in Paragraph (1) of Subsection A of Section 59A-23-3 NMSA 1978 under a plan issued to an out-of-state group policyholder unless the plan complies with Subsections D and G of this Section. Projected loss ratios for new plans or products shall be filed prior to sales and be based on credible data.

C. Rate filing requirements. The superintendent shall post on its website requirements for filing actuarial memorandums and rates for rate filing requests.

D. **Minimum loss ratios for group plans.** A group product subject to this rule shall be subject to the following actual minimum loss ratios, adjusted for low or high average premium forms:

(1) Definitions of renewal clause. The following definitions shall be applied to the table:

Type of Coverage:	OR	CR	GR	NC
Medical Expense	65%	60%	60%	55%
Loss of Income and Other	65%	60%	55%	50%

(a) OR- Optionally Renewable: renewal is at the option of the insurance company;

(b) CR- Conditionally Renewable: renewal can be declined by class; by geographic area or for stated reasons other than deterioration of health;

(c) 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;

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

(2) Low average premium forms. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate 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; and

X is the average annual premium, up to a maximum of I x 250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{(N-1) CPI-U, (1982)}} = \frac{\text{CPI-U, Year}}{97.9}$$

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 based on the 1982=100 basis;

(c) the CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 97.9;

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

(e) Low average annual premium is defined as average annual premium less than or equal to I x 250.

(f) High average annual premium is defined as average annual premium more than or equal to I x 1500.

(3) High average premium forms. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is high (as defined above), 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

(2) above)
X is the average annual premium, not less than I x 1500.

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

(a) R + 5 percentage points, or (b) 68%.

(4) Determination of average premium. A carrier shall determine the average annual premium per form based on the 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 certificates (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

E. Individual plan minimum loss ratio. An individual plan subject to this rule shall be subject to the following actual minimum loss ratios, adjusted for low or high average premium forms:

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

(1) Definitions of renewal clause. The following definitions shall be applied to the table:

(a) OR- Optionally Renewable: renewal is at the option of the insurance company;

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

(c) 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;

(d) NC- Non-cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

(2) Low average premium forms. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is low (as defined below), the appropriate ratio for 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; and

X is the average annual premium, up to a maximum of I x 250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{(N-1) CPI-U, (1982)}} = \frac{\text{CPI-U, Year}}{97.9}$$

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, based on the 1982=100 basis;

(c) the CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 97.9;

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

(3) High average premium forms. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is high (as defined above), the appropriate ratio from the table above should be adjusted upward by the following formula:

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

where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor (as defined in Paragraph

(2) above)

X is the average annual premium, not less than I x 1500.

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

(a) R + 5 percentage points, or

(b) 63%.

(4) Determination of average premium. A carrier shall determine the annual premium per form 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 certificates (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 rates being filed. Thus, where this adjustment is applicable to a rate revision under Paragraph G, 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.

F. Rate revisions. The following requirements shall apply to rate revision requests:

(1) With respect to filing 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 most current standards applicable to rate filings; and

(2) Carriers are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid non-compliance with this rule.

G. Annual rate certification filing procedures. Carriers not filing new or updated premium rates in any given plan year shall file an actuarial memorandum demonstrating that minimum loss ratios have been met for all products.

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

(2) Aggregation. Loss ratios shall be calculated on a consolidated level across policies with the same product type and benefit design.

(3) Measurement period. Compliance with the minimum loss ratio shall be measured over 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). A filing for a new pool shall be based on credible data from generally recognized industry sources. Separate filings shall be made for separate rating pools.

(4) Frequency. Actual loss ratios shall be calculated annually by carriers that issue excepted benefits products specified in this rule, beginning in 2023.

(5) Timeline. The evidence of compliance with the minimum loss ratio requirements shall be filed with the superintendent on the anniversary date when the product or the product's most recent rate filing was approved.

(6) Methodology. Actual loss ratios shall be calculated using company claim data including an estimate for claims incurred but not reported. The claims will be reported 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 after the third year of experience is available). The actual accumulated loss ratio over the measurement period (A) will be compared to original pricing accumulated loss ratios over the measurement period (E) as a method of justifying the minimum loss ratio is being met or showing the need for remedial action if (A)/(E) is below the threshold specified in Paragraph (8) of this subsection.

(7) Waiver. For noncredible blocks of business on a nationwide basis, the company may request a waiver of the requirement. The request shall be made annually and must be accompanied by a letter indicating the nature of the filing, the type of product, and the reason for the request.

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

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

(b) a rate filing to justify the rates, revise rates, modify benefits through a benefit endorsement or to return excess premium, if the actual accumulated loss ratio divided by the expected accumulated loss ratio (A/E) over the measurement period is below eighty-five percent.

(9) The superintendent may require a plan to return excess premiums or increase benefits proportionately if the ratio of the actual accumulated experience to the expected accumulated experience (A/E) is below eighty percent.

(10) A carrier shall not return excess premiums per the above guidelines, until the carrier files a refund plan and calculation with and obtains approval of the plan by the superintendent.

H. Disapproval of forms and rates. The superintendent shall disapprove a form:

(1) if the benefit provided therein is unreasonable in relation to the premium charged; or

(2) that misrepresents the benefits, advantages, conditions or terms of any plan or that unfairly characterizes the plan as more favorable to the covered person than the actual terms of the plan, such as naming coverage for specific diseases whose primary forms of treatment are then listed as exclusions;

(3) that uses any false or misleading statements;

(4) that uses any name or title of any plan or class of plans misrepresenting the true nature thereof, including misrepresenting the plan as major medical coverage; or

(5) that is contrary to law, discriminatory, deceptive, unfair, impractical, unnecessary or unreasonable.

I. Variable MLR. A carrier shall not offer a plan subject to this rule to any person unless each possible plan design selectable by that person meets the MLR requirements as reflected in an approved rate filing. For variable forms, a carrier cannot satisfy MLR requirements with average premiums for the form as a whole. The carrier must base MLR calculations on the average premium for each possible combination of benefits and levels offered by demographics used for underwriting. The superintendent reserves the right to reject a plan that has no meaningful difference from another plan offered by the same carrier. The requirements of this rule do not apply to a non-contributory plan.

J. Premium increases. A carrier shall not increase a covered person's premium under any plan, other than a disability income plan, during the first two years that the covered person's coverage is in force except in cases where one or more persons are added to the policy as covered persons during this two year period. The new premium resulting from the addition of a covered person(s) shall not change for the first two years the policy with the added lives is in force.

[13.10.34.17 NMAC - Rp, 13.10.34.15 NMAC, 07/01/2023]

13.10.34.18 REQUIRED DISCLOSURES AND NOTICES:

A. General notice requirement. An application for an individual plan or plan sold through an association or group described in Paragraphs (2) or (4) of Subsection A of 59A-23-3 NMSA 1978, other than a disability income plan, shall contain in bold, 14-point type, directly above the applicant signature line the following notice:

> NOTICE TO BUYER: PLEASE REVIEW THIS PLAN CAREFULLY. IT ONLY PROVIDES LIMITED BENEFITS, AND IT DOES NOT ON ITS OWN OR IN COMBINATION WITH OTHER LIMITED BENEFITS POLICIES CONSTITUTE MAJOR MEDICAL INSURANCE. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.
>
> TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT [WWW.BEWELLNM.COM] OR CALL [1-833-862-3935]. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

B. Renewal provision. A plan shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of plan to be issued. The provision shall be appropriately captioned, shall appear on the first page of the plan, and shall clearly state the duration of coverage and renewal terms.

C. Riders. A rider, endorsement, or supplement added to a plan after its effective date that reduces or eliminates benefits or coverage shall not be effective unless signed by the covered person. Signature may include electronic signature or voice signature, however, this signature must be recorded by the carrier and time-stamped. This signature requirement does not apply to certificates issued to covered persons in a group plan. A signature shall not be required if the rider, endorsement or supplement reflects a change to the plan that is required by law.

D. Additional premium for riders, endorsements or supplement. If an additional premium is charged for benefits specified in a rider, endorsement or supplement, the plan or certificate shall specify the premium.

E. Preexisting conditions. If a plan includes any preexisting condition exclusion or limitation, the plan or certificate shall include a separate section labeled "Preexisting Conditions, Exclusions and Limitations."

F. Right of return/Free look. A plan shall include a prominent notice, printed on or attached to the first page of the plan, stating that the covered person has the right to return the plan, and cancel any associated voluntary group membership enrolled in contemporaneous with the plan enrollment, within 30 days of its delivery, and to have the premium and membership fees refunded in full if the covered person is not satisfied for any reason.

G. Age factors. If age is a factor that reduces aggregate benefits, that factor shall be prominently set forth in the outline of coverage.

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

I. Medicare supplement notice.

(1) The outline of coverage delivered with an accident-only, specified disease, hospital indemnity, supplemental or non-subject plan shall contain the following notice in bold 14-point type:

THIS IS NOT A MEDICARE SUPPLEMENT PLAN. IF YOU ARE ELIGIBLE

FOR MEDICARE, ASK FOR INFORMATION ABOUT MEDICARE SUPPLEMENT POLICIES.

(2) A carrier shall deliver to persons eligible for Medicare any notice required under 13.10.25 NMAC.

J. Outline of coverage requirements. Each subject plan and certificate shall include the outline of coverage that provides a basic overview of the plan's purpose, benefits, coverage minimums and maximums.

(1) The outline of coverage shall include the following notice, printed in bold 14-point type:

> READ YOUR PLAN CAREFULLY – THIS OUTLINE OF COVERAGE PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR COVERAGE. THIS IS NOT THE INSURANCE CONTRACT AND ONLY THE ACTUAL PLAN PROVISIONS WILL DETERMINE THE TERMS OF COVERAGE. THE PLAN ITSELF SETS FORTH IN DETAIL THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND YOUR INSURANCE COMPANY. IT IS, THEREFORE, IMPORTANT THAT YOU READ YOUR PLAN CAREFULLY!

(2) The outline of coverage shall provide contact information for the OSI consumer assistance bureau.

K. Delivery of plan documents. A carrier shall not bind coverage for any subject plan without delivering all plan documents to a prospective insured and allowing the prospective insured 30 calendar days to review those materials. Nothing in this subsection precludes a carrier from making coverage retroactive to the date that the plan documents were delivered to the prospective insured. The carrier shall maintain proof of compliance with this requirement for each sale for five years from the coverage effective date. For a group plan, either the carrier or the group master policyholder may satisfy the delivery requirement, but the carrier shall remain responsible for any failure to do so by the master policyholder. In the case where the group master policyholder delivers the plan documents to the prospective policyholders, the carrier shall require the group master policyholder to attest to the compliance with the requirements of this section and to provide documents that clearly support the attestation. The carrier shall not bind coverage until it has received the master policyholder's attestation.

[13.10.34.18 NMAC - Rp, 13.10.34.16 NMAC, 07/01/2023]

13.10.34.19 REQUIREMENTS FOR REPLACEMENT OF INDIVIDUAL PLAN COVERAGE:

A. Required questions. An application for an individual plan or a plan sold through an association or group described in Paragraphs (2) or (4) of Subsection A of 59A-23-3 NMSA 1978 shall ask whether the insurance requested will replace any other plan subject to this rule.

B. Notice requirement. Upon determining that a sale will involve replacement of a plan, a carrier, other than a direct response carrier, or its agent, shall furnish the applicant, prior to issuance or delivery of the plan, the notice described in Subsection C below. A direct response carrier shall deliver to the applicant, upon issuance of the plan,

the notice described in Subsection D below. No notice is required for the solicitation of accident-only or single premium nonrenewal policies. The carrier shall retain proof of notice for five years from the coverage effective date.

C. Non-direct response carrier notice:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIMITED BENEFIT HEALTH INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing insurance and replace it with a plan to be issued by [insert company name] Insurance company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new plan.

(1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new plan. This could result in denial or delay of a claim for benefits under the new plan, whereas a similar claim might have been payable under your present plan.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present plan. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present plan and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your plan had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

D. Direct response carrier notice:

NOTICE TO APPLICANT REGARDING REPLACEMENTOF LIMITED BENEFIT HEALTH INSURANCE

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing insurance and replace it with the plan delivered herewith and issued by [insert company name] Insurance company. Your new plan provides 30 days within which you may decide without cost whether you desire to keep the plan. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new plan.

(1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new plan. This could result in denial or delay of a claim for benefits under the new plan, whereas a similar claim might have been payable under your present plan.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present plan. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) [To be included only if the application is attached to the plan]. If, after due consideration, you still wish to terminate your present plan and replace it with new coverage, read the copy of the application attached to your new plan and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

[13.10.34.19 NMAC - Rp, 13.10.34.17 NMAC, 07/01/2023]

13.10.34.20 COORDINATION OF BENEFITS, BUNDLING AND VARIABILITY:

A. Noncoordination of benefits. Benefits under a plan shall:

(1) be provided under a separate plan, certificate, or contract of insurance;

(2) have no coordination with the benefits offered under a health plan; and

(3) pay benefits regardless of any benefits provided under a health plan.

B. No bundling. No carrier, directly or through an affiliated producer, shall market or sell a bundled combination of accident-only, specified disease, hospital indemnity and non-subject worker plans. An application that is used in connection with more than one type of plan subject to this rule shall include a conspicuous notice that the applicant cannot purchase more than one type of plan from the carrier using the same

application. This provision does not preclude the same carrier from selling more than one product type to a single purchaser as long as each policy is available at its own stated premium rate, independent of the other product types. A carrier shall not offer or provide memberships or discounts relating to health care services or products. The provisions of this subsection shall not apply to a plan sold through a group identified in Paragraphs (1) or (3) of Subsection A of 59A-23-3 NMSA 1978, or to a bona fide association.

C. Major medical coverage requirement. Accident-only, specified disease, hospital indemnity and non-subject worker plans, excluding blanket coverage compliant with Section 59A-23-2 NMSA 1978 and group plans described in Paragraph (1) of Subsection A of 59A-23-3 NMSA 1978, shall only be issued to persons who acknowledge that the plan is not major medical or comprehensive health insurance. For purposes of this requirement, short-term, limited-duration insurance shall not be considered major medical coverage.

(1) An application or enrollment form for a plan subject to this subsection shall include an attestation by the applicant affirming that the applicant understands that the individual is not purchasing major medical insurance at the time of application. An application for a hospital indemnity plan, or plan offering other fixed indemnity benefits, shall also include any disclosure required by federal law. The attestation shall be in writing and signed by the applicant before coverage becomes effective. The carrier may retroactively apply coverage to the date of application.

(2) A sale of a plan subject to this subsection is unauthorized if an applicant fails to sign or deliver the attestation described in this rule.

(3) A carrier shall retain a copy of the attestation for at least five years.

(4) If a carrier of a plan subject to this subsection learns, directly or through an agent, that a covered person's major medical coverage has lapsed or was canceled, the carrier shall send the person the following notice:

> YOUR MAJOR MEDICAL COVERAGE MAY HAVE RECENTLY LAPSED. YOUR POLICY WITH [IDENTIFY COMPANY] IS NOT MAJOR MEDICAL HEALTH INSURANCE. THE BENEFITS PROVIDED BY [IDENTIFY COMPANY] DO NOT COVER ALL MEDICAL EXPENSES.
>
> TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT WWW.BEWELLNM.COM. OR CALL 1-833-862-3935. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, MEDICAID OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

D. Matrix forms. The coverages governed by this rule are subject to prohibitions on matrix forms as otherwise specified in New Mexico law.

[13.10.34.20 NMAC - Rp, 13.10.34.18 NMAC, 07/01/2023]

13.10.34.21 PENALTIES:

The sale of any plan that does not comply with this rule is unlawful. In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the New Mexico Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurance carrier or insurance producer by the superintendent. The actions of any producer or third-party administrator relating to the sale of a plan subject to this rule, or a claim under any such plan, shall be deemed the actions of the plan issuer.

[13.10.34.21 NMAC - Rp, 13.10.34.19 NMAC, 07/01/2023]

13.10.34.22 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.34.22 NMAC - Rp, 13.10.34.20 NMAC, 07/01/2023]

PART 35 MINIMUM STANDARDS FOR DENTAL AND VISION PLANS

13.10.35.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

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

13.10.35.2 SCOPE:

This rule applies to every carrier who offers or sells any individual or group dental or vision insurance plan ("plan") separately from a health benefits plan. This rule does not apply to any pediatric dental or vision plan, or to any prepaid dental plan. Subject to the foregoing, this rule applies to a group dental or vision plan offered or sold to a New Mexico resident under a master policy delivered outside of this state.

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

13.10.35.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-23G-1 et seq. NMSA 1978.

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

13.10.35.4 DURATION:

Permanent.

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

13.10.35.5 EFFECTIVE DATE:

January 1, 2022 unless a later date is cited at the end of a section. If the superintendent previously approved a subject plan, that plan shall comply with this rule no later than January 1, 2022, if issued on or after that date.

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

13.10.35.6 OBJECTIVE:

Establish minimum regulatory standards and sales practices relating to dental and vision plans; standardize and simplify the terms and coverages; facilitate public understanding and comparison of coverage; eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims; and require disclosures in the marketing and sale of the subject plans.

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

13.10.35.7 DEFINITIONS:

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

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

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

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

13.10.35.8 GENERAL PROHIBITED POLICY PROVISIONS:

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

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

C. Exclusions. A plan that includes a preexisting condition exclusion shall comply with these requirements:

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

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

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

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

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

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

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

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

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

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

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

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

13.10.35.9 GENERAL STANDARDS FOR POLICIES AND BENEFITS:

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

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

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

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

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

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

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

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

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

(iii) fraud or misrepresentation affecting coverage;

(iv) policyholder request for cancellation;

(v) policy term ends; or

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

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

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

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

(a) be in writing and dated;

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

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

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

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

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

(3) If a plan includes a conversion privilege, the provision shall be captioned, "Conversion Privilege." The provision shall specify who is eligible for conversion and the

circumstances that govern conversion, or may state that the conversion coverage will be provided as an approved plan form used by the carrier for that purpose.

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

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

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

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

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

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

C. For group coverage. A group plan shall comply with Sections 8, 9, 11, and 12 of 13.10.5 NMAC, and Subsection D of 13.10.5.10 NMAC.

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

13.10.35.10 DENTAL PLANS:

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

B. Definitions. For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

dental plan may apply a waiting period of six consecutive months for medically necessary sealants.

(4) Cavities. A dental plan shall cover necessary fillings for cavities.

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

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

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

13.10.35.11 VISION PLANS:

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

B. Definitions. For purposes of this section:

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

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

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

(a) lenses;

(b) frames;

(c) contact lenses; and

(d) spectacle or contact lens treatments and coatings;

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

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

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

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

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

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

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

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

(3) Contact lenses shall be covered as follows:

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

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

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

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

(1) any that are not medically necessary;

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

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

(4) vision therapy; and

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

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

13.10.35.12 COORDINATION AND COMBINATION OF BENEFITS:

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

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

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

13.10.35.13 COVERAGE DOCUMENTATION:

A. Coverage forms and benefits disclosures.

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

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

(a) the covered services, supplies and materials;

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

(c) where and in what manner information is available as to how services may be obtained;

(d) a clear and understandable description of the method for resolving a covered person's complaint.

(e) conditions for renewal and reinstatement;

(f) procedures for filing claims;

(g) a statement of the amounts payable to the carrier by a covered person and the times at which the amounts shall be paid;

(h) the period during which the plan is effective; and

(i) on the front page, the identity of the carrier.

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

B. Notice required. The following language shall be provided in a summary of benefits:

READ YOUR PLAN CAREFULLY - THIS BENEFITS SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

C. Contact information. The policy, certificate or summary of benefits shall state the plan's contact information and the website and phone number of the office of superintendent of insurance.

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

13.10.35.14 NETWORK ADEQUACY:

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

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

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

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

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

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

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

(a) include specialty providers;

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

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

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

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

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

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

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

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

13.10.35.15 UTILIZATION MANAGEMENT DETERMINATIONS:

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

made in accordance with medical necessity standards and appropriate clinical guidelines.

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

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

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

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

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

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

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

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

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

(5) another payer is responsible for the payment;

(6) another payer has already paid the claim;

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

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

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

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

13.10.35.16 CONSUMER COMPLAINTS:

A carrier shall state in all plan documents that a covered person who cannot resolve a complaint with the plan may contact the office of the superintendent of insurance.

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

13.10.35.17 PENALTIES:

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

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

13.10.35.18 SEVERABILITY:

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

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

PART 36: HEALTH CARE AFFORDABILITY FUND

13.10.36.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance ("OSI").

[13.10.36.1 NMAC – N, 5/1/2022]

13.10.36.2 SCOPE:

These rules govern the establishment and provision of a Health Care Affordability Plan and administration of the Health Care Affordability Fund (the "Fund").

[13.10.36.2 NMAC – N, 5/1/2022]

13.10.36.3 STATUTORY AUTHORITY:

Section 59A-23F-12 NMSA 1978 (the "Health Care Affordability Plan").

[13.10.36.3 NMAC – N, 5/1/2022]

13.10.36.4 DURATION:

Permanent.

[13.10.36.4 NMAC – N, 5/1/2022]

13.10.36.5 EFFECTIVE DATE:

May 1, 2022, unless a later date is cited at the end of a section.

[13.10.36.5 NMAC – N, 5/1/2022]

13.10.36.6 OBJECTIVE:

These rules establish policies, procedures, and controls for the establishment and maintenance of a "Health Care Affordability Plan" as funded by the "Health Care Affordability Fund" to achieve the public policy purposes in the manner prescribed under Sections 59A-23F-11 and 59A-23F-12 NMSA 1978.

[13.10.36.6 NMAC – N, 5/1/2022]

13.10.36.7 DEFINITIONS:

Terms are as defined in the Insurance Code, and as supplemented below.

A. "Advance state payments" means marketplace affordability program payments by the fund to a participating health insurance issuer on a monthly basis to lower premium and state out-of-pocket assistance for consumers.

B. "Affordability criteria" means the factors used to determine the amount of premium assistance or state out-of-pocket assistance that will be provided from the fund on behalf of an eligible individual.

C. "Eligible plan" means a health plan sold on the New Mexico health insurance exchange (the "exchange" or "marketplace") that meets the requirements for the state premium assistance program.

D. "Federal poverty level or FPL" means the federal poverty level issued annually by the U.S department of health and human services at aspe.hhs.gov/poverty-guidelines/.

E. "Income criteria" means parameters to establish eligibility for marketplace affordability programs.

F. "Modified adjusted gross income or MAGI" means modified adjusted gross income as defined in 42 CFR § 435.60.

G. "Marketplace affordability program" means a fund program that reduces premiums and OOP costs for individuals and families who purchase individual or family coverage on the exchange.

H. "OOP" means out-of-pocket.

I. "Participating health insurance issuer" means a health insurance issuer who is authorized to sell a QHP on the exchange or in the fully-insured small group market who has confirmed in writing its intention to participate in a specified fund program prior to the commencement of the plan year.

J. "Plan year" means the year for which a participating health insurance issuer underwrites qualifying health insurance coverage.

K. "Premium assistance" means a fund program that pays a participating health insurance issuer to cover a portion of the premium obligation of a person who meets premium assistance affordability criteria.

L. "QHP" means a qualified health plan.

M. "Small business health insurance premium relief initiative" means a program to reduce premiums for small businesses that purchase QHPs in the small group health insurance market.

N. "Small group QHP purchaser" means an employer who purchases one or more QHPs for any of its employees or owners through the small business health options program or directly from a health insurance issuer selling QHPs in the small group health insurance market.

O. "State benchmark plan" means a qualified health plan that has been approved for sale on the exchange and that is identified by the superintendent as the plan to be used in developing affordability criteria.

P. "State out-of-pocket assistance program" means a fund program that reduces OOP costs for households that meet eligibility and income criteria established by the superintendent.

[13.10.36.7 NMAC – N, 5/1/2022; E/A, 6/1/2022; A, 9/1/2022]

13.10.36.8 APPROPRIATIONS REQUESTS:

This rule governs appropriation requests.

A. Annually, the superintendent will submit appropriation requests to the legislative finance committee for each fund program. OSI will post proposed program parameters associated with the budget request on the agency's website upon submission to the legislative finance committee.

B. The request for each fund program shall meet these minimum standards:

(1) for the marketplace affordability program, sufficient funding to provide premium reductions for individuals under four hundred percent of the FPL and OOP cost reductions for individuals under three hundred percent of the FPL;

(2) for the small business health insurance premium relief initiative, sufficient funding to realize premium reductions for qualified health plans across the small group market; and

(3) for the uninsured program, sufficient funding to expand coverage to eligible individuals under two hundred percent of the FPL before expanding further up the income scale.

[13.10.36.8 NMAC – N, 5/1/2022; A/E, 6/1/2022, A, 9/1/2022]

13.10.36.9 PREMIUM ASSISTANCE AND ANNUAL OOP PROGRAMS:

This rule governs the annual state out-of-pocket assistance and premium assistance programs.

A. Affordability criteria: Annually, the superintendent shall publish a bulletin specifying affordability criteria for the ensuing plan year. Absent extenuating circumstances that mandate an earlier rate filing, the superintendent shall allow issuers at least 15 days from publication of the bulletin to make an initial QHP rate filing. If the federal government changes policies that will affect the cost of the program to the state

or the cost to enrollees after the issuance of the bulletin, the superintendent may adjust the affordability criteria.

(1) These are the affordability criteria that the superintendent may consider to determine premium assistance eligibility for a plan year. The superintendent will use these criteria to establish a premium sliding scale based on household income:

(a) the percentage of an enrollee's MAGI as computed according to federal standards;

(b) the percentage of enrollee's MAGI that would be needed to purchase the state benchmark plan as established by the superintendent;

(c) the percentage of New Mexico residents at or below a given the FPL percentage; and

(d) The federal premium sliding scale for marketplace coverage.

(2) These are the affordability criteria that the superintendent may consider to determine state out-of-pocket assistance eligibility. The superintendent will use these criteria to establish state cost sharing reduction variants that improve the actuarial value of certain QHPs offered on the exchange:

(a) an enrollee's MAGI as computed according to federal standards;

(b) plan type and metal level tiers that qualify for state out-of-pocket assistance; and

(c) actuarial values for plans that qualify for state out-of-pocket assistance.

B. Income eligibility parameters. Annually, the superintendent shall publish a bulletin specifying income eligibility parameters for the ensuing plan year. Absent extenuating circumstances that mandate an earlier rate filing, the superintendent shall allow participating health insurance issuers at least 15 days from publication of the bulletin to make an initial QHP rate filing. If the federal government changes policies that will affect the cost of the program to the state or the cost to enrollees after the issuance of the bulletin, the superintendent may adjust the income eligibility parameters. The income eligibility parameters may differ for the premium assistance program, state out-of-pocket assistance program or premium assistance for state residents who are members of federally-recognized tribes. In developing the criteria, the superintendent may consider the following factors:

(1) the income distribution of current marketplace enrollees;

(2) the income distribution of uninsured individuals who qualify for coverage on the New Mexico health insurance exchange; or

(3) health insurance market stability issues and year-over-year trends in premium rate affordability.

C. General eligibility requirements.

(1) To qualify for state out-of-pocket and premium assistance, consumers must:

(a) be eligible to purchase a QHP on the exchange;

(b) qualify for federal premium assistance; and

(c) meet income criteria established annually by the superintendent.

(2) The superintendent will issue criteria for premium assistance that is available to members of federally-recognized tribes. To qualify, individuals must:

(a) meet all other criteria for state premium assistance; and

(b) be a member of a federally-recognized tribe.

D. Premium and state out-of-pocket assistance payment disbursements. Disbursements for premium assistance or state out-of-pocket assistance to a participating health insurance issuer of an eligible enrollee who purchases an eligible plan are governed by this rule. Monthly, by the 15th of each month, the exchange shall report to the superintendent the total amount due to each participating health insurance issuer for premium assistance and state out-of-pocket assistance for coverage of its eligible enrollee(s) for the preceding calendar month.

(1) The monthly payment amount due to a participating health insurance issuer for premium assistance shall be the monthly aggregate amount of premium assistance for all eligible enrollees of the health insurance issuer for the month.

(a) Monthly state premium assistance amounts shall be calculated using the following formula: gross monthly premium for state benchmark plan minus monthly federal premium tax credit minus applicable percentage of income established by superintendent multiplied by expected annual household income as outlined in 45 C.F.R. § 155.305(f)(i) divided by 12.

(b) Within 10 days of receiving the monthly accounting from the exchange, the superintendent will, by voucher, request that the secretary of finance and administration issue warrants as necessary to ensure payment to each participating health insurance issuer for the monthly amount determined to be due by the superintendent.

(2) The monthly payment amount to a participating health insurance issuer for state out-of-pocket assistance shall be determined as a percentage set by the superintendent of gross monthly premiums for enrollees of an eligible plan in a specified income tier, aggregated across all qualifying income tiers.s

(3) To facilitate reconciliation, a health insurance issuer must track or accurately estimate claim costs in accordance with guidance published by the superintendent to allow for the determination of actual utilization of out-of-pocket assistance.

[13.10.36.9 NMAC – N, 5/1/2022]

13.10.36.10 MINIMIZING COVERAGE DISRUPTIONS AFTER THE FEDERAL MEDICAID CONTINUOUS COVERAGE REQUIREMENT EXPIRES:

This rule governs the agency's efforts to ensure a smooth transition into a QHP offered on the New Mexico health insurance exchange for individuals who no longer qualify for medicaid after the expiration continuous coverage requirement in the federal "families first coronavirus response act".

A. Temporary medicaid transition premium relief program. The superintendent may issue a bulletin establishing a program that fully covers the cost of the first month's premium for any QHP sold on the individual health insurance exchange for eligible individuals and families. The premium relief will be available to all members of a household that meet the eligibility requirements in Paragraph B of this section. The payment may be used to effectuate coverage.

B. Eligibility for medicaid transition premium relief program. To qualify, a person must:

(1) be a resident of the state of New Mexico who is eligible to purchase a QHP on the New Mexico health insurance exchange;

(2) have lost medicaid coverage or expect to lose medicaid coverage within 60 days of submitting an application to the New Mexico health insurance exchange;

(3) no longer be enrolled in medicaid at the time their QHP coverage begins;

(4) be eligible for federal premium tax credits; and

(5) have an expected household income below four hundred percent of the federal poverty level during the plan year in which the federal coronavirus disease (COVID-19) public health emergency ends.

C. Duration. The program shall be available on January 1, 2023, or on the day the COVID-19 public health emergency ends, whichever is later. The program shall continue in accordance with legislative appropriations.

[13.10.36.10 NMAC – N/E, 6/1/2022, A, 9/1/2022]

13.10.36.11 SMALL BUSINESS HEALTH INSURANCE PREMIUM RELIEF INITIATIVE:

This rule governs the agency's small business health insurance premium relief initiative, which applies to QHPs sold through the small business health options program or purchased directly from a health insurance issuer selling QHPs in the small group health insurance market.

A. Premium reduction percentage bulletin. Annually, based on available funding, the superintendent will issue a bulletin establishing a premium reduction percentage that will apply to all QHPs sold in the small group health insurance market. Health insurance issuers participating in the market shall discount charges to small group QHP purchasers by the percentage established by the superintendent and show the amount of the discount in all invoices to the purchaser. The superintendent may allow issuers to apply the discount directly or through a credit on the following month's premium. The bulletin will establish the percentage reduction, reporting requirements, timetable and process for issuer reimbursement, and other requirements. The superintendent may issue additional guidance, if needed.

B. Reporting requirements and annual verification of accurate payments. Health insurance issuers selling QHPs in the small group health insurance market must report data related to enrollment, premiums, and reimbursement from the health care affordability fund to the office of superintendent of insurance on a regular basis, based on the requirements of the bulletin. Following each calendar year, on a date established by the superintendent, issuers must report annualized data requested by the agency to verify the accuracy of payments made from the fund. The superintendent will require issuers to replenish the fund if it is determined that any overpayment has been issued.

C. Payments to participating issuers. On a regular basis, as established in the bulletin, the office of superintendent of insurance will make payments from the health care affordability fund to issuers for the remainder of the gross premium that that would otherwise by owed by small group QHP purchasers if the small business health insurance premium relief initiative were not in effect. The data received by OSI pursuant to Paragraph B of Section 10 of this rule serves as the basis for OSI's regular payments to issuers from the health care affordability fund. Issuers must invoice the agency according to the bulletin's instructions in order to receive payment.

D. Notification of small group QHP purchasers. The superintendent will specify a date before the initiative goes into effect by which health insurance issuers must notify their small group QHP purchasers about the premium reductions provided by the

initiative. Issuers subject to the rule should reflect the premium reduction amount in all invoices.

E. Treatment as third-party payment. For the purposes of the federal risk adjustment program and federal medical loss ratio requirements, the state payment under this section should be considered a third-party payment that is part of the gross premium.

[13.10.36.11 NMAC – N/E, 6/1/2022, A, 9/1/2022]

PART 37 to 38: [RESERVED]

PART 39 PATIENTS' DEBT COLLECTION PROTECTIONS

13.10.39.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.10.39.1 NMAC - N, 12/28/2021]

13.10.39.2 SCOPE:

This rule applies to health care facilities, third-party health care providers, medical creditors, medical debt collectors and medical debt buyers subject to Sections 57-32-1 to 57-32-10 NMSA 1978.

[13.10.39.2 NMAC - N, 12/28/2021]

13.10.39.3 STATUTORY AUTHORITY:

Sections 59A-2-9 NMSA 1978 and sections 57-32-1 to 57-32-10 NMSA 1978.

[13.10.39.3 NMAC - N, 12/28/2021]

13.10.39.4 DURATION:

Permanent.

[13.10.39.4 NMAC - N, 12/28/2021]

13.10.39.5 EFFECTIVE DATE:

December 28, 2021 unless a later date is cited at the end of a section.

[13.10.39.5 NMAC - N, 12/28/2021]

13.10.39.6 OBJECTIVE:

To ensure that health care facilities offer and provide screenings to uninsured patients who may be eligible for Medicaid or other public health insurance, and to ensure that medical debt incurred by indigent patients will not be pursued through certain proscribed collection actions.

[13.10.39.6 NMAC - N, 12/28/2021]

13.10.39.7 DEFINITIONS:

For definitions of terms contained in this rule, refer to the Patients' Debt Collection Protection Act Sections 57-32-1 to 57-32-10 NMSA 1978 and in Chapter 59A NMSA 1978, unless otherwise noted below.

A. "Culturally and linguistically appropriate" means communication that meets the following requirements:

(1) the provision of oral and hearing-impaired language services (such as the telephone customer assistance hotline) that includes answering questions in any applicable non-English language, including American sign language (ASL), and providing assistance with filing claims and reviews in any applicable non-English language;

(2) the provisions of, upon request, verbal interpretation or translation of a notice into any applicable non-English language;

(3) the inclusion of, in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care facility;

(4) applicable non-English language is as defined by the centers for Medicare and Medicaid Services; and

(5) any written notice required by this rule must include the required information in English and Spanish.

B. "Day" or "days" means, unless otherwise specified:

(1) one – five days excludes weekends and state holidays; and

(2) six days or more includes weekends and holidays.

C. "Deliver" or "delivery" means email and retain an email delivery confirmation; written documentation of a verbal communication; electronic transmission through a dedicated two-way communication portal and retain delivery confirmation; fax and retain

a fax delivery confirmation; regular mail; or personal delivery. Written documentation may be maintained in a patient's electronic health record.

D. "Disclose" or "disclosure" means the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.

E. "Episode of care" means all emergency or medically necessary health care services related to the treatment of a condition or a service category for such treatment and for acute conditions, includes health care service and treatment provided from the onset of the condition to its resolution or a service category for such treatment and, for chronic conditions, includes health care services and treatment provided over a given period of time.

F. "Federal poverty guidelines" means the poverty guidelines issued annually by the U.S department of health and human services at aspe.hhs.gov/poverty-guidelines/.

G. "Household" means the countable members of the patient's household as defined by modified adjusted gross income.

H. "Medicaid" means the federal health program administered by the New Mexico human services department and established by the federal department of health and human services under Title XIX of the Social Security Act and by state statute, Section 27-1-12 NMSA 1978 et. seq., and regulations, including 8.391.430 NMAC.

I. "Modified adjusted gross income" or "MAGI" means household size and income calculated to determine eligibility for a Medicaid program as set forth by the New Mexico human services department.

J. "Patients' Debt Collection Protection Act" ("the Act") means Sections 1 through 10 of Chapter 57-32 NMSA 1978 and Section 61-18A-2 NMSA 1978.

K. "Public insurance" or "public health insurance" means Medicare, Medicaid, or any other government-supported health insurance and includes insurance offered on the New Mexico insurance exchange or by the New Mexico medical insurance pool.

L. "Screen" or "Screening" means a culturally and linguistically appropriate verbal or written inquiry to the patient about the patient's insured status for purposes of determining presumptive eligibility for Medicaid, eligibility for Medicaid or other public insurance programs, and eligibility for public financial assistance programs, including but not limited to the health care facility's own programs, or county or state indigency assistance.

M. "Uninsured" means that a patient who does not have major medical insurance compliant with the provisions of the Affordable Care Act.

[13.10.39.7 NMAC - N, 12/28/2021]

13.10.39.8 SCREENING FOR INSURANCE AND PROGRAM ELIGIBILITY:

A health care facility shall screen all patients and offer to assist uninsured patients in obtaining or accessing Medicaid, public insurance, public programs that assist with health care costs, and other financial assistance offered by the health care facility, before seeking payment for emergency or medically necessary care. A health care facility shall include a written notification regarding screening with any forms presented to patients for completion prior to service. No collection action shall occur during the screening process or while the patient's financial status or application for insurance or financial assistance is under review or in process. During a screening or provision of application assistance under this section, a health care facility shall not request or require information or documentation that is not necessary to determine eligibility for public insurance, public programs that may assist with health care costs, or financial assistance.

A. Timing. Health care facilities shall affirmatively offer to screen patients and, if the patient accepts the offer, screen patients when the patient is registered or within the following time periods:

(a) a patient who is admitted for emergency care shall be screened when the patient's condition has been stabilized through treatment and prior to discharge;

(b) a patient who is admitted for inpatient care shall be screened at the time that the inpatient care is scheduled or within 48 hours of admission;

(c) a patient who receives outpatient care shall be screened at the time that the outpatient care is scheduled or prior to completion of treatment;

(d) upon request of a patient who is scheduled to receive or has received health care services from the health care facility; or

(e) an incapacitated patient, including unconscious or otherwise unable to communicate, shall be screened when the patient is able to effectively communicate, if such status is achieved prior to discharge. The health care facility shall offer screening to parents, spouses, persons with healthcare powers of attorney or guardians of the patient, on the incapacitated patient's behalf.

(f) screening shall be provided upon request and shall be offered at least once for every episode of care within a 12 month period of time;

(g) completion of the screening process may occur outside of the specified time frames if the facility has made a documented good faith effort to complete the screening timely but is unable to do so due to availability of its screening personnel, inability of the patient to provide necessary documentation, or lack of cooperation of the patient.

B. Scope. Screening for public health insurance and health cost assistance eligibility must be offered to every patient and if requested by the patient, the health care facility shall:

(a) verify whether a patient is uninsured;

(b) if the patient is uninsured, offer information about, offer to screen for and screen the patient for:

(i) all available public insurance including Medicaid, Medicare, New Mexico's children's health insurance program and Tricare;

(ii) public programs that may assist with health care costs including but not limited to the New Mexico health insurance exchange, the New Mexico medical insurance pool, county indigent care programs, COVID-19 claims reimbursement programs, and the Indian health service purchased/referred care program; and

(iii)financial assistance offered by the health care facility.

C. Assistance. Health care facilities shall offer to provide assistance to uninsured patients with the application process for programs identified in the screening and, if requested, provide the assistance. Providing assistance means having adequate staff, systems, and equipment available to enable the completion and submission of any Medicaid, financial assistance or other health insurance application(s) within 15 days after receipt from the patient, or his or her representative, of the information necessary to complete the application.

D. Notification. The health care facility must provide notification regarding the screening to patients who are uninsured as follows.

(a) provide information about the insurance for which the patient appears to be eligible and the contact information for the program to which any application was submitted;

(b) the results of the screening must be delivered to the patient, or the patient's legal guardian or parent, if the patient is a minor or disabled, in writing within 15 days of the completion of the screening.

(c) if the patient declines screening, notification must be delivered to the patient with information about how to apply for health insurance, including Medicaid and the New Mexico health insurance exchange within 15 days of the patient's discharge.

(d) if during the screening the health care facility determines that the patient is indigent, the patient must be notified in writing within 30 days of screening, that the medical cost for the health care services may not be the subject of prohibited collection

action, although the health care facility may bill the patient for the health services as permitted by law.

(e) if the patient is determined indigent during the screening process the health care facility must take steps to ensure that any subsequent medical debt collection efforts do not include prohibited collection action. Such steps may include notifying the health care facility's billing department and any debt collectors or attorneys acting on behalf of the health care facility; and

(f) if the patient is found presumptively eligible for Medicaid, or eligible for any other public health insurance or financial assistance program, written notification of eligibility must be provided to the patient within 30 days of discharge;

(g) notwithstanding sections (a) through (f) above, notification shall not be required if the patient has not provided a valid telephone number or mailing address or if, after three documented attempts, the facility has been unable to contact the patient.

E. Coordination. If the patient's treatment will include a third-party health care provider who will bill the patient, the information gathered in the screening process will be provided by the health care facility to the third-party health care provider within five business days through a secure method of transmission protecting the confidentiality of the patient's information.

(a) if the patient is uninsured, the third-party health care provider will notify the health care facility that results of the screening must be provided to it, and provide the secure method of transmission for such notification.

(i) the third-party healthcare provider will provide contact information to the health care facility for receipt of screening information.

(ii) the health care facility will provide contact information to all third-party providers with privileges at its health care facility for the purpose of notification of patient screening.

(b) the information transmitted shall include the patient's identifying information, whether the patient participated in the screening, the outcome of the screening and any application process, the status of the patient's application for assistance with health care costs, and whether the screening identified the patient as indigent.

(c) if the health care facility has determined that the patient is indigent and provides that information to the third-party health care provider, neither the health care facility nor the third-party health care provider may engage in prohibited collection action to collect unpaid medical debt.

(d) the third-party health care provider shall not seek payment for emergency or medically necessary care until the health care facility has provided the screening information to the third-party healthcare provider. When the third-party health care provider has received the screening information, it will notify the patient that it has received the results and, if in the process of screening for insurance eligibility it was determined that the patient was found indigent, that it will not pursue any prohibited collection action for the medical costs related to the health care services.

F. Confidentiality. A health care facility or third-party health care provider shall not disclose or use information a patient provides during the screening and application process except as permitted or required in the Act and its implementing regulations and as further provided below:

(a) as needed to facilitate the application process for health insurance or financial assistance as described in Paragraph C of this section;

(b) upon request, a health care facility or third-party health care provider shall disclose information obtained during a screening or application assistance conducted pursuant to this rule or during an indigency determination pursuant to Section 9 of this rule to the patient; or

(c) a health care facility or third-party health care provider is required to disclose information provided during screening or application assistance when required by the human services department or the attorney general's office to investigate or determine the health care facility's or third-party health care provider's compliance with the Act; provided, that such information shall not be used or disclosed by the human services department or attorney general's office for any purpose other than the investigation or determination of the health care facility's or third party health care provider's compliance with the Act.

[13.10.39.8 NMAC - N, 12/28/2021]

13.10.39.9 INDIGENT PATIENT DETERMINATION:

Collection action based on charges for health care services and medical debt may not be pursued against an indigent patient. A determination whether a patient is an indigent patient shall be made before collection action is pursued against the patient.

A. Prohibited activity. Medical creditors and medical debt collectors shall not pursue collection action against indigent patients.

(a) A medical creditor may engage in a determination of indigency at the time of service or at any time during or after the provision of services. If the patient is determined to be indigent the medical creditor may not engage in prohibited collection action.

(b) A failure to make a determination of indigency does not waive the prohibition on collection action against indigent patients unless the failure to make the determination is due to noncooperation by the patient. Noncooperation must be documented and the medical creditor or debt collector must be able to demonstrate a minimum of three efforts to contact the patient.

(c) Any bill or statement to a patient must be accompanied by a notice, in English and Spanish, in at least 14-point font in the form prescribed by the superintendent. The superintendent will publish the required notice on its website.

(d) If the patient contacts the medical creditor or medical debt collector to request a determination of indigency, the medical creditor or medical debt collector must make a determination using the methodology set forth below.

B. Methodology. The medical creditor or medical debt collector shall make a determination as to whether the patient is indigent using the following methodology:

(a) household income will be calculated using the methods used to determine Medicaid eligibility by the New Mexico human services department, Title 8 Chapter 200 NMAC, and by the federal Medicaid program utilizing the MAGI protocols promulgated by the New Mexico human services department;

(b) utilizing the most recent federal poverty guidelines, the patient household income and household size, the medical creditor or medical debt collector shall determine whether the patient's income is less than or equal to two hundred percent of the federal poverty guidelines;

(c) in determining household income, the medical creditor or medical debt collector will consider both permanent and temporary income as defined by MAGI;

(d) the inquiry as to indigency is restricted to the categories of income subject to inclusion in the MAGI guidelines;

(e) information obtained from the patient or the patient's household during the determination of indigency shall be considered confidential and may not be used or disclosed for any other purpose; and

(f) the determination of a patient's indigency is valid for 24 months.

C. Indigency tool. The superintendent on an annual basis will provide an optional on-line tool for calculation of indigency for purposes of this section. The superintendent will publish a self-attestation form on its website for use by medical creditors, medical debt collectors and patients in establishing indigency.

D. Use of screening information. If the medical creditor is a health care facility or third-party provider, it may use the information gathered during the screening process to

determine whether the patient is indigent. If the patient is indigent based on information gathered during the screening process, then the health care facility or third-party provider shall ensure that its efforts to collect unpaid medical debt do not include prohibited collection action. The health care facility and third-party provider will also inform any medical debt buyer or medical debt collector that collection action is prohibited against that patient.

E. Medical creditors. Medical creditors will make the determination of indigency based on verbal or written communication with the patient, in which the patient will be asked to prove household income and household size consistent with the MAGI protocols.

(a) the verbal or written communication will inform the patient that the purpose of the communication is to determine indigency for the purpose of whether collection action may be pursued.

(b) if the patient is a minor or incapacitated, the communication should be with the parent(s), spouse, or legal guardian(s) of the patient;

(c) the verbal or written communication with the patient will be documented, including date, time, identity of person engaged in the communication, and complete contents of the information obtained from the communication; and

(d) the patient may respond to the communication by providing a signed attestation as to household income and size, or through provision of documentation such as pay stubs, at the election of the patient.

F. Notification. The patient will be provided with notification of the results of the determination of indigency in writing within 30 days of the date the medical creditor made the determination but in no event more than 60 days after the determination was initiated.

(a) if the patient is determined to be indigent, the notice shall inform the patient that certain collection action for the health care services and medical debt are prohibited by the Act.

(b) the notice will provide information to the patient about how to apply for Medicaid, public insurance, and insurance through the New Mexico health insurance exchange.

(c) the notice shall inform the patient of the right to complain to the New Mexico attorney general and shall include the website and telephone number of that office.

G. Medical debt collectors. A medical debt collector shall inquire of the medical creditor on behalf of whom it is pursuing collection against a patient, whether that

patient had been determined indigent. If the patient has been determined indigent, then certain collection action as defined herein is prohibited.

(a) the action of selling medical debt of an indigent patient to a medical debt buyer or medical debt collector constitutes prohibited collection action.

(b) medical creditors, including but not limited to health care facilities and third-party health providers, shall not hire or otherwise engage third parties to use prohibited collection action or otherwise recover debts from indigent patients. These third parties, including debt collectors and debt buyers, are prohibited from recovering debts from indigent persons, to include activity intended to collect an unpaid medical debt.

[13.10.39.9 NMAC - N, 12/28/2021]

PART 40: VACCINE PURCHASING FUND

13.10.40.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.10.40.1 NMAC - N, 01/01/2023]

13.10.40.2 SCOPE:

These rules apply to every "health insurer" and "group health plan," as defined in the Vaccine Purchasing Act ("VPA"), who are providing coverage to residents of New Mexico, regardless of location of the policy, and are therefore subject to compliance obligations under Sections 24-5A-1 through 24-5A-9 NMSA 1978. For purposes of this rule, a multiple employer welfare arrangement as defined in Section 59A-1-8.1 NMSA 1978 is considered a "health insurer" subject to the VPA.

[13.10.40.2 NMAC - N, 01/01/2023]

13.10.40.3 STATUTORY AUTHORITY:

This rule is issued pursuant to Section 24-5A-8 NMSA 1978.

[13.10.40.3 NMAC - N, 01/01/2023]

13.10.40.4 DURATION:

Permanent.

[13.10.40.4 NMAC - N, 01/01/2023]

13.10.40.5 EFFECTIVE DATE:

January 1, 2023, unless a later date is cited at the end of a section.

[13.10.40.5 NMAC - N, 01/01/2023]

13.10.40.6 OBJECTIVE:

To establish procedures to implement and enforce the provisions of the VPA.

[13.10.40.6 NMAC - N, 01/10/2023]

13.10.40.7 DEFINITIONS:

All definitions of terms found in Section 24-5A-2 NMSA 1978 are incorporated herein as though stated fully. The following definitions apply to this rule only:

A. "covered employer" means any employer who offers group health insurance coverage to a resident of New Mexico through a group health plan or policy issued by a health insurer; and

B. "day" or **"days"** shall be calculated as follows, unless otherwise specified:

(1) one to 10 days means only working days and excludes weekends and state holidays; and

(2) 11 or more days means calendar days, including weekends and state holidays.

[13.10.40.7 NMAC - N, 01/01/2023]

13.10.40.8 REPORTING AND PAYMENT REQUIRED:

As directed in these rules, every health insurer and group health plan shall annually report to the superintendent the number of insured children who are residents of New Mexico under each policy and plan, who were under the age of 19 as of the previous December 31st, even if that number is zero.

A. Report deadline. The required report is due by the date established by the superintendent, but no later than July 31st of each year.

(1) The superintendent may extend the deadline for good cause. A reporter must file a request for an extension, with the reason for the request, at least five days before the report is due.

(2) Failure to report by this deadline shall result in a $500 a day penalty pursuant to Subsection B of Section 24-5A-7 NMSA 1978. The superintendent shall issue written notice of failure to submit a timely report which specifies the statutory penalty to the designated contact person for each health insurer or group health plan.

B. Report contents. The annual report shall include all information requested by the superintendent and, at a minimum, shall provide:

(1) the number of children who were enrolled in or participated in the plan during any part of the prior year, and who were under the age of 19 as of December 31st, excluding any children who are not residents of New Mexico, were enrolled in Medicaid or in any medical assistance program administered by the department or the human services department, and children who are members of a Native American tribe.

(2) the name of a designated contact person, including title, email address, and office phone number.

(a) If the contact changes prior to the billing cycle referenced in the table below or the following year's reporting cycle, then an updated contact shall be provided to the department and the superintendent as soon as practicable after the change occurs, but no later than 30 days after the change.

(b) Communications to and from the designated contact shall be treated as communications between the superintendent and the health insurer or group health plans for all purposes under the VPA. Failure to provide or update contact information shall not relieve a health insurer or group health plan of any obligation under the VPA.

(3) the names of employers or groups on behalf of whom the data is submitted.

(4) if a group health plan or health insurer did not cover any children during the prior year, an attestation of that circumstance.

(5) the annual report shall be submitted even if the number of children to report is zero.

C. Method of reporting. A health insurer or group health plan shall report in the method prescribed by the superintendent. All such reports to the office of the superintendent shall be copied to the department at vpa.fund@state.nm.us.

D. Responsibility for reporting. A health insurer or group health plan is solely responsible for reporting. A group health plan may delegate reporting obligations to an employer group or plan administrator, but the group health plan or health insurer remains responsible for any late report or reporting error, and corresponding statutory penalties.

E. Mid-year plan termination. If an employer terminates its plan with a health insurer or group health plan mid-year, the new health insurer or group health plan shall be responsible for reporting and shall be responsible for reimbursing the vaccine purchasing fund for coverage of the prior years' insured children.

F. Report changes. An erroneous report may be changed only as approved by the superintendent or upon determination of a good faith discrepancy in accordance with Subsection C of Section 24-5A-7 NMSA 1978.

G. Receivership report. Before any health insurer is placed into receivership, it shall report its latest count of covered children to the superintendent.

[13.10.40.8 NMAC - N, 01/01/2023]

13.10.40.9 BILLING AND ENFORCEMENT:

A. Billing cycle. The department shall send out the invoices to each health insurer and each group health plan for one-fourth of its proportionate share of the estimated amount and reserve calculated pursuant to Subsection B of this Section, as required by Subsection D of Section 25-5A-3 NMSA 1978, according to the following billing cycle:

Billing Cycle	Department's Invoices Date	Insurer's and Group Health Plan's Due Date
July 1 to September 30	September 1	October 1
October 1 to December 31	December 1	January 1
January 1 to March 31	March 1	April 1
April 1 to June 30	June 1	July 1

B. Payment. A health insurer or group health plan shall remit payment to the department's fiscal agent in the manner directed by the department in the invoice, with a corresponding notification of remittance to vpa.fund@state.nm.us.

(1) The annual amount to be reimbursed by each health insurer or group health plan shall be a fraction, the denominator of which is the total number of insured children reported by all health insurers and group health plans and the numerator of which is the number of insured children reported by such health insurer or group health plan, multiplied by the total amount as determined by the department to be expended annually in the corresponding year.

(2) Failure to remit payment within 30 days receipt of the invoice will result in the issuance of a penalty pursuant to Subsection D of Section 24-5A-7 NMSA 1978.

C. Provider prohibition. To avoid duplication of payment, any providers who administer vaccines are prohibited from billing health insurers and group health plans for the cost of any vaccine which was provided to them by the department.

D. Initial review. Each health insurer or group health plan may request an initial administrative review of their invoice by the department in the event of a dispute over the invoice amount.

(1) The health insurer or group health plan may submit a letter requesting an initial administrative review of the invoice and any supporting documents to the immunization program manager or designee within 10 days of receipt of the department's invoice. Such requests shall be submitted to the immunization program manager at P.O. Box 26110, Santa Fe, NM 87502-6110, and via email at vpa.fund@state.nm.us. The health insurer or group health plan shall send a copy of the request to OSI.

(2) Within 10 working days of receipt of the request for an initial administrative review of the invoice, the department of health's immunization program manager or designee shall review the request for an initial administrative review of the invoice and any supporting documents. After the administrative review is complete the department's immunization program manager or designee shall notify the health insurer or group health plan by mail if the invoice amount will remain unchanged or modified.

(a) If a modified invoice is issued by the department then payment is due within five days of receipt of the modified invoice or on the due date identified in the original invoice, whichever is later.

(b) If the invoice remains unchanged then the invoice amount is due within five days of receipt of the department's decision or on the due date identified in the original invoice, whichever is later.

E. Referral. The department shall refer to the superintendent any health insurer or group health plan that has failed to fully reimburse, including any applicable late penalties, the department within 30 days of the date of invoice. Referrals for invoices subject to review as authorized in Subsection D shall be made within 30 days of the department's decision.

F. Notices. Within 10 days of receipt of report of delinquent account, the superintendent shall;

(1) Inform a delinquent health insurer or group health plan of the failure to timely pay the invoice, the invoice amount, the $500 a day civil penalty, calculated from the date payment on the invoice was due, and any applicable interest.

(2) Notices shall be delivered in writing to the group health plan or health insurer's designated contact person, and include instructions about how to remit payment.

(3) The superintendent shall provide a copy of this notice to the department.

G. Interest. Interest on late payments and penalties shall accrue at the post-judgment interest rate in effect at the time of default.

[13.10.40.9 NMAC - N, 01/01/2023]

13.10.40.10 PUBLICATION:

The superintendent shall, by January 31st of each calendar year, make publicly available on their website, a comprehensive list of all health insurers and group health plans that a) maintained compliance with the VPA in the preceding year, b) failed to comply with reporting requirements under the VPA, and c) failed to make timely payments under the VPA.

[13.10.40.10 NMAC - N, 01/01/2023]

13.10.40.11 ACCOUNTING OF THE FUND:

A. Expenditures. Money in the fund shall be expended only for the purposes specified in the VPA, by warrant issued by the secretary of finance and administration pursuant to vouchers approved by the secretary of health.

B. Audit. The fund shall be audited in the same manner as other state funds are audited, and all records of payments made from the fund shall be open to the public.

C. Balance. Any balance remaining in the fund shall not revert or be transferred to any other fund at the end of a fiscal year.

D. Investment. Money in the fund shall be invested by the state investment officer in accordance with the limitations in Article 12 Section 7 of the constitution of New Mexico. Income from investment of the fund shall be credited to the fund.

E. Estimate. July 1 of each year thereafter, the department shall estimate the amount to be expended annually by the department to purchase, store, and distribute vaccines recommended by the advisory committee on immunization practices to all insured children in the state, including a reserve of ten percent of the amount estimated.

F. Update. The department may update its estimated amount to be expended annually and its reserve to take into account increases or decreases in the cost of vaccines or the costs of additional vaccines that the department determines should be included in the statewide vaccine purchasing program and adjust the amount invoiced to each health insurer and group health plan the following quarter.

[13.10.40.11 NMAC - N, 01/01/2023]

13.10.40.12 HEARING RIGHTS:

Any person aggrieved by any action, threatened action, or failure to act by the superintendent shall have the same right to a hearing before the superintendent with respect thereto as provided for in general under Chapter 59A, Article 4 NMSA 1978 and the implementing rules. There shall be no right to hearing by the department.

[13.10.40.12 NMAC - N, 01/01/2023]

CHAPTER 11: CASUALTY INSURANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: DEFENSE COSTS AND DEDUCTIBLES WITHIN LIMITS

13.11.2.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[7/1/97; 13.11.2.1 NMAC - Rn & A, 13 NMAC 11.2.1, 6/30/04]

13.11.2.2 SCOPE:

This rule applies to all liability insurance policies as defined herein and supersedes all policies now in effect which contain defense cost offsets within the policy limits or, deductibles.

[10/13/88; 13.11.2.2 NMAC - Rn, 13 NMAC 11.2.2, 6/30/04]

13.11.2.3 STATUTORY AUTHORITY:

Section 59A-2-9 and 59A-16-3 NMSA 1978.

[10/13/88; 13.11.2.3 NMAC - Rn & A, 13 NMAC 11.2.3, 6/30/04]

13.11.2.4 DURATION:

Permanent.

[7/1/97; 13.11.2.4 NMAC - Rn, 13 NMAC 11.2.4, 6/30/04]

13.11.2.5 EFFECTIVE DATE:

October 13, 1988, unless a later date is cited at the end of a section .

[10/13/88, 7/1/97; 13.11.2.5 NMAC - Rn & A, 13 NMAC 11.2.5, 6/30/04]

13.11.2.6 OBJECTIVE:

The purpose of this rule is to prohibit the across-the-board use of legal defense cost offset provisions except for those exceptions found in 13.11.2.8 NMAC and 13.11.2.9 NMAC.

[10/13/88; 13.11.2.6 NMAC - Rn, 13 NMAC 11.2.6, 6/30/04]

13.11.2.7 DEFINITIONS:

For the purpose of this rule, the following definitions apply.

A. "Legal defense costs" mean allocated attorney and all other litigation expenses that can be separately identified as arising from the defense of a specific claim.

B. "Liability insurance policy" means any insurance policy covering liability, even if it also contains other types of coverage.

C. "Self insured retention" for the purposes of this rule is an insurance program whereby the insured retains a deductible of at least $100,000 per claim for his liability exposures.

[10/13/88; 13.11.2.7 NMAC - Rn, 13 NMAC 11.2.7 NMAC, 6/30/04]

13.11.2.8 GENERAL PROHIBITION OF DEFENSE COSTS WITHIN LIMITS:

No liability insurance policy, unless specified in 13.11.2.9 NMAC, shall be issued in this state which contain provisions that:

A. reduce the limits of liability in the policy by the amount of legal defense costs; or

B. permit legal defense costs to be applied against the deductible, if any.

[10/13/88; 13.11.2.8 NMAC - Rn, 13 NMAC 11.2.8 NMAC, 6/30/04]

13.11.2.9 EXCEPTIONS TO GENERAL PROHIBITION:

A. This prohibition shall not apply to aircraft liability policies, fidelity and surety policies, nuclear liability policies, marine protection and indemnity policies, or prepaid legal service plans, reinsurance policies, or self-insured retentions.

B. A legal defense offset provision otherwise prohibited in 13.11.2.8 NMAC may be included in a liability insurance policy only for the following types of risks or coverages, and only where liability limits for all liability risks and coverages under the policy are at least:

(1) $500,000:

(a) pollution and environmental impairment liability;

(b) directors and officers liability;

(c) governmental entity liability;

(d) employee benefit liability;

(e) fiduciary liability;

(f) media, publishing and advertising liability;

(g) errors and omissions liability; and

(h) professional liability, other than medical malpractice liability; or

(2) $5,000,000: any kind of commercial liability risk or coverage except:

(a) motor vehicle liability; or

(b) medical malpractice liability.

[10/13/88; 13.11.2.9 NMAC - Rn, 13 NMAC 11.2.9 NMAC, 6/30/04]

13.11.2.10 REQUIREMENTS:

A liability insurance policy as specified in Subsection B of 13.11.2.9 NMAC which contains a provision limiting legal defense costs shall be issued or renewed in this state only if the requirements of Subsections A and B of 13.11.2.10 NMAC are met, or if the requirement of Subsection C of 13.11.2.10 NMAC is met.

A. Legal defense costs charged against the stated limit of liability shall not exceed fifty percent (50%) of such limits and, except as authorized by Subsection B of 13.11.2.10 NMAC, the insurer shall assume any legal defense cost over the amount of percentage specified in the policy.

B. Legal defense costs charged against the deductible shall not exceed fifty percent (50%) of such deductible and, except as authorized by Subsection A of 13.11.2.10 NMAC, the insurer shall assume any legal defense cost over the amount or percentage specified in the policy in regard to such deductible.

C. The limitation specified in Subsections A and B of 13.11.2.10 NMAC may be omitted if the policy provides that the insured shall have the option to:

(1) select the defense attorney or to consent to the insurer's choice of defense attorney, which consent shall not be unreasonably withheld;

(2) participate in, and assist in the direction of the defense of any claim with such participation and assistance not limiting the insurer's right to control the defense; and

(3) consent to a settlement, which consent shall not be unreasonably withheld.

[10/13/88; 13.11.2.10 NMAC - Rn & A, 13 NMAC 11.2.10 NMAC, 6/30/04]

13.11.2.11 REQUIRED NOTIFICATION:

A. Any policy issued or renewed in this state containing legal defense cost offset provisions must print such provisions in bold type on the face of the application for insurance and on the face of the policy.

B. Any policy containing legal defense cost offset provisions specified in Subsection A of 13.11.2.10 NMAC must contain a statement signed by the insured acknowledging that the insured is aware that the limits of liability contained in the policy shall be reduced up to the amount or percentage stated in the policy by legal defense costs and, in such event, the insurer shall be liable for legal defense costs (except those due to any offset against the deductible) exceeding that amount of percentage.

C. Any policy containing legal defense cost offset provisions specified in Subsection B of 13.11.2.10 NMAC must contain a statement signed by the insured acknowledging that the insured is aware that legal defense costs that are incurred shall be applied against the deductible up to the amount or percentage stated in the policy and, in such event, the insurer shall be liable for legal defense costs (except those due to any offset against policy limits) exceeding that amount or percentage.

D. Any policy containing legal defense cost offset provisions specified in Subsection C of 13.11.2.10 NMAC must contain a statement signed by the insured acknowledging that the insured is aware that the limits of liability contained in the policy shall be reduced, and may be completely exhausted by legal defense costs, and to the extent that policy limits are thereby exceeded, the insurer shall not be liable for legal defense costs or for any judgment or settlement.

E. Any signed statement required by Subsection B of 13.11.2.11 NMAC shall be attached to and made a part of the policy.

[10/13/88; 13.11.2.11 NMAC - Rn, 13 NMAC 11.2.11 NMAC, 6/30/04]

13.11.2.12 ACCOUNTING:

Where the liability limits of the policy are reduced by legal defense costs or where legal defense cost are applied against the deductible, the insurer shall notify the insured of the insured's right, upon written request, to an accounting of legal defense costs actually expended.

[10/13/88; 13.11.2.12 NMAC - Rn, 13 NMAC 11.2.12 NMAC, 6/30/04]

13.11.2.13 COST OFFSET:

The premium and rate for any policy issued or renewed in this state containing legal defense cost offset provisions shall be commensurate with the coverage provided.

[10/13/88; 13.11.2.13 NMAC - Rn, 13 NMAC 11.2.13 NMAC, 6/30/04]

13.11.2.14 EXCEPTIONS TO THIS RULE:

If the superintendent finds that application of this rule unduly hinders the availability of insurance or does not significantly benefit the consumers, he may grant such exemptions as he sees fit.

[10/13/88; 13.11.2.14 NMAC - Rn, 13 NMAC 11.2.14 NMAC, 6/30/04]

CHAPTER 12: MOTOR VEHICLE INSURANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: [RESERVED]

PART 3: UNINSURED AND UNKNOWN MOTORISTS COVERAGE

13.12.3.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[7/1/97; 13.12.3.1 NMAC - Rn & A, 13 NMAC 12.3.1, 5/14/04]

13.12.3.2 SCOPE:

This rule shall govern the delivery or the issuance for delivery of any motor vehicle or automobile policy in this state, insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person or for injury to or destruction of property of others arising out of the ownership, maintenance or use of a motor vehicle or automobile registered or principally garaged in this state, by providing in or supplemental to, uninsured and unknown motorist coverage in limits for bodily injury or death and for injury to or destruction of property as provided in this rule.

[7/1/97; 13.12.3.2 NMAC - Rn, 13 NMAC 12.3.2, 5/14/04]

13.12.3.3 STATUTORY AUTHORITY:

Section 66-5-301 NMSA 1978.

[7/1/97; 13.12.3.3 NMAC - Rn, 13 NMAC 12.3.3, 5/14/04]

13.12.3.4 DURATION:

Permanent.

[7/1/97; 13.12.3.4 NMAC - Rn, 13 NMAC 12.3.4, 5/14/04]

13.12.3.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section.

[7/1/97; 13.12.3.5 NMAC - Rn & A, 13 NMAC 12.3.5, 5/14/04]

13.12.3.6 OBJECTIVE:

The purpose of this rule is to specify the requirements for uninsured and unknown motorists endorsements in accordance with Section 66-5-301 NMSA 1978.

[7/1/97; 13.12.3.6 NMAC - Rn, 13 NMAC 12.3.6, 5/14/04]

13.12.3.7 DEFINITIONS:

For the purposes of this rule:

A. [*] (a single asterisk in brackets) means either the first named insured, named insured or principal named insured, as appropriate for the context of the rule.

B. [**] (a double asterisk in brackets) means either "notice," "notice of accident," or "notice of accident, occurrence or loss," as appropriate for the context of the rule.

[7/1/97; 13.12.3.7 NMAC - Rn, 13 NMAC 12.3.7, 5/14/04]

13.12.3.8 OPTIONAL UNINSURED MOTORIST ENDORSEMENT:

Nothing contained in this rule shall prohibit any insurance company from filing an endorsement providing benefits for uninsured and unknown motorists which, in the opinion of the superintendent of insurance, is more favorable to the policyholder than the provisions permitted by the endorsement prescribed in this rule.

[7/1/97; 13.12.3.8 NMAC - Rn, 13 NMAC 12.3.8, 5/14/04]

13.12.3.9 REJECTION OF UNINSURED MOTORIST COVERAGE:

The rejection of the provisions covering damage caused by an uninsured or unknown motor vehicle as required in writing by the provisions of Section 66-5-301 NMSA 1978

must be endorsed, attached, stamped or otherwise made a part of the policy of bodily injury and property damage insurance.

[7/1/97; 13.12.3.9 NMAC - Rn, 13 NMAC 12.3.9, 5/14/04]

13.12.3.10 REQUIREMENTS FOR AN ENDORSEMENT FOR UNINSURED AND UNKNOWN MOTORIST COVERAGE:

All forms of endorsement for uninsured and unknown motorists coverage shall contain the provisions in 13.12.3.11 through 13.12.3.17 NMAC.

[7/1/97; 13.12.3.10 NMAC - Rn, 13 NMAC 12.3.10, 5/14/04]

13.12.3.11 FIRST PAGE OF UNINSURED AND UNKNOWN MOTORIST COVERAGE ENDORSEMENT:

The first page of the endorsement must contain:

A. Space for insertion of name of company or companies issuing the endorsement and other matter permitted to be stated at the head of this endorsement.

B. Space for description of insured motor vehicle or automobile, listing of rates and premiums for the basic limits coverage insured under the endorsement and for additional excess limits of coverage under the endorsement.

[7/1/97; 13.12.3.11 NMAC - Rn, 13 NMAC 12.3.11, 5/14/04]

13.12.3.12 INSURING AGREEMENTS FOR UNINSURED AND UNKNOWN MOTORISTS COVERAGE ENDORSEMENT:

In consideration of the payment of the premium for this endorsement and subject to all of the terms of this endorsement, the company agrees with the [*] as to the insuring agreements in 13.12.3.13 through 13.12.3.17 NMAC.

[7/1/97; 13.12.3.12 NMAC - Rn, 13 NMAC 12.3.12, 5/14/04]

13.12.3.13 DAMAGES FOR BODILY INJURY AND PROPERTY DAMAGE CAUSED BY UNINSURED MOTOR VEHICLES:

To pay all sums which the insured or his legal representative shall be legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle because of:

A. bodily injury, sickness or disease, including death resulting therefrom, hereinafter called "bodily injury", sustained by the insured; or

B. injury to or destruction of:

(1) motor vehicle registered in New Mexico which is owned by the [*] or by his spouse if a resident of the same household, and to which the liability coverage of the policy applies; and

(2) property owned by the insured which is contained therein, hereinafter called "property damage";

C. when caused by accident and arising out of the ownership, maintenance or use of the uninsured motor vehicle; provided, for the purpose of this endorsement, determination as to whether the insured or such representative is legally entitled to recover such damages, and if so the amount thereof, may be made by agreement between the insured or such representative and the company or, if they fail to agree, by arbitration in accordance with the arbitration provision of this endorsement.

D. No judgment against any person or organization alleged to be legally responsible for the bodily injury or property damage shall be conclusive, as between the insured and the company, of the issues of liability of such person or organization or of the amount of damages to which the insured is legally entitled unless the judgment is entered pursuant to an action prosecuted by the insured with the written consent of the company.

[7/1/97; 13.12.3.13 NMAC - Rn, 13 NMAC 12.3.13, 5/14/04]

13.12.3.14 REQUIRED POLICY DEFINITIONS:

A. Insured means:

(1) the [*] as stated in the policy and, while residents of the same household, the spouse of any such [*] and relatives of either;

(2) any other person while occupying an insured motor vehicle; and

(3) any person with respect to damages he is entitled to recover because of bodily injury to which this endorsement applies sustained by an insured under Paragraphs (1) and (2) of Subsection A of 13.12.3.14 NMAC.

(4) The insurance applies separately with respect to each insured, but the application of the insurance to more than one insured shall not operate to increase the limits of the company's liability.

B. Insured motor vehicle means a motor vehicle:

(1) described in the schedule as an insured motor vehicle to which the bodily injury and property damage liability coverages of the policy apply;

(2) while temporarily used as a substitute for an insured motor vehicle as described in Paragraph (1) of Subsection B of 13.12.3.14 NMAC], when withdrawn from normal use because of its breakdown, repair, servicing, loss or destruction;

(3) while being operated by the [*] or by his spouse if a resident of the same household;

(4) but the term "insured motor vehicle" shall not include:

(a) a motor vehicle while used as a public or livery conveyance;

(b) a motor vehicle while being used without the permission of the owner;

(c) under Paragraphs (2) and (3) of Subsection B of 13.12.3.14 NMAC, a motor vehicle owned by the [*] or by any resident of the same household as such insured; or

(d) under Paragraphs (2) and (3) of Subsection B of 13.12.3.14 NMAC, a motor vehicle furnished for the regular use of the [*] or any resident of the same household.

C. Uninsured motor vehicle means:

(1) a motor vehicle with respect to the ownership, maintenance or use of which there is, in at least the amounts specified by the financial responsibility law of New Mexico, no bodily injury and property damage liability bond or insurance policy applicable at the time of the accident with respect to any person or organization legally responsible for the use of the motor vehicle, or with respect to which there is a bodily injury and property damage liability bond or insurance policy applicable at the time of the accident but the company writing the same denies coverage thereunder or is or becomes insolvent; or

(2) a hit-and-run motor vehicle as defined;

(3) but the term "uninsured motor vehicle" shall not include:

(a) an insured motor vehicle;

(b) a motor vehicle owned by or furnished for the regular use of the [*], his spouse, or a relative of either who is a resident of the same household;

(c) a motor vehicle which is owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or similar law;

(d) a motor vehicle which is owned by the United States of America, Canada, a state, a political subdivision of any such government or agency of any of the foregoing;

(e) a land motor vehicle or trailer if operated on rails or crawler-treads or while located for use as a residence or premises and not as a vehicle; or

(f) a farm type tractor or equipment designed for use principally off public roads, except while actually upon public roads.

D. Hit-and-run motor vehicle means a motor vehicle which causes bodily injury to an insured or property damage arising out of physical contact or attempted physical contact of the motor vehicle with: 1) the insured; 2) a vehicle which the insured is occupying at the time of the accident; or 3) property of the insured, provided:

(1) there cannot be ascertained the identity of either the operator or the owner of such "hit-and-run motor vehicle";

(2) the insured or someone on his behalf shall have reported the accident within 24 hours to a police, peace or judicial officer or to the director of the motor vehicle division, and shall have filed with the company within 30 days thereafter a statement under oath that the insured or his legal representative has a cause or causes of action arising out of such accident for damages against a person or persons whose identity is unascertainable, and setting forth the facts in support thereof; and

(3) at the company's request, the insured or his legal representative makes available for inspection the motor vehicle which the insured was occupying at the time of the accident.

E. Occupying means in or upon or entering into or alighting from.

F. State includes the District of Columbia, a territory or possession of the United States, and a province of Canada.

[7/1/97; 13.12.3.14 NMAC - Rn, 13 NMAC 12.3.14, 5/14/04]

13.12.3.15 POLICY PERIOD AND TERRITORY:

This endorsement applies only to accidents which occur on and after the effective date of the endorsement, during the policy period and within the United States of America, its territories or possessions, or Canada.

[7/1/97; 13.12.3.15 NMAC - Rn, 13 NMAC 12.3.15, 5/14/04]

13.12.3.16 EXCLUSIONS:

This endorsement does not apply:

A. to bodily injury to an insured with respect to which such insured, his legal representative or any person entitled to payment under this endorsement shall, without written consent of the company, make any settlement with any person or organization who may be legally liable therefor;

B. to bodily injury to an insured while occupying a motor vehicle (other than an insured motor vehicle) owned by the [*] or any relative resident in the same household;

C. so as to inure directly or indirectly to the benefit of any workmen's compensation or disability benefits carrier or any person or organization qualifying as a self-insurer under any workmen's compensation or disability benefits law or any similar law;

D. so as to inure directly or indirectly to the benefit of any insurer of property;

E. to the first two hundred and fifty dollars of the total amount of all property damage as the result of any one accident.

[7/1/97; 13.12.3.16 NMAC - Rn, 13 NMAC 12.3.16, 5/14/04]

13.12.3.17 CONDITIONS:

A. Policy provisions: None of the insuring agreements, exclusions or conditions of the policy shall apply to the insurance afforded by this endorsement except the conditions "[**]", "changes", "assignment", "cancellation" and "declarations".

B. Premium: If during the policy period the number of insured motor vehicles owned by the [*] or spouse or the number of dealer's license plates issued to the [*] changes, the insured shall notify the company during the policy period of any change and the premium shall be adjusted in accordance with the manuals in use by the company. If the earned premium thus computed exceeds the advance premium paid, the insured shall pay the excess to the company; if less, the company shall return to the insured the unearned portion paid by the insured.

C. Proof of claim:

(1) As soon as practicable, the insured or other person making claim shall give to the company written proof of claim, under oath if required, including full particulars of the nature and extent of the injuries, treatment, and other details entering into the determination of the amount payable under the endorsement. The insured and every other person making a claim under the endorsement shall submit to examinations under oath by any person named by the company and subscribe the same, as often as may reasonably be required. Proof of claim shall be made upon forms furnished by the company unless the company shall have failed to furnish the forms within 15 days after receiving notice of claim.

(2) The injured person shall submit to physical examination by physicians selected by the company when and as often as the company may reasonably require and he, or in the event of his incapacity his legal representative, or in the event of his death his legal representative or the person or persons entitled to sue on his behalf, shall upon request from the company execute authorization to enable the company to obtain medical reports and copies of records.

(3) The insured or other person making claim for damage to property shall file proof of loss with the company within sixty days after the occurrence of loss, unless such time is extended in writing by the company, in the form of a sworn statement setting forth the interest of the insured and of all others in the property affected, any encumbrances thereon, the actual cash value thereof at time of loss, the amount, place, time and cause of such loss, and the description and amounts of all other insurance covering such property. Upon the company's request, the insured shall exhibit the damaged property to the company.

D. Assistance and cooperation of the insured: After notice of claim under this endorsement, the company may require the insured to take such action as may be necessary or appropriate to preserve his right to recover damages from any person or organization alleged to be legally responsible for the bodily injury or property damage; and in any action against the company, the company may require the insured to join such person or organization as a party defendant.

E. Notice of legal action: If, before the company makes payment of loss under the endorsement, the insured or his legal representative shall institute any legal action for bodily injury or property damage against any person or organization legally responsible for the use of a motor vehicle involved in the accident, a copy of the summons and complaint or other process served in connection with such legal action shall be forwarded immediately to the company by the insured or his legal representative.

F. Limits of liability:

(1) The company's limit of bodily injury liability for all damages, including damages for care and loss of services, arising out of bodily injury sustained by one person in any one accident shall not exceed the amount specified for unknown motorist/uninsured motorist coverage as stated on the declarations page for bodily injury to one person in any one accident. Subject to this provision, the company's limit of liability for all such damages arising out of bodily injury sustained by two or more persons in any one accident shall not exceed the amount specified for unknown motorist/uninsured motorist coverage as stated on the declarations page for bodily injury to two or more persons in any one accident.

(2) The company's limit of property damage liability shall not exceed the amount specified for unknown motorist/uninsured motorist coverage as stated on the declarations page for all damages in excess of $250 arising out of injury to or destruction of all property of one or more insureds as the result of any one accident.

(3) Any amount payable under this coverage because of bodily injury or property damage sustained in an accident by a person who is an insured under this coverage shall be reduced by:

(a) all sums paid on account of such bodily injury or property damage by or on behalf of the owner or operator of the uninsured motor vehicle and any other person or organization jointly or severally liable together with such owner or operator for such bodily injury or property damage including all sums paid under bodily injury liability;

(b) the amount paid and the present value of all amounts payable on account of such bodily injury under any worker's compensation law, disability benefits law or any similar law;

(c) the amount paid or payable to such an insured under any policy of property insurance.

(4) Any payment made under this endorsement to or for any insured shall be applied in reduction of the amount of damages which he may be entitled to recover from any person insured under the bodily injury liability coverage of the policy.

(5) The company shall not be obligated to pay under this coverage that part of the damages which the insured may be entitled to recover from the owner or operator of an uninsured motor vehicle which represents expenses for medical services paid or payable under the medical payments coverage of the policy.

G. Other insurance:

(1) With respect to bodily injury to an insured while occupying a motor vehicle not owned by the [*], the insurance under this endorsement shall apply only as excess insurance over any other similar insurance available to such insured and applicable to such automobile as primary insurance, and this insurance shall then apply only in the amount by which the limit of liability for this coverage exceeds the applicable limit of liability of the other insurance.

(2) Except as provided in Paragraph (1) of Subsection G of 13.12.3.17 NMAC, if the insured has other similar bodily injury insurance available to him and applicable to the accident, the damages for bodily injury shall be deemed not to exceed the higher of the applicable limits of liability of this insurance and such other insurance, and the company shall not be liable for a greater proportion of any loss to which this coverage applies than the limit of liability under this endorsement bears to the sum of the applicable limits of liability of this insurance and the other insurance.

(3) With respect to property damage, the insurance afforded under this endorsement shall be excess insurance over any other valid and collectible insurance against the property damage.

H. Arbitration: The insured and the company may agree to arbitrate any claim or dispute arising under this endorsement. The arbitration shall comply with applicable law, including Sections 66-5-301 through -303 NMSA 1978 regarding uninsured motorist's insurance and the Uniform Arbitration Act, Sections 44-7A-1 through 44-7A-32 NMSA 1978.

I. Trust agreement: In the event of payment to any person under this endorsement:

(1) the company shall be entitled to the extent of the payment to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of the person against any person or organization legally responsible for the bodily injury or property damage because of which the payment is made;

(2) the person shall hold in trust for the benefit of the company all rights of recovery which he shall have against such other person or organization because of the damages which are the subject of a claim made under this endorsement;

(3) the person shall do whatever is proper to secure and shall do nothing after loss to prejudice such rights;

(4) if requested in writing by the company, the person shall take, through any representative designated by the company, action as may be necessary or appropriate to recover the payment as damages from the other person or organization, the action to be taken in the name of the person; in the event of a recovery, the company shall be reimbursed out of the recovery for expenses, costs and attorneys' fees incurred by it in connection therewith;

(5) the person shall execute and deliver to the company instruments and papers as may be appropriate to secure the rights and obligations of the person and the company established by this provision.

J. Payment of loss by the company: A amount due under this endorsement is payable: (a) to the insured; or (b) if the insured be a minor to his parent or guardian; or (c) if the insured be deceased to his surviving spouse; otherwise (d) to a person authorized by law to receive the payment or to a person legally entitled to recover the damages which the payment represents; provided, the company may at its option pay any amount due under this endorsement in accordance with division (d).

K. Action against company. No action shall lie against the company unless, as a condition precedent thereto, the insured or his legal representative has fully complied with all the terms of this endorsement.

L. Conformity with state statutes. Any provision of this endorsement which on its effective date is in conflict with the statutes of the state of New Mexico is hereby amended to conform to the minimum requirements of the statutes.

[7/1/97; 13.12.3.17 NMAC - Rn & A, 13 NMAC 12.3.17, 5/14/04]

PART 4: AUTOMOBILE SELF-INSURANCE

13.12.4.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division, Post Office Box 1269, Santa Fe, NM 87504-1269.

[4/1/99; Recompiled 11/30/01]

13.12.4.2 SCOPE:

This rule applies to all persons seeking to be self-insured.

[4/1/99; Recompiled 11/30/01]

13.12.4.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 66-5-207, and 66-5-207.1 NMSA 1978

[4/1/99; Recompiled 11/30/01]

13.12.4.4 DURATION:

Permanent.

[4/1/99; Recompiled 11/30/01]

13.12.4.5 EFFECTIVE DATE:

April 1, 1999, unless a later date is cited at the end of a section or paragraph.

[4/1/99; Recompiled 11/30/01]

[Compiler's note: The words or paragraph, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.12.4.6 OBJECTIVE:

The purpose of this rule is to provide criteria and procedures for the issuance of certificates of self-insurance to persons who qualify for exemption from the Mandatory Financial Responsibility Act.

[4/1/99; Recompiled 11/30/01]

13.12.4.7 DEFINITIONS:

As used in this rule:

A. **"Act"** means the Mandatory Financial Responsibility Act, Sections 66-5-201 NMSA 1978 et seq.

B. **"Applicant"** means any person subject to the act who seeks to qualify for exemption from the act by obtaining a certificate of self-insurance from the superintendent.

C. **"Change of ownership"** means the occurrence of any change in:

(1) the officers, directors, or holders of more than ten percent of the voting stock of the corporation, if the self-insured is a corporation;

(2) general partners or limited partners contributing ten percent or more of the total value of contributions made to the limited partnership, or entitled to ten percent or more of the profits earned, or other compensation by way of income paid, by the limited partnership, if the self-insured is a limited partnership; or

(3) the trustees or partners or owners of more than ten percent interest in the entity, if the self-insured is a legal entity which is not a corporation or limited partnership.

D. **"Driver"** has the meaning given in Section 66-1-4.4K NMSA 1978.

E. **"Financially solvent"** means a self-insured's continuing ability to pay all existing and future claims to which it is or may become obligated by operation of its motor vehicles on the highways of New Mexico, and that there are no circumstances clearly indicating to the superintendent that there is an imminent danger that the self-insured will likely become insolvent.

F. **"Qualified actuary"** means a member of the casualty actuarial society.

G. **"Tangible net worth"** means net worth less intangible assets and other assets of questionable quality or liquidity and may include other liabilities of the company.

H. **"Safety program"** means a program of activities designed to reduce accidents, and may include driver education courses on safe driving practices or special techniques for driving in dangerous conditions, wearing seat belts, enrollment in accident prevent programs, installation of safety devices, and drug testing.

[4/1/99; Recompiled 11/30/01]

13.12.4.8 SCOPE OF SELF-INSURANCE:

A. A motor vehicle owner may self-insure only its own liability, including its vicarious liability as an employer for an operator who is an employee, in accordance with this rule.

B. Self-insurance does not include uninsured or underinsured motorists coverage.

[4/1/99; Recompiled 11/30/01]

13.12.4.9 CONTENTS OF APPLICATION:

A. An application for a certificate of self-insurance shall be made on the form prescribed by the superintendent. The application shall contain full and specific answers to all questions.

B. The application shall be signed, under oath, by:

(1) the applicant if the applicant is an individual or a sole proprietorship;

(2) a general partner if the applicant is a partnership;

(3) an officer of the applicant if the applicant is a corporation.

C. The application must be accompanied by a non-refundable filing fee of two hundred dollars ($200.00), made payable to the insurance division.

D. The superintendent may request additional information regarding any of the evaluation factors enumerated in this rule and any other information the superintendent deems relevant or necessary.

[4/1/99; Recompiled 11/30/01]

13.12.4.10 OTHER REQUIRED DOCUMENTS:

The application shall be accompanied by the following documents:

A. a certified copy of the applicant's most recent audited financial statement; If the last audited statement is more than six months old, there shall be included an affidavit signed by the applicant's treasurer stating that there has been no material lessening of the tangible net worth or other adverse change since the date of the statement. If there has been such a material or adverse change since the date of the statement, an explanation shall be attached or a new statement prepared;

B. if the applicant is a corporation, a resolution adopted by the board of directors, in a form approved by the superintendent, authorizing and directing the corporation to undertake to self-insure itself and to comply with the rules of the superintendent;

C. if the applicant is a subsidiary corporation, a parental guarantee from the subsidiary's upper-most parent in a form acceptable to the superintendent. If the applicant is a brother-sister corporation applying as one self-insurer, mutual guarantees from each corporation in a form acceptable to the superintendent;

D. a plan of operation for the self-insurance program, as provided in this rule;

E. detailed resumes, on biographical affidavit forms prescribed by the superintendent, of all the principals of the applicant;

F. a binder from an insurance company authorized to transact insurance business in New Mexico specifying the limits and the terms and conditions of excess insurance coverage to be obtained if the application is approved;

G. if the applicant is a corporation, a certificate of good standing from the corporations bureau;

H. if automobiles are leased or rented to others, a copy of the lease or rental agreement containing the terms under which automobiles are leased or rented.

[4/1/99; Recompiled 11/30/01]

13.12.4.11 EVALUATION FACTORS:

In determining if an applicant will be able to meet its obligations as a self-insured, both at the time of application and continuously thereafter if applicant is granted a certificate of self-insurance, the factors to be considered by the superintendent shall include, but not be limited to, the following:

A. whether the applicant has a tangible net worth of at least two million dollars ($2,000,000.00);

B. whether the applicant is financially solvent;

C. whether the applicant has a risk management system;

D. whether the applicant has an adequate claims management system;

(1) If a third party administrator or claims administration service is to be used, it must be licensed in New Mexico.

(2) If claims are handled in-house, the self-insured must employ a New Mexico-licensed adjuster.

E. whether the applicant has a reserve method for claims;

F. whether applicant's automobiles are leased or rented to others;

G. the ratio of applicant's tangible net worth to its annual self-insurance retention;

H. the ratio of applicant's current assets to its current liabilities;

I. the ratio of applicant's debt to its tangible net worth;

J. the ratio of applicant's tangible net worth to its annual automobile bodily injury and property damage projected losses;

K. applicant's profit and loss history, including credit reports and credit ratings;

L. applicant's automobile bodily injury and property damage exposure, premium, and loss history;

M. applicant's organizational structure and the character and reputation of its management;

N. applicant's claims administration personnel, policies, and procedures;

O. applicant's safety program;

P. the source and reliability of financial information about applicant;

Q. the number of applicant's employees and the number who regularly drive automobiles, or if applicant is an individual, the number of persons who regularly drive applicant's automobiles;

R. the adequacy of applicant's reserves;

S. the adequacy of applicant's excess insurance coverage;

T. the adequacy of applicant's surety bond or other security;

U. the catastrophic loss potential of applicant.

[4/1/99; Recompiled 11/30/01]

13.12.4.12 PLAN OF OPERATIONS FOR SELF-INSURANCE PROGRAMS:

Aicant shall prepare and maintain an up-to-date, detailed plan of operations for its self-insurance program. At a minimum, such plan shall include:

A. an overview and narrative description of the proposed plan, with comments on all major aspects of operations, including administration, data and record keeping, claims, investment, reinsurance, and any other important topic;

B. a description of the structure and organization of the company, the type of company (stock, mutual, etc.), holding company, affiliates, and subsidiaries;

C. the qualifications and experience of management personnel;

D. a description of the self-insured's claims management program;

E. an explanation of the use of any management agreements, or agreements with claims adjusters or third party administrators, and any other significant contractual arrangements;

F. the names of any reinsurer(s) and descriptions of the types, terms and conditions, and cost of coverage, and the maximum retained exposure;

G. a detailed summary of the applicant's automobile premium, exposure and loss history for at least the last three (3) years;

H. an explanation of the applicant's safety and loss control program and a copy of the safety manual, if one exists; include the name of the person in charge of the safety program and vehicle inspection schedule;

I. an actuarial evaluation of the applicant's projected loss for the coming year.

[4/1/99; Recompiled 11/30/01]

13.12.4.13 CERTIFICATION PROCEDURE:

A. Upon receipt of the completed application, filing fee and other required documents, the superintendent shall approve or disapprove the application or shall advise the applicant of the requirements to be met before approval will be granted.

B. Upon the superintendent's approval of the application, and receipt of proof that all requirements have been met, the superintendent shall issue a certificate of self-insurance. A certificate of self-insurance shall be continuous until terminated or revoked as provided in this rule.

C. The superintendent shall deny an application for self-insurance if the applicant has failed to demonstrate to the superintendent's satisfaction that it has met, and will be able to continue to meet, all requirements of this rule.

[4/1/99; Recompiled 11/30/01]

13.12.4.14 FINANCIAL RESPONSIBILITY REQUIREMENTS:

Prior to issuance of a certificate of self-insurance, and continuously thereafter if applicant is granted a certificate of self-insurance, the applicant must comply with each of the following requirements:

A. **Security:** The applicant shall furnish security for payment of claims, in one of the following forms:

(1) by depositing securities specified in Section 59A-10-3 NMSA 1978 as eligible for deposit, in the amount of two hundred thousand dollars ($200,000.00), or twenty-five percent (25%) of projected losses and loss adjustment expenses, whichever is greater;

(2) by a financial guaranty bond in favor of the superintendent in the amount of one hundred thousand dollars ($100,000.00) or twenty-five percent (25%) of projected losses and loss adjustment expenses, whichever is greater, guaranteeing automobile loss payments in New Mexico, on a form prescribed or approved by the superintendent; or

(3) by other security prescribed by the superintendent, provided, however, that the superintendent shall approve the amount and form of the proposed security prior to the applicant being issued a certificate of self-insurance.

B. **Excess insurance coverage:** The applicant shall obtain excess insurance coverage issued by a carrier acceptable to the superintendent with a limit of not less than one million dollars ($1,000,000.00) per occurrence, and provide photocopies of the declarations page and all endorsements providing or limiting coverage in New Mexico. The superintendent shall determine the maximum amount of retention for each self-insured.

C. **Initial reserve:** If applicant will be newly self-insured, the applicant shall set aside as an initial reserve an amount not less than seventy-five percent (75%) of the first year's **projected** losses and loss adjustment expense, as determined by a qualified actuary.

D. **Loss reserve fund:**

(1) The applicant shall establish and maintain a loss reserve fund sufficient to provide for the prompt payment of existing and projected loss claims which shall be fully covered by liquid assets or other assets agreeable to the superintendent.

(2) The applicant shall prepare and maintain records showing the calculation of the required amount of loss reserve fund. The fund shall cover incurred but not reported (IBNR) claims.

(3) The superintendent may waive the requirement of a loss reserve fund, or accept another method of setting reserves, upon receipt of a written request setting out specific facts supporting the exception to the requirement.

[4/1/99; Recompiled 11/30/01]

13.12.4.15 MINIMUM LIMITS OF SELF-INSURANCE COVERAGE:

A. For motor carriers required to obtain an operating authority from the motor transportation division of the public regulation commission, the minimum limits of self-insurance coverage per vehicle owned by the applicant shall be the same as the minimum limits of insurance coverage required by Section 232.03 of SCC Rule 232, Insurance Requirements, or its successor provision.

B. For motor carriers not required to obtain an operating authority from the motor transportation division of the public regulation commission, the minimum limits of self-insurance coverage shall be one hundred thousand dollars ($100,000) combined single limit per vehicle owned by the applicant.

C. For rental cars and other private passenger vehicles, the minimum limits of self-insurance coverage shall be twenty-five thousand dollars ($25,000)/fifty thousand dollars ($50,000) bodily injury liability and ten thousand dollars ($10,000) property damage liability per vehicle owned by the applicant.

D. The superintendent may require higher limits of coverage than specified in this section based on evidence of the need to protect the public from a higher exposure than the norm or other existing or anticipated circumstances requiring higher limits of liability coverage. The superintendent may take into account:

(1) the financial stability of the applicant;

(2) the previous loss history of the applicant;

(3) the safety record of the applicant;

(4) the size, nature of operations, and other characteristics of the applicant.

[4/1/99; Recompiled 11/30/01]

13.12.4.16 DISCLOSURE BY SELF-INSURED CAR RENTAL COMPANIES:

If a self-insured car rental company takes the position that the insurance coverage of a lessee or other authorized driver is primary for the purpose of meeting the minimum financial responsibility requirements of the act, then this position must be prominently disclosed on the front of the car rental contract.

[4/1/99; Recompiled 11/30/01]

13.12.4.17 COMPLIANCE AND REPORTING REQUIREMENTS:

By accepting a certificate of self-insurance, a self-insured agrees to:

A. promptly discharge all of its liabilities and responsibilities in accordance with the requirements of this rule;

B. notify the superintendent within fifteen (15) calendar days in case of contemplated liquidation, sale or transfer of ownership, or material reduction in New Mexico operations; and arrange for the payment of all existing liability and any disability or liability arising thereafter by guaranty bond, deposit of securities, or otherwise, as required by the superintendent;

C. notify the superintendent within fifteen (15) calendar days prior to making any material change in any excess insurance policy or surety bond or other security required by the superintendent as a condition of self-insurance;

D. notify the superintendent within fifteen (15) calendar days of any change in the kind or amount of services provided by any service company named in the application;

E. promptly notify the superintendent of any material, adverse change in its financial condition;

F. provide full disclosure to the superintendent, or the superintendent's agents and staff, of all matters required to be disclosed, and to cooperate fully in any lawful review, evaluation, examination, or audit of any matter pertaining to the applicant's compliance with this rule or any lawful order or communication of the superintendent;

G. notify the superintendent within thirty (30) calendar days if there is a change of ownership of a self-insured, and submit biographical affidavits for the new owners;

H. meet any other reasonable criteria deemed necessary by the superintendent to guarantee payment of automobile claims

[4/1/99; Recompiled 11/30/01]

13.12.4.18 ANNUAL REPORTS:

Each self-insured shall prepare an annual report on the form provided by the superintendent. The report shall be filed within ninety (90) days after the end of the self-insured's fiscal year and shall be accompanied by the following documents:

A. a certified annual financial statement;

B. actuarial reports, unless waived by the superintendent, attesting to the loss reserve requirements and projected losses and loss adjustments expense for the coming year;

C. a report of automobile claims activity;

D. a copy of its current plan of operations; and

E. a copy of the current declarations page and all endorsements providing or limiting excess insurance coverage in New Mexico.

[4/1/99; Recompiled 11/30/01]

13.12.4.19 EXAMINATIONS AND REVIEWS:

A. The superintendent may direct at any time that an applicant or a self-insured be reviewed or evaluated by a qualified person approved by the superintendent. As part of such review or evaluation, the superintendent reserves the right at any time to direct such qualified person:

(1) to audit or review the applicant's or self-insured's records regarding any representation made on its financial statement;

(2) to audit or review or take the testimony under oath of the applicant or self-insured, or any of its agents or employees, regarding any matter within their knowledge and pertaining to the obligations of the applicant or self-ins ured under this rule; and

(3) to review the application form and all supporting documents submitted by an applicant or self-insured.

B. By signing and submitting an application for self-insurance, or by accepting a certificate of self-insurance, the applicant or self-insured agrees to bear the costs of any review or evaluation conducted pursuant to this section.

[4/1/99; Recompiled 11/30/01]

13.12.4.20 TERMINATION OR REVOCATION OF A CERTIFICATE:

A. A certificate of self-insurance may be terminated at the request of the self-insured. The superintendent shall not grant the request of a self-insured to terminate its certificate unless the self-insured makes arrangements to otherwise guarantee payment of any known or unknown obligations covered by the certificate. The self-insured shall file proof of such arrangements with the superintendent, subject to the superintendent's prior written approval.

B. A certificate may be revoked by the superintendent for the grounds specified in Section 66-5-207.1 NMSA 1978 , or for any of the following reasons:

(1) failure of a self-insured to comply with any provisions or requirements of this rule, or with any lawful order or communication of the superintendent;

(2) insolvency or bankruptcy of the self-insured or any surety or guarantor;

(3) impairment of any aspect of the self-insured's financial responsibility requirements; or

(4) failure to abide by the provisions of Section 59A-16-20 NMSA 1978 regarding unfair claims practices.

C. Revocation of a certificate of self-insurance shall be made by an order signed by the superintendent. Every such order shall state its effective date and shall concisely state what is ordered, the grounds on which the order is based, and the provision of this rule pursuant to which the action is taken.

[4/1/99; Recompiled 11/30/01]

13.12.4.21 REINSTATEMENT:

Any person who seeks reinstatement of a revoked certificate of self-insurance shall apply to the superintendent on the form prescribed by the superintendent. Such person shall demonstrate compliance with all requirements of this rule as if the person were a new applicant, except that in lieu of providing all the specific information required by the application form, an applicant for recertification may incorporate by reference any responsive and still-current information which was filed with the superintendent on the original application form. A non-refundable filing fee of one hundred fifty dollars ($150.00) must accompany an application for reinstatement of a revoked certificate.

[4/1/99; Recompiled 11/30/01]

13.12.4.22 HEARINGS:

Any person aggrieved by a decision of the superintendent made pursuant to this rule may request a hearing before the superintendent in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978.

[4/1/99; Recompiled 11/30/01]

CHAPTER 13: PROPERTY INSURANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: RESIDENTIAL PROPERTY INSURANCE COVERAGE REQUIREMENTS

13.13.2.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.13.2.2 SCOPE:

This rule applies to residential property insurance, as defined in this rule, written by authorized insurers.

[9/15/93; Recompiled 11/30/01]

13.13.2.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-3-6 and 59A-18-17 NMSA 1978.

[9/15/93; Recompiled 11/30/01]

13.13.2.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.13.2.5 EFFECTIVE DATE:

September 15, 1993, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[9/15/93, 7/1/97; Recompiled 11/30/01]

13.13.2.6 OBJECTIVE:

This rule establishes definitions and uniform coverage provisions for claims settlement practices required by Subsection 59A-18-17C NMSA 1978.

[9/15/93; Recompiled 11/30/01]

13.13.2.7 DEFINITIONS:

A. **"Authorized insurer"** has the meaning given in Section 59A-1-8 NMSA 1978. For purposes of this rule, the FAIR plan established pursuant to Chapter 59A, Article 29 NMSA 1978, is not an authorized insurer.

B. **"Claims settlement"** means an agreement between an authorized insurer and claimant as to the amount of money owed to the claimant on a particular claim.

C. **"Coinsurance requirement"** means a provision in an insurance policy that requires that the limit of liability be within a specified percentage of the replacement cost of the covered property.

D. **"Extended coverage peril"** means: windstorm, hail, smoke, explosion, riot or civil commotion, aircraft damage, vehicle damage, or volcanic eruption.

E. **"Fire"** means a rapid oxidation with a flame or glow that is hostile, or goes beyond intended confines.

F. **"Replacement cost"** means material and labor expenses plus all other reasonable and necessary expenses involved in the repair or replacement of damaged property.

G. **"Residence"** means a structure used solely as a place for people to live and having not more than four apartments or units; or, a residence means an individually owned condominium, rowhouse, or townhouse used solely as a place for people to live. A residence is not an out-building, shed, barn, detached garage or similar structure, vacant structure, motel, hotel, licensed health care facility, homeless shelter, shelter for battered women and/or children, jail, camp, a vehicle licensed by a governmental agency, barracks, orphanage, dormitory or any other structure where people live on a transient basis. Personal property contained within a residence is not part of a residence.

H. **"Residential property insurance"** means insurance of a residence against direct loss or damage from fire or extended coverage peril. Residential property insurance does not include insurance against the liability of the insured for loss or damage to the property or property interest of another, title insurance as defined by Section 59A-7-9 NMSA 1978, or other consequential loss or damage resulting from fire or extended coverage peril.

I. **"Vacant structure"** means a structure in which no person has lived for at least thirty consecutive days.

[9/15/93, 7/1/97; Recompiled 11/30/01]

13.13.2.8 RESIDENTIAL PROPERTY INSURANCE COVERAGE REQUIREMENTS:

A. Residential property insurance policies shall be provided on a replacement cost basis.

B. Residential property insurance policy provisions may limit an authorized insurer's liability for loss due to a single occurrence to less than replacement cost of a residence, provided the authorized insurer's liability shall not be reduced pursuant to a coinsurance requirement. A residential property insurance policy that limits an authorized insurer's liability for loss due to a single occurrence to less than replacement cost of a residence, but does not reduce the authorized insurer's liability pursuant to a coinsurance requirement does not violate the provisions of Section 59A-18-17C NMSA 1978, and shall not be construed to require that losses be paid in excess of stated policy limits.

C. An insured may elect to effectuate repairs to a residence himself or herself under a residential property insurance policy. In such a case, claims settlement shall provide for replacement cost.

D. This rule does not supersede other loss settlement limitations, conditions, exclusions or other provisions contained in the residential property insurance policy.

[9/15/93; Recompiled 11/30/01]

13.13.2.9 GENERAL PENALTY:

In addition to any other penalty provided by law or regulation, violation of the provisions of this rule is subject to penalties for violation of the Insurance Code.

[9/15/93; Recompiled 11/30/01]

PART 3: THE NEW MEXICO FAIR PLAN

13.13.3.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.13.3.2 SCOPE:

This rule applies to all insurers providing essential property insurance pursuant to the FAIR Plan Act, Chapter 59A, Article 29 NMSA 1978.

[9/15/93, 7/1/97; Recompiled 11/30/01]

13.13.3.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-3-6, 59A-18-17 and 59A-29-2 NMSA 1978.

[9/15/93; Recompiled 11/30/01]

13.13.3.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.13.3.5 EFFECTIVE DATE:

September 15, 1993, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[9/15/93, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.13.3.6 OBJECTIVE:

This rule specifies minimum coverages to be provided by the New Mexico property insurance program, the underwriting association established under Section 59A-29-2 NMSA 1978 of the FAIR Plan Act.

[9/15/93; Recompiled 11/30/01]

13.13.3.7 DEFINITIONS:

A. **"Actual cash value"** means replacement cost minus depreciation.

B. **"Essential property insurance"** means any policy of insurance which contains insurance against direct loss to real and tangible personal property at a fixed location as defined and limited in the standard fire policy and extended coverage endorsement and vandalism or malicious mischief endorsement (including builders risk coverage) approved by the superintendent. Essential property insurance does not include automobile risks, farm risks, or manufacturing risks.

C. **"Extended coverage"** means coverage for a package of perils insured on an optional basis, including: windstorm, hail, smoke, explosion, riot or civil commotion, aircraft damage, vehicle damage, and volcanic eruption. The package of perils included in extended coverage may change by custom or order of the superintendent.

D. **"Fire"** means a rapid oxidation with a flame or glow that is hostile, or goes beyond intended confines.

E. **"Manufacturing risks"** means all properties used for the fabrication, processing, or assembly of products or components of products, each of which: (a) employ fifteen or more persons; and (b) have an insurable value in excess of two hundred fifty thousand dollars ($250,000).

F. **"Replacement cost"** means the cost to repair or replace damaged property.

G. **"Vandalism or malicious mischief"** means the willful and malicious damage or destruction of property.

[9/15/93; Recompiled 11/30/01]

13.13.3.8 FAIR PLAN OPERATIONS:

FAIR plan articles of association, by-laws, guidelines and operating procedures of the New Mexico property insurance program shall be subject to the superintendent's prior approval.

[9/15/93; Recompiled 11/30/01]

13.13.3.9 FAIR PLAN ESSENTIAL PROPERTY INSURANCE:

For purposes of the FAIR Plan Act, Chapter 59A, Article 29 NMSA 1978, all authorized insurers authorized to write and writing essential property insurance shall be members of the New Mexico property insurance program and shall participate in the program in accordance with the FAIR plan articles of association, by-laws, guidelines and operating procedures of the New Mexico property insurance program.

[9/15/93; Recompiled 11/30/01]

13.13.3.10 FAIR PLAN COVERAGES AND RATES:

A. The New Mexico property insurance program shall, at a minimum, offer insurance for the perils of fire, extended coverage and vandalism or malicious mischief for buildings and contents. Additional coverages may be provided, so long as they are included in the FAIR plan articles of association, by-laws, guidelines and operating procedures of the New Mexico property insurance program. Replacement cost coverage may be provided by the New Mexico property insurance program subject to reasonable eligibility criteria approved by the superintendent, so long as it is provided for in the FAIR plan articles of association, by-laws, guidelines and operating procedures of the New Mexico property insurance program. Replacement cost coverage, if offered, shall be an optional coverage.

B. Insurance coverage shall be provided to eligible properties located within the state of New Mexico. Reasonable eligibility criteria may be specified by the New Mexico property insurance program, as approved by the superintendent.

C. Actual cash value coverage shall be offered by the New Mexico property insurance program subject to applicable eligibility criteria. Section 59A-18-17C NMSA 1978, requiring residential property insurance policies to cover the cost to repair or replace without deduction for depreciation, does not apply to the New Mexico property insurance program.

D. FAIR Plan Act insurance shall be written on policy forms filed with and approved by the superintendent.

E. FAIR Plan Act rates shall be subject to the superintendent's prior approval.

[9/15/93; Recompiled 11/30/01]

13.13.3.11 GENERAL PENALTY:

In addition to any other penalty provided by law or regulation, violation of the provisions of this rule is subject to penalties for violation of the Insurance Code (Chapter 59A NMSA 1978).

[9/15/93; Recompiled 11/30/01]

CHAPTER 14: TITLE INSURANCE

PART 1: GENERAL PROVISIONS

13.14.1.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.1.1 NMAC – Rp, 13.14.1.1 NMAC, 1/1/2021]

13.14.1.2 SCOPE:

This rule applies to all title insurers, title insurance agencies, and title insurance agents conducting the business of title insurance in New Mexico.

[13.14.1.2 NMAC – Rp, 13.14.1.2 NMAC, 1/1/2021]

13.14.1.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.1.3 NMAC – Rp, 13.14.1.3 NMAC, 1/1/2021]

13.14.1.4 DURATION:

Permanent.

[13.14.1.4 NMAC – Rp, 13.14.1.4 NMAC, 1/1/2021]

13.14.1.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.1.5 NMAC – Rp, 13.14.1.5 NMAC, 1/1/2021]

13.14.1.6 OBJECTIVE:

The purpose of this rule is to define terms applicable throughout Title 13, Chapter 14 of the New Mexico Administrative Code.

[13.14.1.6 NMAC – Rp, 13.14.1.6 NMAC, 1/1/2021]

13.14.1.7 DEFINITIONS:

For definitions of terms contained in this rule, refer to Section 59A-30-3 NMSA 1978, unless otherwise noted below.

A. "Abstract plant" means title plant.

B. "Agency" means a business entity as defined in Subsection B of Section 59A-12-2 NMSA 1978, including a sole proprietorship that transacts title insurance business.

C. "ALTA" means the American Land Title Association.

D. "Basic premium rate" means the premiums set from time to time by the superintendent for an original owner's policy.

E. "Commitment" means an NM form 6 issued to a customer.

F. "Day or Days" means, unless otherwise specified:

(1) one to five days excludes weekends and state holidays; and

(2) six days or more, includes weekends and holidays.

G. "Down date" means the date that a subsequent search and examination of the public records affecting title to property is completed and effective.

H. "Escrow" means a transaction in which funds are delivered or given to a person not otherwise having any right, title, or interest in them, to be held by that person for

delivery or disbursement to another person upon the happening of a specified event or the performance of a specified condition.

I. "Escrow account" means an account established pursuant to Sections 58-28-4 or 59A-12-22 NMSA 1978.

J. "Escrow funds" means all monies the issuing title insurance agency or title insurer receives when conducting escrows, settlements, closings or tax deferred exchanges in connection with the issuance of a title insurance policy.

K. "Escrow instructions" means a dated, written, and signed agreement of the parties to an escrow, including a duly appointed agent or attorney-in-fact, specifying the event or condition upon which the escrowed funds shall be delivered or disbursed. This term shall include a purchase agreement, or lender's instructions, and modifications of escrow instructions.

L. "Escrow officer" means an individual affiliated with a title insurance agency or title insurer who is directly responsible for the settlement of a real estate transaction, as evidenced by their signature on a settlement statement.

M. "Extra chain of title" means a parcel having a separate chain of title from the original chain being searched.

N. "Funds subject to immediate withdrawal" as used in Subsection F of Section 59A-30-3 means money collected and deposited in an escrow account with a financial institution held in the name of and subject to the control of a title insurance agency, a title insurer, or third party fiduciary for a real estate closing, that can be totally disbursed immediately by cash withdrawal or cashier's checks without relying on the balance created by other deposit in the account not made as part of the real estate closing for which disbursement is being made.

(1) The following funds are subject to immediate withdrawal collected on the day of deposit:

(a) cash;

(b) received wired funds managed by the federal reserve system;

(c) a cashier's check or certified check which is issued payable to the title insurance agency, title insurer, or third party fiduciary and has been deposited to its account at the financial institution which issued it; and guaranteed by the financial institution as collected funds for immediate disbursement;

(d) a cashier's check which is payable to and was purchased by the title insurance agency, title insurer, or third party fiduciary, and has been deposited to its

account at a financial institution and guaranteed by the financial institution for immediate disbursement.

(2) The following funds are considered available funds on the next business day after day of deposit:

(a) treasury checks, postal money orders, federal reserve bank checks and federal home loan bank checks;

(b) state of New Mexico and local government checks which have been deposited at a financial institution located in New Mexico using a special deposit slip if required by the depository institution for next day availability;

(c) cashier's checks, certified check and teller's checks which have been deposited at a financial institution located in New Mexico using a special deposit slip if required by the depository institution for next day availability.

(d) All other modes used for the transfer of monies will be available funds on the earliest date they are considered collected funds in accordance with Regulation CC, "Availability of Funds and Collection of Checks" established by the board of governors of the federal reserve system as amended.

(e) Any funds received under the automated clearing house (ACH) network shall not be considered "available funds" until collected.

O. "HECM" means a home equity conversion mortgage administered by the federal housing administration (FHA).

P. "HUD" means the United States department of housing and urban development.

Q. "Loan policy" means an NM form 2 issued to a customer.

R. "Mortgage" means either a mortgage or deed of trust.

S. "One to four family residential property" means any real property primarily designed and used for residential occupancy of from one to four families, including a residential unit in a condominium if such unit is designed and used primarily for occupancy by one to four families, regardless of the total number of units in the condominium complex.

T. "Owner's policy" means an NM form 1 or NM form 34, as applicable, issued to a customer.

U. "Pro forma policy" means a sample of an owner's or loan policy prepared prior to issuance of the policy, with completed schedules A and B and endorsements, identifying the proposed insured, the exceptions that are proposed to be placed in the

final policy to be issued, and the name of the title insurer and title insurance agency, including samples of endorsements.

V. "Referrer" means any person in a position to refer business to a title insurer or title insurance agency.

W. "Simultaneous Issue" means issuing two or more policies bearing the same effective date and insuring part or all of the same land.

X. "Title plant" means a collection of real estate records meeting the requirements of Section 59A-12-13 NMSA 1978.

Y. "Title rate case" means a proceeding that results in the establishment of rates, or charges pertaining to the business of title insurance and includes, without limitation, the title rate case required by Section 59A-30-8 NMSA 1978.

Z. "Unusual complexity" means when circumstances cause an unusually long search or complicated examination as determined by a reasonable title insurance agent or title insurer.

AA. "Vestee" means the person or persons in whom title to the land is vested.

[13.14.1.7 NMAC – Rp, Sections 7 through 33 of 13.14.1 NMAC, 1/1/2021; A, 1/1/2024]

13.14.1.8 GENERAL PROVISIONS:

A. Every title insurer shall establish written instructions and underwriting standards consistent with these rules, including, without limitation, underwriter approval requirements and underwriting approval record retention requirements. Unless otherwise specifically required or limited by these rules, a title insurer in its discretion may determine what risks the insurer is willing to insure.

B. Unless otherwise specified, whenever these rules allow modification or deletion of provisions of a form of policy or endorsement or permit the modification of language required by these rules to be included in policies (including pro forma policies), commitments or endorsements, that change may be made by:

(1) striking through the language of the form;

(2) deleting the language of the form; or

(3) attaching an endorsement to the policy that makes the change.

C. The premiums and charges authorized by these rules shall be established by order of the superintendent in a title rate case conducted pursuant to Subsection A of Section 59A-30-8 NMSA 1978, or as amended or supplemented by order issued after a

hearing conducted pursuant to Subsection B of Section 59A-30-8 NMSA 1978. All references to premiums and charges shall mean the premiums and charges established by the superintendent's order in the most recent title rate case and in effect at the time the premium or charge is incurred.

D. When a statute or rule requires a title insurer or title insurance agency to deliver a document, or otherwise provide notice, to a person, delivery or notice to an authorized agent of that person satisfies that requirement.

E. Except as expressly authorized in these rules, it shall not be permissible to insure around any adverse matter or document by intentionally omitting it from any commitment or policy.

[13.14.1.8 NMAC – N, 1/1/2021]

13.14.1.9 RULE NONCOMPLIANCE:

Failure to comply with any provision of these rules is punishable under the applicable provisions of the Insurance Code.

[13.14.1.9 NMAC – N, 1/1/2021]

PART 2: LICENSING AND REPORTING REQUIREMENTS

13.14.2.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.2.1 NMAC – Rp, 13.14.2.1 NMAC, 1/1/2021]

13.14.2.2 SCOPE:

This rule applies to all title insurers, title insurance agencies, and title insurance agents conducting title insurance business in New Mexico.

[13.14.2.2 NMAC – Rp, 13.14.2.2 NMAC, 1/1/2021]

13.14.2.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.2.3 NMAC – Rp, 13.14.2.3 NMAC, 1/1/2021]

13.14.2.4 DURATION:

Permanent.

[13.14.2.4 NMAC – Rp, 13.14.2.4 NMAC, 1/1/2021]

13.14.2.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.2.5 NMAC – Rp, 13.14.2.5 NMAC, 1/1/2021]

13.14.2.6 OBJECTIVE:

The purpose of this rule is to establish title insurance agency and agent licensing and reporting requirements.

[13.14.2.6 NMAC – Rp, 13.14.2.6 NMAC, 1/1/2021]

13.14.2.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.2.7 NMAC – Rp, 13.14.2.7 NMAC, 1/1/2021]

13.14.2.8 LICENSING:

A. OSI shall inspect or cause to be inspected any title plant owned, operated, or controlled within this state.

(1) An agency shall maintain its title plant for a period of at least 20 years immediately prior to the date of application for license.

(2) An agency shall keep its title plant not more than 30 days in arrears in posting, unless such arrearage is caused by delay in indexing of the public records in the county for which such plant is maintained, or by other factors that OSI deems as being undue hardships in obtaining the public records or facsimiles thereof, in which event the title plant must at least be current with the public records as then indexed.

B. If a title plant is not in compliance with the provisions of Section 59A-12-13 NMSA 1978 or of this rule at the time of such inspection, OSI will require that such plant be brought into compliance within a specified period of time. If the plant is not compliant within such period of time, OSI may suspend the license of the title insurance agency using the plant until the title plant is compliant, and any title insurer that has appointed the title insurance agency will be notified.

C. A title insurer shall notify OSI in writing of the cancellation of the appointment of any title insurance agent or agency within 30 days of the cancellation's effective date.

D. An agency shall notify title insurers in writing of the termination of any employee appointed as an agent by said title insurer within 30 days of the termination's effective date.

E. An escrow officer shall be licensed as a title insurance agent.

[13.14.2.8 NMAC – Rp, 13.14.2.8 NMAC, 1/1/2021]

13.14.2.9 OWNS, OPERATES OR CONTROLS:

For purposes of Section 59A-12-13 NMSA 1978 "owns, operates, or controls" include the following activities:

A. "Owns" - holding legal or equitable title or controlling interest in a title plant, either as sole or joint proprietor, any partner of a general partnership, or the general partner of a limited partnership, holder of more than ten percent of the voting stock of a corporation, or as a lessee under a written lease agreement or lease purchase agreement.

B. "Operates" - directly responsible for the maintenance, updating or retrieval of information contained in a title plant or the searching, abstracting, or examining of title to real property or preparation of abstracts, searches, or commitments relating to real property derived from research from a title plant.

C. "Controls" - ultimate regulating authority or any intermediate supervisory authority over any person directly responsible for the operation of a title plant, who promulgates or administers the general policies providing for the direction and management of a title plant, including general policies of maintenance, updating, and retrieval of information from a title plant or the purchase, sale, or leasing of a title plant. A lease of a title plant shall qualify as "control" if the following conditions are met:

(1) All initial leases for a title plant must contain the terms of a minimum of five years and renewals for a minimum term of three years. No early termination of leases shall be allowed without the express written consent of OSI.

(2) A lease agreement shall be invalid unless approved by OSI.

(3) Access to a title plant under a lease agreement has not been terminated, suspended or denied.

(a) If the lessee is denied access to a leased title plant, the lessee shall notify OSI of the date of denial of access and the reason.

(b) Upon notification of a lessee's denial of access to a leased title plant, OSI shall notify each title insurer who has appointed the lessee of such denial of access.

[13.14.2.9 NMAC – N, 1/1/2021]

13.14.2.10 MAINTENANCE ASSESSMENTS:

The superintendent shall annually issue a directive establishing the maintenance assessment authorized by Section 59A-30-12 NMSA 1978 on policies written during the preceding calendar year insuring property or interests in property in New Mexico for each fiscal year commencing on July 1 and ending on June 30. The directive shall be issued at least 30 days before it is to become effective and shall include a brief statement describing how the maintenance assessment was determined. A title insurer shall correctly calculate its assessment based upon its New Mexico gross premium for the most recent preceding full calendar year and shall remit the same to OSI as specified in the superintendent's directive. A title insurer's assessment shall be rounded to the nearest dollar after computation has been performed. Fifty cents or more shall be rounded up; 49 cents or less shall be rounded down.

[13.14.2.10 NMAC – Rp, 13.14.2.12 NMAC, 1/1/2021]

13.14.2.11 AUDITS:

OSI may at any time audit any title insurance agent, agency, or title insurer. If the audit provides cause for additional examination, such examination shall be conducted pursuant to Article 4 of Section 59A NMSA 1978, as applicable.

[13.14.2.11 NMAC – N, 1/1/2021]

13.14.2.12 TITLE INSURANCE AGENCIES CEASING OPERATION:

Prior to ceasing the business of title insurance, an agency shall comply with the following requirements:

A. Forty-five days prior to its ceasing of operations, the agency shall notify each of the following of the cessation date:

(1) OSI title insurance bureau;

(2) all appointing title insurers; and

(3) the public by prominently displaying on the front of the business and on the landing page of the agency website, a notice reading, "Notice: this title insurance agency will cease operations on "[date]."

B. The agency and its appointing insurers shall conduct a final audit of the agency's trust fund accounts, the records pertaining thereto and the unused forms in the agency's possession.

(1) The final audit and final accounting required by this section shall be delivered to OSI and to each appointing insurer within 90 days after the agency ceases operations.

(2) If an appointing title insurer does not receive a final audit report within 90 days, the title insurer shall:

(a) report the non-receipt to OSI not later than the 100th day after the cessation date; and

(b) use its best efforts to complete and submit a final audit to OSI within 150 days of the cessation date. The title insurer shall provide written explanation and justification to OSI documenting those portions of the final audit that the title insurer was not able to complete, and describing the records and personnel available to the title insurer and the efforts used in the attempt to complete the final audit.

C. No later than 10 days after providing notice to OSI, the agency shall confer with OSI to develop a wind down plan. If the agency does not fulfill this requirement, OSI will contact each appointing insurer of that agency, who shall make arrangements satisfactory to OSI for the collection and preservation of the agency records.

D. The affiliation of any licensed title insurance agent employed by an agency who ceases business shall automatically terminate upon cessation of the business.

[13.14.2.12 NMAC – N, 1/1/2021]

13.14.2.13 [RESERVED]

[13.14.2.13 NMAC - Rn, 13 NMAC 14.3.13.1, 5/15/2000, Repealed 1/1/2021]

13.14.2.14 [RESERVED]

[13.14.2.14 NMAC - Rn, 13 NMAC 14.3.13.3 & A, 5/15/2000; A, 1/1/2001; A, 3/1/2002; A, 7/1/2005, Repealed 1/1/2021]

13.14.2.15 [RESERVED]

[13.14.2.15 NMAC - Rn, 13 NMAC 14.3.14, 5/15/2000, Repealed 1/1/2021]

PART 3: AGENCY AGREEMENTS

13.14.3.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.3.1 NMAC – Rp, 13.14.3.1 NMAC, 1/1/2021]

13.14.3.2 SCOPE:

This rule applies to all title insurers, title insurance agencies, and title insurance agents conducting the business of title insurance in New Mexico.

[13.14.3.2 NMAC – Rp, 13.14.3.2 NMAC, 1/1/2021]

13.14.3.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.3.3 NMAC – Rp, 13.14.3.3 NMAC, 1/1/2021]

13.14.3.4 DURATION:

Permanent.

[13.14.3.4 NMAC – Rp, 13.14.3.4 NMAC, 1/1/2021]

13.14.3.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.3.5 NMAC – Rp, 13.14.3.5 NMAC, 1/1/2021]

13.14.3.6 OBJECTIVE:

The purpose of this rule is to establish requirements for agreements between title insurers and title insurance agency and agents.

[13.14.3.6 NMAC – Rp, 13.14.3.6 NMAC, 1/1/2021]

13.14.3.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.3.7 NMAC – Rp, 13.14.3.7 NMAC, 1/1/2021]

13.14.3.8 AGENCY AGREEMENTS:

A. All agreements and amendments between title insurers and title insurance agencies or agents shall comply with these rules, and shall be filed with OSI within 30 days of execution. All existing agency agreements shall be amended within 60 days of the effective date of any applicable change to these rules. An amendment may be in the form of an addendum to an existing agreement.

B. An agreement between a title insurance agency or agent and a title insurer shall specify that the title insurance agency or agent has no authority to negotiate or settle policy claims.

[13.14.3.8 NMAC – Rp, 13.14.3.12 NMAC, 1/1/2021]

13.14.3.9 PAYMENTS OF PREMIUM AND MAINTENANCE TAXES OR ASSESSMENTS BY TITLE INSURERS:

An agreement between a title insurance agency or agent and a title insurer shall require that the title insurer pay all premium taxes or assessments and all maintenance taxes or assessments as the same may come due and payable, and shall require that the title insurer report all premiums received by it directly or by any of its title insurance agencies or agents on a one hundred percent gross basis for the purposes of reporting said taxes and assessments.

[13.14.3.9 NMAC – Rp, 13.14.3.10 NMAC, 1/1/2021]

13.14.3.10 PREMIUM DIVISION WITH TITLE INSURANCE AGENTS – OTHER CHARGES:

A. A title insurance agency or agent or title insurer shall not pay or receive any compensation for title insurance business or for referral of business, other than the division of premiums established in a title rate case. A title insurer shall not reward or otherwise compensate a title insurance agency or agent (or vice versa) directly or indirectly for business other than as established in a title rate case.

B. A title insurance agency or agent shall not be required to contribute or pay any amount to an insurer for reinsurance or otherwise, and any contractual provision to the contrary shall be void and unenforceable.

C. A title insurer may pay on behalf of, or reimburse, a title insurance agency or agent for expenses associated with instruction, lectures or seminars conducted by that title insurer for title insurance agencies or agents, if such instruction, lectures or seminars have been approved in advance by OSI for continuing education credit. A title insurer conducting such instruction, lectures or seminars shall submit to the superintendent for approval, in advance, an agenda and detailed budget for such instruction, lectures or seminars. Such courses of instruction, lectures or seminars shall be offered by a title insurer to all of its appointed title insurance agents on a non-discriminatory basis.

[13.14.3.10 NMAC – Rp, 13.14.3.11 NMAC, 1/1/2021]

13.14.3.11 ASSUMPTION OF RISK BY A TITLE INSURANCE AGENCY OR AGENT:

No agreement between a title insurance agency or agent and a title insurer shall directly or indirectly require a title insurance agency or agent to assume either partial or total liability for an insured risk, except as follows:

A. if a title insurance agency or agent, or any person employed by a title insurance agency, commits gross negligence, fraud, deceit, or theft in connection with a title transaction, and if such act causes loss to the title insurer;

B. if a title insurance agency or agent, or any person employed by a title insurance agency, disregards lawful written instructions of a title insurer or other party to a title transaction, and if such act causes loss to the title insurer; or

C. if the title insurance agency or agent, or any person employed by the agency, shall do or fail to do any act which results in the insurer paying a claim to any person pursuant to a New Mexico closing protection letter issued by the title insurer.

[13.14.3.11 NMAC – Rp, 13.14.3.8 NMAC, 1/1/2021]

13.14.3.12 PROHIBITED CONDUCT:

A title insurance agency or agent or title insurer shall not provide, either directly or indirectly, any goods or services to a referrer without receiving fair market value therefor. This includes, but is not limited to, the following activities:

A. making any monetary payment to any producer, unless the payment is for the actual cost of bona fide supplies or services received by the title insurer or title insurance agency or agent;

B. making any in kind payment to any producer or provide any free products or services, including but not limited to postage, postage machines, facsimile machines, computer hardware or software, copy machines, telephones, or office space to any producer;

C. engaging in joint advertising by any means of communication or media that names a specific producer unless the producer pays its share of the advertising cost in direct proportion to its prominence in the advertisement;

D. providing video equipment or any other type of electronic or cyber equipment or services, such as "virtual tours" unless the producer pays at least the actual cost for the equipment or services;

E. providing advertising by any means of communication or media for a producer unless the producer pays at least the actual cost for the advertisement to the title insurer or title insurance agency or agent;

F. sponsoring, co-sponsoring, or providing free door prizes, refreshments or meals at any producer's open house, tour of open houses, awards banquet, or company party unless a representative of the title insurer or agency is present and educational or marketing materials and signage are on-site for the function; at no time shall the cost of any sponsorship exceed the commensurate advertising benefit of the educational or marketing materials and signage provided;

G. providing free meals to any producer unless a representative of the title insurer or title insurance agency is present, title insurance business is discussed and the meals are not a regular occurrence; a title insurer or title insurance agency or agent shall not provide free recreational activities or entertainment to any producer under any circumstance;

H. entering into any lease or rental agreement for office space with a producer unless:

(1) the lease or rental agreement is for commercially reasonable terms and at least the fair market rental rate of the property; and

(2) the property is physically occupied by at least one bona fide full time employee of the title insurer or title insurance agency if the producer is the lessor or by one bona fide full time employee of the producer if the title insurer or title insurance agency or agent is the lessor; or

I. providing a career continuing education course for producers, unless each producer in attendance pays at least the actual per person cost for the course to the title insurer or title insurance agency or agent.

[13.14.3.12 NMAC – N, 1/1/2021]

13.14.3.13 CHARGE TO BE MADE FOR ALL SERVICES:

A. A title insurance agency or agent or title insurer shall not furnish services, information, subdivision ownership lists, farm packages, estimates or income production potential, pre-search or listing packages, information kits or similar packages containing information about one or more parcels of real property without making a charge for the same.

B. A title insurance agency or agent or title insurer shall collect charges in the ordinary course of their business operations. A title insurance agency or agent or title insurer shall not provide additional or new services to an individual who has failed to pay charges for prior services.

[13.14.3.13 NMAC – Rp 13.14.13 NMAC, 2/1/2022]

13.14.3.14 DUTIES OF TITLE INSURERS WITH RESPECT TO AGENCIES:

A. A title insurer shall not accept title insurance business from an agency unless there is in force a written agreement between the title insurer and the agency.

B. For each agency, the title insurer shall have on file a statement of financial condition. The statement shall include an income statement of title insurance business done during the preceding year and a balance sheet showing the condition of affairs as of the prior December 31. The agency shall certify the statement is true and correct.

C. A title insurer shall, at least annually, conduct a review of the underwriting, claims, and escrow practices of the agency which shall include a review of the title insurance policy form inventory and processing operations. If the agency does not maintain separate financial institution or trust accounts for each title insurer it represents, the title insurer shall verify that the funds held on its behalf are reasonably ascertainable from the books of account and records of the agency.

D. Within 30 days after executing or terminating an agreement with an agency, a title insurer shall provide written notification of the appointment or termination and the reason for the termination to OSI. The notice of appointment of an agency shall be made on a form prescribed or approved by OSI.

E. A title insurer shall maintain an inventory of all title insurance policy forms or title insurance policy numbers allocated to each agency.

F. Before entering into an agreement with an agency, a title insurer shall confirm that the agency has a current and appropriate license to transact title insurance business.

[13.14.3.14 NMAC – N, 1/1/2021, Rn & A, 2/1/2022]

13.14.3.15 [RESERVED]

[13.14.3.14 NMAC - Rn, 13 NMAC 14.4.14, 5/15/2000; Repealed 1/1/2021; Rn, 2/1/2022]

13.14.3.16 [RESERVED]

[13.14.3.15 NMAC - N, 7/1/2006; Repealed 1/1/2021, Rn, 2/1/2022]

PART 4: ESCROW SERVICES

13.14.4.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.4.1 NMAC – Rp, 13.14.4.1 NMAC, 1/1/2021]

13.14.4.2 SCOPE:

This rule applies to title insurers, title insurance agencies, title insurance agents, and their owners, officers, directors, partners or employees whose duties include or relate to the provision of escrow services.

[13.14.4.2 NMAC – Rp, 13.14.4.2 NMAC, 1/1/2021]

13.14.4.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.4.3 NMAC – Rp, 13.14.4.3 NMAC, 1/1/2021]

13.14.4.4 DURATION:

Permanent.

[13.14.4.4 NMAC – Rp, 13.14.4.4 NMAC, 1/1/2021]

13.14.4.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.4.5 NMAC – Rp, 13.14.4.5 NMAC, 1/1/2021]

13.14.4.6 OBJECTIVE:

The purpose of this rule is to establish requirements for title insurers and title insurance agencies and agents who provide escrow services and to protect parties to transactions who deposit funds with title insurers or agents.

[13.14.4.6 NMAC – Rp, 13.14.4.6 NMAC, 1/1/2021]

13.14.4.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.4.7 NMAC – Rp, 13.14.4.7 NMAC, 1/1/2021]

13.14.4.8 REQUIREMENTS FOR PROVIDING ESCROW SERVICES:

A title insurer or title insurance agency providing escrow services shall:

A. only accept funds pursuant to escrow instructions;

B. not make changes to escrow instructions without the consent of all parties in the manner specified by the escrow instructions;

C. receive and handle all funds pursuant to the requirements of Sections 58-28-1 et seq. and 59A-12-22 NMSA 1978;

(1) an escrow account shall be separate from all operating accounts, and shall be designated as an escrow, trust or custodial account by the financial institution and in the books and records of the title insurer or title insurance agency; and

(2) title insurers and title insurance agencies are prohibited from receiving for their own use any interest from escrow accounts or money accepted for escrow, except that nothing herein shall preclude participation in the Land Title Trust Fund Act pursuant to the Mortgage Loan Company Act, Section 58-28-1 NMSA 1978 et seq.;

D. disburse or deliver escrow funds only in accordance with escrow instructions;

E. disburse funds only out of an escrow account deposited for that transaction and that are available funds in compliance with Section 59A-30-5.1 NMSA 1978 and Subsection F of Section 59A-30-3 NMSA 1978;

F. interplead or hold any funds that are the subject of conflicting demands by the parties to an escrow until the title insurer or title insurance agency receives written instructions signed by all parties to the escrow transaction which resolve the conflict or until a final court order;

G. upon completion of an escrow transaction, deliver to each party a written statement of the escrow specifying all receipts and disbursements of funds made by or on behalf of each party to the escrow, whether disbursed to or from the escrow account, including from whom received and to whom made, except that when the transaction involves consumer credit, the most current version of the federal truth in lending regulation, 12. C.F.R. § 1026, shall govern the delivery of documents to the parties;

H. act with impartiality toward all parties to an escrow in the disbursement of funds; and

I. comply with all escrow audits ordered by OSI and make available to OSI all information requested by the superintendent.

[13.14.4.8 NMAC – Rp, 13.14.4.8 NMAC, 1/1/2021, A, 2/1/2022]

13.14.4.9 BOOKS AND RECORDS:

A title insurer or agency shall, on a current basis:

A. establish and maintain a separate subsidiary ledger for each escrow transaction;

B. post all receipts and disbursements from each subsidiary ledger to a control ledger daily and at least monthly, prepare a trial balance of all subsidiary ledgers. The monthly trial balance reconciliation shall be performed by a person who did not perform the receipt and disbursement function; and

C. on a daily basis, reconcile the book balance and escrow account balance.

D. At least once each calendar month, prepare a three-way reconciliation for each escrow account. Each three-way reconciliation is required to be prepared within 10 business days of the closing date of the bank statement and to be approved by a title insurance agent who did not perform the reconciliation. The reconciliation shall include at a minimum as of the reconcile date:

(1) the bank statement;

(2) reconciliation sheet or summary page with book balance;

(3) outstanding deposits list and list of deposits in transit;

(4) open escrow file listing or trial balance; and

(5) outstanding disbursements list, all as of the reconciliation date.

E. Reconciliations and underlying statements, listings and reports shall be preserved in a logical sequence to trace an individual escrow transaction and shall be available electronically.

[13.14.4.9 NMAC – Rp, 13.14.4.9 NMAC, 1/1/2021]

13.14.4.10 ACCOUNTING PROCEDURES AND INTERNAL CONTROLS:

A title insurer or agency shall:

A. require two signatures on all escrow checks; one signature of which shall be a title insurance agent;

B. assign each escrow file a unique number; name identification is not acceptable;

C. on a monthly basis, an owner, officer or director shall review and approve the reconciliation for escrow accounts open for longer than six months;

D. remove the signature blocks from voided checks or otherwise render them ineffective;

E. require management approval for any transfers of funds between escrow accounts;

F. notify the seller within one day after receiving notice an earnest money check deposited in the account is returned by the financial institution to the title insurer or agency due to insufficient funds, unless the check is replaced by available funds within the one day time period; the insurer or agency shall retain a copy of written notices;

G. display related escrow file numbers directly on all escrow checks and deposit slips to provide a clear and direct connection between the document and the related escrow file;

H. maintain in each escrow file a complete, current disbursement sheet that lists the date, source and type of all receipts; date, check number, item description, payee and amount of any other disbursements and any remaining balance; voided checks that have been canceled where funds have been credited back to the account shall be shown on the disbursement sheet;

I. keep invoices substantiating, or sufficient evidence to support, all disbursements in the escrow files;

J. require reimbursement of all shortages from the title insurer's or agency's operating account within three days that reflects the transaction creating the escrow receivable or shortage, unless the shortage is the result of fraud or suspected fraud, in which case the shortage shall be cured within 45 days, unless otherwise ordered by the superintendent;

K. if a settlement statement requires changes, prepare a new statement or have all parties affected by the changes initial pen and ink changes;

L. issue a signed, pre-numbered receipt for any escrow funds received in cash;

M. if a bank does not return actual cancelled checks with bank statements, the agency shall either acquire and retain clearly legible copies of the front and back of each check, or have on file in the office an agreement with the depositor bank that ensures readily available access to such copies for at least four years;

N. an escrow account shall have the designation of "escrow" or "trust" on the bank account, checks and deposit slips; and

O. preserve for at least 15 years all escrow transaction records. This 15 year requirement for escrow records shall apply with respect to title policies issued on or after June 1, 2010.

[13.14.4.10 NMAC – Rp, 13.14.4.10 NMAC, 1/1/2021]

13.14.4.11 ANNUAL ESCROW COMPLIANCE PROCEDURES:

A. Title insurers and agencies shall, at their own expense, engage an independent certified public accountant to certify the procedures required by OSI. Title insurers and agencies shall require the certified public accountant to follow and comply with all requirements of any order of OSI relating to the performances of escrow duties as set out in these rules.

B. The certified public accountant shall be licensed and in good standing.

[13.14.4.11 NMAC – Rp, 13.14.4.11 NMAC, 1/1/2021]

13.14.4.12 NOTICE TO OSI:

A. A title insurer, agency or title insurance agent, who discovers any of the following, shall provide notice to OSI within five days of:

(1) notice of suit in any civil or criminal action against the title insurer, title insurance agency, or title insurance agent involving any alleged misconduct or liability of the title insurer, title insurance agency, or title insurance agent concerning a New Mexico escrow; or

(2) any disciplinary action taken by the disciplinary board or by the supreme court of New Mexico involving misconduct concerning an escrow by a title insurer or title insurance agent who is a licensed attorney.

B. A title insurer, agency or title insurance agent, who discovers theft or fraud of an escrow account, shall notify OSI within two days of discovery.

[13.14.4.12 NMAC – Rp, 13.14.4.12 NMAC, 1/1/2021]

13.14.4.13 [RESERVED]

[13.14.4.13 NMAC - N, 7/1/2005; A, 3/1/2016, Repealed 1/1/2021]

13.14.4.14 [RESERVED]

[13.14.4.14 NMAC - N, 7/1/2005; Repealed 1/1/2021]

13.14.4.15 [RESERVED]

[13.14.4.15 NMAC - N, 7/1/2005; Repealed 1/1/2021]

13.14.4.16 [RESERVED]

[13.14.4.16 NMAC - N, 7/1/2005; Repealed 1/1/2021]

PART 5: COMMITMENTS OR BINDERS

13.14.5.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.5.1 NMAC – Rp, 13.14.5.1 NMAC, 1/1/2021]

13.14.5.2 SCOPE:

This rule applies to all title insurers, title insurance agencies, and title insurance agents conducting title insurance business in New Mexico.

[13.14.5.2 NMAC – Rp, 13.14.5.2 NMAC, 1/1/2021]

13.14.5.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.5.3 NMAC – Rp, 13.14.5.3 NMAC, 1/1/2021]

13.14.5.4 DURATION:

Permanent.

[13.14.5.4 NMAC – Rp, 13.14.5.4 NMAC, 1/1/2021]

13.14.5.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.5.5 NMAC – Rp, 13.14.5.5 NMAC, 1/1/2021]

13.14.5.6 OBJECTIVE:

The purpose of this rule is to establish requirements for commitments issued for title insurance.

[13.14.5.6 NMAC – Rp, 13.14.5.6 NMAC, 1/1/2021]

13.14.5.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.5.7 NMAC – Rp, 13.14.5.7 NMAC, 1/1/2021]

13.14.5.8 ISSUANCE OF A COMMITMENT:

A. Upon acceptance of an order for any type of title insurance, a title insurer or title insurance agency shall deliver to the proposed insured, a commitment showing the exceptions which will appear in the proposed policy as of the date of the commitment and requirements to insure the title in accordance with the order. Such commitment shall be delivered as soon as practical, using the title insurer's or title insurance agency's best efforts, allowing reasonably sufficient time to review prior to the completion of the transaction.

B. When a commitment is for a one to four family residential property, it shall be delivered with NM form 35, as the cover page. The NM form 35, when required, shall be signed by purchaser(s) at or before the time of settlement and retained in the agency's file. The NM form 35 is not required if, prior to the delivery of the commitment, the proposed insured(s) signs a contract for sale of the insured land that includes substantially identical language to that included in NM form 35 and that is completed by checking all appropriate blanks.

C. When requested by a proposed insured lender the following language may be added to a title commitment "note for information only: according to the public records, there have been no deeds conveying the property in this commitment within a period of (six to 24) months prior to the date of this commitment, except as follows:" The inclusion of such language in the commitment does not increase or otherwise modify coverage under the commitment or policy.

D. When a to-be-determined title commitment is issued, the following language shall be included: "This title commitment is not effective until schedule A is completed and the company reserves the right to amend and supplement this commitment with additional information, requirements and exceptions based upon the provision of additional information."

[13.14.5.8 NMAC – N, 1/1/2021]

13.14.5.9 DURATION OF COMMITMENT:

A commitment shall be valid for a period of six months. A commitment may be extended or renewed by endorsement for up to three additional six month periods when the pending order for title insurance remains active and the required additional premiums are paid. Whenever an insured under a loan policy on property taken by foreclosure or deed in lieu of foreclosure, or by a state or federal agency, requests a commitment, the commitment may be initially endorsed to be valid for no more than two years upon payment of the required premiums for both issuance and extensions.

[13.14.5.9 NMAC – Rp, 13.14.5.11 NMAC, 1/1/2021]

13.14.5.10 STANDARD EXCEPTIONS IN SCHEDULE B:

A. All commitments shall contain each of the following exceptions in the order stated herein.

(1) Rights or claims of parties in possession not shown by the public records.

(2) Easements, or claims of easements, not shown by the public records.

(3) Encroachments, overlaps, conflicts in boundary lines, shortages in area, or other matter which would be disclosed by an accurate survey and inspection of the premises.

(4) Any lien, claim or right to a lien, for services, labor or materiel heretofore or hereafter furnished, imposed by law and not shown by the public records.

(5) Community property, survivorship, or homestead rights, if any, of any spouse of the insured (or vestee in a leasehold or loan policy).

(6) Water rights, claims or title to water.

(7) Taxes for the year _____, and thereafter. (See 13.14.5.12 NMAC)

(8) Defects, liens, encumbrances, adverse claims or other matters, if any, created first appearing in the public records or attaching subsequent to the effective date hereof but prior to the date the proposed insured acquires for value of record the estate or interest or mortgage thereon covered by this commitment.

B. Additionally, each commitment may contain the following statement when said commitment is issued to commit for both an owner's policy and a loan policy or a loan policy only: "Exceptions _____ will not appear in the loan policy but will appear in the owner's policy, if any."

C. If the commitment is for a loan policy containing a two-year claims made limitation, the following statement must be added: "The loan policy containing a two-year claims made limitation will contain an exception limiting its coverage to two years duration."

D. Each commitment shall contain the following statement: "Standard exceptions 1, 2, 3, and or 4, may be deleted from a policy upon compliance with all provisions of the applicable rules, upon payment of all additional premiums required by the applicable rules, upon receipt of the required documents and upon compliance with the company's underwriting standards for each such deletion.

E. Standard exception 5 may be deleted from the policy if the named insured in the case of an owner's policy, or the vestee, in the case of a leasehold or loan policy, is a corporation, a partnership, or other artificial entity, or a person holding title as trustee."

[13.14.5.10 NMAC – Rp, 13.14.5.9 NMAC, 1/1/2021; A/E, 1/24/2024]

13.14.5.11 ADDITIONAL TAX EXCEPTION:

In those areas of New Mexico where there are taxes or assessments which may be a lien by law but are not filed for record with the county clerk's office by local custom or practice, and upon approval of the insurer, the following additional tax exception may be added to policies or commitments: "Any possible taxes or assessments which may be a lien by law but have not been filed for record in the office of the county clerk of _____ county."

[13.14.5.11 NMAC – N 1/1/2021]

13.14.5.12 STANDARD EXCEPTIONS:

A policy shall contain in schedule B the standard exceptions 1 through 7, except as otherwise provided by these rules. Said standard exceptions may be preprinted in schedule B and, when specifically authorized, may be deleted by stating, "exceptions _____ are hereby deleted in their entirety". Standard exception 5 shall refer to "spouse of the vestee" in all owner's policies and in all situations where the vestee and insured are not the same.

A. Parties in possession - Standard exception 1: Standard exception 1 may be deleted upon satisfactory proof that there are no parties in possession of the property being insured other than those claiming rights or possession in the property through matters of public record.

B. Unrecorded easements - Standard exception 2: Standard exception 2 may be deleted if a survey of the property being insured satisfactorily shows that there are no easements or claims of easements affecting the insured property other than those shown by the public records.

C. Survey coverage – Standard exception 3:

Standard exception 3 may be deleted in its entirety if the insurer considers the risk acceptable. Any additional premium required by these rules must be paid and the title insurer or its title insurance agency must be furnished with a survey of the insured property meeting the insurer's underwriting standards prior to the deletion.

D. Mechanics' and Materialmen's Lien Coverage – Standard Exception 4:

(1) In an owner's policy, standard exception 4 may be deleted in only one of two circumstances:

(a) the statutory period for filing mechanics' or materialmen's liens expires prior to the date of the policy;

(b) some or all of the improvements will be "new construction" (or recently completed), and the statutory period for the filing of said liens will not have expired; or

(c) in either circumstance the construction of all improvements on the insured property must have been fully completed and accepted by the insured owner and the appropriate additional premiums required by these rules must be paid.

(2) In a loan policy, standard exception 4 may be deleted in only one of two circumstances:

(a) if the insurer's underwriting requirements for evidence of priority have been met; or

(b) if the insurer's underwriting requirements for evidence of priority have not been met but the insurer's underwriting requirements of the risk incurred by reason of the lack of priority have been met.

(c) In either circumstance, the appropriate additional premiums as established in a title rate case shall be paid.

E. Spousal rights – Standard exception 5: Standard exception 5 may be deleted from a policy if the vestee named in such policy is not an individual.

F. Water rights – Standard exception 6: Standard exception 6 shall not be modified or deleted.

G. Taxes – Standard exception 7: Standard exception 7 may be modified as follows:

(1) To read: "Taxes for the second half of the year _____, and thereafter." Such modification shall not be made unless all taxes assessed or assessable through and including the first half of the ad valorem tax year have been paid or are being paid out of funds which are under the control of the title insurance agency or title insurer in an escrow account.

(2) To read: "Taxes for the year _____, and thereafter, not yet due or payable."

(3) If the ad valorem taxes for the first half of a year have been paid, and taxes for the second half are not yet delinquent, standard exception 7 may be modified, by adding the phrase: "not yet delinquent."

H. Gap period – Standard exception 8: Standard exception 8 shall not be included in a policy.

[13.14.5.12 NMAC – N, 1/1/2021; A/E, 1/24/2024]

13.14.5.13 PRO FORMA POLICIES:

A pro forma policy may be issued only if the land is not one to four family residential property. In such case, schedule A shall conspicuously state: "This is a pro forma policy furnished to or on behalf of the party proposed to be insured for discussion only. It does not reflect the present status of title and is not a commitment to insure the estate or interest as shown herein, nor does it evidence the willingness of the company to provide any coverage shown herein. Any such commitment must be an express written undertaking issued on the appropriate forms of the company."

[13.14.5.13 NMAC – Rp, 13.14.5.13 NMAC, 1/1/2021]

PART 6: OWNER'S, LEASEHOLD OWNER'S, AND CONTRACT PURCHASER'S POLICIES

13.14.6.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.6.1 NMAC – Rp, 13.14.6.1 NMAC 1/1/2021]

13.14.6.2 SCOPE:

This rule applies to all title insurers, title insurance agencies, and title insurance agents conducting title insurance business in New Mexico.

[13.14.6.2 NMAC – Rp, 13.14.6.2 NMAC 1/1/2021]

13.14.6.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.6.3 NMAC – Rp, 13.14.6.3 NMAC 1/1/2021]

13.14.6.4 DURATION:

Permanent.

[13.14.6.4 NMAC – Rp, 13.14.6.4 NMAC 1/1/2021]

13.14.6.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.6.5 NMAC – Rp, 13.14.6.5 NMAC 1/1/2021]

13.14.6.6 OBJECTIVE:

The purpose of this rule is to establish requirements for title insurance policy provisions.

[13.14.6.6 NMAC – Rp, 13.14.6.6 NMAC 1/1/2021]

13.14.6.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.6.7 NMAC – Rp, 13.14.6.7 NMAC 1/1/2021]

13.14.6.8 OWNER'S POLICIES:

A. An owner's policy shall be written to protect the estate or interest in land held by the insured (e.g., fee simple, easement, etc.). Except as otherwise provided herein, an owner's policy shall be issued for the amount of the sales price of the land and any existing appurtenant improvements, or at the option of the insured, the cost of improvements immediately contemplated to be erected thereupon.

B. If no sale is being made at time of a policy issuance, an owner's policy shall be issued for an amount equal to the value of the land and any existing appurtenant improvements. If an owner's policy is issued at the time of payoff of a real estate contract and recording of a warranty deed, the owner's policy shall be issued for the amount of the contract price, except if the purchaser requests and provides evidence of value, then the owner's policy may be issued for the amount equal to the value of the land and any existing improvements, with the same option concerning immediately contemplated improvements.

C. An owner's policy may be endorsed to reflect the current value of the estate insured (upon payment of the current basic premium according to the current schedule less the insured current basic premium previously paid for the policy) if the insurer's underwriting standards are met; provided, however, that the effective date of the policy shall remain unchanged and no affirmative coverages or down dates shall be added.

D. NM form 55 shall be provided to any insured requesting the endorsement on an owner's policy issued prior to August 1, 2008 without the endorsement.

E. Owner's policy insuring a leasehold estate: An owner's policy shall be issued to insure the leasehold estate in the amount, at the option of the insured, of:

(1) the total amount of the rentals payable under the lease contract; or

(2) the value of the land and any existing improvements.

(3) Unless otherwise specifically stated, an owner's policy insuring a leasehold estate shall contain the same standard exceptions, be subject to the same premium and be subject to deletion of the same standard exceptions in the same manner as a standard owner's policy.

(4) An NM form 20 shall be attached to an owner's policy to create a leasehold owner's policy. An owner's policy insuring a leasehold estate may be endorsed to insure a fee simple estate by attaching an NM form 31.

F. Owner's policy insuring contract purchaser's interest:

(1) An owner's policy to insure a contract purchaser's interest shall be written to insure the estate or interest in land upon which the insured holds a contractual interest because of a recorded real estate contract or agreement, or a sufficient recorded memorandum thereof. Unless otherwise specifically provided, an owner's policy to insure a contract purchaser's interest shall be subject to all rules and regulations that apply to an owner's policy, and in the same manner.

(2) The estate or interest in the land insured in schedule A under an owner's policy insuring contract purchaser's interest shall be automatically converted to fee simple without the requirement for a policy endorsement, if the contract purchaser acquires the fee title interest by the filing of the deed from the contract seller for the transaction that was previously insured. The effective date of the policy shall not change. No additional premium shall be charged.

(3) Upon request of an insured, an owner's policy to insure a contract purchaser's interest may be converted and down dated to a standard owner's policy by the issuance of NM form 91.

[13.14.6.8 NMAC – Rp, 13.14.6.8 NMAC, 1/1/2021]

13.14.6.9 U.S. POLICIES:

A. NM form 34 shall contain standard exceptions subject to deletion as provided in these rules.

B. Whenever the United States postal service acquires title to property being insured, it is permissible to:

(1) amend the NM form 34 by striking therefrom in all places the name "United States of America" and substituting in lieu thereof the name "United States Postal Service;" and

(2) to insert the following paragraph to the conditions and stipulations: "In the event that the interests of the United States postal service with respect to the land referred to in this policy are not represented by the attorney general of the United States

at the time any election, notice, request, permission, cooperation, assistance, or statement is required or permitted by these conditions and stipulations, then such election, notice, request, permission, cooperation, assistance, or statement, as so required or permitted, and otherwise conforming hereto, should be given or furnished by or to the United States postal service."

[13.14.6.9 NMAC – N, 1/1/2021]

13.14.6.10 STANDARD EXCEPTIONS:

An owner's policy shall contain standard exceptions 1 through 7, except as otherwise provided by these rules.

[13.14.6.10 NMAC – Rp, 13.14.6.11 NMAC, 1/1/2021]

13.14.6.11 REISSUE OWNER'S POLICIES:

A. An owner's policy shall qualify for reissue rates only when insuring one of the following:

(1) a purchaser or lessee of the same real estate from one whose title thereto as owner's has been insured by any company in a previous policy issued prior to the application for a new policy; or

(2) a purchaser or lessee of the same real estate from an insured under a loan policy of any company which has acquired title to the same property described in said loan policy by foreclosure or by voluntary conveyance in extinguishment of the debt.

B. The proof of a prior title insurance policy requires a complete copy of all schedules of the prior policy.

C. The title insurer or agency which issues the reissue rate policy shall maintain proof of the prior policy for at least two years. The reissue rate shall apply, only if proof of the prior policy is in the possession of the title insurance insurer or agency issuing the reissue rate policy before the commencement of the title search for that policy.

D. The title insurer or agency may request the prior owner's policy from the prior title insurance agency or title insurer. Within five days, the prior title insurance agency or title insurer shall provide a copy of that policy in response to the request. The prior title insurance agency or title insurer may charge a reasonable retrieval fee for providing the copy of the prior title policy as authorized by these rules.

[13.14.6.11 NMAC – N, 1/1/2021]

13.14.6.12 SUBDIVIDERS OR CONSTRUCTION BULK RATE QUALIFICATIONS:

An insured owner qualifies for a subdivider or construction bulk rate only if the owner acquires title directly from a person who meets at least one of the following conditions:

A. owns of record at the same time two or more lots in the same approved subdivision holding the same for immediate sale upon completion of building improvements thereon;

B. owns two or more unsold vacant lots or acreage tracts at the same time in the same approved subdivision and has contracted with the insurer to purchase an owner's policy on each and every lot or tract as the same is sold; or

C. is the owner of record of two or more lots or tracts in the same approved subdivision, and:

(1) is a subdivider or builder who subdivides property for one to four family residential property use; or

(2) builds one to four family residential property for immediate resale upon completion of improvements and said lots or tracts are restricted to or zoned for one to four family residential property use or actually improved by one to four family residential property use at the time the policy is issued.

[13.14.6.12 NMAC – N, 1/1/2021]

13.14.6.13 REPLACING OWNER'S POLICY UPON RECEIVERSHIP:

A. A title insurer or agency may sell a replacement policy to the insured of a title insurer under receivership.

B. A title insurer shall require the insured to surrender the existing policy before providing a replacement policy. A copy of the existing policy may be received in lieu of the original policy. The date of policy for the replacement policy shall be the same date as for the replaced policy. If a copy of an existing policy is requested from the prior title insurance agency or title insurer, a reasonable retrieval fee may be charged by the prior title insurance agency or title insurer.

C. A title insurer shall not issue a replacement policy without exceptions to coverage for defects, liens, encumbrances, adverse claims or for other matters known to exist by the insured on the date of issuance of the replacement policy, including but not limited to claims known by any owner's or other insured and claims reported under existing policies or claims that have been made against the receiver. A replacement policy shall contain the following exception on schedule B: "defects, liens, encumbrances, adverse claims or other matters not known to the issuing title insurance agency or title insurer at the issue date of this replacement policy, but known to any owner's or other insured claimant and not disclosed in writing to the title insurance agency or title insurer by the

insured claimant prior to the date the insured claimant became insured under this policy."

D. A replacement owner's policy shall be issued in the amount of insurance shown on the replaced owner's policy. No search or examination of title or evidence thereof is required of a title insurance agency or insurer issuing a replacement policy pursuant to this rule. However, a title insurance agency or title insurer may conduct a search and examination at no additional expense to the insured, unless otherwise provided in these rules.

E. A replacement policy shall be marked as such by the words "REPLACEMENT POLICY; NO SEARCH REQUIRED," prior to the policy number on the cover page of the policy and on the top center of all other pages not considered a policy cover or jacket. After the words "REPLACEMENT POLICY; NO SEARCH REQUIRED," the date the replacement policy was issued shall be indicated after the word "issued" is typed.

F. A title insurer or agent shall accept as evidence either a replacement owner's policy or an owner's policy of an insurer under receivership, or a copy of the same, for purposes of the reissue rate.

[13.14.6.13 NMAC – N, 1/1/2021]

13.14.6.14-13.14.6.24 [RESERVED]

[13.14.6.14 – 13.14.6.24 NMAC – Rn, 13 NMAC 14.6.14-24, 5/15/2000; Repealed 1/1/2021]

PART 7: LOAN, LEASEHOLD LOAN, AND CONSTRUCTION LOAN POLICIES

13.14.7.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.7.1 NMAC – Rp, 13.14.7.1 NMAC, 1/1/2021]

13.14.7.2 SCOPE:

This rule applies to all title insurers, all title insurance agencies, and all title insurance agents conducting title insurance business in New Mexico.

[13.14.7.2 NMAC – Rp, 13.14.7.2 NMAC, 1/1/2021]

13.14.7.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.7.3 NMAC – Rp, 13.14.7.3 NMAC, 1/1/2021]

13.14.7.4 DURATION:

Permanent.

[13.14.7.4 NMAC – Rp, 13.14.7.4 NMAC, 1/1/2021]

13.14.7.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.7.5 NMAC – Rp, 13.14.7.5 NMAC, 1/1/2021]

13.14.7.6 OBJECTIVE:

The purpose of this rule is to establish requirements for loan policies.

[13.14.7.6 NMAC – Rp, 13.14.7.6 NMAC, 1/1/2021]

13.14.7.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.7.7 NMAC – Rp, 13.14.7.7 NMAC, 1/1/2021]

13.14.7.8 LOAN POLICIES:

A. A loan policy shall be issued for the face amount of the loan or loans insured. When the land covered in the policy represents only part of the security of the loan(s), the policy shall be written in the amount of the value of such land or the amount of the loan(s) insured, whichever is less. When requested by an insured, a loan policy may be issued in an amount equal to the original principal amount of the indebtedness plus interest (capitalized or otherwise) not to exceed twenty percent of the principal amount.

B. A loan policy may insure liens on multiple tracts in the same manner as an owner's policy.

C. A title insurer or title insurance agency issuing a loan policy shall deliver the new owner's(s) NM form 9, containing all of the required information available at that time and shall ask the owner's(s) to indicate whether an owner's policy is declined. The title insurer or title insurance agency shall retain a copy of the completed NM form 9 with a copy of the loan policy for at least two years whenever an owner's policy is declined.

D. Unless otherwise provided in these rules, a loan policy with a leasehold loan endorsement shall contain the same standard exceptions, be subject to the same premium and be subject to deletion of the same standard exceptions as a standard loan policy. A leasehold loan endorsement shall be attached to a loan policy to create a loan policy insuring a leasehold estate.

[13.14.7.8 NMAC – Rp, 13.14.7.8 NMAC, 1/1/2021; A/E, 1/24/2024]

13.14.7.9 [RESERVED]

[13.14.7.9 NMAC – Rn, 13 NMAC 14.7.9, 5/15/2000; A, 3/1/2002, Repealed, 1/1/2021]

13.14.7.10 STANDARD EXCEPTIONS:

A loan policy shall contain standard exceptions 1 through 7 except as otherwise provided by these rules.

[13.14.7.10 NMAC – Rp, 13.14.7.10 NMAC, 1/1/2021]

13.14.7.11 [RESERVED]

[13.14.7.11 NMAC – Rn, 13 NMAC 14.7.9, 5/15/2000; A, 10/1/2012, Repealed, 1/1/2021]

13.14.7.12 [RESERVED]

[13.14.7.12 NMAC – Rn, 13 NMAC 14.7.12, 5/15/2000; A, 10/1/2012, Repealed, 1/1/2021]

13.14.7.13 [RESERVED]

[13.14.7.13 NMAC – Rn, 13 NMAC 14.7.13, 5/15/2000; A, 10/1/2012, Repealed, 1/1/2021]

13.14.7.14 [RESERVED]

[13.14.7.14 NMAC – Rn, 13 NMAC 14.7.14, 5/15/2000; A, 10/1/2012, A, 7/31/2014, A, 3/1/2016, Repealed, 1/1/2021]

13.14.7.15 [RESERVED]

[13.14.7.15 NMAC – Rn, 13 NMAC 14.7.15, 5/15/2000; A, 10/1/2012, Repealed, 1/1/2021]

13.14.7.16 POLICY INSURING A CONSTRUCTION LOAN - PENDING DISBURSEMENT CLAUSE:

A. When a title insurer or agency issues a loan policy insuring a construction loan mortgage, the title insurer may require a specific pending disbursement clause. Such clause may be in the form directed by the title insurer, or it may be in the following form: "Pending disbursement of the full proceeds of the loan secured by the mortgage or deed of trust set forth under schedule A hereof, this policy insures only to the extent of the amount actually disbursed but increases as each disbursement is made, in good faith, and without knowledge of any defect in, or objections to, the title, up to the face amount of the policy." Prior to each disbursement of the loan proceeds, the title shall be down dated for possible liens or objections intervening between the date hereof and the date of such disbursement.

B. At the time of each disbursement, NM form 22 may be issued showing any changes in title to the insured property and stating the total amount of the proceeds of the construction loan advanced by the lender at the date the endorsement is issued.

[13.14.7.16 NMAC – N, 1/1/2021]

13.14.7.17 REPLACING LOAN POLICY UPON RECEIVERSHIP:

Issuance of a replacement loan policy shall be governed by the rules applicable to a replacement owner's policy, except that a title insurer or agency shall accept as evidence either a replacement loan policy or a loan policy of an insurer under receivership, or a copy of the same, for purposes of providing any applicable discount.

[13.14.7.17 NMAC – N, 1/1/2021]

13.14.7.18 LIMITED PRE-FORECLOSURE TITLE INSURANCE POLICY:

NM form 41 and, if desired, NM form 42 may be issued upon receipt of an order in anticipation of the filing of an action to judicially foreclose a mortgage, or other lien or security instrument encumbering title, or to non-judicially foreclose a deed of trust. No commitment shall be issued in connection with the policy. The amount of coverage shall be equal to the unpaid principal indebtedness due under the lien or note secured by the security instrument to be foreclosed. The policy shall be furnished solely for the purpose of facilitating the foreclosure.

[13.14.7.18 NMAC – Rp, 13.14.7.22 NMAC, 1/1/2021]

13.14.7.19 RESIDENTIAL LIMITED COVERAGE JUNIOR LOAN POLICY:

A title insurer or title insurance agency may, issue NM form 45 if all of the following conditions exist:

A. the real property to be insured is one to four family residential property;

B. the real property is located within an approved and recorded subdivision;

C. the title insurance agency or title insurer has a complete copy of the loan policy issued to an insured senior lender before the commencement of the title search; and

D. the loan is less than or equal to $125,000.

[13.14.7.19 NMAC – N, 1/1/2021]

13.14.7.20 [RESERVED]

[13.14.7.20 NMAC - Rn, 13 NMAC 14.7.20, 5/15/2000; A, 3/1/2016, Repealed 1/1/2021]

13.14.7.21 RESIDENTIAL LIMITED COVERAGE MORTGAGE MODIFICATION POLICY:

A title insurer or title insurance agency may issue NM form 90 if all of the following conditions exist:

A. the amount of the policy shall not exceed the outstanding principal balance of the loan on the date of the policy;

B. the policy shall not increase the amount of coverage under the prior policy;

C. the real property to be insured is one to four family residential property; and

D. the title insurer or title insurance agent has a complete copy of the prior loan policy before the commencement of the title search.

[13.14.7.21 NMAC – Rp, 13.14.7.27 NMAC, 1/1/2021]

13.14.7.22 [RESERVED]

[13.14.7.22 NMAC - Rn, 13 NMAC 14.7.22, 5/15/2000; A, 7/1/2004; A, 9/15/2010; A, 3/1/2016; A, 7/1/2018, Repealed 1/1/2021]

13.14.7.23 [RESERVED]

[13.14.7.23 NMAC - Rn, 13 NMAC 14.7.23, 5/15/2000, Repealed 1/1/2021]

13.14.7.24 [RESERVED]

[13.14.7.24 NMAC - N, 7/1/2004; Repealed, 9/15/2009]

13.14.7.25 [RESERVED]

[13.14.7.25 NMAC - N, 7/1/2004; A, 7/1/2005; Repealed, 9/15/2009]

13.14.7.26 [RESERVED]

[13.14.7.26 NMAC - N, 9/15/2010; A, 10/1/2012; A, 3/1/2016, Repealed 1/1/2021]

PART 8: ENDORSEMENTS

13.14.8.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.8.1 NMAC – Rp, 13.14.8.1 NMAC, 1/1/2021]

13.14.8.2 SCOPE:

This rule applies to all title insurers, all title insurance agencies, and all title insurance agents conducting title insurance business in New Mexico.

[13.14.8.2 NMAC – Rp, 13.14.8.2 NMAC, 1/1/2021]

13.14.8.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-5, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.8.3 NMAC – Rp, 13.14.8.3 NMAC, 1/1/2021; A, 1/1/2024]

13.14.8.4 DURATION:

Permanent.

[13.14.8.4 NMAC – Rp, 13.14.8.4 NMAC, 1/1/2021]

13.14.8.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.8.5 NMAC – Rp, 13.14.8.5 NMAC, 1/1/2021]

13.14.8.6 OBJECTIVE:

The purpose of this rule is to establish requirements for endorsements to title insurance policies.

[13.14.8.6 NMAC – Rp, 13.14.8.6 NMAC, 1/1/2021]

13.14.8.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.8.7 NMAC – Rp, 13.14.8.7 NMAC, 1/1/2021]

13.14.8.8 USE OF CORRECTION/MULTIPURPOSE ENDORSEMENT:

NM form 11 may be used only as follows:

A. to modify any promulgated form if the modification is authorized by these rules;

B. to insert, delete or add to a commitment, policy or endorsement, language required or authorized by any of these rules when appropriate to do so; or

C. to correct errors in the information inserted in the appropriate spaces of any preprinted commitment, policy or endorsement (but not to change, alter or waive the promulgated terms) in the following manner: "This endorsement amends (commitment, policy or endorsement) numbered _____, dated _____ to read as follows: [here insert language identifying the specific item being corrected and the specific correction information."] No other amendments are made by this endorsement."

[13.14.8.8 NMAC – Rp, 13.14.8.8 NMAC, 1/1/2021]

13.14.8.9 [RESERVED]

[13.14.8.9 NMAC - Rn, 13 NMAC 14.8.9, 5/15/2000; A, 3/1/2002; Repealed 1/1/2021]

13.14.8.10 [RESERVED]

[13.14.8.10 NMAC - Rn, 13 NMAC 14.8.11, 5/15/2000; A, 7/1/2006; A, 8/17/2009; Repealed 1/1/2021]

13.14.8.11 IDENTIFIED RISK COVERAGE ENDORSEMENT:

NM form 85 may be attached to a policy only when authorized by order of the superintendent and subject to such terms, conditions and rate(s) specified by the superintendent.

[13.14.8.11 NMAC – Rp, 13.14.8.12 NMAC, 1/1/2021]

13.14.8.12 INSURING AROUND ENDORSEMENT:

A. NM form 43 may be attached to a policy to insure around a lien or other adverse matter excepted to in Schedule B if the title insurer has determined that the lien or other adverse matter does not pose a material risk under the policy.

B. In lieu of attaching NM form 43, the exception to the lien or other adverse matter may be omitted from the policy provided the insured requests the omission, and the request and approval are documented or otherwise memorialized in writing.

[13.14.8.12 NMAC – Rp, 13.14.8.12 NMAC, 1/1/2021]

13.14.8.13 CO-INSURANCE ENDORSEMENTS:

NM form 77 shall be attached to a policy to provide coordinated and proportionate coverage by two or more title insurers. Such coverage may be provided, either by endorsement attached to a single policy and executed by or on behalf of the co-insuring title insurers, or by the issuance of separate policies by or on behalf of each of the co-insuring title insurers.

[13.14.8.13 NMAC – Rp, 13.14.8.14 NMAC, 1/1/2021; A, 1/1/2024]

13.14.8.14 RESTRICTIONS, ENCROACHMENTS, AND MINERALS ENDORSEMENTS:

A. Upon being furnished with a satisfactory survey:

(1) NM form 50 and NM form 50.1 may be attached to a loan policy;

(2) NM form 56 and NM form 56.1 may be attached to an owner's policy covering unimproved land;

(3) NM form 57 and NM form 57.1 may be attached to an owner's policy covering improved land; and

(4) NM Forms 50, 50.1, 56, 56.1, 57, and 57.1 shall not be attached to policies issued on one to four family residential property.

B. Each endorsement is to be issued only in conjunction with the issuance of survey coverage pursuant to Subsection C of 13.14.5.12 NMAC.

C. Paragraph (3) (b) of NM form 50, Paragraph 4 of NM form 50.1, Paragraph (2) of NM form 56 and NM form 56.1, Paragraph (2) (b) of NM form 57, or Paragraph 3 of NM form 57.1, as appropriate, may be deleted by the insurer, in its discretion, if the insurer deems the risk of issuing minerals coverage to be unacceptable.

[13.14.8.14 NMAC – Rp, 13.14.8.16 NMAC, 1/1/2021, A, 2/1/2022]

13.14.8.15 LAND ABUTS STREET ENDORSEMENT:

NM form 51 may be attached to a policy, upon being furnished with a satisfactory survey. This endorsement may not be attached to a policy that insures one to four family residential property.

[13.14.8.15 NMAC - Rp, 13.14.8.17 NMAC, 1/1/2021]

13.14.8.16 LOCATION ENDORSEMENT:

NM form 52 may be attached to a policy upon being furnished with a satisfactory survey. This endorsement may not be attached to a policy that insures one to four family residential property.

[13.14.8.16 NMAC - Rp, 13.14.8.18 NMAC, 1/1/2021]

13.14.8.17 SAME AS SURVEY AND SAME AS PORTION OF SURVEY ENDORSEMENTS:

NM form 78 or 79 may be attached to a policy upon being furnished with a satisfactory survey if the policy provides survey coverage. These endorsements may not be attached to a policy that insures one to four family residential property.

[13.14.8.17 NMAC - Rp, 13.14.8.19 NMAC, 1/1/2021]

13.14.8.18 CONTIGUITY OF PARCELS ENDORSEMENTS:

NM form 54 or 66 may be attached to a policy upon being furnished with a satisfactory survey. These endorsements may not be attached to a policy that insures one to four family residential property.

A. For an owner's policy, the insured shall, have an interest (in fee, leasehold, or easement) in both parcels referred to in NM form 54, or in all parcels referred to in NM form 66.

B. For a loan policy the insured lender shall, have a lien upon an interest (in fee, leasehold, or easement) on both parcels referred to in NM form 54, or on all parcels referred to in NM form 66.

[13.14.8.18 NMAC - Rp, 13.14.8.20 NMAC, 1/1/2021]

13.14.8.19 FIRST LOSS ENDORSEMENT:

NM form 58 may be attached to a loan policy. This endorsement may not be attached to a policy that insures one to four family residential property.

[13.14.8.19 NMAC - Rp, 13.14.8.21 NMAC, 1/1/2021]

13.14.8.20 AGGREGATION ENDORSEMENTS:

NM form 60 or NM form 60.1 may be attached to a loan policy. These endorsements may not be attached to a policy that insures one to four family residential property.

[13.14.8.20 NMAC – N, 1/1/2021]

13.14.8.21 FOUNDATION ENDORSEMENT:

NM form 61 may be attached to a loan policy upon being provided a satisfactory survey.

[13.14.8.21 NMAC - Rp, 13.14.8.24 NMAC, 1/1/2021]

13.14.8.22 ASSIGNMENT OF RENTS OR LEASES ENDORSEMENT:

NM form 62 may be attached to a loan policy. This endorsement may not be attached to a policy that insures one to four family residential property.

[13.14.8.22 NMAC - Rp, 13.14.8.25 NMAC, 1/1/2021]

13.14.8.23 ZONING UNIMPROVED LAND ENDORSEMENTS:

NM form 64 or NM form 64.1 may be attached to a policy. These endorsements shall not be attached to a policy that insures one to four family residential property.

[13.14.8.23 NMAC - Rp, 13.14.8.26 NMAC, 1/1/2021]

13.14.8.24 ZONING - COMPLETED STRUCTURE ENDORSEMENT, ZONING - LAND UNDER DEVELOPMENT ENDORSEMENT, AND ZONING -COMPLETED STRUCTURE - NO APPLICABLE ZONING ORDINANCES ENDORSEMENT:

NM form 65, 65.1 or 65.2 may be attached to a policy upon being furnished with a satisfactory survey.

A. These endorsements shall not be attached to a policy that insures one to four family residential property.

B. The coverage provided by any part of each endorsement may not be increased, but may be deleted.

[13.14.8.24 NMAC - Rp, 13.14.8.27 NMAC, 1/1/2021]

13.14.8.25 ACCESS AND ENTRY ENDORSEMENT:

NM form 67 may be attached to a policy upon being furnished a satisfactory survey. A separate endorsement shall be issued for each public street, road or highway for which

the insured wants access and entry coverage, and a separate premium shall be paid for each endorsement issued.

[13.14.8.25 NMAC - Rp, 13.14.8.28 NMAC, 1/1/2021]

13.14.8.26 INDIRECT ACCESS AND ENTRY ENDORSEMENT:

NM form 68 may be attached to a policy upon being furnished a satisfactory survey. A separate endorsement shall be issued for each public street, road or highway for which the insured wants access and entry coverage, and a separate premium shall be paid for each endorsement issued.

[13.14.8.26 NMAC - Rp, 13.14.8.29 NMAC, 1/1/2021]

13.14.8.27 UTILITY ACCESS ENDORSEMENT:

NM form 69 may be attached to a policy upon satisfactory proof that the insured property has access to specified public utilities.

[13.14.8.27 NMAC - Rp, 13.14.8.30 NMAC, 1/1/2021]

13.14.8.28 COMMERCIAL ENVIRONMENTAL PROTECTION LIEN ENDORSEMENT:

NM form 70 may be attached to a policy. This endorsement shall not be attached to a policy that insures one to four family residential property.

[13.14.8.28 NMAC - Rp, 13.14.8.31 NMAC, 1/1/2021]

13.14.8.29 REVERSE MORTGAGE ENDORSEMENT:

NM form 71 may be attached to a loan policy that insures one to four family residential property.

A. The loan policy issued on a reverse mortgage may be issued in either the total amount of advances or one hundred-fifty percent of the total amount of advances as requested by the lender. Schedule B of the loan policy issued on a reverse mortgage shall contain the following special exception: "pending disbursement of the full proceeds of the loan secured by the mortgage or deed of trust set forth under schedule A hereof, this policy insures only to the extent of the amount actually disbursed but increases as each disbursement is made, in good faith, and without knowledge of any defect in or objections to, the title, up to the full amount of the policy."

B. The two mortgages filed on a HUD HECM reverse mortgage loan may be insured on one loan policy if the priority of the mortgages is disclosed when describing the mortgages being insured in schedule A. The bracketed language in Subsection F of

Paragraph 4 of NM form 71 may be deleted from the endorsement with the approval of the title insurer if:

(1) the risk is deemed acceptable; and

(2) standard exception No. 4 from schedule B of the underlying loan policy has been deleted, at no additional premium. Otherwise, the brackets themselves shall be removed and the language of Subsection F of Paragraph 4 of NM form 71 shall be included in the endorsement.

[13.14.8.29 NMAC - Rp, 13.14.8.32 NMAC, 1/1/2021]

13.14.8.30 SINGLE TAX PARCEL ENDORSEMENT:

NM form 72 may be attached to a policy. This endorsement shall not be attached to a policy that insures one to four family residential property.

[13.14.8.30 NMAC - Rp, 13.14.8.33 NMAC, 1/1/2021]

13.14.8.31 MULTIPLE TAX PARCEL ENDORSEMENT:

NM form 73 may be attached to a policy. This endorsement shall not be attached to a policy that insures one to four family residential property.

[13.14.8.31 NMAC - Rp, 13.14.8.35 NMAC, 1/1/2021]

13.14.8.32 DOING BUSINESS ENDORSEMENT:

NM form 74 may be attached to a loan policy. This endorsement shall not be attached to a policy that insures one to four family residential property.

[13.14.8.32 NMAC - Rp, 13.14.8.35 NMAC, 1/1/2021]

13.14.8.33 SUBDIVISION ENDORSEMENT:

NM form 75 may be attached to a policy. This endorsement shall not be attached to a policy that insures one to four family residential property.

[13.14.8.33 NMAC - Rp, 13.14.8.36 NMAC, 1/1/2021]

13.14.8.34 EASEMENT - DAMAGE OR ENFORCED REMOVAL ENDORSEMENT:

NM form 76 may be attached to a policy. This endorsement shall not be attached to a policy that insures one to four family residential property.

[13.14.8.34 NMAC - Rp, 13.14.8.37 NMAC, 1/1/2021]

13.14.8.35 [RESERVED]

[13.14.8.35 NMAC – N, 9/15/2010; Repealed, 1/1/2021]

13.14.8.36 ENERGY PROJECT ENDORSEMENTS:

NM form 88, 88.1, 88.2, 88.3, 88.4, 88.5, 88.6, 88.7, or 88.8 may be attached to a policy, as applicable. These endorsements shall not be attached to a policy that insures one to four family residential property.

[13.14.8.36 NMAC - Rp, 13.14.8.39 NMAC, 1/1/2021]

13.14.8.37 MEZZANINE FINANCING ENDORSEMENT:

NM form 89 may be attached to an owner's policy. This endorsement shall not be attached to a policy that insures one to four family residential property.

[13.14.8.37 NMAC - Rp, 13.14.8.40 NMAC, 1/1/2021]

13.14.8.38 [RESERVED]

[13.14.8.38 NMAC – N, 9/15/2010; Repealed, 1/1/2021]

13.14.8.39 [RESERVED]

[13.14.8.39 NMAC - N, 3/1/2016; Repealed, 1/1/2021]

13.14.8.40 [RESERVED]

[13.14.8.40 NMAC - N, 3/1/2016; Repealed, 1/1/2021]

13.14.8.41 [RESERVED]

[13.14.8.41 NMAC - N, 7/1/2018; Repealed, 1/1/2021]

13.14.8.42 CONDOMINIUM ENDORSEMENTS:

NM form 12 and NM form 30 may be attached to a policy, as applicable. Paragraph 3 of NM form 30 may be deleted at the option of the title insurer.

[13.14.8.42 NMAC – N, 1/1/2021]

13.14.8.43 PLANNED UNIT DEVELOPMENT ENDORSEMENTS:

NM form 13 and NM form 13.1 may be attached to a policy, as applicable. Paragraph 1 of NM form 13 may be deleted at the option of the title insurer.

[13.14.8.43 NMAC - N, 1/1/2021]

13.14.8.44 [RESERVED]

[13.14.8.44 NMAC - N, 1/1/2021]

13.14.8.45 DOWN DATE ENDORSEMENT TO RESIDENTIAL LIMITED COVERAGE JUNIOR LOAN POLICY JR 1:

A. NM form 46 may be issued one or more times after issuance of NM form 45.

B. NM form 46 may not be issued more than one year after the date of policy stated in NM form 45.

C. Upon request of the named insured and the proper recording of all necessary documents meeting the title insurer's underwriting standards, the amount of the loan secured by the insured's mortgage insurance previously stated in NM form 45 may be increased by adding a Paragraph D, which shall read as follows: "D. The amount of insurance of the policy is hereby amended to be $____," subject to the payment of the applicable premium, for the additional insurance.

[13.14.8.45 NMAC - N, 1/1/2021]

13.14.8.46 [RESERVED]

[13.14.8.46 NMAC - N, 1/1/2021]

PART 9: GENERAL RATE PROVISIONS

13.14.9.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.9.1 NMAC – Rp, 13.14.9.1 NMAC, 1/1/2021]

13.14.9.2 SCOPE:

This rule applies to all title insurers, title insurance agencies, and title insurance agents conducting the business of title insurance in New Mexico.

[13.14.9.2 NMAC – Rp, 13.14.9.2 NMAC, 1/1/2021]

13.14.9.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.9.3 NMAC – Rp, 13.14.9.3 NMAC, 1/1/2021]

13.14.9.4 DURATION:

Permanent.

[13.14.4 NMAC – Rp, 13.14.9.4 NMAC, 1/1/2021]

13.14.9.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.9.5 NMAC – Rp, 13.14.9.5 NMAC, 1/1/2021]

13.14.9.6 OBJECTIVE:

To establish matters related to the promulgation of title insurance rates and charges.

[13.14.9.6 NMAC – Rp, 13.14.9.6 NMAC, 1/1/2021]

13.14.9.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.9.7 NMAC – Rp, 13.14.9.7 NMAC, 1/1/2021]

13.14.9.8 SCHEDULE OF PREMIUM RATES:

The rates and charges authorized by these rules shall be established by order of the superintendent in a title rate case conducted pursuant to Subsection A of Section 59A-30-8 NMSA 1978, or as amended or supplemented by order issued after a hearing conducted pursuant to Subsection B of Section 59A-30-8 NMSA 1978. All references to rates and charges in these rules shall mean the rates and charges established by the superintendent's order in the most recent rate hearing case, including any amending or supplementing order, in effect at the time the premium or charge is incurred. On his own motion, or at the request of an interested person, the superintendent may, at any time, conduct a formal or informal hearing to consider whether to promulgate a new or amended rate or charge.

[13.14.9.8 NMAC – Rp, 13.14.9.8 NMAC, 1/1/2021; A, 2/1/2022]

13.14.9.9 COMBINATIONS OF CREDITS OR DISCOUNTS:

No title insurer or title insurance agency shall grant more than one premium credit, reduction or discount for a single transaction, unless one original owner policy premium

in the largest amount is charged; provided, however, that a simultaneous issue rate regulation may be combined with any appropriate single issue rate regulation.

[13.14.9.9 NMAC – Rp, 13.14.9.9 NMAC, 1/1/2021]

13.14.9.10 PREMIUM RATES INCLUSIVE:

The premium rates and charges established by the superintendent include all premiums for title insurance, examination of the title or titles to be insured, determining that each insured estate has been created, conveyed or modified as shown in the policy, and determining what exceptions, if any, to insert in or delete from the policies to be issued as provided in these rules. No other rates or charges shall be charged for title insurance or title services.

[13.14.9.10 NMAC – Rp, 13.14.9.10 NMAC, 1/1/2021; A, 2/1/2022]

13.14.9.11 PAYMENTS OF PREMIUM TO OTHERS:

No portion, split or percentage of any premium shall be paid either directly or indirectly to any person, firm or organization for title insurance, title examination, or determining status of title as set forth above, except a division of premium between an insurer admitted to transact title insurance business in New Mexico and its New Mexico title insurance agency pursuant to their agency agreement, or between New Mexico title insurance agencies (or title insurance agencies who do not have agency agreements in a county where some of the property is located) who are cooperating to close a transaction involving New Mexico property situated in more than one county to be insured in a single policy when each title insurance agency or title insurer is rendering part of the services included in the premiums established in a title rate case. Any title insurance agency who has cancelled its agency agreement or had its agency agreement cancelled by an underwriter may prepare endorsements to existing policies then in force at the time of cancellation upon request by the insured and approval by the underwriter. Any such endorsement shall be signed by an officer of the underwriter. The premium for any such endorsement shall be collected by the cancelled title insurance agent and divided according to the controlling promulgated rates at the time of issuance of the endorsement(s). The payment or receipt of referral fees by or between title insurers or agencies and any person is prohibited.

[13.14.9.11 NMAC – Rp, 13.14.9.11 NMAC, 1/1/2021]

13.14.9.12 REBATES AND UNAUTHORIZED DISCOUNTS:

A title insurance agency or title insurer shall charge the applicable rates and charges for each transaction and shall not offer or grant a credit, discount or rebate that is not authorized by these rules.

[13.14.9.12 NMAC – Rp, 13.14.9.12 NMAC, 1/1/2021; A, 2/1/2022]

13.14.9.13 ROUNDING TO THE NEAREST DOLLAR:

All premiums charged for title insurance policies, endorsements, or commitments shall be rounded to the nearest dollar after all necessary computations have been performed. Fifty cents or more shall be rounded up; 49 cents or less shall be rounded down.

[13.14.9.13 NMAC – Rp, 13.14.9.13 NMAC, 1/1/2021]

13.14.9.14 FRACTIONAL THOUSAND DOLLARS OF LIABILITY:

To compute any premium, a $1,000 fraction of coverage shall be calculated as a full $1,000.

[13.14.9.14 NMAC – Rp, 13.14.9.14 NMAC, 1/1/2021]

13.14.9.15 NON-DISCRIMINATION IN AUTHORIZED DISCOUNTS:

A title insurance agency or title insurer shall charge premiums rates, charges and fees on a non-discriminatory basis for like risks and like insureds.

[13.14.9.15 NMAC – Rp, 13.14.9.15 NMAC, 1/1/2021]

13.14.9.16 ADDITIONAL CHARGES:

Whenever the search or examination conducted for the issuance of a policy involves either an extra chain of title or other unusual complexity, fees shall be charged for each additional chain of title pertaining to platted tracts and for each tract of unusual complexity of search and examination. If the separate values for each tract are not apportioned in the policy, their values for the purposes of this section shall be in the same proportions as their areas bear to the entire area insured.

[13.14.9.16 NMAC – Rp, 13.14.9.16 NMAC, 1/1/2021]

13.14.9.17 NON-PAYMENT OF PREMIUM:

No policy or endorsement (excluding pro formas) shall be issued without payment in full of the premium for such policy or endorsement within 15 days of the issuance of any policy or endorsement in accordance with Section 59A-30-5.1 NMSA 1978. In the event that payment in available funds is not made within 15 days of the issuance of any policy or endorsement, the title insurer shall cancel the policy or endorsement. The title insurer shall mail the insured(s) and lender notice of the cancellation by certified mail, return receipt requested, to the last known address, and by first class mail. Cancellation shall be effective 10 days after mailing notice to the insured. A title insurance agency shall promptly notify the title insurer of the non-receipt of premiums within the period specified herein.

[13.14.9.17 NMAC – Rp, 13.14.9.17 NMAC, 1/1/2021; A, 2/1/2022]

13.14.9.18 [RESERVED]

[13.14.9.18 NMAC – 13.14.9.18 NMAC - Rn, 13 NMAC 14.9.8.11 & A, 5/15/2000; A, 5/31/2000; A, 8/1/2000; A, 3/1/2002; A, 7/1/2003; A, 7/1/2004; A, 7/1/2005; A, 7/1/2006; A, 9/1/2007; A, 7/1/2008; A, 8/1/2009; A, 10/1/2012; A, 8/15/2014; A/E, 7/1/2018; A, 12/27/2018; Repealed 1/1/2021]

13.14.9.19 NON-POLICY CHARGES:

A. A charge shall be collected for the initial six months and for each additional six-month renewal or extension (or portion thereof) of a commitment. If a new version of a commitment is issued to correct an error by the title insurer or agency, the new version shall be issued at no charge.

B. If the transaction fails to close and no policy is issued, the title insurer or agency shall charge a cancellation fee.

C. The charge for a pro forma policy shall be established in a title rate case. If a pro forma is issued to correct an error by the issuing title insurer or agency, the corrected version shall be issued at no charge.

[13.14.9.19 NMAC – Rp, 13.14.9.19 NMAC, 1/1/2021]

13.14.9.20 ORIGINAL OWNER'S POLICY SINGLE ISSUE RATES:

Original owner's policies not issued simultaneously with another policy or policies and not as a reissue of an owner's policy shall be issued at the basic premium rate according to the schedule in effect as of the date of the policy.

[13.14.9.20 NMAC – Rp, 13.14.9.20 NMAC, 1/1/2021]

13.14.9.21 ORIGINAL POLICY INSURING LEASEHOLD ESTATE SINGLE ISSUE RATES:

Original policies insuring a leasehold estate, not issued simultaneously with another policy and not as a reissue of a policy insuring a leasehold estate, shall be charged at the basic premium rate according to the schedule in effect as of the date of the policy. Original policies insuring a leasehold estate which are reissues of original owner's policies, including a policy pertaining to a sale and leaseback transaction, shall qualify for the reissue rate.

[13.14.9.21 NMAC – Rp, 13.14.9.21 NMAC, 1/1/2021]

13.14.9.22 ORIGINAL LOAN POLICY RATES:

Premiums for an original loan policy shall be determined in a title rate case.

[13.14.9.22 NMAC – Rp, 13.14.9.22 NMAC, 1/1/2021]

13.14.9.23 [RESERVED]

[13.14.9.23 NMAC – 13.14.9.23 NMAC - Rn, 13 NMAC 14.9.10.4, 5/15/2000; Repealed 1/1/2021]

13.14.9.24 ABSTRACT RETIREMENT CREDIT:

When the applicant for an owner's policy transfers, at the time of application for the policy, to the title insurance agency or title insurer ownership of the abstract of title covering all or part of the premises to be insured, a credit shall be determined based on a percentage of the appropriate premium for the owner's policy.

[13.14.9.24 NMAC – Rp, 13.14.9.24 NMAC, 1/1/2021]

13.14.9.25 [RESERVED]

[13.14.9.25 NMAC – 13.14.9.25 NMAC - Rn, 13 NMAC 14.9.10.6, 5/15/2000; Repealed 1/1/2021]

13.14.9.26 REPLACEMENT POLICY RATE:

When a title insurer is placed in receivership, and a replacement title insurance policy is issued by a title insurance agency, the title insurance agency's division of premium shall be computed in accordance with the current division ordered by the superintendent. If a title insurer issues the policy directly, the title insurer shall retain the full premium.

[13.14.9.26 NMAC – Rp, 13.14.9.26 NMAC, 1/1/2021]

13.14.9.27 [RESERVED]

[13.14.9.27 NMAC – Rp, 13.14.9.27 NMAC, 1/1/2021]

13.14.9.28 LIMITED PRE-FORECLOSURE TITLE INSURANCE POLICY AND DOWNDATE ENDORSEMENT:

The premium for NM form 41 and 42 shall be established in a title rate case. If an NM 41 form is issued and an owner's policy is issued following completion of the foreclosure, the owner's policy shall qualify for a reissue rate ordered by the superintendent in a title rate case. All liability insured above the amount of the foreclosure title insurance policy for a new owner's policy must be computed at the basic premium rates in the applicable bracket. If an NM form 41 is issued and if the foreclosure is not completed or is terminated by reinstatement of the pertinent security

instrument, and a new owner's policy is issued to a new purchaser within one year of the date of the NM form 41, a percentage of the premium paid for the NM form 41 shall be credited toward the new owner's policy premium as established by the superintendent in a title rate case.

[13.14.9.28 NMAC – Rp, 13.14.9.28 NMAC, 1/1/2021]

13.14.9.29 [RESERVED]

[13.14.9.29 NMAC – 13.14.9.29 NMAC - Rn, 13 NMAC 14.9.10.10, 5/15/2000; Repealed 1/1/2021]

13.14.9.30 [RESERVED]

[13.14.9.30 NMAC – 13.14.9.30 NMAC - Rn, 13 NMAC 14.9.11.1, 5/15/2000; Repealed 1/1/2021]

13.14.9.31 [RESERVED]

[13.14.9.31 NMAC – 13.14.9.31 NMAC - Rn, 13 NMAC 14.9.11.2, 5/15/2000; Repealed 1/1/2021]

13.14.9.32 SIMULTANEOUS ISSUE MULTIPLE OWNER'S POLICIES ON SAME LAND:

When two or more owner's policies, including leasehold owner's policies, covering the same land are:

A. issued simultaneously to different insureds, the applicable owner's rate shall apply to the policy in the largest amount; or

B. issued to different insureds where a policy is issued in one transaction and one or more policies are issued within 30 days in a subsequent transaction or transactions, provided,

(1) each transaction covers identical land;

(2) all conveyances relating to the land to be insured in the subsequent transaction(s) are recorded no more than 30 days after the conveyances of the first transaction are recorded and all policies are issued by the same title insurer or title insurance agency no later than 30 days after the first transaction; and

(3) an owner's policy is issued insuring the interest of each and every owner created by the subsequent transaction(s), the premium for the first policy shall be the applicable owner's rate in effect as of the date of the first policy. If any subsequently

issued policy exceeds the amount of insurance written in the first policy, the premium for the difference must be computed at the basic premium rates by brackets.

[13.14.9.32 NMAC – Rp, 13.14.9.32 NMAC, 1/1/2021]

13.14.9.33 [RESERVED]

[13.14.9.33 NMAC – 13.14.9.33 NMAC - Rn, 13 NMAC 14.9.11.4, 5/15/2000; Repealed 1/1/2021]

13.14.9.34 [RESERVED]

[13.14.9.34 NMAC – Rp, 13.14.9.34 NMAC, 1/1/2021]

13.14.9.35 [RESERVED]

[13.14.9.35 NMAC – 13.14.9.35 NMAC - Rn, 13 NMAC 14.9.12.1, 5/15/2000; A, 3/1/2002; Repealed 1/1/2021]

13.14.9.36 SECOND MORTGAGES OR SUBSEQUENT ISSUES:

The premium for a loan policy insuring any mortgage granted by the owner of property subsequent to the original date of his owner's policy shall be determined by the superintendent in a title rate case. In no event shall the premium collected be less than the regular minimum promulgated rate for an owner's policy.

[13.14.9.36 NMAC – Rp, 13.14.9.36 NMAC, 1/1/2021]

13.14.9.37 COMPUTATION OF RATES WHEN INSURED PROPERTY IS NOT IDENTICAL:

When only a portion of the land previously insured is being insured by a reissue owner's policy or by a subsequent issue loan policy, or when the land previously insured is only a portion of the land being insured by a reissue owner's policy or by a subsequent issue loan policy, the rates shall be adjusted in proportion to the areas insured in the original policy and the current policy. For example, if the original policy insured one acre and the current policy insures three acres, the reissue rates will apply to one-third of the current value up to the face amount of the original policy; but, if the situation is reversed, the reissue rates will only apply up to one-third of the face amount of the original policy. In no event shall the reissue rates be applied to allow more than one hundred percent of the face amount of the original policy to be used cumulatively in the computation of reissue rates.

[13.14.9.37 NMAC – Rp, 13.14.9.37 NMAC, 1/1/2021; A, 2/1/2022]

13.14.9.38 COMPUTATION OF RATES UPON CONVERSION OF LEASEHOLD OWNER'S POLICY TO STANDARD OWNER'S POLICY:

When a leasehold owner's policy is converted to a standard owner's policy and more insurance is desired or required under the standard owner's policy than was written in the leasehold owner's policy, the difference must be computed at the basic premium rates in the applicable bracket or brackets in the same manner as excess liability is computed.

[13.14.9.38 NMAC – Rp, 13.14.9.38 NMAC, 1/1/2021]

13.14.9.39 SUBSTITUTION RATE ON LOANS TO TAKE UP, RENEW, EXTEND OR SATISFY AN EXISTING INSURED LOAN:

A. For purpose of the premium discount on refinanced property pursuant to Section 59A-30-6.1 NMSA 1978, the term "same borrower" in Section 59A-30-6.1 NMSA 1978 shall have the same meaning as "insured" as defined in Paragraph 1 (D) of the conditions set forth in NM form 1.

B. The term "same property" in Section 59A-30-6.1 NMSA 1978 shall mean the identical property or any portion thereof. The reduction in rate pursuant to Section 59A-30-6.1 NMSA 1978 shall not apply in any case where any additional property not covered by the original policy or policies is included in the policy to be issued.

C. If two or more previous loan policies insuring different properties are presented to the title insurance agency or title insurer for a refinance discount pursuant to Section 59A-30-6.1 NMSA 1978, and provided that the new policy will contain the same properties as shown in said previous policies, the discount will be computed as follows: title insurance agency or title insurer shall base the discount on the date of issue of the oldest previous policy and upon a liability amount equal to the sum of the liability amounts of the previous policies. In no event shall the premium collected be less than the regular minimum promulgated rate for an owner's policy.

D. This rule, may be applied in connection with the issuance of a series of mortgage policies issued by reason of noted being apportioned to individual units in connection with a master policy covering the aggregate indebtedness, including improvements. Individual loan policies must be issued at the original first loan single issue rate.

[13.14.9.39 NMAC – Rp, 13.14.9.39 NMAC, 1/1/2021]

13.14.9.40 INSURING CONSTRUCTION LOANS AND DELETING STANDARD EXCEPTION 4 IN LOAN POLICIES:

A. A loan policy may be issued to insure a construction loan mortgage if the loan policy contains the following two-year claims made limitation: "Notwithstanding any other provision of this policy, the company shall be liable only for such loss or damage

insured against by this policy which is actually sustained by the insured and reported to the company as provided in the conditions and stipulations on or before two years after the recording of the mortgage described in Schedule A. (Upon payment to the company of the required full loan policy premium prior to the expiration of said policy, the term limitation may be deleted from this policy)."

B. A construction loan policy or a loan policy containing the two-year claims made limitations pursuant to Subsection A of this section may be extended beyond its initial two-year term for additional premium.

C. The issuance of a construction loan policy, or a standard loan policy with a two-year claims made limitation, may not be used as the basis for claiming a credit or discount on a refinanced property premium pursuant to Section 59A-30-6.1, NMSA 1978; a subsequent issue, or a substitution issue loan.

[13.14.9.40 NMAC – Rp, 13.14.9.40 NMAC, 1/1/2021]

13.14.9.41 SINGLE POLICY MULTIPLE COUNTIES:

In the event a proposed insured requests that a single policy be issued insuring multiple New Mexico properties that may be located in more than one county, the amount of insurance shall be allocated to each county based upon a supported amount as provided in writing by the proposed insured. The premium shall be calculated as if a policy was being issued separately in each county and the aggregated gross premiums shall be combined to determine the gross premium for the single policy. A New Mexico title insurance agency or title insurer that maintains a title insurance agency or direct operation in one of the counties in which the property is located ("direct operation") (collectively "issuing company") must issue the policy and disburse, or direct the payee to disburse, the gross premium attributable to each county to the title insurance agency or direct operation in such county for such policy to be remitted to the title insurer in accordance with the division of premium rule in affect at the time of issuance. The policy schedules applicable to the land located in each county shall be countersigned by the title insurance agency or direct operation and provided to the issuing company. The issuing company shall provide each title insurance agency or direct operation with a complete copy of the final policy which shall be maintained in accordance with underwriter and regulatory requirements. Each title insurance agency or direct operation shall report the policy utilizing the combined policy number but only the gross premium it received attributable to the property within its county shall be reported. Issuance of a single policy shall not be used when the transaction involves property outside of New Mexico. This rule shall not be interpreted to allow a title insurer to issue what is commonly referred to as home office issued policies.

[13.14.9.41 NMAC – Rp, 13.14.9.41 NMAC, 1/1/2021]

13.14.9.42 [RESERVED]

[13.14.9.42 NMAC – N, 3/1/2016; A, 7/1/2018; Repealed 1/1/2021]

PART 10: ENDORSEMENT RATES [REPEALED]

[13.14.10. NMAC N, 3/1/1974; R, 2/8/2022]

PART 11-15: [RESERVED]

PART 16: AGENT'S STATISTICAL REPORT

13.14.16.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.16.1 NMAC – Rp, 13.14.16.1 NMAC, 1/1/2021]

13.14.16.2 SCOPE:

This rule applies to all title insurers, title insurance agencies, and title insurance agents conducting title insurance business in New Mexico.

[13.14.16.2 NMAC – Rp, 13.14.16.2 NMAC, 1/1/2021]

13.14.16.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.16.3 NMAC – Rp, 13.14.16.3 NMAC, 1/1/2021]

13.14.16.4 DURATION:

Permanent.

[13.14.16.4 NMAC – Rp, 13.14.16.4 NMAC, 1/1/2021]

13.14.16.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.16.5 NMAC – Rp, 13.14.16.5 NMAC, 1/1/2021]

13.14.16.6 OBJECTIVE:

The purpose of this rule is to provide forms and rules for preparing the required agency statistical report.

[13.14.16.6 NMAC – Rp, 13.14.16.6 NMAC, 1/1/2021]

13.14.16.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.16.7 NMAC – Rp, 13.14.16.7 NMAC, 1/1/2021]

13.14.16.8 AGENCY STATISTICAL REPORT:

Every agency shall report income and expenses annually on both county-by-county and summary-of-all counties bases. The agency shall use the agency statistical report form set forth in this rule, Agency Statistical Report, and instructions published by OSI. The superintendent shall annually issue an order to fix the date and location for the filing of each agency statistical report for the calendar year and shall notify each agency of the date at least sixty days prior to the filing deadline; provided, however, that in no event shall an agency be required to file its statistical report prior to May 15th of the year following the end of the calendar year being reported. Each agency shall maintain such minimum basic records on each New Mexico transaction as shall be necessary to accurately report such transactions.

[13.14.16.8 NMAC – Rp, 13.14.16.8 NMAC, 1/1/2021]

13.14.16.9 SCHEDULE A - STATEMENT OF INCOME AND EXPENSES:

NEW MEXICO TITLE INSURANCE AGENCY STATISTICAL REPORT **SCHEDULE A - STATEMENT OF INCOME AND EXPENSES** For the Calendar Year Ending December 31, 20___.		
AGENCY NAME		
LICENSE NUMBER		
ADDRESS		
CONTACT NAME		
Check one:		
	INDEPENDENT (NON-AFFILIATED)	Title insurance agencies that are independently owned and write title insurance business for one or more title insurers.
	AFFILIATED	Title insurance agencies with 10% or greater ownership by a title insurer, including wholly-owned agencies.
	DIRECT	Agency-type operations performed by the home or branch office of a title insurer. This does NOT include wholly-owned agencies.

Part A: Revenue		
1.	Title insurance written premiums (from Schedule B)	
2.	Less: Remitted title insurance premiums (from Schedule B)	
3.	Retained title insurance premiums (from Schedule B)	
4.	Other income (from Schedule C)	
5.	Total Revenue	
Part B: Expenses		
1.	Employees' salaries and wages	

2.	Owners' and partners' salaries and wages	
3.	Employee benefits	
4.	Rent	
5.	Insurance	
6.	Legal expense	
7.	Licenses, taxes and fees	
8.	Title plant expense and maintenance	
9.	Office supplies	
10.	Depreciation	
11.	Automobile expense	
12.	Communication expense	
13.	Education expense	
14.	Bad debts	
15.	Interest expense	
16.	Employee travel and lodging	
17.	Loss and loss adjustment expense (from Schedule D)	
18.	Accounting and auditing expense	
19.	Public relations expense	
20.	Other expenses (from Schedule E)	
21.	Total Expenses	
Part C: Net Income for Ratemaking Purposes		
1.	Income (Loss) from Operations	
Part D: Excluded Expenses		
1.	NMLTA lobbying expense	
2.	Direct lobbying expense	
3.	Political contributions	
4.	State and federal income tax expense	
5.	½ of meals and entertainment expense	
6.	Penalties	
7.	Country club dues	
8.	Salaries in excess of salary cap	
9.	Other excluded expenses (from Schedule E)	
10.	Total Excluded Expenses	
Part E: Net Income		
1.	Net income as reported on the books of the agency	
Part F: Equity		
1.	Total equity as reported on balance sheet of the agency	
Part G: Number of Employees		
1.	Total number of employees	

[13.14.16.9 NMAC – Rp, 13.14.16.9 NMAC, 1/1/2021]

13.14.16.10 SCHEDULE B - PREMIUMS BY UNDERWRITER:

NEW MEXICO TITLE INSURANCE AGENCY STATISTICAL REPORT
SCHEDULE B - PREMIUMS BY INSURER
For the Calendar Year Ending December 31, 20___.

Name of each insurer for which this agency charged premiums	**Title premiums written by this agency**	**Title premiums remitted or owed by this agency to insurers**	**Title premiums retained by this agency**
Total			
	(Carry total forward to Schedule A, line A-1)	(Carry total forward to Schedule A, line A-2)	(Carry total forward to Schedule A, line A-3)
Percentage of premiums remitted: 0.0%			

[13.14.16.10 NMAC – Rp, 13.14.16.10 NMAC, 1/1/2021]

13.14.16.11 SCHEDULE C - IDENTIFICATION OF OTHER INCOME:

NEW MEXICO TITLE INSURANCE AGENCY STATISTICAL REPORT
SCHEDULE C - IDENTIFICATION OF OTHER INCOME
For the Calendar Year Ending December 31, 20___.

Description of Income Item		
A.	Closing fees	
B.	Abstracting and title report income	
C.	Recording fees	
D.	Copy fees	
E.	Inspection fees	
F.	Interest income	
G.	Charges for unusual complexity/extra chain or abstract retirement	
Itemization of All Other Income		
H.		
I.		
J.		
K.		
L.		
M.		
N.		
O.		

P.		
Q.		
R.		
S.		
Total Other Income(Carry forward to Schedule A, line A-4)		0

[13.14.16.11 NMAC – Rp, 13.14.16.11 NMAC, 1/1/2021]

13.14.16.12 SCHEDULE D - LOSSES AND LOSS ADJUSTMENT EXPENSES:

NEW MEXICO TITLE INSURANCE AGENCY STATISTICAL REPORT
SCHEDULE D - LOSSES AND LOSS ADJUSTMENT EXPENSES
For the Calendar Year Ending December 31, 20___.

Description of Expense Item		
1.	Closing Losses	
2.	Agency Errors	
3.	Unfair Trade Practices	
4.	Loss Adjustment Expenses	
5.	Insurance Premiums (Itemize)	
	Total (Carry forward to Schedule A, line B-17)	

[13.14.16.12 NMAC – Rp, 13.14.16.12 NMAC, 1/1/2021]

13.14.16.13 SCHEDULE E - IDENTIFICATION OF OTHER EXPENSES:

NEW MEXICO TITLE INSURANCE AGENCY STATISTICAL REPORT
SCHEDULE E - IDENTIFICATION OF OTHER EXPENSES
For the Calendar Year Ending December 31, 20___.

Part A - Deductible Expenses		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

16.		
17.		
18.		
19.		
20.		
	Total (Carry forward to Schedule A, line B-20)	0
Part B - Excluded Expenses		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
	Total (Carry forward to Schedule A, line D-9)	0

[13.14.16.13 NMAC – Rp, 13.14.16.13 NMAC, 1/1/2021]

13.14.16.14 [RESERVED]

[13.14.16.14 NMAC - Rp, 13.14.16.14 NMAC, 7/1/2006; Repealed, 09/15/2010]

13.14.16.15 SCHEDULE F - INCOME OR EXPENSE ALLOCATION FROM OTHER AFFILIATES:

NEW MEXICO TITLE INSURANCE AGENCY STATISTICAL REPORT
SCHEDULE F - INCOME OR EXPENSE ALLOCATION FROM OTHER AFFILIATES
For the Calendar Year Ending December 31, 20___.

1	2	3	4	5
Name and Address of Affiliate	**Relation to Your Agency**	**Amount**	**Description Code**	**Reported Elsewhere in this Report?**

	Total	0		

Description	Code
Income	I
Expense Allocation	E

[13.14.16.15 NMAC – Rp, 13.14.16.15 NMAC, 1/1/2021]

13.14.16.16 SCHEDULE G - PREMIUMS BY COUNTY:

NEW MEXICO TITLE INSURANCE AGENCY STATISTICAL REPORT
SCHEDULE G - PREMIUMS BY COUNTY
For the Calendar Year Ending December 31, 20___.

COUNTY	TITLE PREMIUMS WRITTEN
Bernalillo	
Catron	
Chaves	
Cibola	
Colfax	
Curry	
De Baca	
Eddy	
Grant	
Guadalupe	
Harding	
Hidalgo	
Lea	
Lincoln	
Los Alamos	
Luna	
McKinley	
Mora	
Otero	
Quay	
Rio Arriba	
Roosevelt	
San Juan	
San Miguel	
Sandoval	
Santa Fe	
Sierra	

Socorro	
Taos	
Torrance	
Union	
Valencia	
TOTAL	

Crosscheck with Schedule B	0
Difference	0

Explanation for Difference (if any)

[13.14.16.16 NMAC – Rp, 13.14.16.16 NMAC, 1/1/2021]

13.14.16.17 SCHEDULE H - IDENTIFICATION OF OWNERS:

NEW MEXICO TITLE INSURANCE AGENCY STATISTICAL REPORT
SCHEDULE H - IDENTIFICATION OF OWNERS
For the Calendar Year Ending December 31, 20___.

1	2	3
Name of Each Individual or Entity Owner	**Percentage of Agency Owned**	**Description Code (see below)**
TOTAL		

Description	**Code**
Attorney	A
Real Estate Agent	REA
Real Estate Developer	RED
Lending institution	L
Underwriter	UW
None of the above	NA

[13.14.16.17 NMAC – Rp, 13.14.16.17 NMAC, 1/1/2021]

PART 17: UNDERWRITER'S STATISTICAL REPORT

13.14.17.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.17.1 NMAC – Rp, 13.14.17.1 NMAC, 1/1/2021]

13.14.17.2 SCOPE:

This rule applies to all title insurers, title insurance agents, and title insurance agents conducting title insurance business in New Mexico.

[13.14.17.2 NMAC – Rp, 13.14.17.2 NMAC, 1/1/2021]

13.14.17.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.17.3 NMAC – Rp, 13.14.17.3 NMAC, 1/1/2021]

13.14.17.4 DURATION:

Permanent.

[13.14.17.4 NMAC – Rp, 13.14.17.4 NMAC, 1/1/2021]

13.14.17.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.17.5 NMAC – Rp, 13.14.17.5 NMAC, 1/1/2021]

13.14.17.6 OBJECTIVE:

The purpose of this rule is to provide forms and rules for preparing the required insurer statistical report.

[13.14.17.6 NMAC – Rp, 13.14.17.6 NMAC, 1/1/2021]

13.14.17.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.17.7 NMAC – Rp, 13.14.17.7 NMAC, 1/1/2021]

13.14.17.8 ANNUAL STATISTICAL REPORT REQUIRED:

Every title insurer shall report income and expenses annually on both county-by-county and summary-of-all counties bases. The title insurer shall use the statistical report form set forth in this rule, insurer statistical report, and instructions published by OSI. The superintendent shall annually issue an order to fix the date and location for the filing of each insurer statistical report for the calendar year and shall notify each title insurer of the date at least 60 days prior to the filing deadline; provided, however, that in no event shall a title insurer be required to file its statistical report prior to May 15th of the year following the end of the calendar year being reported. Each insurer shall maintain such minimum basic records on each New Mexico transaction as shall be necessary to accurately report such transactions.

[13.14.17.8 NMAC – Rp, 13.14.17.8 NMAC, 1/1/2021]

13.14.17.9 FORM 1 - STATEMENT OF INCOME AND EXPENSES:

NEW MEXICO TITLE INSURER STATISTICAL REPORT
FORM 1 - STATEMENT OF INCOME AND EXPENSES
For the Calendar Year Ending December 31, 20___
NEW MEXICO EXPERIENCE ONLY

Insurer							
NAIC Code							
		Direct Operations	Non-Affiliated Agency Operations	Affiliated Agency Operations	Total	NAIC Annual Statement Schedule T	Difference
Part A - Revenue							
1	Direct written premiums				0		0
2	Direct written premiums retained by agency				0		
3	Direct written premiums remitted to insurer	0	0	0	0		
4	Escrow and settlement service charges				0		
5	Other title fees and service charges				0		
6	Total other income	0	0	0	0		0

7	**Total revenue**	0	0	0	0		
For an insurer that charges rates below the promulgated rates:						From Form 3	Difference
8	Direct premiums as if they had been written at promulgated rates				0	0	0
Part B - Expenses Line 1 as defined per NAIC annual statement, STATEMENT OF INCOME exhibit. Lines 2 through 22 as defined per NAIC annual statement, EXPENSES exhibit. All entries should show NEW MEXICO expenses only and should NOT include direct charges from direct operations.							
1	Losses and loss adjustment expenses incurred				0		
2	Total personnel costs				0		
3	Total production services purchased outside				0		
4	Advertising				0		
5	Boards, bureaus, and associations				0		
6	Title plant rent and maintenance				0		
7	Claim adjustment services				0		
8	Amounts charged off, net of recoveries				0		
9	Marketing and promotional expenses				0		
10	Insurance				0		
11	Directors' fees				0		
12	Travel and travel items				0		
13	Rent and rent items				0		
14	Equipment				0		
15	Cost or depreciation of EDP equipment and software				0		
16	Printing, stationery, books, and periodicals				0		
17	Postage, telephone,				0		

	messenger, and express delivery				
18	Legal and auditing				0
19	Total taxes, licenses, and fees				0
20	Real estate expenses				0
21	Real estate taxes				0
22	Aggregate write-ins for miscellaneous expenses				0
23	**Total Expenses**	0	0	0	0
Part C - Net Income					
1	Income (Loss)	0	0	0	0

[13.14.17.9 NMAC – Rp, 13.14.17.9 NMAC, 1/1/2021]

13.14.17.10 [RESERVED]

13.14.17.11 FORM 2- RESERVES, INVESTMENT GAIN, AND SURPLUS:

NEW MEXICO TITLE INSURER STATISTICAL REPORT
FORM 2 - RESERVES, INVESTMENT GAIN, AND SURPLUS
For the Calendar Year Ending December 31, 20___
COUNTRYWIDE EXPERIENCE

Insurer		
		Countrywide
1	Known claims reserve	
2	Statutory premium reserve	
3	Aggregate of other reserves required by law	
4	Supplemental reserve	
5	Total reserves	0
6	Net investment income earned	
7	Net realized capital gains (losses)	
8	Total net investment gain	0
9	Federal and foreign income taxes incurred	
10	Surplus as regards policyholders	

[13.14.17.11 NMAC – Rp, 13.14.17.11 NMAC, 1/1/2021]

13.14.17.12 FORM 3 -TRANSACTION REPORT:

NEW MEXICO TITLE INSURER STATISTICAL REPORT
FORM 3 - TRANSACTION REPORT
For the Calendar Year Ending December 31, 20__

NEW MEXICO EXPERIENCE ONLY						
Insurer						
						For an Insurer That Charges or Rates Below the Promulgated Rates
NM Form No.	Trans-action Code	Transaction Type	No. of Trans-actions	Direct Premiums Written	Dependent on Basic Premium Rate?	Direct Premiums As If They Had Been Written at Promulgated Rates
none	0004	Loan Policy - Mechanic's Lien Coverage With Evidence of Priority			No	
none	0005	Loan Policy - Mechanic's Lien Coverage Without Evidence of Priority			Yes	
none	0006	Owner's Policy - Mechanic's Lien Coverage - Filing Period Expired			No	
none	0007	Owner's Policy - Mechanic's Lien Coverage - Filing Period Not Expired			Yes	
none	0008	Survey Coverage – Owner's Policy			Yes	
none	0009	Survey Coverage - Loan Policy			No	
none	0010	Pro Forma Policy - Owner			No	
none	0011	Pro Forma Policy – Loan			No	
none	0012	Duplicate Original Policy			No	
1	0101	Owner's Policy			Yes	
1	0102	Owner's Policy - With Bulk Rate			Yes	
1	0103	Simultaneous Issue - Multiple Owners on Same Land			Yes	
1	0104	Replacement Owner's Policy			Yes	
1	0105	Owner's Policy After Foreclosure -Completed Foreclosure			Yes	
1	0106	Owner's Policy After Foreclosure -Terminated Foreclosure			Yes	
1	0110	Owner's Policy - Reissue (10% Discount)			Yes	
1	0115	Owner's Policy - Reissue (15% Discount)			Yes	
1	0120	Owner's Policy - Reissue (20% Discount)			Yes	
1	0125	Owner's Policy - Reissue (25% Discount)			Yes	
2	0201	Loan Policy - Single Issue			Yes	
2	0202	Loan Policy - Simultaneous Issue with Owner's Policy			No	

2	0203	Loan Policy - Second Mortgage or Subsequent Issue			Yes	
2	0204	Replacement Loan Policy			Yes	
2	0205	Loan Policy with Two-Year Claims Made Limitation			No	
2	0206	Loan Policy with Two-Year Claims Made Limitation Extension			No	
2	0240	Loan Policy – Substitution and Statutory Rate (within 3 years – 40%)			Yes	
2	0250	Loan Policy - Substitution and Statutory Rate (more than 3 years, less than 5 years - 50%)			Yes	
2	0260	Loan Policy – Substitution and Statutory Rate (more than 5 years, less than 10 years - 60%)			Yes	
2	0280	Loan Policy – Substitution and Statutory Rate (more than 10 years, less than 20 years - 80%)			Yes	
6	0600	Commitment for Title Insurance			No	
11	1104	Correction/Multipurpose Endorsement			No	
11	1105	Renewal, Extension & Partial Release Endorsement			No	
11	1106	Extension of Commitment			No	
11	1108	Increase in Coverage			Yes	
12	1200	Condominium Endorsement – All Assessments (ALTA 4-06)			No	
13	1300	Planned Unit Development Endorsement – All Assessments (ALTA 5-06)			No	
13.1	1301	Planned Unit Development Endorsement – Unpaid Assessments (ALTA 5.1-06)			No	
14	1400	Variable Rate Mortgage Endorsement (ALTA 6-06)			No	
15	1500	Variable Rate Mortgage Endorsement - Negative Amortization (ALTA 6.2-06)			No	
16	1600	Manufactured Housing Unit Endorsement (ALTA 7-06)			No	
16.1	1601	Manufactured Housing Unit (Conversion Loan) Endorsement (ALTA 7.1-06)			No	
16.2	1602	Manufactured Housing Unit (Conversion Owner's) Endorsement (ALTA 7.2-06)			No	
17	1700	Revolving Credit Endorsement			No	
20	2000	Leasehold – Owner's Endorsement (ALTA 13-06)			No	
21	2100	Leasehold Loan Endorsement (ALTA 13.1-06)			No	

22	2200	Pending Disbursement Down Date Endorsement			No	
23	2300	Pending Improvements Endorsement			No	
24	2400	Assignment Endorsement (ALTA 10-06)			No	
24.1	2401	Assignment and Down Date Endorsement (ALTA 10.1-06)			No	
25	2500	Additional Advance Endorsement			No	
26	2600	Partial Coverage Endorsement			No	
28	2800	Non-Imputation - Full Equity Transfer Endorsement (ALTA 15-06)			Yes	
28.1	2801	Non-Imputation – Additional Interest Endorsement (ALTA 15.1-06)			Yes	
28.2	2802	Non-Imputation – Partial Equity Transfer Endorsement (ALTA 15.2-06)			Yes	
29	2900	Environmental Protection Lien Endorsement (ALTA 8.1-06)			No	
30	3000	Condominium Endorsement Unpaid Assessments (ALTA 4.1-06)			No	
31	3100	Owner's Leasehold Conversion Endorsement			Yes	
33	3300	Change of Name Endorsement			No	
34	3400	U.S. Policy (ALTA 12-03-12)			Yes	
41	4100	Limited Pre-Foreclosure Title Insurance Policy (ALTA 12-03-12)			Yes	
42	4200	Limited Pre-Foreclosure Title Insurance Policy Down Date Endorsement (ALTA 12-03-12)			No	
43	4300	Insuring Around Endorsement			No	
44	4400	Revolving Credit -Increased Credit Limit Endorsement			No	
45	4500	Residential Limited Coverage Junior Loan Policy ALTA (Rev. 08-01-12)			No	
46	4600	Down Date Endorsement to Residential Limited Coverage Junior Loan Policy JR1 (ALTA 08-01-12)			No	
47	4700	Endorsement to Residential Limited Coverage Junior Loan Policy JR2 (ALTA 08-01-12)			No	
50	5000	Restrictions, Encroachments and Minerals Endorsement - Loan Policy (ALTA 9-06)			Yes	
50.1	5001	Restrictions Encroachments, Minerals – Loan Policy Endorsement (ALTA 9.3-06)			Yes	

51	5100	Land Abuts Street Endorsement			No	
52	5200	Location Endorsement (ALTA 22-06)			No	
54	5400	Contiguity Single Parcel Endorsement (ALTA 19.1-06)			No	
55	5500	Named Insured Endorsement			No	
56	5600	Restrictions, Encroachments, Minerals– Owner's Policy (Unimproved Land) Endorsement (ALTA 9.1-06)			Yes	
56.1	5601	Restrictions, Encroachments, Minerals – Owner's Policy – (Unimproved Land) Endorsement (ALTA 9.4-06)			Yes	
57	5700	Restrictions, Encroachments, Minerals – Owner's Policy (Improved Land) Endorsement (ALTA 9.2-06)			Yes	
57.1	5701	Restrictions, Encroachments, and Minerals (Owner's Policy - Improved Land) Endorsement (ALTA 9.5-06)			Yes	
58	5800	First Loss - Multiple Parcel Transactions Endorsement (ALTA 20-06)			No	
60	6000	Aggregation Endorsement (ALTA 12-06)			No	
60.1	6001	Aggregation Endorsement (ALTA 12.1-06)			No	
61	6100	Foundation Endorsement			No	
62	6200	Assignment of Rents or Leases Endorsement (ALTA 37-06)			No	
64	6400	Zoning - Unimproved Land Endorsement (ALTA 3-06)			Yes	
64.1	6401	Zoning – Unimproved Land - No Applicable Zoning Ordinances Endorsement			Yes	
65	6500	Zoning - Completed Structure Endorsement (ALTA 3.1-06)			Yes	
65.1	6501	Zoning – Land Under Development Endorsement (ALTA 3.2-06)			Yes	
65.2	6502	Zoning- Completed Structure - No Applicable Zoning Ordinances Endorsement			Yes	
66	6600	Contiguity - Multiple Parcels Endorsement (ALTA 19-06)			No	
67	6700	Access and Entry Endorsement (ALTA 17 - 06)			No	
68	6800	Indirect Access and Entry Endorsement (ALTA 17.1-06)			No	
69	6900	Utility Access Endorsement (ALTA 17.2-06)			No	

70	7000	Commercial Environmental Protection Lien Endorsement (ALTA 8.2-06)			No	
71	7100	Reverse Mortgage Endorsement (ALTA 14.3-06)			No	
72	7200	Single Tax Parcel Endorsement (ALTA 18-06)			No	
73	7300	Multiple Tax Parcel Endorsement (ALTA 18.1-06)			No	
74	7400	Doing Business Endorsement (ALTA 24-06)			No	
75	7500	Subdivision Endorsement (ALTA 26-06)			No	
76	7600	Easement - Damage or Enforced Removal Endorsement (ALTA 28-06)			No	
77	7700	Co-Insurance - Single Policy Endorsement (ALTA 23-06)			No	
78	7800	Same as Survey Endorsement (ALTA 25-06)			No	
79	7900	Same as Portion of Survey Endorsement (ALTA 25.1-06)			No	
80	8000	Mortgage Modification Endorsement (ALTA 11-06)			No	
80.1	8001	Mortgage Modification With Subordination Endorsement (ALTA 11.1-06)			No	
80.2	8002	Mortgage Modification With Additional Amount of Title Insurance Endorsement (ALTA 11.2-06)			Yes	
83	8300	Construction Loan –Endorsement (ALTA 32.0-06)			No	
83.1	8301	Construction Loan – Direct Payment Endorsement (ALTA 32.1-06)			No	
83.2	8302	Construction Loan – Insured's Direct Payment Endorsement (ALTA 32.2-06)			No	
84	8400	Disbursement Endorsement (ALTA 33-06)			No	
85	8500	Identified Risk Coverage Endorsement			No	
88	8800	Energy Project Leasehold/Easement - Owner's Endorsement (ALTA 36-06)			Yes	
88.1	8801	Energy Project Leasehold/Easement - Loan Endorsement (ALTA 36.1-06)			Yes	
88.2	8802	Energy Project - Leasehold - Owner's Endorsement (ALTA 36.2-06)			Yes	
88.3	8803	Energy Project - Leasehold - Loan Endorsement (ALTA 36.3-06)			Yes	

88.4	8804	Energy Project Covenants, Conditions & Restrictions - Land under Development - Owner's Endorsement (ALTA 36.4-06)			Yes	
88.5	8805	Energy Project Covenants, Conditions & Restrictions - Land Under Development - Loan Endorsement (ALTA 36.5-06)			Yes	
88.6	8806	Energy Project - Encroachments Endorsement (ALTA 36.6-06)			Yes	
88.7	8807	Energy Project - Fee Estate - Owner's Policy Endorsement (ALTA 36.7-06)			Yes	
88.8	8808	Energy Project - Fee Estate - Loan Policy Endorsement (ALTA 36.8-06)			Yes	
89	8900	Mezzanine Financing Endorsement (ALTA 16-06)			No	
90	9000	Residential Limited Coverage Modification of Mortgage Policy			Yes	
91	9100	Contract Purchaser Conversion Endorsement			Yes	

TOTAL:					

Crosscheck with Form 1:	
Difference:	

Explanation for Difference (if any):

[13.14.17.12 NMAC – Rp, 13.14.17.12 NMAC, 1/1/2021; A/E, 1/24/2024]

13.14.17.13 FORM 4 - PREMIUM DISTRIBUTION BY LIABILITY RANGE:

NEW MEXICO TITLE INSURER STATISTICAL REPORT
FORM 4 - PREMIUM DISTRIBUTION BY LIABILITY RANGE
For the Calendar Year Ending December 31, 20___
NEW MEXICO EXPERIENCE ONLY
TRANSACTIONS THAT ARE DEPENDENT ON THE BASIC PREMIUM RATE
Note: Include all transactions listed as "Yes" in the "Dependent on Basic Premium Rate?" column of Form 3

Insurance Company			
Liability Range ($000)		**Number of transactions**	**Direct written premium**
More than	**But no more than**		
0	5		
5	10		
10	20		
20	30		
30	40		
40	50		

50	60		
60	70		
70	80		
80	90		
90	100		
100	200		
200	300		
300	400		
400	500		
500	1,000		
1,000	2,000		
2,000	3,000		
3,000	4,000		
4,000	5,000		
5,000	10,000		
10,000	15,000		
15,000	25,000		
25,000	50,000		
50,000	75,000		
75,000	100,000		
Over 100,000			
ALL		0	0

Crosscheck with Form 3:	
Difference	

Explanation for Difference (if any)

[13.14.17.13 NMAC – Rp, 13.14.17.13 NMAC, 1/1/2021]

13.14.17.14 FORM 5 - DIRECT PAID LOSS DEVELOPMENT:

NEW MEXICO TITLE INSURER STATISTICAL REPORT
FORM 5 - DIRECT PAID LOSS DEVELOPMENT
For the Calendar Year Ending December 31, 20___
NEW MEXICO EXPERIENCE ONLY

Insurance Company												
Years in which policies were written	**CUMULATIVE PAID LOSSES AND ALLOCATED LOSS ADJUSTMENT EXPENSES AT YEAR END (000 OMITTED)**										**Number of claims closed with loss payment**	**Number of claims closed without loss payment**
	Latest PY-9	Latest PY-8	Latest PY-7	Latest PY-6	Latest PY-5	Latest PY-4	Latest PY-3	Latest PY-2	Latest PY-1	Latest PY		
Prior												
Latest PY-19												
Latest PY-18												

Latest PY-17												
Latest PY-16												
Latest PY-15												
Latest PY-14												
Latest PY-13												
Latest PY-12												
Latest PY-11												
Latest PY-10												
Latest PY-9												
Latest PY-8												
Latest PY-7												
Latest PY-6												
Latest PY-5												
Latest PY-4												
Latest PY-3												
Latest PY-2												
Latest PY-1												
Latest PY												

Note: Use the same reporting instructions as for schedule P, part 2A of the NAIC annual statement, except that loss and ALAE should be direct of reinsurance and should be New Mexico claims only.

	Latest PY-1	Latest PY
Total	0	0
Total payments during Latest PY		0
New Mexico direct losses paid as shown on NAIC Annual Statement Schedule T		
	Difference	0

Explanation for Difference (if any)

[13.14.17.14 NMAC – Rp, 13.14.17.14 NMAC, 1/1/2021]

13.14.17.15 FORM 6 - DIRECT CASE BASIS RESERVES:

NEW MEXICO TITLE INSURER STATISTICAL REPORT
FORM 6 - DIRECT CASE BASIS RESERVES
For the Calendar Year Ending December 31, 20___
NEW MEXICO EXPERIENCE ONLY

Insurance Company												
Years in which policies were issued	**Direct Written Premium ($000s)**	**Amount of insurance written in millions**	**CASE BASIS LOSS AND ALLOCATED LOSS ADJUSTMENT EXPENSE RESERVES AT YEAR END (000 OMITTED)**									
			Latest PY-9	Latest PY-8	Latest PY-7	Latest PY-6	Latest PY-5	Latest PY-4	Latest PY-3	Latest PY-2	Latest PY-1	Latest PY
Prior												
Latest PY-19												
Latest PY-18												
Latest PY-17												
Latest PY-16												
Latest PY-15												
Latest PY-14												
Latest PY-13												
Latest PY-12												
Latest PY-11												
Latest PY-10												
Latest PY-9												
Latest PY-8												
Latest PY-7												
Latest PY-6												
Latest PY-5												

Latest PY-4												
Latest PY-3												
Latest PY-2												
Latest PY-1												
Latest PY												

Note: Use the same reporting instructions as for schedule P, part 2B of the NAIC annual statement, except that loss and ALAE should be **direct of reinsurance** and should be **New Mexico** claims only.

	Latest PY-1	Latest PY
Total	0	0
Increase in reserves during Latest PY		0
Total payments during Latest PY		0
Case incurred loss during Latest PY		0
New Mexico direct losses incurred as shown on NAIC Annual Statement Schedule T		
	Difference	0

Explanation for Difference (if any)

[13.14.17.15 NMAC – Rp, 13.14.17.15 NMAC, 1/1/2021]

PART 18: FORMS

13.14.18.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.14.18.1 NMAC – Rp, 13.14.18.1 NMAC, 1/1/2021]

13.14.18.2 SCOPE:

This rule applies to all title insurers, title agencies, and title insurance agents conducting title insurance business in New Mexico.

[13.14.18.2 NMAC – Rp, 13.14.18.2 NMAC, 1/1/2021]

13.14.18.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9, 59A-30-4, 59A-30-6, 59A-30-6.1, 59A-30-6.2 and 59A-30-8 NMSA 1978.

[13.14.18.3 NMAC – Rp, 13.14.18.3 NMAC, 1/1/2021]

13.14.18.4 DURATION:

Permanent.

[13.14.18.4 NMAC – Rp, 13.14.18.4 NMAC, 1/1/2021]

13.14.18.5 EFFECTIVE DATE:

January 1, 2021, unless a later date is cited at the end of a section.

[13.14.18.5 NMAC – Rp, 13.14.18.5 NMAC, 1/1/2021]

13.14.18.6 OBJECTIVE:

The purpose of this rule is to provide conditions and restrictions regarding the use of promulgated forms.

[13.14.18.6 NMAC – Rp, 13.14.18.6 NMAC, 1/1/2021; A, 1/1/2024]

13.14.18.7 DEFINITIONS:

See 13.14.1 NMAC.

[13.14.18.7 NMAC – Rp, 13.14.18.7 NMAC, 1/1/2021]

13.14.18.8 PROMULGATED FORMS:

For purposes of Section 59A-30-5 NMSA 1978, the superintendent shall promulgate title insurance forms by order after conducting a hearing pursuant to 13.1.5 NMAC or 13.1.6 NMAC, as the circumstances require. On their own motion, or at the request of an interested person, the superintendent may, at any time, conduct a hearing to consider whether to promulgate a new form, to revoke a previously promulgated form, or to modify a previously promulgated form. The forms compiled and filed with the New Mexico State Rules Center and Archives as the New Mexico Title Insurance Forms shall be the promulgated forms, and those forms are incorporated into this rule by reference. The superintendent shall publish a table of the promulgated title insurance forms with the corresponding rates in a form that is easily accessible by the public on the OSI's website.

A. A title insurer or title insurance agency shall not use any new promulgated form unless:

(1) the superintendent promulgates a rate for the form, if the order promulgating the form states that a rate is required to issue the form;

(2) the superintendent has promulgated a rule for the form, if the order promulgating the form states that use of the form is contingent on promulgating a rule; and

(3) the title insurer has provided to its title insurance agencies underwriting guidelines, compliant with these rules, to govern the use of the form.

B. A title insurer or title insurance agency shall not use any modified or replacement form unless:

(1) the superintendent determines that the existing rate and rule, if applicable, for the form applies to the modified or replacement form, or the superintendent has promulgated a new rate and rule, if applicable, for the modified or replacement form; and

(2) the title insurer has provided to its title insurance agencies underwriting guidelines, compliant with these rules, to govern the use of the form.

(3) A title insurer shall only issue forms that match in all substantive respects the promulgated forms authorized by these rules.

[13.14.18.8 NMAC – Rp, 13.14.18.8 NMAC, 1/1/2021; A, 1/1/2024; A/E, Appendices, 1/24/2024]

13.14.18.9 ALTERATION OF FORMS PROHIBITED; EXCEPTIONS; AND LETTERS OF INTERPRETATION OR WAIVER THAT CHANGE THE TERMS, PROHIBITED:

A. No person, firm or organization may alter or otherwise change any title insurance form promulgated by the superintendent, or use any non-promulgated endorsement, whether by deletion or omission of terms, except:

(1) upon a determination by the superintendent following a hearing pursuant to 13.1.5 or 13.1.6 NMAC, as applicable, that the same be proper; or

(2) in a manner specifically authorized by these regulations.

B. Factual information required to identify and describe the risk being undertaken may be inserted in an authorized form. This includes, but is not limited to, information necessary to identify the insured, the insured's estate or interest of record, the property

description, all matters of record affecting the insured's interest which are exceptions to the policy, all matters, facts and circumstances, whether or not shown by the public records, constituting a lien, claim, encumbrance, impairment or limitation upon the estate to be insured, whether arising by operation of law or by reason of no recorded information establishing the insured matters, the amount of liability of the policy and, in case of a commitment, any matter constituting a requirement prior to issuance of a policy, may be inserted in the proper places in the various forms, provided that other information necessary to complete each form is inserted in the form prior to its issuance.

C. Additions to language in the promulgated form, if required to correctly identify and describe the risk being undertaken may be inserted in an authorized form. Any such modification must be approved by:

(1) Legal counsel for the insured; or

(2) An authorized representative of the insured in a transaction that does not involve one to four family residential property.

D. Nothing in this rule shall prevent a title insurer from:

(1) adding blanks, spaces, labels or brief instructions to the promulgated forms; or

(2) from typesetting a promulgated form utilizing type styles, margins or paginations different from the promulgated forms; provided, however, that all language contained in each promulgated form must appear verbatim in each form, and further provided that nothing may be added to a promulgated title insurance form which changes any of the terms of such form except as specifically provided by these rules.

E. Nothing in these rules prohibits use of translated language other than English, provided, however, that any translated form shall contain the following language in bold-face type on the first page of the form in English and in the translated language: "This translation is provided as a convenience only. The English language version of this form shall control and shall be the operative document for all legal purposes."

F. The following language shall be added at the top of schedule A of all commitments and policies in a font not less than the font size of the remaining print of schedule A and be in bold italicized print "Pursuant to the New Mexico title insurance law Section 59A-30-4 NMSA 1978, and title insurance rule 13.14.18.9 NMAC, no part of any title insurance commitment, policy or endorsement form promulgated by the New Mexico superintendent of insurance may be added to, altered, inserted in or typed upon, deleted or otherwise changed from the title insurance form promulgated by the New Mexico superintendent of insurance, nor issued by a person or company not licensed with regard to the business of title insurance by the New Mexico superintendent of insurance, nor issued by a person or company who does not own, operate or control an

approved title abstract plant as defined by New Mexico law and regulations for the county wherein the property is located, except as authorized by law."

G. No title insurer or title insurance agency shall issue, publish or circulate a letter, memorandum or other writing which directly or indirectly modifies or waives the terms or any part of the terms of any promulgated form, nor shall any such person agree to directly or indirectly do or not do anything, the effect of which is or would be to offer insurance coverages other than those in the promulgated title insurance forms, whether the same be more, less, substitute, alternative, negative or affirmative coverages or risks, except as specifically authorized by these rules.

[13.14.18.9 NMAC – Rp, 13.14.18.9 NMAC, 1/1/2021; A, 1/1/2024]

13.14.18.10 ADDITIONAL AFFIRMATIVE COVERAGES:

In a commitment issued for a loan policy, but not with respect to any other type of commitment or policy:

A. The following language may be added to each covenant, deed, or other recorded restriction exception: "Violations of this restriction (or these restrictions), if any, and any future violation thereof shall not cause a forfeiture or reversion of title and will not affect the validity or priority of the lien of the mortgage herein insured. This assurance does not extend to restriction(s) relating to environmental protection unless a notice of a violation thereof has been recorded or filed in the public records and is not referenced in Schedule B. However, this policy insures that any violation of this restriction (or these restrictions) relating to environmental protection shall not cause a forfeiture or reversion of title and will not affect the validity or priority of the lien of the mortgage insured herein."

B. When protrusions, encroachments or overlaps into or upon easements, rights-of-way, adjacent property, the property to be insured, or building set-back lines (as described in restrictive covenants or plats filed of record) are revealed by a survey, the following paragraph may be added as a separate specific exception: "Encroachment (protrusion or overlap) of the improvements over (on, onto, in, into or upon) the (here describe the easement, right-of-way, adjacent property, the land to be insured, or building set-back line) as shown on a survey prepared by _____ dated _____. This policy insures against loss or damage as defined in this policy by reason of the entry of any final decree entered in a court of competent jurisdiction and of last resort ordering the removal of said improvements presently situate on the land which constitute the (protrusion, overlap or encroachment)." This affirmative coverage language may also be inserted into the NM form 61.

[13.14.18.10 NMAC – Rp, 13.14.18.10 NMAC, 1/1/2021]

13.14.18.11 PRINTING OF FORMS:

Each title insurance form shall contain the headings and form designations included on the promulgated form.

[13.14.18.11 NMAC – Rp, 13.14.18.12 NMAC, 1/1/2021]

13.14.18.12 [RESERVED]

[13.14.18.12 NMAC – Rp, 13.14.18.12 NMAC, 3/1/2016; Repealed 1/1/2021]

13.14.18.13 [RESERVED]

[13.14.18.13 NMAC - Rp, 13.14.18.13 NMAC, 3/1/2016; A, 7/1/2018; Repealed 1/1/2021]

PART 19: TITLE INSURER RATE FILINGS

13.14.19.1 ISSUING AGENCY:

Office of Superintendent of Insurance, Title Insurance Bureau.

[13.14.19.1 NMAC - N, 12-30-10; A, 3-1-16]

13.14.19.2 SCOPE:

This rule applies to all title insurers and title insurance agents conducting title insurance business in New Mexico.

[13.14.19.2 NMAC - N, 12-30-10]

13.14.19.3 STATUTORY AUTHORITY:

NMSA 1978 Sections 59A-30-4 and 59A-30-6.

[13.14.19.3 NMAC - N, 12-30-10]

13.14.19.4 DURATION:

Permanent.

[13.14.19.4 NMAC - N, 12-30-10]

13.14.19.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[13.14.19.5 NMAC - N, 12-30-10]

13.14.19.6 OBJECTIVE:

The purpose of this rule is to establish standards and procedures by which a title insurance rate lower than the promulgated rate shall be filed and may be approved.

[13.14.19.6 NMAC - N, 12-30-10]

13.14.19.7 DEFINITIONS:

[RESERVED]

[See 13.14.7 NMAC for definitions.]

13.14.19.8 STANDARDS FOR RATES THAT ARE LOWER THAN THE PROMULGATED RATES:

Rates that are lower than the promulgated rates must meet the standards set forth in Section 59A-30-6(C) NMSA 1978 and the superintendent shall also consider the interests and protection of consumers and independent title insurance agents and the potential impact on competition within the title insurance industry.

[13.14.19.8 NMAC - N, 12-30-10]

13.14.19.9 FILING OF RATES THAT ARE LOWER THAN THE PROMULGATED RATE:

A title insurer that proposes to charge rates that are lower than the promulgated rates shall file with the superintendent its proposed rates, supplementary rate information and supporting information at least ninety days before the proposed effective date. Such filing shall specify the county or counties in which these proposed rates would apply and shall be submitted electronically via the national association of insurance commissioners' system for electronic rate and form filing ("SERFF").

[13.14.19.9 NMAC - N, 12-30-10]

13.14.19.10 NOTICE OF RATE FILING:

Within ten days of receipt of a filing submitted under 13.14.19.9 NMAC, the superintendent shall provide notice of the filed title insurance rates to the attorney general and to all title insurance agents and title insurers doing business in the county or counties in which the filed rates would apply. The superintendent shall promptly provide a complete copy of the filing, including supplementary rate information and supporting information, to any party that, upon receiving the superintendent's notification of the filing, requests such information.

[13.14.19.10 NMAC - N, 12-30-10]

13.14.19.11 OPPORTUNITY TO OPINE ON RATE FILING:

Within thirty days after the superintendent's issuance of notification of the filed rates under 13.14.19.10 NMAC, a party receiving such notification may submit to the superintendent in writing its comments on the propriety of the proposed rates or may request a hearing pursuant to Section 59A-30-8 [NMSA 1978] to argue the propriety of the proposed rates.

[13.14.19.11 NMAC - N, 12-30-10]

13.14.19.12 APPROVAL OF FILED RATES:

In determining whether to approve a filing submitted under 13.14.19.9 NMAC, the superintendent shall consider the provisions of 13.14.19.8 NMAC as well as any comments or testimony provided under 13.14.19.11 NMAC The superintendent shall issue a final order approving or disapproving a filing submitted under 13.14.19.9 NMAC within 60 days after receipt of the filing or, if a hearing regarding the filing is held pursuant to 13.14.19.11 NMAC, within 60 days after the conclusion of such a hearing.

[13.14.19.12 NMAC - N, 12-30-10]

13.14.19.13 MAINTENANCE OF DOUBLE-RATING RECORD SYSTEM:

A title insurer that uses filed and approved rates that are lower than the promulgated rates shall maintain a record of both the charged rate and the promulgated rate for each policy and endorsement issued.

[13.14.19.13 NMAC - N, 12-30-10]

13.14.19.14 EFFECT OF RATE PROMULGATIONS UPON FILED AND APPROVED RATES:

If a rate promulgation by the superintendent produces rates that are lower than those contained in a previously approved rate filing, those rates in the previously approved rate filing that are in excess of the promulgated rates shall expire upon the effective date of the rate promulgation.

[13.14.19.14 NMAC - N, 12-30-10]

13.14.19.15 CANCELLATION OF FILED AND APPROVED RATES:

A title insurer using filed and approved rates that wishes to revert to the use of promulgated rates shall file with the superintendent the effective date of cancellation of its filed and approved rates. Such filing shall be submitted at least 30 days prior to the insurer's reversion to promulgated rates, shall specify the county or counties in which the reversion will apply and shall be submitted electronically via the national association

of insurance commissioners' system for electronic rate and form filing ("SERFF"). Such filing shall not be subject to the prior approval of the superintendent. The title insurer shall provide notice of the reversion, at least 30 days prior to the effective date of the reversion, to its appointed agents in the county or counties where the reversion will apply.

[13.14.19.15 NMAC - N, 12-30-10]

13.14.19.16 REVIEW OF THE SUPERINTENDENT'S ACTIONS:

Any person aggrieved by the superintendent's refusal to hold a hearing requested under 13.14.19.11 NMAC or by a final order issued by the superintendent under 13.14.19.12 NMAC shall have the rights to review and appeal provided in Section 59A-30-9 NMSA 1978.

[13.14.19.16 NMAC - N, 12-30-10]

CHAPTER 15: MARINE AND TRANSPORTATION INSURANCE [RESERVED]

CHAPTER 16: SURETY INSURANCE [RESERVED]

CHAPTER 17: WORKERS' COMPENSATION INSURANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: WORKERS' COMPENSATION DISPUTE BOARD

13.17.2.1 ISSUING AGENCY:

Office of Superintendent of Insurance.

[7-1-97; 13.17.2.1 NMAC - Rn & A, 13 NMAC 17.2.1, 5-15-01; A, 3-14-14]

13.17.2.2 SCOPE:

This rule applies to grievances relating to experience modification factors, classification assignments and manual rules and other related matters deemed pertinent by the superintendent, as applied to specific workers' compensation insurance policies, which are to be heard by the New Mexico workers' compensation dispute board.

[1-1-93, 7-1-97; 13.17.2.2 NMAC - Rn, 13 NMAC 17.2.2, 5-15-01; A, 3-14-14]

13.17.2.3 STATUTORY AUTHORITY:

NMSA 1978 Sections 59A-2-9, 59A-3-6, 59A-17-5, 59A-17-8, 59A-17-19, 59A-17-27 and 59A-17-30.

[1-1-93; 13.17.2.3 NMAC - Rn, 13 NMAC 17.2.3, 5-15-01]

13.17.2.4 DURATION:

Permanent.

[7-1-97; 13.17.2.4 NMAC - Rn, 13 NMAC 17.2.4, 5-15-01]

13.17.2.5 EFFECTIVE DATE:

January 1, 1993, unless a later date is cited at the end of a section.

[1-1-93, 7-1-97; 13.17.2.5 NMAC - Rn & A, 13 NMAC 17.2.5, 5-15-01]

13.17.2.6 OBJECTIVE:

The purpose of this rule is to establish a workers compensation dispute board to provide a mechanism by which aggrieved parties may obtain review of the application of the rules of the workers' compensation system to their individual workers' compensation policies, and to engage in other activities as more clearly set forth in 13.17.2.2 NMAC.

[1-1-93; 13.17.2.6 NMAC - Rn, 13 NMAC 17.2.6, 5-15-01; A, 3-14-14]

13.17.2.7 DEFINITIONS:

"Advisory organization" means an entity as defined by Section 59A-17-4(A) NMSA 1978, licensed in accordance with Section 59A-17-19 NMSA 1978 and designated by the superintendent pursuant to Section 59A-17-8(A) NMSA 1978.

[13.17.2.7 NMAC - N, 5-15-01; A, 3-14-14]

13.17.2.8 COMPOSITION OF DISPUTE BOARD:

The superintendent shall appoint the members of the dispute board, which shall consist of five voting members, one non-voting regulatory participant and two non-voting advisors as follows:

A. The one non-voting regulatory participant shall be from the staff of the office of superintendent of insurance.

B. The five voting members shall be from the private sector as follows:

(1) one voting member shall be a private sector employer or a representative of a private sector employer located in New Mexico;

(2) one voting member shall be affiliated with a local chamber of commerce, small business federation, or similar business association in New Mexico;

(3) two voting members shall be independent insurance agents licensed in New Mexico;

(4) one voting member shall be a representative from a New Mexico self-insurance group;

(5) each voting member shall be knowledgeable concerning workers' compensation insurance, rules, and classifications and shall be familiar with the business environment and business community of New Mexico;

(6) no voting member shall be, or be an employee of, an insurance company, insurance broker, law firm, actuary, or any association of any such entities; neither shall any such member be under contract to any such entity;

(7) no two voting memberships shall be affiliated with the same business organization, affiliated group, business league, or labor organization and

(8) all voting memberships shall be held in the name of the individual.

C. One non-voting advisor shall be an insurance company that writes workers' compensation insurance policies in New Mexico.

(1) The insurance company shall designate one salaried employee to represent it on the dispute board, and another salaried employee as an alternate.

(2) The company representative or alternate representative shall attend each meeting of the dispute board and shall serve as a technical and business resource. The representative will provide advice to the dispute board on issues relating to experience modification factors, classification assignments, manual rules and other related matters deemed pertinent by the superintendent. The company representative may participate in the discussion but shall have no vote in determining the dispute board's decisions.

D. One non-voting advisor shall be an employee of the advisory organization and shall serve as a technical resource for the dispute board. The representative from the advisory organization will provide advice to the dispute board on issues relating to experience modification factors, classification assignments, manual rules and other related matters deemed pertinent by the superintendent. The advisory organization representative may participate in the discussion, but shall have no vote in determining the dispute board's decisions.

[1-1-93; 13.17.2.8 NMAC - Rn & A, 13 NMAC 17.2.8, 5-15-01; A, 3-14-14]

13.17.2.9 [RESERVED]

[1-1-93; 13.17.2.9 NMAC - Rn & A, 13 NMAC 17.2.9, 5-15-01; Repealed, 3-14-14]

13.17.2.10 TERMS OF DISPUTE BOARD MEMBERS:

A. Each member's term on the dispute board shall be for three years, staggered per the discretion of the superintendent so that the terms of no more than two voting members shall expire concurrently. No voting member shall be permitted to serve more than two consecutive three-year terms. There shall be no limitation on a non-voting regulatory participant's or a non-voting advisor's reappointment to serve successive terms.

B. The term of each dispute board member shall commence on April 1 and expire on March 31 three years later.

C. If a vacancy occurs on the dispute board, the superintendent shall appoint a replacement for the remainder of the unexpired term. Such replacement shall be from the same class as the retiring member.

[1-1-93; 13.17.2.10 NMAC - Rn, 13 NMAC 17.2.10, 5-15-01; A, 3-14-14]

13.17.2.11 [RESERVED]

[1-1-93; 13.17.2.11 NMAC - Rn & A, 13 NMAC 17.2.11, 5-15-01; Repealed, 3-14-14]

13.17.2.12 REIMBURSEMENT:

The advisory organization shall reimburse members for reasonable expenses connected with dispute board functions including, but not limited to, travel expenses, food and lodging. Such reimbursement may be provided as a per diem allowance. Members shall receive no other compensation for their participation.

[1-1-93; 13.17.2.12 NMAC - Rn & A, 13 NMAC 17.2.12, 5-15-01; A, 3-14-14]

13.17.2.13 CHAIR:

The dispute board shall meet either in person or by teleconference at the beginning of each term for purpose of electing a chair. The chair shall be responsible for organizing the agenda of each meeting and each hearing, arranging facilities, providing notice as required, and for the conduct of each hearing. The chair may appoint from among the members a secretary to which it may delegate any of its administrative functions.

[1-1-93; 13.17.2.13 NMAC - Rn, 13 NMAC 17.2.13, 5-15-01; A, 3-14-14]

13.17.2.14 HEARING PROCEDURES:

The dispute board shall meet as needed and in accordance with the provisions of state law.

A. Upon receipt of a grievance, the dispute board shall schedule a hearing within sixty (60) days, unless state law mandates a shorter period.

B. The dispute board shall provide written notice of hearing to the appellant, the insurer, the policyholder, the producing agent and the advisory organization within thirty (30) days after receipt of the grievance, but not less than ten (10) days prior to the hearing.

C. Hearings may not be held unless a majority of the dispute board is present either in person or by teleconference.

D. Any party to a hearing may request permission to have a court reporter or other recording method present at the hearing at the cost of the requesting party. The requested permission to record the hearing must be made in writing to the chairman of the dispute board at least fifteen (15) days before the date of the hearing. The request must explain the intended purpose and use of the recorded record of the hearing. The chairman shall call a meeting of the dispute board, in person or by telephone to consider such request and the dispute board may consent or deny permission to record the hearing procedure. The requesting shall be notified in writing of the decision of the dispute board, at least two working days before the hearing date.

[1-1-93; 13.17.2.14 NMAC - Rn & A, 13 NMAC 17.2.14, 5-15-01; A, 3-14-14]

13.17.2.15 CONFLICTS OF INTEREST:

A. If a dispute board member has a conflict of interest with respect to a hearing scheduled before the dispute board, a substitute shall be appointed by the chair for purposes of that particular hearing. A substitute member shall be from the same class as the member being replaced.

B. A member will be deemed to have a conflict of interest if:

(1) the member is associated with either party to the appeal;

(2) the member is a direct competitor of either party;

(3) the member is part of an affiliated group, any member of which is a direct competitor of either party; or

(4) the member has any other material conflicting interest which would call into question that member's ability to render an unbiased decision.

C. A member is associated or affiliated with a party if they are involved in a common business enterprise or if they are members of a controlled group as that term is defined by Section 851(c)(3) of the Internal Revenue Code. A member is associated with the party if there is any familial relationship between them.

D. The insurance company advisor will be deemed to have a conflict of interest only if it is one of the parties to the dispute. In the event such conflict of interest is deemed to exist for the insurance company advisor, a substitute insurance company shall be appointed by the chair to serve as the non-voting insurance company advisor for purposes of the particular hearing scheduled before the dispute board in which the conflict of interest exists.

E. A conflict of interest may be waived if, after full disclosure of the facts raising such a conflict, all parties to the appeal agree to such waiver.

F. Notwithstanding the provisions of Subsection B of this section, neither of the representatives from the office of superintendent of insurance and the advisory organization shall be deemed to have a conflict of interest with respect to any appeal brought before the dispute board based solely upon the representatives' affiliation with the advisory organization or the office of superintendent of insurance.

[1-1-93; 13.17.2.15 NMAC - Rn & A, 13 NMAC 17.2.15, 5-15-01; A, 3-14-14]

13.17.2.16 DECISIONS OF DISPUTE BOARD:

A. The decision of the dispute board will be by majority vote of those voting members of the dispute board who are present at the hearing. A member's vote may be cast only by the member or, in the member's absence, by the member's alternate who has been designated in writing. Otherwise, proxy voting shall not be permitted.

B. Each decision shall be supported by a written memorandum stating the reason(s) for the decision, which memorandum shall be sent to both parties and to the superintendent.

C. The votes of each member shall not be recorded on this memorandum.

D. This memorandum shall be prepared by the chair of the dispute board or by a member or non-voting advisor designated by the chair.

[1-1-93; 13.17.2.16 NMAC - Rn, 13 NMAC 17.2.16, 5-15-01; A, 3-14-14]

13.17.2.17 REVIEW:

Review of decisions of the dispute board shall be accorded pursuant to Section 59A-17-30B NMSA 1978. The chair of the dispute board, or the secretary appointed by the

chair, shall advise each appellant in writing of his or her rights of appeal and the procedure to be followed.

[1-1-93; 13.17.2.17 NMAC - Rn & A, 13 NMAC 17.2.17, 5-15-01; A, 3-14-14]

PART 3: [RESERVED]

PART 4: WORKERS' COMPENSATION ASSIGNED RISK POOL

13.17.4.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[7/1/97; 13.17.4.1 NMAC - Rn & A, 13 NMAC 17.4.1, 12/31/04]

13.17.4.2 SCOPE:

This rule applies to all workers' compensation insurers participating as reinsurers of the New Mexico Worker's Compensation Assigned Risk Pool.

[1/1/90, 7/1/97; 13.17.4.2 NMAC - Rn, 13 NMAC 17.4.2, 12/31/04]

13.17.4.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-33-3, 59A-33-8 and 59A-33-9 NMSA 1978.

[1/1/90; 13.17.4.3 NMAC - Rn, 13 NMAC 17.4.3, 12/31/04]

13.17.4.4 DURATION:

Permanent.

[7/1/97; 13.17.4.4 NMAC - Rn, 13 NMAC 17.4.4, 12/31/04]

13.17.4.5 EFFECTIVE DATE:

January 1, 1990, unless a later date is cited at the end of a section.

[1/1/90, 7/1/97; 13.17.4.5 NMAC - Rn & A, 13 NMAC 17.4.5, 12/31/04]

13.17.4.6 OBJECTIVE:

This rule defines the methods by which workers' compensation insurers shall participate in the Workers' Compensation Assigned Risk Pool as reinsurers. The methods of assessment are structured to promote the voluntary assumption of workers' compensation risks by workers' compensation insurers.

[1/1/90, 7/1/97; 13.17.4.6 NMAC - Rn, 13 NMAC 17.4.6, 12/31/04]

13.17.4.7 DEFINITIONS:

When used in this rule, **the agency** refers to the Workers' Compensation Assigned Risk Pool as defined in Section 59A-33-4B NMSA 1978.

[1/1/90; 13.17.4.7 NMAC - Rn, 13 NMAC 17.4.7, 12/31/04]

13.17.4.8 PARTICIPATION OF WORKERS' COMPENSATION INSURERS:

A. The undertakings of any policy issued by the agency shall be fully reinsured by all members of the pool in proportion to the amount that the net direct workers' compensation line premium on the insurance written in the state during the preceding calendar year by the issuing member bears to the total of workers' compensation line premiums written in this state during the preceding calendar year by all members of the agency. Net direct workers' compensation line premium shall be direct written premium exclusive of policyholder dividends and New Mexico Workers' Compensation Assigned Risk Pool premiums.

B. The premium used for the basis of proration, as described in Subsection A of 13.17.4.8 NMAC-shall be those premiums reported to the New Mexico department of insurance in the annual statement. Each member company may file with the agency for exclusion of those premiums classified as workers' compensation premiums on the annual statement.

C. The exclusions applicable in Subsection B of 13.17.4.8 NMAC shall not reduce the member's assessment base below zero.

D. Application for exclusion under Subsection B of 13.17.4.8 NMAC shall be made prior to April 1 of the following calendar year and shall be certified by a responsible officer of the member company. Members may apply for the exclusions described above on a form prescribed by the agency and approved by the superintendent and may be required by the agency to provide other information as may be necessary to verify the information contained in the application.

[1/1/90, 7/1/97; 13.17.4.8 NMAC - Rn & A, 13 NMAC 17.4.8, 12/31/04]

13.17.4.9 SMALL POLICY EXEMPTIONS:

A. A member of the agency which insures on a voluntary basis any policyholder having $5,000 or less in annual workers' compensation premium shall be exempt from participation in the agency to the extent approved by the New Mexico insurance division.

B. The premium threshold of $5,000 applies to policies issued or renewed during 1990. The agency may file a request for an adjustment to the premium threshold with the New Mexico insurance division. No requested adjustment shall become effective nor shall it be used until approved by the New Mexico insurance division, at which time it may be used.

C. The exemption applicable to a member shall not reduce the member's assessment base below zero.

D. Eligibility for the small policy exemptions shall be established prior to April 1 of the following calendar year and shall be certified by a responsible officer of the member company. Members may apply for the small policy exemptions in the manner prescribed by the agency and approved by the New Mexico insurance division and may be required by the agency to provide other information as may be necessary to verify the information contained in the application.

[1/1/90; 13.17.4.9 NMAC - Rn & A, 13 NMAC 17.4.9, 12/31/04]

13.17.4.10 TAKE-OUT CREDITS:

A. The following policies shall be eligible for take-out credit:

(1) $5,000 or less in estimated standard annual workers' compensation premium as shown on the expiring policy as provided for in 13.17.4.9 NMAC; and

(2) any other such policy that was an assigned risk policy immediately prior to being voluntarily assumed by the member company.

B. The agency shall file its take-out credit program with the New Mexico insurance division. No take-out credit program shall become effective nor shall it be used until approved by the New Mexico insurance division, at which time it may be used.

C. The total credits applicable to a member shall not reduce the member's assessment base below zero.

D. Eligibility for take-out credit shall be established prior to April 1 of the following calendar year and shall be certified by a responsible officer of the member company. Members may apply for take-out credit in the manner prescribed by the agency and approved by the New Mexico insurance division and may be required by the agency to provide other information as may be necessary to verify the information contained in the application.

[1/1/90; 13.17.4.10 NMAC - Rn & A, 13 NMAC 17.4.10, 12/31/04]

PART 5: CLASSIFICATION AND RATING FOR EMPLOYERS AND LEASING CONTRACTORS

13.17.5.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.17.5.2 SCOPE:

This rule applies to workers' compensation and employer's liability insurance as defined in Section 59A-7-6A(3) NMSA 1978.

[9/6/91; Recompiled 11/30/01]

13.17.5.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-3-6, 59A-17-5, 59A-18-29, 59A-33-9.1, and 59A-33-10 and 59A-2-9.1 NMSA 1978.

[9/6/91; Recompiled 11/30/01]

13.17.5.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.17.5.5 EFFECTIVE DATE:

September 6, 1991, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[9/6/91, 7/1/97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.17.5.6 OBJECTIVE:

The purpose of this rule is to carry out the requirements of Laws 1990 (2nd Special Session), Chapter 2 relating to proper workers' compensation classification and rating, including defining temporary and leased employees, providing for proper classification and rating, providing for the prevention of experience modifier reductions through employee leasing arrangements and imposing penalties for the use of subterfuge to evade the proper application of workers' compensation classification and rating.

[9/6/91; Recompiled 11/30/01]

13.17.5.7 DEFINITIONS:

A. **"Assigned risk pool** or **pool"** means the workers' compensation insurance assigned risk facility established by Chapter 59A, Article 33 NMSA 1978.

B. **"Client"** means an employer which obtains workers through an employee leasing arrangement.

C. **"Employee leasing arrangement"** means any arrangement whereby an employer contracts with a leasing contractor to provide all or some of the employer's workers; provided, that the term does not include the provision of temporary workers.

D. **"Employer"** means any person or entity, including a leasing contractor and a client, as defined in, or having the right to control workers within the meaning of case precedents applicable to, the Workers' Compensation Act (Chapter 52, Article 1 NMSA 1978) or the New Mexico Occupational Disease Disablement Law (Chapter 52, Article 3 NMSA 1978).

E. **"Leased worker"** means a worker provided to a client through an employee leasing arrangement; provided that, if a worker has been previously employed by the client prior to working for a leasing contractor, it shall be presumed that the worker is a leased worker, not a temporary worker; and further provided that, if a worker works and should be classified in any construction class, or in any oil and gas well-service or drilling class, the worker shall be presumed to be a leased worker.

F. **"Leasing contractor"** means any person or entity which provides all or any part of a client's New Mexico workers through an employee leasing arrangement.

G. **"Premium subject to dispute"** means premium for a workers' compensation policy as to which the insured has provided a written notice of dispute to the insurer or servicing carrier, and has filed a written request for pending administrative review or has initiated pending litigation. To qualify as premium subject to dispute, the insured must have identified and detailed specific areas of dispute, have provided a reasonable estimate of the premium believed to be correct, and have paid the amount of such undisputed premium in full.

H. **"Rating based upon experience"** includes any workers' compensation premium rating plan which provides for premium adjustments based upon an insured's loss experience under a workers' compensation insurance policy, including but not limited to any approved experience rating plan and the assigned risk adjustment program (ARAP).

I. **"Subterfuge"** means any artifice, trick, device, misrepresentation or concealment, whether committed knowingly or negligently, including but not limited to:

(1) providing false or misleading information to an insurer, its agent, a rating bureau or the assigned risk pool;

(2) failing or refusing to make full disclosure to an insurer, its agent, a rating bureau or the pool of an employer's, client's or leasing contractor's true ownership, change of ownership, or current or previous employee leasing arrangements;

(3) failing or refusing to make full disclosure of any employer's, client's or leasing contractor's operations, location, payrolls, worker's compensation loss experience, experience modifiers, worker classifications or other necessary rating information;

(4) failing or refusing to disclose the existence of more than one policy covering an employer's, client's or leasing contractor's workers; or

(5) failing or refusing to disclose the identity of all former insurers and self-insurance plans providing workers compensation coverage to an employer's, client's or leasing contractor's workers, including but not limited to workers provided to any client through an employee leasing arrangement.

J. **"Temporary worker"** means a worker hired and employed by an employer to support or supplement another's work force in special work situations such as employee absences, temporary skill shortages, seasonal workloads and special temporary assignments such as temporary work for the production of a motion picture; and

K. **"Worker"** includes **"worker"** or **"workman"** as defined pursuant to the Workers' Compensation Act and employee as defined pursuant to the New Mexico Occupational Disease Disablement Law.

[9/6/91; Recompiled 11/30/01]

13.17.5.8 SUBTERFUGE; GENERAL PROHIBITION; PENALTY:

A. The use of subterfuge or any other action to evade the proper application of workers' compensation insurance classifications, ratings based upon experience or other premium rating procedures is prohibited.

B. In addition to any other penalty provided by law or this rule, any person whom the Superintendent finds, after hearing, to have committed subterfuge shall be subject to the penalties provided in 59A-1-18 NMSA 1978. Each act of subterfuge, whether like or unlike other acts, shall constitute a separate violation.

[9/6/91, 7/1/97; Recompiled 11/30/01]

13.17.5.9 COVERAGE OF TEMPORARY WORKERS:

In the voluntary market and in the assigned risk pool, coverage for temporary workers shall be through a standard workers' compensation policy issued to that employer which has the right to control hiring, salary, assignment and payment of the temporary workers.

[9/6/91; Recompiled 11/30/01]

13.17.5.10 COVERAGE OF LEASED WORKERS IN THE VOLUNTARY MARKET:

A. In the voluntary insurance market, a leasing contractor shall obtain or cause to be obtained workers' compensation coverage for leased workers either through individual policies issued to each client or, with the voluntary market insurer's knowledge and consent, through a standard workers' compensation policy issued to the leasing contractor as co-employer of and covering all such leased workers. The leasing contractor's voluntary market insurer may take all reasonable steps to ascertain exposure under any such policy and to collect the appropriate premium, including the following:

(1) requiring a complete description of the leasing company's and its predecessors-in-interest's clients and operations, past and present;

(2) conducting periodic audits and requiring periodic reports of payroll, classifications, ratings based upon experience and jurisdictions with exposure. In addition, the insurer may require the leasing contractor to submit its IRS Form 941 or its equivalent to the insurer on a quarterly basis;

(3) conducting audits of client operations; and

(4) taking or requiring the leasing contractor to take other reasonable measures appropriate to determining payroll, worker classifications, loss experience, ratings based upon experience and premium.

B. Every voluntary market insurer which provides workers' compensation coverage to a leasing contractor as co-employer of leased workers shall maintain a written record of information in sufficient detail that each individual client's payroll, classifications, losses and ratings based upon experience can be determined. Upon request made at any time before or after the expiration of the leasing contractors' policy, the insurer shall furnish such detail to the client, any rating agency, a subsequent insurer or the assigned risk pool.

C. If a client changes from one leasing contractor to another or terminates its leasing arrangement, the leasing contractors' voluntary market insurers or their rating organizations shall re-determine rating factors for the leasing contractors using the best data available, including but not limited to the client's ratings based upon experience developed pursuant to 13 NMAC 17.5.13 [now 13.17.5.13 NMAC]. This section shall not be construed to require re-determination of a leasing contractor's rating based upon

experience more often than annually; provided, that a re-determination may be made more often, upon a client change, in the insurers' discretion.

[9/6/91, 7/1/97; Recompiled 11/30/01]

13.17.5.11 COVERAGE OF LEASED WORKERS IN THE ASSIGNED RISK POOL:

A. In the assigned risk pool, a leasing contractor shall obtain or cause to be obtained workers' compensation coverage for leased workers through individual policies issued to and in the name of each client for whom the leased workers work.

B. The assigned risk pool shall cooperate in facilitating the joint administration of workers' compensation policies covering all workers leased by a single leasing contractor. Such cooperation may include assignment of all client policies to a single servicing carrier, a common effective date for all client policies if the leasing contractor so requests, and joint auditing.

[9/6/91; Recompiled 11/30/01]

13.17.5.12 PROVISIONS APPLICABLE TO VOLUNTARY MARKET AND ASSIGNED RISK POOL:

A. An insurer or the assigned risk pool may require the following information from an employer, client or leasing contractor making application for coverage:

(1) a list by jurisdiction of every name under which an employer, client or leasing contractor has operated at any time during the preceding five years, including but not limited to business names of all predecessors-in-interest, together with the names of all insurers and policy numbers of policies issued to the employer, client or leasing contractor under each such name, and a copy of the leasing contractor's most recently filed internal revenue service form 941 or equivalent;

(2) a list of every person and entity which has owned a five percent or greater interest in the employer, client or leasing contractor or any of their predecessors-in-interest at any time during the five-year period immediately preceding the application;

(3) for each person and entity identified in the preceding paragraph, a list of all other businesses in which each such person and entity has owned a five percent or greater interest at any time during the five-year period immediately preceding the application;

(4) a list by jurisdiction of every current client of a leasing contractor, together with every name under which each client has operated at any time during the five-year period immediately preceding the application, and a copy of the most recently filed internal revenue service form 941 or equivalent for each client;

(5) a sworn affidavit, signed by the chief executive officer of each client and a responsible officer of its leasing contractor, stating the names of each insurer and policy number of each workers' compensation insurance policy issued to the client under each name under which the client has operated at any time during the five-year period immediately preceding the application;

(6) a list by name of all workers, giving the social security number, classification code and wage of each; and

(7) a sworn affidavit, signed by the chief executive office of each client and a responsible officer of its leasing contractor, stating that all non-leased workers are covered by workers' compensation coverage. In addition, the affidavit may be required to state the name of all insurers, the policy numbers, the policy periods, the number of workers and the aggregate payroll applicable to each classification code of the non-leased workers. This affidavit may be required as often as an insurer or the pool deems reasonably necessary.

B. Leasing contractors may assist in securing and maintaining coverage for clients in the voluntary market or the pool; provided, that this section does not authorize leasing contractors to act as insurance agents and shall not be construed to exempt them from insurance agent or other applicable licensing requirements.

C. Leasing contractors and clients shall provide information in sufficient detail to satisfy the requirements of this rule. Monthly reporting may be required.

D. If an employer provides both leased workers and temporary workers to another, the leased workers shall be covered as specified herein for leased workers of a leasing contractor and the temporary workers shall be covered as specified for temporary workers.

[9/6/91; Recompiled 11/30/01]

13.17.5.13 TERMINATION OF EMPLOYEE LEASING ARRANGEMENT; RATING OF CLIENT:

When any employee leasing arrangement terminates, all prior experience of the client's own direct workers and its previously leased workers shall be used in rating the client. Every rating organization and insurer shall make a reasonable effort, including a special audit if necessary, to obtain and verify the information necessary to calculate a rating based upon experience, where premium is sufficient to make such rating applicable.

[9/6/91; Recompiled 11/30/01]

13.17.5.14 REVIEW:

A. Any rating determination made pursuant to this rule may be appealed as provided under Section 59A-17-30B NMSA 1978.

B. Any other determination or decision made pursuant to this rule may be reviewed through seeking a hearing pursuant to Section 59A-4-15 NMSA 1978.

C. If the application for review concerns an assigned risk pool policy, the assigned risk pool shall continue to provide coverage, if requested, during the period of any review proceeding, through a final decision by the superintendent. Premiums, other than premiums subject to dispute, shall be timely paid in full in order to continue coverage during review. The superintendent may require the amount of all premiums subject to dispute to be deposited in an interest-bearing trust account to be distributed after all decisions are final.

[9/6/91; Recompiled 11/30/01]

13.17.5.15 GENERAL PENALTY:

A. In addition to any other penalty provided by law or rule, violation of any provision of this rule by an employer, client or leasing contractor is grounds for cancellation or non-renewal of workers' compensation insurance. Notice of such cancellation or non-renewal, stating the reason, shall be provided the insured at least 30 days in advance of the effective date of the cancellation.

B. In addition to any other penalty provided by law or this rule, violation of the provisions of this rule is subject to other penalties for violation of the Insurance Code (Chapter 59A NMSA 1978).

C. In addition to any other penalty imposed for violation of this rule, the person or entity violating the rule may be required to pay any unpaid premium found to be due plus interest at the rate of 15% a year from the date such premium should have been paid.

D. An insured covered through the assigned risk pool may avoid cancellation or non-renewal pursuant to 13 NMAC 17.5.15.1 [now Subsection A of 13.17.5.15 NMAC] by taking such corrective action as the pool may specify in a timely manner. The pool may grant an insured a reasonable grace period, not to exceed 30 days, if the insured pays to the pool sufficient deposit premiums to cover ultimate premiums, as estimated by the pool.

[9/6/91; Recompiled 11/30/01]

13.17.5.16 TRANSITION PROVISION:

All leasing contractors and all employers providing temporary workers covered through the assigned risk pool on the effective date of this rule shall submit a new application for

coverage to the pool on or before September 30, 1991, in order to establish eligibility for pool coverage in accordance with this rule. The application shall contain and be accompanied by all the information and documentation specified in 13 NMAC 17.5.12, paragraphs 17.5.12.1.1 through 17.5.12.1.7 [now Paragraphs (1) through (7) of Subsection A of 13.17.5.12 NMAC]. Effective October 30, 1991, the pool shall recreate and reissue coverage to all such persons or entities to the extent they qualify for pool coverage under this rule, and shall cancel all others to the extent they do not qualify under this rule, giving 30 days' notice of cancellation. Within 10 days of the date of the notice of cancellation, every such person and entity shall deliver written notice of cancellation to every client and shall seek replacement coverage in accordance with this rule.

[9/6/91; Recompiled 11/30/01]

PART 6: PREMIUM ADJUSTMENT PROGRAM

13.17.6.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Insurance Division.

[7-1-97; 13.17.6.1 NMAC – Rn & A, 13 NMAC 17.6.1, 5-15-01]

13.17.6.2 SCOPE:

This rule authorizes premium credits for workers' compensation and employer's liability insurance as defined in NMSA 1978 Section 59A-7-6A(3) for those employers utilizing certain qualifying classifications. The premium credit calculation in this rule shall apply to new or renewal qualifying policies effective on and after July 1, 1992.

[4-1-92; 13.17.6.2 NMAC – Rn & A, 13 NMAC 17.6.2, 5-15-01]

13.17.6.3 STATUTORY AUTHORITY:

NMSA 1978 Sections 59A-2-9, 59A-3-6, and 59A-17-5.

[4-1-92; 13.17.6.3 NMAC – Rn, 13 NMAC 17.6.3, 5-15-01]

13.17.6.4 DURATION:

Permanent.

[7-1-97; 13.17.6.4 NMAC – Rn, 13 NMAC 17.6.4, 5-15-01]

13.17.6.5 EFFECTIVE DATE:

April 1, 1992, unless a later date is cited at the end of a section.

[4-1-92, 7-1-97; 13.17.6.5 NMAC – Rn & A, 13 NMAC 17.6.5, 5-15-01]

13.17.6.6 OBJECTIVE:

The purpose of this rule is to implement NMSA 1978 Section 59A-17-8C directing the Superintendent of Insurance to equalize and calculate workers' compensation premium rates on a basis that does not discriminate against or penalize employers who pay higher wages than other employers to workers in the same job classification. The legislative objective is satisfied by retaining the present payroll-based system modified by the application of progressively greater premium credits to progressively higher hourly wages on policies for qualifying classifications. [4-1-92; 13.17.6.6 NMAC – Rn & A, 13 NMAC 17.6.6, 5-15-01]

13.17.6.7 DEFINITIONS:

In addition to the definitions in the Workers' Compensation Act, NMSA 1978 Sections 52-1-1 et seq., as used in this rule:

A. aggregate call for experience means the requests by the WCSO to workers' compensation carriers for summaries of payroll, premium or loss experience data;

B. ARAP calculations means the Assigned Risk Adjustment Program approved by the Superintendent pursuant to NMSA 1978 Section 59A-33-10;

C. basic manual means the Basic Manual for Workers' Compensation and Employers Liability Insurance applicable to New Mexico filed by the WCSO and approved by the Superintendent;

D. experience rating means any workers' compensation premium rating plan which provides for premium adjustments based upon an insured's prior loss experience;

E. final earned premium means that premium which applies after the application of payroll audits and retrospective rating adjustments;

F. manual premium means the product of payroll per $100 and the manual rate for a given classification. Manual premium for a policy means the sum of the manual premiums for the classification applicable to that policy;

G. manual rate means workers' compensation base rates filed by authorized insurers or the workers' compensation assigned risk pool and approved by the Superintendent;

H. qualifying classifications means those workers' compensation classifications listed in subsection C of 13.17.6.8 NMAC;

I. **qualifying policy** means a workers' compensation or employer's liability policy the premium for which is attributable to one or more qualifying classifications;

J. **rate service organization** has the meaning given in NMSA 1978 Section 59A-17-4;

K. **remuneration** shall have the meaning used in Rule V of the Basic Manual for Workers Compensation and Employers Liability Insurance;

L. **standard earned premium** means the premiums on which general rate levels are set as defined in the Basic Manual for Workers' Compensation;

M. **Workers' Compensation Service Organization (WCSO)** means either a rate service organization licensed in accordance with NMSA 1978 Section 59A-17-19 or an advisory organization licensed in accordance with NMSA 1978 Section 59A-17-24 that is designated by the Superintendent of Insurance in workers' compensation matters.

[4-1-92, 7-1-97; 13.17.6.7 NMAC – Rn & A, 13 NMAC 17.6.7, 5-15-01]

13.17.6.8 QUALIFYING CLASSIFICATIONS:

A. The Superintendent may amend this rule to add or delete classifications from the schedule by providing at least thirty (30) days' notice to the WCSO and otherwise furnishing public notice as required by the Insurance Code.

B. NOC means "not otherwise classified".

C. The premium credit program established by this rule applies only to premium attributable to one or more of the following classifications:

3365	Welding or cutting – NOC & drivers
3724	Millwright work NOC & drivers (Concrete sawing & drilling) & drivers
3726	Boiler installation or repair - steam
5020	Ceiling installation - suspended acoustical grid type
5022	Masonry NOC
5037	Painting - metal structures
5040	Iron or steel erection - erecting iron or steel frame structures
5057	Iron or steel erection NOC
5059	Iron or steel erection - frame structures not over two stories
5069	Iron or steel erection in the construction of dwellings not exceeding two stories
5102	Door, door frame or sash erection
5146	Furniture or fixtures installation in offices or stores NOC
5160	Elevator erection or repair

5183	Plumbing - NOC & drivers
5188	Automatic sprinkler installation & drivers
5190	Electrical wiring (within buildings) & drivers
5213	Concrete construction NOC - including foundations
5215	Concrete work - construction of private residence
5221	Concrete or cement work (floors, driveways, yards, or sidewalks) & drivers
5222	Concrete construction in connection with bridges or culverts
5223	Swimming pool construction (not iron or steel) all operations & drivers
5348	Tile, stone, mosaic or terrazzo work - interior construction only
5402	Hothouse erection - all operations
5403	Carpentry - NOC
5437	Carpentry - installation of cabinet work or interior trim
5443	Lathing & drivers
5445	Wallboard installation (within buildings) & drivers
5462	Glaziers (away from shop) & drivers
5474	Painting or paper hanging NOC & shop operations, drivers
5479	Insulation work & drivers
5480	Plastering NOC & drivers
5491	Paper hanging & drivers
5506	Street or road construction, paving or repaving all kinds & drivers
5507	Street or road construction, clearing or right of way & drivers
5508	Street or road construction, rock excavation & drivers
5538	Sheet metal work erection NOC & drivers
5551	Roofing (all kinds) & drivers
5606	Contractor - executive supervisors
5610	Cleaner - engaged in removal of debris
5645	Carpentry - in the construction of detached private residences
5651	Carpentry - in the construction of dwellings not exceeding three stories in height
5703	Building raising or moving & drivers
5705	Salvage operation - removing, sorting, reconditioning & distributing merchandise in building
6003	Pile driving & drivers
6005	Jetty or breakwater construction & drivers
6017	Concrete work in connection with dams or locks - all types
6018	Earth moving or placing in connection with dams or locks - all types
6045	Levee construction & drivers
6217	Excavation & drivers
6229	Irrigation or drainage system construction & drivers
6251	Tunneling (not pneumatic)
6252	Shaft sinking (all work to completion)/Caisson work (all work to completion)
6306	Sewer construction (all operations) & drivers
6319	Gas mains or connections construction & drivers
6325	Conduit construction for cables or wires & drivers

6400	Fence construction (metal)
7538	Electric light or power line construction & drivers
7601	Telephone, telegraph or fire alarm line construction & drivers
7855	Railroad construction: maintenance of way by contractors & drivers
8227	Construction or erection permanent yard for maintenance of equipment or storage of material
9534	Mobile crane & hoisting service contractors NOC (All operations/yard employees)

[4-1-92; 13.17.6.8 NMAC – Rn & A, 13 NMAC 17.6.8, 5-15-01]

13.17.6.9 ADMINISTRATIVE REQUIREMENTS:

The premium credit program shall be administered in the following manner:

A. Each workers' compensation carrier shall issue a premium credit application form for each qualifying policy. This form must be issued by each individual carrier and shall be sent to each insured employer prior to policy issuance or within sixty (60) days after the policy's effective date. The Superintendent shall approve such forms prior to their use. The carrier shall maintain proof of mailing in its files and shall make such proof available to the New Mexico Insurance Division upon request.

B. The employer shall complete the required information and shall mail the completed form to the WCSO not later than 180 days after the policy's effective date.

C. The WCSO shall compute the insured's average hourly wage for each qualifying classification and shall apply the percentage of premium credit using the criteria and Premium Credit Schedule established in this rule. These calculations shall be displayed on a Policy Credit Worksheet. The WCSO shall mail a copy of the completed worksheet to the insured's carrier.

D. The carrier shall use the applicable credits to calculate the insured's estimated premium at policy issuance.

E. The experience used to determine loss cost and/or manual rates for each classification shall be reflective of the premium credit program in subsequent rate filings.

F. The applicable premium credits shall be reflected in the experience rating and ARAP calculations.

G. Standard earned premium reported to the WCSO on the aggregate call for experience must include the effects of premium credits.

[4-1-92; 13.17.6.9 NMAC – Rn & A, 13 NMAC 17.6.9, 5-15-01]

13.17.6.10 AUDIT; PREMIUM CREDIT REVISION:

Upon audit at the end of the policy term, the carrier shall use the same credits in the calculation of the insured's final earned premium, provided that the carrier may verify the original qualification criteria as well as the data originally provided by the insured for the computation of the premium credits by reviewing those records upon which the insured's data were originally based. If this process uncovers any errors, revised payroll and/or hours worked data must be submitted to the WCSO. The carrier shall use the revised data to calculate corrected premium credits and revised premium.

[4-1-92; 13.17.6.10 NMAC – Rn & A, 13 NMAC 17.6.10, 5-15-01]

13.17.6.11 CALCULATION OF AVERAGE HOURLY WAGE AND PREMIUM CREDIT:

The average hourly wage and premium credit shall be calculated in the following manner:

A. The average hourly wage for each policy's qualifying classifications shall be determined by dividing the total payroll or remuneration for each classification by the number of actual hours worked.

B. Total payroll and hours worked during the third calendar quarter of the year preceding the policy effective date as reported to taxing authorities shall be utilized in determining average hourly wage. If the insured did not engage in operations for the complete quarter, then the first complete quarter after policy inception shall be used.

C. In the absence of specific employer records demonstrating actual hours worked for a given employee, remuneration for such an employee shall not be included in the determination of average hourly wage, and the premium attributable to such remuneration shall not be subject to the premium credit program.

D. The percentage credit to be applied to the manual rate shall be determined separately for each classification, and shall initially be in accordance with the following Premium Credit Schedule until the schedule is amended pursuant to subsection F of this section:

INITIAL PREMIUM CREDIT SCHEDULE

Average Hourly Wage	Credit From Manual Premium	Average Hourly Wage	Credit From Manual Premium
$10.99 or less	None	$14.50 - $14.99	13%
$11.00 - $11.49	6%	$15.00 - $15.49	14%
$11.50 - $11.99	7%	$15.50 - $15.99	15%
$12.00 - $12.49	8%	$16.00 - $16.49	16%
$12.50 - $12.99	9%	$16.50 - $16.99	17%
$13.00 - $13.49	10%	$17.00 - $17.49	18%
$13.50 - $13.99	11%	$17.50 - $17.99	19%
$14.00 - $14.49	12%	$18.00 and above	20%

E. The credit shall be calculated for each qualifying classification utilizing the percentage credit determined in accordance with subsection D of this section. The discounted rates shall then be utilized to develop the manual premium.

F. By September 1 of each year beginning in 1992, the WCSO shall file for approval by the Superintendent an amended Premium Credit Schedule to adjust the starting and ending points for each of the wage groups in increments of $.10 to reflect any increase or decrease in the maximum compensation rate for total disability as established pursuant to NMSA 1978 Section 52-1-41. To determine the updated starting point for a wage increment, the previous starting point shall be adjusted by a percentage equal to the percentage increase in the maximum compensation rate for total disability. The result shall be rounded to the nearest $.10. No amendment of this rule shall be necessary in order to implement an adjustment made pursuant to this section.

[4-1-92; 13.17.6.11 NMAC – Rn & A, 13 NMAC 17.6.11, 5-15-01]

13.17.6.12 PERIODIC UPDATING OR REVISION:

Pursuant to NMSA 1978 Section 59A-17-8D the rate classification system relied on for workers' compensation shall be updated and revised periodically to reflect changes in the workplace.

[4-1-92; 13.17.6.12 NMAC – Rn & A, 13 NMAC 17.6.12, 5-15-01]

13.17.6.13 REVIEW:

A. By rate service organization or insurer. Any rating determination made pursuant to this rule may be appealed as provided in NMSA 1978 Section 59A-17-30B.

B. By Superintendent. Any other determination or decision made pursuant to this rule may be reviewed by requesting a hearing pursuant to NMSA 1978 Section 59A-4-15.

4-1-92; 13.17.6.13 NMAC – Rn & A, 13 NMAC 17.6.13, 5-15-01]

13.17.6.14 PENALTIES:

The Superintendent may revoke, suspend or refuse to continue the license or certificate of authority of any person who fails to comply with this rule and may impose such other applicable administrative penalties as may be authorized by the Insurance Code.

[4-1-92; 13.17.6.14 NMAC – Rn, 13 NMAC 17.6.14, 5-15-01]

CHAPTER 18: CREDIT INSURANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: CREDIT LIFE AND CREDIT HEALTH INSURANCE

13.18.2.1 ISSUING AGENCY:

New Mexico Public Regulation Commission Insurance Division.

[7/1/97; 13.18.2.1 NMAC - Rn & A, 13 NMAC 18.2.1, 12/31/07]

13.18.2.2 SCOPE:

This rule applies to all life insurance and accident and health insurance sold in connection with loans or other credit transactions, except such insurance sold in connection with a loan or other credit transaction of more than ten (10) years' duration, and except for such insurance the issuance of which is an isolated transaction on the part of the insurer not related to an agreement or plan for insuring debtors of the creditor.

[7/1/97; 13.18.2.2 NMAC - Rn, 13 NMAC 18.2.2, 12/31/07]

13.18.2.3 STATUTORY AUTHORITY:

Section 59A-2-9, NMSA 1978.

[7/1/97; 13.18.2.3 NMAC - Rn , 13 NMAC 18.2.3, 12/31/07]

13.18.2.4 DURATION:

Permanent.

[7/1/97; 13.18.2.4 NMAC - Rn, 13 NMAC 18.2.4, 12/31/07]

13.18.2.5 EFFECTIVE DATE:

July 1, 1997, unless a later date is cited at the end of a section or paragraph.

[7/1/97; 13.18.2.5 NMAC - Rn, 13 NMAC 18.2.5, 12/31/07]

[Note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.18.2.6 OBJECTIVE:

The purpose of this rule is to implement the Law for Regulation of Credit Life Insurance and Credit Health Insurance, Sections 59A-25-1 to 59A-25-14 NMSA 1978.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.6 NMAC - Rn, 13 NMAC 18.2.6, 12/31/07]

13.18.2.7 DEFINITIONS:

A **"Account"** means the aggregate credit life insurance or credit accident and health coverage for a single plan of insurance for a single class of business written through a single creditor, or written through more than one creditor under common control or ownership, by the insurer, whether coverage is written on a group or individual basis.

B. **"Average number of life years"** means the average of the number of group certificates or individual policies in force each month during the experience period (without regard to multiple coverage) times the number of years in the experience period.

C. **"Case"** means either a single account case or a multiple account case as follows.

(1) Single account case means an account that is at least 25 percent credible or, at the option of the insurer, any higher percentage as determined by the credibility table. An insurer exercising this option must notify the superintendent, in writing, of the credibility factor it will use to define a single account case. Once the superintendent is so notified, the credibility factor will remain in effect for the insurer until a different election has been filed in writing by the insurer and approved by the superintendent.

(2) Multiple account case means a combination of all the insurer's accounts of the same plan of insurance and class of business which combination has experience in this state, excluding all single account cases defined in (1) above, or with the approval of the superintendent, multiple account case also means two or more accounts of the insurer having like underwriting characteristics which are combined by the insurer for premium rating purposes, excluding all single account cases defined in (1) above and other multiple account cases defined above.

D. **"Claims incurred"** means the liability resulting from the happening of the contingency insured against, whether paid, reported, not reported or resisted on accounting dates, valued by the date of accounts and or amounts, excluding claims expenses, sufficient to discharge the company from all liability.

E. **"Class of business"** means one of the following determined by the source of the business:

(1) credit unions;

(2) commercial banks and savings and loan association;

(3) finance companies;

(4) motor vehicle dealers;

(5) other sales finance;

(6) production credit associations;

(7) bank agricultural loans; or

(8) all others.

F. **"Credibility factor"** means the degree to which the past experience of a case can be expected to occur in the future. The credibility factor is based either on the average number of life years or the incurred claim count during the experience period as shown in the credibility table below. The insurer shall notify the superintendent, in writing, which of these two methods it will use in measuring credibility. Once the superintendent is so notified, the method will remain in effect for the insurer until a change has been filed and approved by the superintendent.

G. **"Earned premium"** means premium earned during the experience period at the presumptive rate.

H. **"Experience"** means the earned premium and incurred claims for a single or multiple account case. Experience will be the most recent experience in this state for a plan of insurance of a class of business, and may include the experience of the case while with a prior insurer to the extent necessary to achieve credibility.

I. **"Experience period"** means the period of time for which experience is reported, but not for a period longer than three years.

J. **"Incurred claims"** means the total claims incurred during the experience period.

K. **"Incurred claim count"** means the number of claims incurred for the case during the experience period. This means the total number of claims reported during the experience period (whether paid or in the process of payment) plus any incurred but not reported at the end of the experience period less the number of claims incurred but not reported at the beginning of the experience period. If a debtor has been issued more than one certificate for the same plan of insurance, only one claim is counted. If a debtor receives disability benefits, only the initial claim payment for that period of disability is counted.

L. **"Open-end credit"** means consumer credit extended by a creditor under a plan in which:

(1) the creditor reasonably contemplates repeated transactions;

(2) the creditor may impose a finance charge from time to time on an outstanding unpaid balance; and

(3) the amount of credit that may be extended to the consumer during the term of the plan (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

M. **"Plan of insurance"** means a plan of credit life insurance or a plan of credit accident and health insurance for which rates are prescribed in 13.18.2.18 NMAC or 13.18.2.26 NMAC.

N. **"Premiums earned"** means the total gross premiums which become due the insurance company, adjusted only to reflect premiums refunded or adjusted on account of termination of coverage, appropriately adjusted for charges in unearned premiums. Unearned premiums, for the purpose of determining premiums earned shall be calculated as described in 13.18.2.35 NMAC for the purpose of determining refunds.

[7/1/97; 13.18.2.7 NMAC - Rn, 13 NMAC 18.2.7, 12/31/07]

13.18.2.8 TERMINATION UPON DISCHARGE OF INDEBTEDNESS:

Each individual policy or group certificate of credit life insurance or credit accident and health insurance delivered or issued for delivery in this state shall, in addition to the other requirements of law, contain a statement indicating that upon discharge of the indebtedness the insurance shall be terminated, but without prejudice to any claim originating prior to such termination, and that in all cases of termination prior to scheduled maturity, a refund of any unearned premium paid by or charged to the debtor for insurance shall be made in accordance with the appropriate formula set forth in 13.18.2.35 NMAC. Such refund shall be paid or credited to the debtor or paid to the second beneficiary if the debtor is not living. No such refund is required if the total amount of the refund is three dollars ($3.00) or less.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.8 NMAC - Rn, 13 NMAC 18.2.8, 12/31/07]

13.18.2.9 CONTINUATION OF ACCIDENT AND HEALTH INSURANCE BENEFITS:

If an accident and health insurance claim is in progress at the time of discharge of indebtedness, such claim shall continue during the originally scheduled term of insurance, as if there has been no such discharge of indebtedness.

[7/1/97; 13.18.2.9 NMAC - Rn, 13 NMAC 18.2.9, 12/31/07]

13.18.2.10 REFUND OF PREMIUMS:

A. Upon the termination of such continuing claim within the original scheduled term of insurance a refund shall be made of any then unearned premium. If, however, during the pendency of an accident and health insurance claim the insurer elects to prepay and discharge the full remaining balance thereon immediately in one payment, the accident

and health premium paid or then due and payable to the insurer is earned and no refund is required.

B. In the case of termination of credit life insurance in which death benefits are not payable due to the exclusions in the policy, the insurer will refund the unearned premium in accordance with 13.18.2.35 NMAC. In the case of termination of credit life insurance by payment of death benefits, the life insurance premiums paid or then due and payable to the insurer are deemed earned and no refund thereof is required; however, in such instances the accident and health premium is not deemed earned and shall be refunded to the second beneficiary in accordance with 13.18.2.35 NMAC.

[7/1/97; 13.18.2.10 NMAC - Rn, 13 NMAC 18.2.10, 12/31/07]

13.18.2.11 PAYMENTS OF BENEFITS TO THE INSURED:

A. Excess benefit checks or drafts made in accordance with Section 59A-25-7B NMSA 1978 shall be delivered only by the insurer or, at the option of the insurer, by the creditor. In any case, the insurer shall be responsible for the delivery of such excess benefit checks or drafts. Electronic funds transfers may be used.

B. The creditor agent or group policyholder shall not require that any benefit be applied to the reduction of any indebtedness other than the indebtedness in connection with which the insurance was written.

C. Notice of payments under credit life insurance shall be provided to the insureds' estate. The insured shall be provided notice of initiation of benefits under a credit accident and health insurance policy along with a statement that such benefits will continue while the insured is disabled under the terms of the insurance policy. The insurer shall be responsible for such notice; however, such duty may be delegated to the creditor provided the insurer maintains the responsibility for seeing that these notice requirements are met.

D. Benefit checks or drafts payable to a beneficiary or an insured may not be offset by any insurer against amounts due from a creditor or an agent to the insurer or anyone acting on behalf of the insurer unless the benefit check or draft is endorsed by the beneficiary or the insured to whom it was made payable.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.11 NMAC - Rn, 13 NMAC 18.2.11, 12/31/07]

13.18.2.12 POLICY PROVISIONS:

A. The policy or certificate shall not contain provisions which would encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive, or contrary to the law of this state.

B. Provisions in individual policies or group certificates pertaining to underwriting rules, conditions of eligibility or issue, or maximum amounts or terms of insurance may be used only to determine initial eligibility and may not, except as provided herein, be used as the basis for the termination or reduction of coverage or the denial of claims.

C. The policy may state that if coverage is issued in excess of a maximum amount or term limitation, the insurer has the right, within ninety days of effective date of coverage, to reduce the excess coverage and refund the charge for excess insurance, or terminate the coverage and refund the full charge for insurance, provided such adjustment is accomplished and the appropriate refund is made prior to the incurred date of any claim under such coverage.

D. The policy may state that if a debtor exceeds the eligibility age defined in Subsection B of 13.18.2.22 NMAC for credit life and Subsection D of 13.18.2.27 NMAC for credit accident and health, and has not incorrectly stated his or her age in writing, and the coverage is issued in error, the insurer has the right, within ninety days of the effective date of coverage, to terminate the coverage and refund the full charge for insurance, provided such termination is accomplished and the appropriate refund is made prior to the incurred dated of any claim under such coverage.

E. Coverage issued in connection with open-end transactions may contain provisions limiting the maximum amount of insurance which may become effective thereunder, and may contain provisions for automatic termination of coverage upon the attainment of a specified age of 72.

F. Nothing herein is intended to preclude an insurer, during the contestable period, from contesting coverage on the basis of a material misstatement by a debtor, subject to the requirement that the misstatement must be contained in a written statement signed by the debtor, and a copy of the statement must be furnished to the debtor or to his or her beneficiary.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.12 NMAC - Rn, 13 NMAC 18.2.12, 12/31/07]

13.18.2.13 INSURANCE FOR PERIODS BEYOND PAYMENT PERIOD OF THE POLICY:

A. If a group certificate of insurance is issued to a debtor under any plan charging the debtor an identifiable amount for insurance for a period of time greater than that of the shortest premium payment period of the group policy issued to the creditor, the following rules shall apply.

B. The certificate shall in addition to all other requirements of this rule and the laws of this state, clearly and prominently set forth that:

(1) the creditor alone is liable for such excess charges as are unearned;

(2) the insurance company is not liable for such excess unearned charges not received;

(3) the liability of the insurance company for the benefit is on a month to month basis, or otherwise as set out in the group policy of insurance;

(4) the coverage may be terminated by the insurance company or the creditor upon thirty days written notice to the debtor;

(5) the insurer is not liable for claims beyond such interval; and

(6) the certificate shall be so phrased as not to violate the public policy of the state of New Mexico not to indicate to the ordinary debtor that the insurance coverage had been provided commensurate to the identifiable charge appearing upon the certificate for the full term of the indebtedness nor that the insurer would be obligated to the debtor for any such excess unearned charges.

[7/1/97; 13.18.2.13 NMAC - Rn, 13 NMAC 18.2.13, 12/31/07]

13.18.2.14 GROUP POLICY TERMINATION PROVISIONS:

The following provisions apply to termination of coverage under a group policy.

A. If a debtor is covered by a group credit insurance policy providing for the payment of a single premium to the insurer, the master policy and certificate shall provide that in the event of termination of the group policy for any reason, insurance coverage with respect to any debtor then insured under such policy shall be continued for the entire period for which the single premium has been paid, subject to the provisions of the policy relative to early termination of a debtor's insurance.

B. If a debtor is covered by a group credit insurance policy providing for payment of premium to the insurer on a monthly outstanding balance basis, then the policy and certificate shall provide that, in the event of termination of such group policy for any reason, the insured debtor shall be given written notice that coverage will continue for thirty (30) days from the date of such notice, except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without interruption of coverage and a new certificate reflecting such replacement coverage is delivered to such debtor. The notice of termination required by this paragraph shall be given by the insurer or, at the option of the insurer, by the creditor.

[7/1/97; 13.18.2.14 NMAC - Rn, 13 NMAC 18.2.14, 12/31/07]

13.18.2.15 INSURED FINANCE CHARGES, ETC:

If the creditor adds identifiable insurance charge or premiums for credit insurance to the indebtedness, and any direct or indirect finance, carrying credit or service charge is

made to the debtor on such insurance charge or premiums, the charge to the debtor shall be of the same mode and in an amount not to exceed the insurer's charge.

[7/1/97; 13.18.2.15 NMAC - Rn, 13 NMAC 18.2.15, 12/31/07]

13.18.2.16 OPEN END TRANSACTIONS:

The following rules shall apply to open-end transaction forms.

A. The policy and certificate must be identified when used for open-end transactions by either a form number followed by the suffix (25-OE) or a check-off block and may be used for coverage of any other types of indebtedness if previously approved by the superintendent.

B. The premiums paid by the creditor and any insurance charges paid by the debtor for such insurance must be at the same mode.

C. If the insurer imposes conditions of insurability for an increase in coverage, then the policy must state such conditions. The conditions must be consistent with 13.18.2.25 NMAC and 13.18.2.28 NMAC of this rule.

D. If the disability benefit for an open-end indebtedness is based upon a minimum payment, then the method of determining the minimum payment must be stated in the policy.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.16 NMAC - Rn, 13 NMAC 18.2.16, 12/31/07]

13.18.2.17 FILING OF FORMS AND RATES:

A. Every insurance company, when submitting a schedule of rates for consideration by the superintendent of insurance, shall identify the rates to be used with the policy form submitted for approval. In the alternative, specific reference in the case of each submission shall be made to the particular schedule of rates, or portions thereof, which are applicable to the specific policy form. The face and face page of every form or schedule submitted to the superintendent of insurance for his consideration under Article 25, New Mexico Insurance Code, shall have added to its identifying number the additional identification (25). Such additional identification shall appear on issued copies of such forms.

B. Tests for reasonableness of premiums.

(1) The benefits of credit life insurance, individual or group, shall be considered to be reasonable in relation to the premium charged if it can reasonably be anticipated that a loss ratio of claims incurred to premiums earned of not less than 55 percent will be developed.

(2) The benefits of credit accident and health insurance, individual or group, shall be considered to be reasonable in relation to the premiums charged if it can reasonably be anticipated that a loss ratio of claims incurred to premiums earned of not less than 55 percent will be developed.

C. Any individual policy, application, group policy, group certificate, or notice or proposed insurance shall be in full compliance with the law and this rule.

D. Any insurer contracting with creditor policyholders, agents, general agents, sub-agents, or any other representative(s) who in the aggregate are paid based upon the production of credit life or credit accident and health insurance premiums, individual or group, if the compensation is based upon production of such insurance where the aggregate of all such compensation exceeds 45 percent of the aggregate premiums within a calendar year shall be presumed by the superintendent to be in automatic violation of the required minimum loss ratios stated in this rule without the need of any other proof.

E. Each violation of the minimum loss ratios required by now Paragraph (1) of Subsection B of 13.18.2.17 NMAC for credit life insurance or Paragraph (2) of Subsection B of 13.18.2.17 NMAC for credit accident and health insurance that occurs due to compensation exceeding the amount set out in Subsection D of 13.18.2.17 NMAC is subject to the penalties of Section 59A-1-18 NMSA 1978.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.17 NMAC - Rn, 13 NMAC 18.2.17, 12/31/07]

13.18.2.18 PRESUMPTIVELY ACCEPTABLE CREDIT LIFE INSURANCE PREMIUMS (PRIMA FACIE RATES):

The superintendent of insurance may presume (subject, however, to a rebuttal of the presumption) that the benefits of a credit life insurance policy are reasonable in relation to the premium charged if the premium rate for death benefits as filed does not exceed an amount equal, or actuarially equivalent, to the following rates.

A. Coverage on a single life provided on the outstanding indebtedness basis: $0.84 per month per $1,000.00 of outstanding balance indebtedness.

B. Coverage on a single life on the single premium basis:

(1) $0.52 per year of coverage per $100.00 of initial insured indebtedness for all credit transactions when the insured indebtedness is payable in substantially equal monthly installments during the term of coverage; and

(2) $1.00 per year of coverage per $100.00 of level life insurance where the amount of insured indebtedness remains level during the term of coverage and is repayable in a single sum at the end of the term.

C. Coverage on joint lives on the outstanding indebtedness basis: $1.26 per month per $1,000.00 of outstanding balance indebtedness.

D. Coverage for joint lives on the single premium basis:

(1) $0.78 per year of coverage per $100.00 of initial insured indebtedness for all credit transactions when the insured indebtedness is repayable in substantially equal monthly installments during the term of coverage; and

(2) $1.50 per year of coverage per $100.00 of level life insurance where the amount of insured indebtedness remains level during the term of coverage and is repayable in a single sum at the end of the term.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.18 NMAC - Rn, 13 NMAC 18.2.18, 12/31/07]

13.18.2.19 USE OF JOINT CREDIT LIFE INSURANCE:

Joint lives as used in Subsections C and D of 13.18.2.18 NMAC above means only spouses or business partners, and such person must be jointly and severally liable for repayment of the single indebtedness and be joint signers of the instrument of indebtedness. Endorsers and guarantors are not eligible for credit insurance coverage. Joint life coverage shall not be written covering more than two lives. Jointly indebted persons shall not both be covered separately at single life rates.

[7/1/97; 13.18.2.19 NMAC - Rn, 13 NMAC 18.2.19, 12/31/07]

13.18.2.20 COMPOSITE SINGLE JOINT OUTSTANDING BALANCE RATE (PRIMA FACIE):

A. Joint life rates may not be charged for single life coverage, except that a composite single joint outstanding balance life rate may be used for open-end accounts where more than 50 percent of a creditor's open-end accounts are held jointly. Such rate shall be completed as follows: COB = .84 (PSA) - 1.26 (PJA), where:

(1) COB = composite outstanding balance life rate per $1,000 per month;

(2) PSA = percentage of open-end accounts held by a single person expressed as a decimal fraction (for the first year, use all accounts; for subsequent years, use insured accounts);

(3) PJA = percentage of revolving accounts held jointly expressed as a decimal fraction (for the first year, use all accounts; for subsequent years, use insured accounts).

B. Composite rates shall be recomputed when the percentage of insured account jointly held drops by more than ten percentage points below the percentage used to

compute the composite rate. Composite rates shall be discontinued when the percentage of insured accounts jointly held drops below 50 percent. Recomputation or discontinuance shall be effective within six months of the end of the policy year in which the changes requiring such action occurred.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.20 NMAC - Rn, 13 NMAC 18.2.20, 12/31/07]

13.18.2.21 ACTUARIAL EQUIVALENT PREMIUM FOR UNEQUAL MONTHLY INSTALLMENTS:

Premiums and premium rates for insurance concerning obligations payable in other than substantially equal monthly installments during the period of coverage, or for coverage which declines on other than a straight line basis, shall be determined in a manner which produces a rate not exceeding the actuarial equivalent of the foregoing rates.

[7/1/97; 13.18.2.21 NMAC - Rn, 13 NMAC 18.2.21, 12/31/07]

13.18.2.22 INSURABILITY REQUIREMENTS PERMITTED:

The presumptively reasonable premiums for credit life insurance shall apply only to plans containing provisions consistent with the following.

A. That the credit life insurance contract may require submission of the debtor's written and signed evidence of the debtor's insurability or that the debtor be in gainful employment at the time the insurance becomes effective, or both, on a form filed with and approved by the superintendent of insurance, and that such contract contains no conditions for validity of insurance more restrictive than contestability based on material misrepresentation and no exclusions other than for suicide, flight in nonscheduled aircraft, and war or military hazard.

B. The insurer must require and be responsible in its contract with the group policyholder and the creditor that proof be retained for three years following the offer by the creditor, group policyholder or the insurer and made available for examination by the superintendent that credit life insurance coverage is provided or offered to all debtors not older than the applicable age limit without age discrimination. The applicable age limit for credit life using presumptively acceptable credit life premiums shall not be less than the attained age of 70 years if such limit applies to the age when the insurance is issued, or not less than the attained age of 72 if such limit applies to the age on the scheduled maturity date of debt. Coverage issued in connection with open-end transactions may contain a provision for automatic termination of coverage upon attainment of a specified age, which shall not be less than 72. The use of any other age limits will require that premiums be filed under the deviation procedures in this rule.

[7/1/97, 3/1/98, 6/1/98, 9/1/98; 13.18.2.22 NMAC - Rn, 13 NMAC 18.2.22, 12/31/07]

13.18.2.23 PREMIUM RATE ADJUSTMENTS FOR AGE BRACKETS:

If the premiums are determined according to the age of the insured debtor or by age brackets, appropriate adjustments in the rate and premium may be made according to age if such adjustments are actuarially consistent with the foregoing rates when applied regardless of actual age at issue and if such adjustments produce an aggregate premium not greater than that produced by the foregoing rates, and such rates and actuarially consistent computations are filed with and approved by the superintendent of insurance.

[7/1/97; 13.18.2.23 NMAC - Rn, 13 NMAC 18.2.23, 12/31/07]

13.18.2.24 PREMIUM RATES FOR OTHER LAWFUL BENEFITS:

If a contract of insurance includes other lawful benefit or benefits for which standards of reasonableness of benefits in relation to premiums are not elsewhere in this rule determined or described, any premium charged therefor shall be shown to the satisfaction of the superintendent of insurance to be based upon credible data and shall meet the basic test of reasonableness described in Subsection B of 13.18.2.17 NMAC of this rule.

[7/1/97; 13.18.2.24 NMAC - Rn, 13 NMAC 18.2.24, 12/31/07]

13.18.2.25 INSURABILITY REQUIREMENTS PERMITTED FOR INCREASED OPEN-ENDED CREDIT LIFE INSURANCE:

If a debtor has credit life insurance under an open-end outstanding balance policy, the policy may provide that an increase in the amount of insurance because of an increase in the amount of indebtedness will be subject to conditions of insurability. Any policy provision regarding evidence of insurability for an increase will comply with the following.

A. No charge for or cost of any such additional coverage will be incurred by any debtor, except by voluntary acceptance of the coverage and submission of such lawful statement as is required by the insurer. Voluntary acceptance will not be deemed to have occurred except by a specific positive written response by the debtor to a notice of availability of the coverage; it may not be automatic subject to an act of rejection or notification by the debtor.

B. The effective date of any such increase in coverage may be either of the following:

(1) the date on which the indebtedness is increased. In this event, however, if specific positive written response is not received within 75 days of such increase, or if such response is not satisfactory to the insurer, then the additional insurance shall not be effective, and any premium which has been paid therefore shall be refunded or

credited to the account of the debtor not more than 90 days after the increase in indebtedness; any claim which occurs when positive response has not been received, but before the date by which such response must be received, will be paid if the debtor was eligible for the insurance under the terms of the policy; if the premium has been paid, but not refunded or credited to the account of the debtor not more than 90 days after the increase in indebtedness, the insurance shall be effective regardless of the eligibility of the debtor; or

(2) the date on which specific positive written response satisfactory to the insurer is received by the insurer;

(3) nothing herein shall preclude a policy provision prohibiting any increases in the amount of insurance while the insured is disabled.

[7/1/97; 13.18.2.25 NMAC - Rn, 13 NMAC 18.2.25, 12/31/07]

13.18.2.26 PRESUMPTIVELY ACCEPTABLE RELATION OF CREDIT ACCIDENT AND HEALTH BENEFITS TO PREMIUMS (PRIMA FACIE):

A. The superintendent may presume (subject, however, to a rebuttal of the presumption) that the benefits of an accident and health insurance form are reasonable in relation to the premium charged if the premium rate schedule for such accident and health benefits, as filed, does not exceed an amount equal to, or actuarially consistent with the following rate:

CREDIT ACCIDENT AND HEALTH INSURANCE

SINGLE PREMIUM RATE PER $100 OF INITIAL INSURED INDEBTEDNESS

ORIGINAL NUMBER OF EQUAL MONTHLY INSTALLMENTS	BENEFITS PAYABLE AFTER THE 14TH DAY OF DISABILITY		BENEFITS PAYABLE AFTER THE 30TH DAY OF DISABILITY	
	RETROACTIVE TO THE FIRST DAY	NON-RETROACTIVE	RETROACTIVE TO THE FIRST DAY	NON-RETROACTIVE
3	0.73	0.51		
4	0.95	0.67		
5	1.17	0.84		
6	1.34	1.01	0.94	0.63
7	1.42	1.13	1.03	0.72
8	1.49	1.20	1.11	0.81
9	1.54	1.26	1.18	0.88
10	1.60	1.31	1.26	0.95

11	1.66	1.37	1.30	1.01
12	1.70	1.41	1.34	1.07
13	1.75	1.45	1.39	1.12
14	1.80	1.50	1.44	1.17
15	1.86	1.54	1.50	1.22
16	1.91	1.58	1.55	1.26
17	1.97	1.61	1.61	1.31
18	2.02	1.64	1.66	1.35
19	2.08	1.67	1.72	1.39
20	2.13	1.70	1.77	1.44
21	2.18	1.73	1.82	1.46
22	2.23	1.76	1.87	1.48
23	2.30	1.79	1.94	1.51
24	2.34	1.82	1.98	1.53
25	2.40	1.85	2.03	1.54
26	2.45	1.87	2.09	1.56
27	2.51	1.90	2.14	1.58
28	2.56	1.94	2.18	1.60
29	2.62	1.98	2.23	1.63
30	2.66	2.03	2.29	1.67
31	2.73	2.09	2.34	1.71
32	2.78	2.14	2.39	1.75
33	2.83	2.19	2.45	1.79
34	2.88	2.24	2.50	1.83
35	2.94	2.30	2.54	1.88
36	2.99	2.34	2.59	1.92
37	3.02	2.38	2.63	1.96
38	3.05	2.42	2.66	2.01
39	3.07	2.45	2.70	2.05
40	3.10	2.49	2.73	2.09
41	3.13	2.52	2.76	2.13
42	3.16	2.56	2.79	2.18
43	3.18	2.59	2.82	2.22
44	3.21	2.63	2.86	2.26
45	3.24	2.66	2.89	2.30
46	3.26	2.70	2.93	2.34
47	3.29	2.74	2.95	2.38
48	3.31	2.78	2.99	2.43
49	3.34	2.80	3.02	2.48
50	3.37	2.82	3.05	2.54
51	3.38	2.85	3.07	2.59
52	3.41	2.87	3.10	2.64
53	3.44	2.90	3.13	2.68
54	3.46	2.92	3.16	2.75
55	3.48	2.94	3.18	2.79
56	3.51	2.97	3.21	2.83

57	3.53	2.99	3.24	2.89
58	3.55	3.02	3.26	2.94
59	3.58	3.04	3.29	3.00
60	3.60	3.06	3.31	3.04
61	3.62	3.09	3.34	3.07
62	3.66	3.11	3.38	3.08
63	3.67	3.14	3.39	3.11
64	3.70	3.16	3.42	3.12
65	3.73	3.18	3.46	3.15
66	3.74	3.21	3.48	3.16
67	3.77	3.23	3.50	3.19
68	3.80	3.26	3.53	3.20
69	3.82	3.28	3.56	3.23
70	3.84	3.30	3.59	3.24
71	3.87	3.33	3.61	3.27
72	3.89	3.35	3.64	3.29
73	3.91	3.38	3.67	3.31
74	3.94	3.40	3.70	3.32
75	3.96	3.42	3.72	3.35
76	3.98	3.45	3.74	3.38
77	4.02	3.47	3.78	3.39
78	4.03	3.50	3.81	3.41
79	4.06	3.52	3.82	3.44
80	4.09	3.54	3.86	3.46
81	4.10	3.57	3.89	3.48
82	4.13	3.59	3.91	3.50
83	4.16	3.62	3.94	3.52
84	4.18	3.64	3.98	3.55
85	4.20	3.66	3.99	3.56
86	4.23	3.69	4.02	3.59
87	4.25	3.71	4.04	3.62
88	4.27	3.74	4.07	3.65
89	4.30	3.76	4.10	3.66
90	4.32	3.78	4.13	3.69
91	4.34	3.81	4.15	3.71
92	4.38	3.83	4.18	3.73
93	4.39	3.86	4.21	3.75
94	4.42	3.88	4.24	3.78
95	4.45	3.90	4.26	3.81
96	4.46	3.93	4.29	3.83
97	4.49	3.95	4.32	3.85
98	4.52	3.98	4.34	3.88
99	4.54	4.00	4.37	3.91
100	4.56	4.02	4.39	3.93
101	4.59	4.05	4.42	3.96
102	4.61	4.07	4.46	3.98

103	4.63	4.10	4.47	4.01
104	4.66	4.12	4.50	4.03
105	4.68	4.14	4.54	4.06
106	4.70	4.17	4.56	4.09
107	4.74	4.19	4.58	4.11
108	4.75	4.22	4.61	4.13
109	4.78	4.24	4.64	4.16
110	4.81	4.26	4.67	4.19
111	4.82	4.29	4.69	4.21
112	4.85	4.31	4.72	4.25
113	4.88	4.34	4.75	4.28
114	4.90	4.36	4.78	4.30
115	4.92	4.38	4.80	4.33
116	4.95	4.41	4.82	4.36
117	4.97	4.43	4.86	4.38
118	4.99	4.46	4.89	4.41
119	5.02	4.48	4.90	4.45
120	5.04	4.50	4.94	4.46

B. A monthly premium of $0.15 per $100 of outstanding balance may be presumed reasonable for a disability benefit which consists of a lump sum payment of the amount of indebtedness covered at the beginning of disability, such payment to be made after disability has continued for 90 consecutive days. A daily benefit does not apply to this coverage.

C. Except for credit accident and health insurance sold in connection with open-end loans, the rates for premiums payable on other than a single premium basis shall be actuarially consistent with the rates set forth in Subsection A of 13.18.2.26 NMAC above. Such premium rates will be deemed actuarially consistent with the foregoing single premium rates if such rates produce a total premium for any duration and amount of insurance equal to the corresponding single premium for the same duration and amount of insurance. Rates computed according to the following formula are presumed to satisfy this requirement: Op = 20SPn/n+1, where:

(1) *SPn* = single premium rate per $100 of initial indebtedness repayable in "n" installments;

(2) *Op* = monthly outstanding balance premium rate per $1,000;

(3) *n* = original repayment period, in months.

D. In credit accident and health insurance sold in connection with open-end transactions or monthly closed-end transactions, the superintendent may presume (subject, however, to a rebuttal of the presumption) that the benefits are reasonable in

relation to the premium charged if the premium rate schedule for such accident and health insurance transactions does not exceed an amount equal to, or actuarially consistent with, the following rates:

(1) benefits payable after the 14th day of disability:

(a) retroactive to first day: $0.19 per month per $100 of outstanding balance insured indebtedness;

(b) non-retroactive: $0.15 per month per $100 of outstanding balance insured indebtedness;

(2) benefits payable after the 30th day of disability:

(a) retroactive to first day: $0.16 per month per $100 of outstanding balance insured indebtedness;

(b) non-retroactive: $0.11 per month per $100 of outstanding balance insured indebtedness.

E. The premium in Paragraphs (1) and (2) of Subsection D of 13.18.2.26 NMAC above are based upon the assumption that benefits will be paid as long as there is an outstanding balance and the insured is disabled. If there is a provision that benefit payment may cease during the disability of the insured before the indebtedness outstanding on the date of disability, including interest on such indebtedness, is retired, then these premiums will be adjusted to reflect, in the opinion of the superintendent of insurance, the effect of such provision.

F. If a contract of insurance includes other lawful benefit or benefits for which standards of reasonableness of benefits in relation to premium are not elsewhere in this rule determined or described, any premium charged therefor shall be shown to the satisfaction of the superintendent to be based upon credible data and shall meet the basic tests of reasonableness described in Paragraphs (1) and (2) of Subsection B of 13.18.2.17 NMAC.

[7/1/97, 3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.26 NMAC - Rn, 13 NMAC 18.2.26, 12/31/07]

13.18.2.27 STANDARD OF BENEFITS FOR CREDIT ACCIDENT AND HEALTH INSURANCE:

The standards and principles for the application of the rates set forth for credit accident and health insurance are as follows.

A. The initial amount of insured indebtedness to which the rate is applied shall not exceed the aggregate of the insured portion of the periodic scheduled unpaid installments of the indebtedness.

B. Except for open-end accounts, the indebtedness must be payable in substantially equal monthly or other periodic installments during the period of coverage.

C. The credit accident and health insurance contract may require written and signed evidence of insurability and, where offered, shall be offered to all eligible debtors and shall contain:

(1) no provision for validity of insurance more restrictive than contestability based on material misrepresentation; an insurer may not rely on material misrepresentation as a defense against the payment of a claim unless the insurer required the insured to sign a written statement in which the alleged misrepresentation was made;

(2) no provision which excludes or restricts liability in the event of disability caused in a specific manner or under specific condition, except that it may contain provisions excluding or restricting coverage in the event of:

(a) elective abortion;

(b) normal pregnancy, except complications of pregnancy;

(c) intentionally self-inflicted injuries;

(d) flight in nonscheduled aircraft;

(e) loss resulting from war or military service;

(3) provision for a daily benefit equal in amount to one-thirtieth (or other applicable fraction) of the scheduled monthly (or other specified mode of installment) payment or indebtedness;

(4) for the purpose of total disability insurance, a definition of total disability which provides coverage during the first 12 months of such disability even though the insured is able to perform an occupation other than the one he held at the time such disability occurred; during the first 12 months of each disability, the definition of total disability must relate such disability to the occupation of the debtor at the time the disability commenced; after disability continues for more than 12 months, the definition of total disability may relate such continuing disability to the inability to perform any occupation for which the debtor is reasonably fitted by education, training or experience.

D. The credit accident and health insurance must be offered to all debtors regardless of age, or to all debtors not older than the applicable age limit. The

applicable age limit shall not be less than the attained age of 66 years if such limit applies to the age when the insurance is issued, or not less than attained age 67 if such limit applies to the age on the scheduled maturity date of the debt. Coverage issued in connection with open-end transactions may contain a provision for the automatic termination of coverage upon the attainment of a specified age, which shall not be less than 67. The use of any other age limits will require that premiums be filed under the deviation procedures in this rule.

E. There shall be no provisions excluding or denying a claim for disability under credit accident and health insurance resulting from pre-existing conditions except for those conditions for which the insured debtor received medical diagnosis or treatment within six months immediately preceding the effective date of the debtor's coverage and which caused a period of loss within six months following the effective date of coverage; provided, however, that any subsequent period of disability resulting from such condition that commences or recommences more than six months after the effective date of the coverage shall be covered under the provisions of the policy. The effective date for each part of the insurance attributable to a different advance or charge to the account is the date on which the advance or charge is posted to the account of the debtor.

[7/1/97, 3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.27 NMAC - Rn, 13 NMAC 18.2.27, 12/31/07]

13.18.2.28 INCREASES IN OUTSTANDING BALANCE OPEN-END COVERAGE:

A. If a debtor has credit accident and health insurance under an open-end outstanding balance policy, the policy may provide that an increase in the insurance benefits because of an increase in the indebtedness will be subject to conditions of insurability. Any policy provision regarding evidence of insurability for an increase will comply with the following.

(1) No charge for or cost of any such additional coverage will be incurred by a debtor except by voluntary acceptance of the coverage and submission of such lawful statement as is required by the insurer. Voluntary acceptance will not be deemed to have occurred except by a specific positive written response by the debtor to a notice of availability of the coverage; it may not be made automatic subject to an act of a rejection or notification by the debtor.

(2) The effective date of any such increase in coverage may be either of the following:

(a) the date on which the indebtedness is increased: In this event, however, if specific positive response is not received within 75 days of such increase, or if such response is not satisfactory to the insurer, then the additional insurance shall not be effective, and any premium which has been paid therefore shall be refunded or credited to the account of the debtor not more than 90 days after the increase in indebtedness;

any claim which occurs when specific positive written response has not been received, but before the date by which such response must be received, will be paid if the debtor was eligible for the insurance under the terms of the policy; if the premium has been paid but not refunded or credited to the account of the debtor within 90 days after the increase in indebtedness the insurance shall be effective regardless of the eligibility of the debtor; or

(b) the date on which specific positive written response satisfactory to the insurer is received by the insurer.

B. Nothing herein shall preclude a policy provision prohibiting any increases in the amount of insurance while the debtor is disabled.

[7/1/97; 13.18.2.28 NMAC - Rn, 13 NMAC 18.2.28, 12/31/07]

13.18.2.29 DEVIATION PROCEDURES:

A. Notwithstanding the determination of presumptively acceptable maximum rates which are reasonable in relation to the benefits of a policy providing the coverage to which the rates are applicable:

(1) an insurer who has experienced excessive loss ratios for a case consisting of a single account or combination of accounts, as account is defined herein, will be permitted, at its own request, to adjust the premium rate or premium rate schedule for such case in accordance with the deviation procedures set out in the following; and

(2) an insurer who fails, on upward deviated accounts, or downward deviated accounts that modify the age limits downward as allowed in this rule to develop the minimum loss ratios as defined in Subsection B of 13.18.2.17 NMAC, for a case consisting of a single account or combination of accounts, as accounts is defined in this rule, will be required by the superintendent to adjust the premium rate or premium rate schedule for such case in accordance with the deviation procedures in this rule.

B. A request for a deviated rate must be made in writing and shall include all of the information which is required under this rule.

C. It must be accompanied by a list of the creditors whose experience is the basis for such request, and must be attested to by an officer of the insurer. The use of any deviation approved by the superintendent is limited to those creditors whose names appear on such list. No rate deviation may be used unless and until approved by the superintendent in writing. Any request for deviated presumptive rates shall be submitted to the superintendent in the manner prescribed on Form CI-DRF.

[7/1/97, 3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.29 NMAC - Rn, 13 NMAC 18.2.29, 12/31/07]

13.18.2.30 DEVIATION CREDIBILITY TABLE:

AVERAGE NUMBER OF LIFE YEARS

CREDIT LIFE	CREDIT ACCIDENT AND HEALTH PLANS RETROACTIVE AND NON-RETROACTIVE		INCURRED CLAIM COUNT	CREDIBILITY FACTOR
	14 DAY	30 Day		
1	1	1	1	.00
1,800	141	209	9	.25
2,400	188	279	12	.30
3,000	234	349	15	.35
3,600	281	419	18	.40
4,600	359	535	23	.45
5,600	438	651	28	.50
6,600	516	767	33	.55
7,600	394	884	38	.60
9,600	750	1,116	48	.65
11,600	906	1,349	58	.70
14,600	1,141	1,698	73	.75
17,600	1,375	2,047	88	.80
20,600	1,609	2,395	105	.85
25,600	2,000	2,977	123	.90
30,600	2,391	3,558	153	.95
40,000	3,125	4,651	200	1.00

A. For credit life insurance, the currently charged premium rates will be considered the case rates if the single premium (or its equivalent) case rate per $100 of initial amount of insured indebtedness repayable in 12 equal monthly installments as determined by the method described herein is within 5 percent of the corresponding premium under the currently charged premium rates for the case.

B. For credit accident and health insurance, the currently charged premium rates will be considered the case rate if the case rate as determined by the method described herein is within 5 percent of the currently charged premium rates for the case.

C. The effective date for any rate deviation shall be no earlier than 90 days or later than 180 days after the date of approval in writing by the superintendent.

D. An upward or downward deviated single account case rate remains with the case, regardless of any change of insurers, and shall continue for a period equal to the experience period on which it was based, not to exceed three (3) years.

E. For cases which are not of credible size, or have no experience, no deviation shall be made in the presumptive rates under these deviation procedures; except that nothing herein shall be construed as preventing any insurer from filing its rate schedules as otherwise provided in Article 25 of the New Mexico Insurance Code.

F. For purpose of this rule, if the coverage for a single creditor which qualifies as a case has been in force with the insurer for less than the experience period;

(1) the claim experience of the creditor while covered by any prior insurer shall be included to the extent necessary in determining the appropriate case ratios; and

(2) the experience considered in the determination of multiple state case rates shall be New Mexico experience unless the insurer makes the one-time election to use nationwide experience; the election to use only nationwide experience must be accompanied by a certification that the insurer uses the same nationwide basis in determining the case ratios in each state in which the case has experience; a grouping of states may be used subject to the same requirements of consistency and certification.

G. When submitting form CI-DRF as required herein, the insurer shall also file a schedule of new case rates, as determined by form CI-DRF.

H. Any request for deviated presumptive rates shall be submitted to the superintendent in the manner presented by the forms in 13.18.2.31 NMAC.

[7/1/97, 3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.30 NMAC - Rn, 13 NMAC 18.2.30, 12/31/07]

13.18.2.31 FORM CI-DRF: PART A - GENERAL INFORMATION:

Company
Code_____

Company
Name_____

Creditor
Name_____

This deviation request form must be completed separately for each plan of credit life or credit disability insurance written by the creditor or group of creditors requesting the deviation. Experience of accounts may be combined only within the same plan of

benefits and class of business. If experience of accounts is combined, attach a list of those included.

Based on the Experience Period commencing _____ and ending _____.

(month/day/year) (month/day/year)

Class of Business:

(1) ( ) Credit Unions

(2) ( ) Commercial Banks and Savings and Loan Associations

(3) ( ) Finance Companies

(4) ( ) Motor Vehicle Dealers

(5) ( ) Other Sales Finance

(6) ( ) Production Credit Association Bank Agricultural Loans

(7) ( ) All Others

Plan of Benefits: ( ) Credit Life, Death Benefits Only

( ) Credit Disability

_____ days

_____ RETRO _____ NON RETRO

[7/1/97; 13.18.2.31 NMAC - Rn, 13 NMAC 18.2.31, 12/31/07]

13.18.2.32 FORM CI-DRF: PART B - CASE EXPERIENCE:

19___ 19___ 19___ 19___

1. Actual Earned Premiums

a. Net Written Premiums* _____ _____ _____ _____

b. Premium Reserve Beginning of Period _____ _____ _____ _____

c. Premium Reserve End of Period _____ _____ _____ _____

d. Earned Premiums (a+b-c) _____ _____ _____ _____

2. Earned Premiums at Presumptive Rates _____ _____ _____ _____

3. Incurred Claims

a. Claims Paid _____ _____ _____ _____

b. Unreported Claims, Beginning of Period _____ _____ _____ _____

c. Unreported Claims, End of Period _____ _____ _____ _____

d. Claim Reserve, Beginning of Period _____ _____ _____ _____

e. Claim Reserve, End of Period _____ _____ _____ _____

f. Incurred Claims, (a+b+c-d-e) _____ _____ _____ _____

4. Actual Loss Ratio for Case at Presumptive

Rates: 3(f) [divided by] 2 _____ _____ _____ _____

5. Average Number of Life Years _____ _____ _____ _____

6. Incurred Claim Count** _____ _____ _____ _____

*Net written premiums are to be determined as Gross Premium written (before deductions for dividends and experience rating credits) less refunds on terminations.

**Entries on 5. and 6. should be based on the Credibility Table elected by the insurer.

[7/1/97; 13.18.2.32 NMAC - Rn, 13 NMAC 18.2.32, 12/31/07]

13.18.2.33 FORM CI-DRF: PART C - DETERMINATION OF DEVIATED PRESUMPTIVE CASE RATE:

A. **Single account cases:** If the account is 100 percent credible or if it is within the definition of single account case as filed by the insurer, the deviated presumptive case rate for the account will be determined by the appropriate formula set forth in Subsection C of 13.18.2.33 NMAC below.

B. **Multiple account cases:** If the account is in a multiple account case, the deviated presumptive case rate for the account will be the case rate for that multiple account case determined by the appropriate formula set forth in Subsection C of 13.18.2.33 NMAC below.

C. **Calculation of deviated presumptive case rates.**

(1) Symbols and definitions:

(a) NCR = new case rate;

(b) PFR = presumptive rate;

(c) ALR = actual loss ratio for case at presumptive rate basis;

(d) ELR = expected loss ratio at presumptive rate basis;

(e) Z = credibility factor for case;

(f) CLR = credibility adjusted case loss ratio at presumptive basis = Z(ALR) = (1-Z)(ELR).

(2) New case rate: credit life insurance:

(a) if CLR is greater than ELR, NCR = PFR [1 + 1.1. (CLR - ELR)];

(b) if CLR is less than ELR, NCR = PFR [1 - (ELR - CLR)].

(3) New case rate: credit disability insurance:

(a) if CLR is greater than ELR, NCR = PFR [1 + 1.2 (CLR ELR)];

(b) if CLR is less than ELR, NCR = PFR [1 - (ELR - CLR)].

[7/1/97; 13.18.2.33 NMAC - Rn, 13 NMAC 18.2.33, 12/31/07]

13.18.2.34 STATISTICAL DATA:

Insurers writing credit life insurance and/or credit accident and health insurance in New Mexico shall keep statistical data in such form and manner as necessary to enable the superintendent to determine if rates are reasonable in relation to the benefits afforded by the various policy contracts. Every company shall file with the superintendent and the national association of insurance commissioner (NAIC) support and service offices, on or before the first of April of each year, statistics on these kinds of insurance for the year ending December 31 immediately preceding. Such statistics shall be filed on forms designated as the credit insurance supplement - annual statement blank approved by the NAIC unless modified by the superintendent.

[7/1/97, 3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.34 NMAC - Rn, 13 NMAC 18.2.34, 12/31/07]

13.18.2.35 PREMIUM REFUNDS:

A. With respect to the policies issued and certificates delivered after the effective date of these rules.

(1) The refund of an unearned amount paid by or charged to a debtor for reducing term credit life insurance, or for credit accident and health insurance, on which charges to the debtor are payable by other than a single sum, and for level term credit life insurance, must be not less than the pro rata gross unearned amount charged.

(2) The refund of an unearned amount paid by or charged to a debtor for uniformly reducing term credit life insurance on which the insurance charges to the debtor are paid in single sum must not be less than the single premium for the scheduled remaining insured amount and the remaining term of coverage using the premium rate schedule applicable at the time the original premium was determined.

(3) The refund of an unearned amount paid by or charged to a debtor for credit life insurance which is neither level nor uniformly reducing, on which the insurance charges to the debtor are paid in a single sum, must be based upon a formula approved by the superintendent of insurance.

(4) The refund of an unearned amount paid by or charged to a debtor for credit accident and health insurance on which the insurance charges to the debtor are paid in a single sum must be not less than the mean of the pro rata gross unearned amount charged and the amount of unearned premium computed by the Rule of 78.

B. Upon termination of insurance prior to maturity, and in accordance with the refund formulas presented in this rule, and in accordance with the insurer's established refund procedures, each insured debtor shall receive from the insurer any refund or unearned identifiable insurance charge either in cash, or by check, electronic funds transfer, or credit to and against the insured debtor's indebtedness (provided that such credit shall be applied only to the indebtedness to which the insurance charges are attributable). Insurers shall be responsible for the establishment of procedures by which refunds or credits are to be made, and shall furnish to the creditors schedules for refunds or credits to be made in the event of termination of insurance. Insurers also shall furnish instructions to creditors with respect to the duties in the making of such refunds or credits.

C. Where insurance charges or premiums were paid by or charged to the debtor and such funds are paid to the insurer, the insurer is responsible for making the refund to the debtor (or to the debtor's estate). Where discharge of the insurer's responsibility for completion of such refunds is delegated by the insurer to the creditor, the actions of such creditor will be deemed by the superintendent of insurance to be acts of the insurer.

D. The requirement for filing refund formulas will be satisfied if the formulas are set forth in the individual policy or group policy filed with the superintendent and not disapproved. If the refund formula, or part of the refund formula is the sum of the digits formula, commonly known as the Rule of 78, it shall be sufficient to so refer to such formula by either description in the policy.

E. A premium refund or credit need not be made if the amount of the refund is three dollars ($3.00) or less.

F. In calculating such refunds, partial months may be treated as though the insurance had terminated on the last day of the premium month in which the insurance is terminated.

G. The insurer shall provide a statement of refund directly to the insured debtor. The statement of refund form shall:

(1) disclose, separately, the amount of credit life premium and the amount of credit disability premium being refunded; and

(2) provide a statement which will inform the insured debtor as to how the refund of premiums was disposed or applied.

[7/1/97, 3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.35 NMAC - Rn, 13 NMAC 18.2.35, 12/31/07]

13.18.2.36 RESPONSIBILITIES AND OBLIGATIONS OF INSURANCE COMPANIES:

Each insurer transacting credit insurance business in this state shall in compliance with the laws of this state and this rule promulgated thereunder, be responsible for:

A. the approval, production, reproduction, amendment, and modification of its policies, certificates of insurance, and other insurance forms, including rate schedules, and for the issuance, cancellation, or termination of such policies, certificates, or forms;

B. the election and appointment of its agents and representatives;

C. the proper charge, collection, remittance, and refund of credit insurance premiums;

D. the receipt of copies of all certificates of insurance and other insurance forms issued in its name by its agents and representatives or the receipt of electronic or other data therefore which can be substantiated by certificates of insurance or other insurance forms;

E. the computation and maintenance of policy and claim liabilities in accordance with 13.18.2.42 NMAC; and

F. the investigation of claims or written complaints filed against the insurer and the payment, adjustment, settlement, or denial of such claims;

G. none of the foregoing responsibilities of the insurer may be delegated, nor may the performance of such responsibilities be assigned to any creditor or to any agent or representative selected and appointed by the insurer, except as provided in these rules.

[7/1/97; 13.18.2.36 NMAC - Rn, 13 NMAC 18.2.36, 12/31/07]

13.18.2.37 RESPONSIBILITIES AND OBLIGATIONS THAT MAY BE DELEGATED TO THE GROUP POLICY CREDITOR OR AGENT:

The insurer, by its group policy, may authorize the group policy creditor to issue certificates of group insurance or may authorize a legally appointed insurance agent of the insurer to issue certificates of insurance or policies of insurance, and respectively, to collect the insurance charge under the group policy, or premium therefore under an individual policy, provided that the master group insurance policy with the creditor or agent's agreement with the agent under which such authority is granted shall require that:

A. the creditor issue such group certificate, or the agent issue such certificate of insurance or insurance policy in the name of the insurer, and payment of the respective policy premium shall be by a check payable to the insurer or by a deposit to an account of the insurer under the sole control of the insurer;

B. a copy of each certificate or policy so issued, or electronic or other data therefore which can be substantiated by such certificate or policy, together with the premium therefore, shall be delivered to the insurer within thirty (30) days after the close of the calendar month in which the certificate or policy is issued;

C. refunds of unearned premiums shall be made in accordance with 13.18.2.35 NMAC of this rule;

D. no insurer may authorize, and no insurance agent or group policyholder, within their respective capacities, may issue any policy or certificate of insurance or collect any premium or insurance charge therefore or make any refund of premium except only pursuant to and in accordance with either a master group insurance policy or an agents' agreement in compliance with this rule;

E. any changes in the amount of coverage, premium or term of coverage after issuance of the original group certificate, a certificate of insurance or the insurance policy issued on a single premium basis shall cause the insurer to issue a new certificate or individual policy, a copy of which must be provided to the insured(s), along

with a statement of additional charges or any credits or refunds in premiums; this includes any coverage changes in 13.18.2.12 NMAC;

F. copies of all records pertaining to each risk shall be provided to the insurer or be maintained for examination by the superintendent though the next examination period.

[7/1/97, 3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.37 NMAC - Rn, 13 NMAC 18.2.37, 12/31/07]

13.18.2.38 CREDITOR MUST BE FIRST BENEFICIARY:

No group policy may be issued to other than a creditor. No first beneficiary may be designated except a creditor. No creditor may be designated as owner of the individual policy nor have any rights thereunder other than that of first beneficiary as specifically authorized by law.

[7/1/97; 13.18.2.38 NMAC - Rn, 13 NMAC 18.2.38, 12/31/07]

13.18.2.39 AUTHORIZED REPRESENTATIVES OF THE INSURER:

The insurer may designate or engage one or more representatives for the purpose of investigating or settling claims and complaints, processing production reports, calculating reserves, printing of approved forms, and providing other administrative services authorized by law, provided:

A. such services are performed under the supervision and direction of the insurer, and the insurer shall remain responsible for their proper performance;

B. the work product of representatives of the insurer are the property of the insurer and shall be available for examination by the superintendent, together with the supporting data used in their preparation;

C. all claims shall be promptly reported to the insurance company, or its designated claim representative, and all claims shall be settled as soon as reasonably possible and in accordance with the terms of the insurance contract.

[7/1/97; 13.18.2.39 NMAC - Rn, 13 NMAC 18.2.39, 12/31/07]

13.18.2.40 REQUIREMENTS FOR HANDLING CLAIMS:

A. The insurance company shall establish an adequate claims register and claim files, which may be reviewed and examined by the superintendent of insurance.

B. Adequate proofs of loss must be in the possession of the insurance company at the time its funds are disbursed in payment of claims, except as provided in Subsection D of 13.18.2.40 NMAC below. Such proofs of loss shall include data sufficient for the

insurer to determine proper amounts of any excess benefits payable to a beneficiary other than the creditor.

C. All claims shall be paid either by draft drawn on the insurer, electronic funds transfer, or check of the insurer to the specific beneficiary to whom payment of the claim is due.

D. No plan or arrangement shall be used whereby any person, firm, or corporation other than the insurer or its designated claim representatives shall be authorized to settle or adjust claims. The creditor shall not be designated as a claim representative for the insurer in settling or adjusting claims; however, a group policyholder may, by arrangement with the group insurer, draw drafts or checks or use electronic funds transfer for payment of claims due only to the group policyholder or other beneficiary, subject to audit and review by the insurer. Nothing in this section may be construed to relieve the insurance company of the responsibility for the proper settlement, adjustment and payment of all claims to proper beneficiaries in accordance with the terms of the insurance contract.

[7/1/97, 3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.40 NMAC - Rn, 13 NMAC 18.2.40, 12/31/07]

13.18.2.41 CLAIM RESERVES:

A. The insurer shall set up adequate liabilities for claims for credit life and credit accident and health insurance, in addition to the policy reserves already described. Such liabilities shall be based upon appropriate consideration for each of the following categories:

(1) the liability for claims which are known to be due and payable, but which have not yet been paid;

(2) the reserve for continuing disability benefits which have been reported and on which future payments will be due during the continuance of this disability;

(3) the liability for claims which have been insured but not yet reported, with benefits now due;

(4) the reserve for disability benefits which are incurred but not yet reported, and on which future payments will be due during the continuance of this disability.

B. The company may rely upon credible experience developed by its own claim experience, industry wide experience, or any other available source which produces an adequate liability for claims.

[7/1/97; 9/1/98; 13.18.2.41 NMAC - Rn & A, 13 NMAC 18.2.41, 12/31/07]

13.18.2.42 APPROVAL AND RE-FILING OF FORMS:

Pursuant to Section 59A-25-8 NMSA 1978, all forms to be used in connection with credit life and/or credit accident and health insurance shall be filed by the insurer with the superintendent of insurance. Any such forms which were approved by the superintendent prior to the effective date of this rule shall be made to conform with the requirements of this rule and re-filed with the superintendent for approval within 180 days after the effective date of this rule. If an insurer fails to re-file within the prescribed period of time, the superintendent shall initiate actions to propose a withdrawal of that insurer's forms under Section 59A-25-8D NMSA 1978 and may take any other appropriate actions under the penalty provisions of the New Mexico Insurance Code to respond to the insurer's failure to comply with the lawful rule of the superintendent.

[7/1/97; 13.18.2.42 NMAC - Rn, 13 NMAC 18.2.42, 12/31/07]

13.18.2.43 PREEXISTING CONDITIONS ON CREDIT LIFE INSURANCE ON OPEN-ENDED CREDIT:

There shall be no provisions excluding or denying a claim for death from pre-existing conditions, except that on insurance written in connection with open-end outstanding balance accounts, a provision will be permitted that excludes or denies a claim resulting from a medical condition for which the debtor received medical diagnosis or treatment within six months immediately preceding the effective date of coverage and which caused or substantially contributed to the death of the insured debtor within 6 months following the effective date of coverage. The effective date of coverage for each part of the insurance attributable to a different advance or charge to the account is the date on which the advance or charge is posted to the account.

[7/1/97; 13.18.2.43 NMAC - Rn, 13 NMAC 18.2.43, 12/31/07]

13.18.2.44 ADJUSTMENT OF PRESUMPTIVELY ACCEPTABLE CREDIT LIFE INSURANCE PREMIUMS:

If for the calendar year 2000 as filed in the statistical statement, or following any even calendar year thereafter, the combined loss ratios of all insurers writing credit life insurance, individual or group, does not equal or exceed ninety percent of the loss ratio stated in Paragraph (1) of Subsection B of 13.18.2.17 NMAC then the credit life insurance premiums stated in Subsections A through D of 13.18.2.18 NMAC and Subsection A of 13.18.2.20 NMAC or as subsequently adjusted by this section shall be reduced by ten percent with the results rounded to the higher whole cent and shall be effective at the beginning of the next calendar year as the prima facie rate.

[3/1/98, 4/1/98, 6/1/98, 9/1/98; 13.18.2.44 NMAC - Rn, 13 NMAC 18.2.44, 12/31/07]

13.18.2.45 ADJUSTMENT OF PRESUMPTIVELY ACCEPTABLE CREDIT ACCIDENT AND HEALTH INSURANCE PREMIUMS:

If for the calendar year 2000 as filed in the statistical statement, or following any even calendar year thereafter, the combined loss ratios of all insurers writing credit accident and health insurance, individual or group, does not equal or exceed ninety percent of the loss ratio stated in Paragraph (2) of Subsection B of 13.18.2.17 NMAC then the credit accident and health insurance premiums as stated in Subsections A and B of 13.18.2.26 NMAC, Subparagraphs (a) and (b) of Paragraph (1) Subsection D of 13.18.2.26 NMAC and Subparagraphs (a) and (b) of Paragraph (2) of Subsection D of 13.18.2.26 NMAC or as subsequently adjusted by this section shall be reduced by ten percent with the results rounded to the higher whole cent and shall be effective at the beginning of the next calendar year as the prima facie rate.

[3/1/98, 6/1/98, 9/1/98; 13.18.2.45 NMAC - Rn, 13 NMAC 18.2.45, 12/31/07]

PART 3: CREDITOR-PLACED INSURANCE

13.18.3.1 ISSUING AGENCY:

New Mexico Office of Superintendent of Insurance, P.O. Box 1689, Santa Fe, NM 87504-1689.

[13.18.3.1 NMAC – Rp, 13.18.3.1 NMAC, 7/24/2018]

13.18.3.2 SCOPE:

A. This rule applies to any person transacting creditor-placed insurance on property located in New Mexico.

B. This rule does not apply to:

(1) creditor-placed insurance first issued on property located in another state but subsequently moved to this state;

(2) insurance for which no specific charge is made to the debtor or the debtor's account; or

(3) blanket insurance, whether paid for by the debtor or the creditor.

[13.18.3.2 NMAC – Rp, 13.18.3.2 NMAC, 7/24/2018]

13.18.3.3 STATUTORY AUTHORITY:

Sections 59A-2-9, 59A-12-10, 59A-16-14, 59A-16-18, 59A-17-6, 59A-17-16, 59A-17-28 and 59A-18-12 NMSA 1978.

[13.18.3.3 NMAC – Rp, 13.18.3.3 NMAC, 7/24/2018]

13.18.3.4 DURATION:

Permanent.

[13.18.3.4 NMAC – Rp, 13.18.3.4 NMAC, 7/24/2018]

13.18.3.5 EFFECTIVE DATE:

July 24, 2018, unless a later date is cited at the end of a section or paragraph.

[13.18.3.5 NMAC – Rp, 13.18.3.5 NMAC, 7/24/2018]

13.18.3.6 OBJECTIVE:

The purpose of this rule is to establish guidelines within which creditor-placed insurance may be written in this state, to regulate rates, and to prohibit unfair practices in the transaction of creditor-placed insurance.

[13.18.3.6 NMAC – Rp, 13.18.3.6 NMAC, 7/24/2018]

13.18.3.7 DEFINITIONS:

As used in this rule:

A. "Actual cash value" means the cost of replacing damaged or destroyed property with comparable new property, minus depreciation and obsolescence.

B. "Assigned risk plan" means the insurance plan established pursuant to the Motor Vehicle Assigned Risks Law, Sections 59A-32-1 et. seq NMSA 1978;

C. "Blanket insurance" means a policy of insurance issued to a creditor that covers direct accidental damage to collateral without listing the specific items of collateral covered;

D. "Collateral" means property that is pledged as security for the satisfaction of a debt;

E. "Credit agreement" means the written document that sets forth the terms of the credit transaction and includes the security agreement;

F. "Credit property insurance" means property insurance written in connection with credit transactions under which the creditor is the primary beneficiary;

G. "Credit transaction" means a transaction by the terms of which the repayment of money loaned or credit commitment made, or payment for goods, services, or properties sold or leased, is to be made at a future date;

H. "Creditor" means a lender of money or vendor or lessor of goods, services, property, rights or privileges for which payment is arranged through a credit transaction, or any successor to the right, title or interest of a lender, vendor or lessor, and includes affiliates, subsidiaries, agents, employees, and representatives of the creditor;

I. "Creditor-placed insurance" means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against direct loss or damage to collateralized property. It is purchased according to the terms of the credit agreement as a result of the debtor's failure to provide required physical damage insurance, with the cost of the coverage being charged to the debtor;

J. "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction;

K. "FAIR plan" means the insurance plan established pursuant to the FAIR Plan Act, Sections 59A-29-1 et. seq NMSA 1978;

L. "Insurance tracking" means activities undertaken by a person other than a creditor to monitor evidence of insurance on collateralized credit transactions to determine whether insurance required by the credit agreement has lapsed and to communicate with debtors concerning the status of insurance coverage;

M. "Lapse" means that the insurance coverage required by the credit agreement is not in force;

N. "Limited dual interest insurance" means insurance purchased by the creditor to insure its interest in the collateral that does not contain the three conditions for loss payment required for single interest insurance and extends coverage on the collateral while it is in the possession of the debtor;

O. "Loss ratio" means incurred losses divided by earned premiums;

P. "Motor vehicles" means those vehicles subject to the Mandatory Financial Responsibility Act, Sections 66-5-201 et. seq NMSA 1978;

Q. "Net debt" means the amount necessary to liquidate the remaining debt in a single lump-sum payment, excluding all unearned interest and other unearned charges;

R. "Personal property" means all tangible property other than real property and includes motor vehicles, mobile homes and manufactured housing;

S. "Single interest insurance" means insurance purchased by the creditor to insure its interest in the collateral securing a debtor's credit transaction which requires that three conditions be met for payment of loss under the policy:

(1) the debtor has defaulted in payment on the credit transaction;

(2) the creditor has legally repossessed the collateral, unless collateral has been stolen from the debtor; and

(3) the creditor has suffered an impairment of interest.

T. "Skip, confiscation and conversion coverage" means coverage protecting the creditor from fraud, theft, larceny, conversion, embezzlement or secretion on the part of the debtor.

[13.18.3.7 NMAC – Rp, 13.18.3.7 NMAC, 7/24/2018]

13.18.3.8 LIMITED AUTHORIZATION TO TRANSACT:

A. An insurer shall not issue creditor-placed insurance to a creditor unless the creditor has an insurable interest in the collateral.

B. No insurer shall transact creditor-placed insurance without first having obtained from the superintendent a license to transact general casualty insurance or vehicle insurance in the case of motor vehicles or property insurance in the case of all other kinds of property.

C. Creditor-placed insurance shall be either single interest insurance or limited dual interest insurance.

D. Creditor-placed insurance shall not be transacted as inland marine insurance.

[13.18.3.8 NMAC – Rp, 13.18.3.8 NMAC, 7/24/2018]

13.18.3.9 POLICY TERM:

A. Effective date: Creditor-placed insurance shall become effective on the latest of the following dates:

(1) the date of the credit transaction;

(2) the date prior coverage, including prior creditor-placed insurance coverage, lapsed;

(3) for personal property, one year before the date on which the charge for creditor-placed insurance is made to the debtor's account; or

(4) a later date provided for in the agreement between the creditor and insurer.

B. Termination date: Creditor-placed insurance shall terminate on the earliest of the following dates:

(1) the date other acceptable insurance becomes effective, subject to the debtor providing acceptable evidence of the other insurance to the creditor;

(2) the date the collateralized property is repossessed, unless the property is returned to the debtor within 10 days of the repossession;

(3) the date the collateralized property is damaged beyond repair;

(4) the date the debt is completely extinguished; or

(5) an earlier date specified in the individual policy or certificate of insurance.

C. Policy term: The term of a creditor-placed insurance certificate shall not exceed 12 months.

[13.18.3.9 NMAC – Rp, 13.18.3.9 NMAC, 7/24/2018]

13.18.3.10 CALCULATION OF PREMIUMS:

This section is not intended to limit the amount of coverage.

A. For credit transactions collateralized by property that does not include land, the premium for creditor-placed insurance shall be calculated on the net debt, even though the coverage may limit the insurer's liability to the least of the net debt, actual cash value or cost of repair.

B. When calculating premiums for creditor-placed insurance on credit transactions collateralized by property that includes land, the exposure base shall not include the value of the land. For this purpose, the value of the land shall be its appraised value as determined by a licensed appraiser or the value assigned by the appropriate taxing authority.

C. Other premium calculation methods that more closely reflect the exposure of each insured item may be employed with the approval of the superintendent.

[13.18.3.10 NMAC – Rp, 13.18.3.10 NMAC, 7/24/2018]

13.18.3.11 PROHIBITED COVERAGES:

Nothing in this section shall be construed to prohibit the issuance of a separate policy providing the coverages listed below to the creditor. Creditor-placed insurance may not include:

A. coverage for the cost of repossession or the cost of storing repossessed collateral;

B. skip, confiscation and conversion coverage;

C. coverage that pays the credit transaction deficiency or insurance premium deficiency;

D. coverage for payment of mechanics' or other liens that do not arise from a covered loss or occurrence;

E. coverage that indemnifies creditors for losses caused by their failure to record instruments which provide evidence of collateral security;

F. for motor vehicles, coverage other than collision and comprehensive; or

G. for mobile homes, coverage that is broader than a basic fire and extended coverage policy such as ISO Form DP001 06 96.

[13.18.3.11 NMAC – Rp, 13.18.3.11 NMAC, 7/24/2018]

13.18.3.12 EVIDENCE OF COVERAGE:

Creditor-placed insurance shall be set forth in an individual policy or certificate of insurance. A copy of the individual policy, certificate of insurance coverage, or other evidence of insurance coverage shall be mailed, first class mail, or delivered in person to the last known address of the debtor.

[13.18.3.12 NMAC – Rp, 13.18.3.12 NMAC, 7/24/2018]

13.18.3.13 FILING AND APPROVAL OF FORMS AND RATES:

A. All policy forms and certificates of insurance to be delivered or issued for delivery in this state, and the schedules of premium rates pertaining to them, shall, pursuant to Sections 59A-17-9 and 59A-18-12 NMSA 1978, be filed with and approved by the superintendent prior to use in this state.

B. Policy forms applicable to creditor-placed insurance for motor vehicles shall not require deductibles lower than one hundred dollars ($100).

C. Policy forms applicable to creditor-placed insurance for mobile homes, manufactured housing and real property shall not require deductibles lower than two hundred fifty dollars ($250).

D. For each type of collateral, insurers shall file a schedule of premium rates that is not unreasonable in relation to the benefits provided by the form to which the schedule

applies. Types of collateral include, but are not limited to, real property, motor vehicles, mobile homes, and other personal property. A premium rate or schedule of premium rates that produces or may reasonably be expected to produce a loss ratio of less than fifty percent shall be presumed to be unreasonable in relation to the benefits provided.

E. Nothing in this section shall prohibit the superintendent from approving other loss ratios that may be found reasonable. An insurer may file a rate that produces or may reasonably be expected to produce a loss ratio of less than fifty percent provided that the provision in the rate for commissions, acquisition costs, insurance tracking, expense reimbursement to creditors, and all similar expenses incurred directly or indirectly does not exceed thirty percent.

[13.18.3.13 NMAC – Rp, 13.18.3.13 NMAC, 7/24/2018]

13.18.3.14 REFUND OF UNEARNED PREMIUMS:

A. Within 60 calendar days after the termination of creditor-placed insurance coverage, an insurer shall refund any unearned premium or other identifiable charges for creditor-placed insurance on a daily pro rata basis, subject to a minimum premium charge filed with and approved by the superintendent.

B. Within 60 calendar days after the termination date of creditor-placed insurance coverage, the insurer shall provide to the debtor a statement of refund disclosing the effective date, the termination date, the amount of premium being refunded and the amount of premium charged for the coverage provided. No statement shall be required in the event that the policy terminates pursuant to Paragraph (4) of Subsection B of 13.18.3.9 NMAC.

C. The entire amount of premiums, minimum premiums, fees or charges of any kind shall be refunded if no coverage was provided.

[13.18.3.14 NMAC – Rp, 13.18.3.14 NMAC, 7/24/2018]

13.18.3.15 CLAIMS:

A. Insurers shall promptly investigate and settle claims in accordance with Section 59A-16-20 NMSA 1978, Unfair Claim Settlement Practices.

B. The settlement value on creditor-placed insurance covering personal property shall be the least of the following, determined as of the date of the loss, less any applicable deductible, retained salvage, or compensation received from a third party:

(1) the actual cash value of the collateral;

(2) the cost of repairing or replacing the collateral to its pre-loss condition; or

(3) the net debt.

C. Whenever a claim is made on a creditor-placed insurance policy, the insurer shall furnish to the debtor and creditor a written statement of the loss explaining the settlement amount and the method of settlement.

D. Insurers shall not deny a claim made on a creditor-placed insurance policy on the grounds that the collateral is ineligible for coverage if the insurer has first accepted a premium on the collateral. This section does not apply in those cases where coverage is denied because of fraud or subrogation or when other insurance was in effect.

[13.18.3.15 NMAC – Rp, 13.18.3.15 NMAC, 7/24/2018]

13.18.3.16 REBATES PROHIBITED:

No insurer shall offer, and no creditor shall accept, a rebate or inducement. This section does not prohibit or restrict an insurer that provides creditor-placed insurance for a creditor from doing business with that creditor if the business is conducted in accordance with the same terms and conditions and at the regular and customary interest rates and charges the creditor applies to its other customers.

A. An insurer shall not pay directly or indirectly to a creditor commissions, fees, rent, expense reimbursement, or other compensation greater than thirty percent of earned premium net of terminations.

B. An insurer shall not pay to a creditor a policyholder dividend, retrospective premium adjustment, profit sharing, or similar return of premium.

C. An insurer transacting creditor-placed insurance shall not provide other insurance coverages to a creditor at inadequate rates.

D. An insurer shall not pay a commission to a person who is not a duly licensed and appointed agent of the insurer.

E. An insurer shall not purchase or offer to purchase certificates of deposit from a creditor or maintain or offer to maintain accounts with a creditor in connection with a creditor-placed insurance solicitation.

F. An insurer shall not purchase certificates of deposit from a creditor or maintain accounts with a creditor at less than market interest rates.

G. An insurer shall not pay for damages that occurred outside the period of coverage or for other losses not covered under the policy.

H. An insurer shall not require a creditor to purchase insurance tracking or any other services from a specific person but may require that such services meet minimum quality standards.

I. A creditor shall not knowingly recover for damages that occurred outside the period of coverage or for other losses not covered under the policy.

J. A creditor shall credit a debtor's account for the amount of any refunded premium upon cancellation of creditor-placed insurance if the creditor has debited the debtor's account for the amount of the premium.

[13.18.3.16 NMAC – Rp, 13.18.3.16 NMAC, 7/24/2018]

13.18.3.17 NOTICE OF CREDITOR-PLACED INSURANCE:

An insurer shall, within 15 days of the initial placement or renewal of creditor-placed insurance, either directly or through the creditor, using the form prescribed in 13.18.3.20 NMAC or a substantially similar form mail to the debtor by first-class mail a copy of the certificate of insurance or policy. In the case of limited dual-interest insurance, the insurer shall also explain the debtor's rights to file a claim for damages incurred after the effective date of the coverage.

[13.18.3.17 NMAC – Rp, 13.18.3.17 NMAC, 7/24/2018]

13.18.3.18 REPORTING REQUIREMENTS:

A. Required reports. On or before July 1 of each year, every insurer offering creditor-placed insurance policies in New Mexico shall file the following reports covering the prior calendar year:

(1) Form A, summary experience report, on the form provided on the OSI website;

(2) Form B, creditor's experience report, on the form provided on the OSI website;

(3) Form C, other insurance report, on the on the form provided on the OSI website;

(4) Form D, reconciliation report, on the form provided on the OSI website, explaining the basis of data compilation, data peculiarities and reconciling any material differences between Form A, Form B, and the annual statement it files.

B. Affidavit: A responsible officer of the insurer shall submit the affidavit prescribed by the superintendent in 13.18.2.20 NMAC when filing the reports required by this section.

C. Electronic filing: Reports shall be submitted both in writing and in EXCEL or other format approved by the superintendent. Instructions for filing are provided with the forms on the OSI website.

[13.18.3.18 NMAC – Rp, 13.18.3.18 NMAC, 7/24/2018]

13.18.3.19 NOTICE OF CREDITOR-PLACED INSURANCE FROM INSURER:

NOTICE OF CREDITOR-PLACED INSURANCE

You are required to maintain insurance on the property that is the collateral for your debt. You have not provided proof of insurance in response to the notices previously sent you. Therefore, *[insert name of creditor]* has placed insurance coverage for you in accordance with the terms of your credit agreement. A copy of that policy/certificate is attached. It states the total cost to you of the insurance and the period of time the insurance will be in force. You may purchase other insurance coverage at any time; as soon as you provide proof of other coverage to *[insert name of creditor]*, we will cancel this creditor-placed coverage and refund to you any unearned premiums that you have paid.

If you have had difficulty obtaining insurance, you may be eligible to purchase:

- New Mexico Assigned Risk Plan coverage for motor vehicles from your local agent or from the New Mexico Assigned Risk Plan at 1-800-227-4659;
- FAIR Plan coverage for real property or mobile homes from your local agent or from the New Mexico Property Insurance Program at 505-878-9563 or 2201 San Pedro NE, Building 20, Albuquerque, New Mexico 87110.

The insurance placed by *[insert name of creditor]* will pay claims for covered physical damage to the property until the debt is paid. The insurance placed by *[insert name of creditor]* will not give you any liability insurance coverage and will not meet the requirements of the New Mexico Mandatory Financial Responsibility Law.

[For limited dual interest policies]

As the debtor, you have the right to file a claim for damage incurred on or after the effective date of coverage stated in the policy/certificate. This insurance will pay no more than the unpaid balance on the loan, which may be less than the value of the property. In order to file a claim, you must:

[insert instructions for filing a claim]

[13.18.3.19 NMAC – Rp, 13.18.3.20 NMAC, 7/24/2018]

13.18.3.20 AFFIDAVIT:

NEW MEXICO CREDITOR-PLACED INSURANCE EXPERIENCE REPORTS FOR THE CALENDAR YEAR ENDING DECEMBER 31, _____

AFFIDAVIT

STATE OF _____

COUNTY OF _____

I,_____, the (position)_____ of (name of Company) _____, being duly sworn, deposes and says that on the 31st day of December last, all of the income and expenses of the named company described in Form A, Form B, Form C, and Form D submitted with this Affidavit, together with any related reports, exhibits, schedules and explanations contained in this filing, or annexed to or referred to in this filing, are a full and true statement in accordance with the instructions provided of income and expenses for the year ended on that date, according to the best of my information, knowledge and belief.

_____

Signature

SUBSCRIBED AND SWORN TO BEFORE ME

this _____day of _____, _____.

_____

Notary Public

My Commission Expires _____

[13.18.3.20 NMAC – Rp, 13.18.3.25 NMAC, 7/24/2018]

CHAPTER 19: NON-ADMITTED OR SURPLUS LINES INSURANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: WRITING SURPLUS LINE BUSINESS

13.19.2.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[1/1/99; Recompiled 11/30/01]

13.19.2.2 SCOPE:

This rule applies to the transaction of surplus lines insurance business within the state.

[1/1/99; Recompiled 11/30/01]

13.19.2.3 STATUTORY AUTHORITY:

Sections 59A-2-9 NMSA 1978.

[1/1/99; Recompiled 11/30/01]

13.19.2.4 DURATION:

Permanent.

[1/1/99; Recompiled 11/30/01]

13.19.2.5 EFFECTIVE DATE:

January 1, 1999, unless a later date is cited at the end of a section or paragraph.

[1/1/99; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.19.2.6 OBJECTIVE:

The purpose of this rule is to implement Chapter 59A, Article 14 NMSA 1978 Surplus Line Insurance.

[1/1/99; Recompiled 11/30/01]

13.19.2.7 DEFINITIONS:

In addition to the definitions in Section 59A-14-2 NMSA 1978, the following definitions apply in this rule:

A. **"Alien insurer"** has the meaning given in Section 59A-5-2 NMSA 1978.

B. **"Foreign insurer"** means an insurer organized under the laws of a state other then New Mexico.

C. **"IRIS"** means the insurance regulatory information system of the national association of insurance commissioners.

D. **"Type of insurance"** has the meaning given in Section 59A-14-2F NMSA 1978.

[1/1/99; Recompiled 11/30/01]

13.19.2.8 EXPORT ON BASIS OF RATE PROHIBITED:

The possibility or actuality that insurance may be obtained at a lower cost from an unauthorized insurer is not sufficient rationale for the transaction of surplus lines insurance if an authorized insurer is willing to provide the insurance.

[1/1/99; Recompiled 11/30/01]

13.19.2.9 PROHIBITION ON ARTIFICIAL DIVISION OF COVERAGE:

A. Artificial divisions of coverage in one class or any form of coverage under one class into two or more proposed contracts for the purpose of obtaining a marketing or rate advantage upon the entire risk is prohibited where the entire coverage sought in that class or form would be acceptable as a single contract to an authorized insurer.

B. Combinations of primary coverage and excess coverage shall not be considered a violation of this section if the excess insurance is written by an eligible surplus lines insurer:

(1) because of a refusal in writing by the primary authorized insurer to assume the limits of liability desired by the person seeking insurance; or

(2) on a written demand, including specific reasons, by the person seeking insurance that the entire liability not be placed with one insurance company.

[1/1/99; Recompiled 11/30/01]

13.19.2.10 INVESTIGATION OF FINANCIAL CONDITION OF INSURER:

A. Prior to placing insurance with an eligible surplus lines insurer, the surplus lines broker must ascertain that the insurer is in sound financial condition. To fulfill this requirement, the surplus lines broker must:

(1) determine that the insurer is on the most recent list of eligible surplus lines insurers maintained by the superintendent; and

(2) make inquiry sufficient to satisfy the surplus lines broker that the insurer is well managed, possesses financial capacity adequate to its business, and has a good reputation in the community.

B. Whenever it comes to the attention of the surplus lines broker that there is any reasonable basis for doubt as to 13 NMAC 19.2.10.1 [now Subsection A of 13.19.2.10 NMAC] for a particular insurer, the surplus lines broker shall not place any further business with such insurer and shall promptly notify the superintendent.

[1/1/99; Recompiled 11/30/01]

13.19.2.11 NONRESIDENT SURPLUS LINES BROKERS:

A licensed nonresident agent or broker may also be licensed as a surplus lines broker in order to place exportable surplus lines coverage with a risk retention group or on behalf of a risk purchasing group. A nonresident surplus line broker shall be subject to the requirements of Section 59A-14-10 NMSA 1978.

[1/1/99; Recompiled 11/30/01]

13.19.2.12 APPLICATION PROCESS FOR SURPLUS LINES INSURER:

A. An alien insurer listed on the national association of insurance commissioners' international insurer's department quarterly listing of alien insurers will be deemed to have met the requirements of this section.

B. To apply for qualification as an eligible surplus lines insurer, an unauthorized foreign insurer shall file with the superintendent the information required in Section 59A-14-4 NMSA 1978. In support of the application, the insurer shall file the following items, using forms prescribed and provided by the superintendent where available:

(1) a letter requesting approval as an eligible surplus lines insurer;

(2) a certified copy of the insurer's articles of incorporation, bearing the seal of the state official having custody of the original;

(3) a copy of the insurer's bylaws, certified by its corporate secretary, with its corporate seal affixed to the document;

(4) a properly executed power of attorney authorizing the superintendent to accept service of process on behalf of the insurer;

(5) a copy of the latest annual statement of the insurer, certified by the state of domicile;

(6) a document indicating compliance by the insurer with the laws of its home state as to the kind or kinds of insurance which the insurer is authorized to transact in its state of domicile, certified by the state of domicile;

(7) a document indicating the amount and description of the securities deposited with the insurer's home state or any other state for the benefit of all its policyholders and/or creditors, certified by the state of domicile;

(8) a report of examination from the insurer's home state;

(9) a copy of the insurer's last quarterly statement;

(10) conflict of interest forms;

(11) a list of the insurer's officers, directors and key personnel and a biographical affidavit for each;

(12) a list and description of the insurer's reinsurance contracts;

(13) a statement of the insurer's plan of operation in this state;

(14) an A.M. Best's gallery report of the insurer;

(15) an IRIS report of the insurer;

(16) a copy of the latest audit report of the insurer, in no case older than one year, certified by the individual or company undertaking the audit;

(17) an actuarial certification of the insurer;

(18) a statement as to whether the insurer has written any business in the past or present for any risks located in New Mexico, with complete details if the answer is affirmative;

(19) a copy of the declaration page of the fidelity bond;

(20) a surplus lines insurer contact processing form prescribed by the superintendent; and

(21) any other information the superintendent may require.

C. In all submissions to the superintendent, all information requested shall be provided and all questions shall be answered. Failure to answer all of the questions, to provide all of the information, or to respond to an inquiry by the superintendent shall result in an automatic disqualification of the applicant until such time as this requirement

is satisfied fully. The superintendent may require information to be furnished under oath in accordance with Section 59A-4-3 NMSA 1978.

D. Upon approval of an application for surplus lines insurer eligibility, the superintendent may require the insurer to make a special deposit in accordance with Section 59A-5-19 NMSA 1978.

[1/1/99; Recompiled 11/30/01]

13.19.2.13 EXCEPTION TO ELIGIBILITY REQUIREMENTS FOR SURPLUS LINES INSURERS:

For good cause shown, the superintendent may waive in writing the eligibility requirements of Section 59A-14-4 NMSA 1978 to permit insurance to be placed as to a particular risk and insurer if the insurance is not otherwise reasonably obtainable from an authorized insurer or eligible surplus lines insurer. The superintendent may consider the following factors in determining good cause for this waiver:

A. the financial integrity, quality of management, record and reputation of the unauthorized insurer, including its management experience, A.M. Best's rating, IRIS reports, rate of growth, loss ratios, reserves, general financial condition, the length of time the insurer has been authorized in its state of domicile, the results of any previous regulatory action, and other related factors that the superintendent may determine are useful in making this assessment;

B. the capital and surplus of the unauthorized insurer's parent company, including the financial solidity of the parent company and the commitment by the parent company to support the unauthorized insurer through reinsurance;

C. the profitability of the unauthorized insurer, including its net income, stability and consistency; and

D. the interests of the public and policyholders.

[1/1/99; Recompiled 11/30/01]

13.19.2.14 REFUSAL OR WITHDRAWAL OF SURPLUS LINES INSURER ELIGIBILITY:

The superintendent may refuse to initially list or continue to list an unauthorized insurer on the superintendent's list of eligible surplus lines insurers for any one of the following reasons:

A. the insurer's key management, owners or other employees have been involved in fraud, mismanagement, bankruptcy or other activities that reflect unfavorably on the integrity of the insurer;

B. the insurer operates through managing general agents without appropriate safeguards;

C. the insurer has a material conflict of interest;

D. the insurer has been in business for less than three years;

E. the insurer has had new owners or management for less than three years;

F. the insurer has an a.m. best's rating of B or lower;

G. the insurer has had three or more adverse IRIS reports, unless the superintendent accepts a valid explanation by the insurer;

H. the insurer has had a rate of growth greater than 20% per year over the last three years, unless other financial indicators are favorable;

I. the insurer has been unprofitable for each of the last three years or has a long-term history of chronic unprofitability, unless the superintendent accepts a valid explanation by the insurer;

J. the insurer has a questionable financial condition for any other reason;

K. the superintendent has reason to believe that the insurer meets the ineligibility standards of Section 59A-14-14.1 NMSA 1978; or

L. the superintendent determines that such action is necessary for protection of the public.

[1/1/99; Recompiled 11/30/01]

13.19.2.15 APPEAL OF SUPERINTENDENT'S ACTION:

An unauthorized insurer aggrieved by any action of the superintendent may request a hearing before the superintendent pursuant to Section 59A-4-15 NMSA 1978 et seq.

[1/1/99; Recompiled 11/30/01]

13.19.2.16 NOTICE OF WITHDRAWAL:

If the superintendent withdraws eligibility from an eligible surplus lines insurer, the superintendent shall promptly mail notice of such withdrawal to the insurer and to every surplus lines broker. Surplus lines brokers who placed insurance with such insurer shall follow the requirements in 13 NMAC 19.2.10.2 [now Subsection B of 13.19.2.10 NMAC].

[1/1/99; Recompiled 11/30/01]

13.19.2.17 DOCUMENTATION AND REPORTING REQUIREMENTS:

A. The producing broker shall maintain files documenting the diligent search for an authorized insurer and supporting the producing broker affidavit in accordance with Section 59A-12-21 NMSA 1978. Each producing broker who places any surplus lines insurance shall comply with the affidavit requirement of Section 59A-14-11 NMSA 1978 by providing the form prescribed in 13 NMAC 19.2.19 [now 13.19.2.19 NMAC] to the surplus lines broker within fifteen days of issuance of the policy.

B. The superintendent interprets Section 59A-14-11 NMSA 1978 to permit the surplus lines broker to substitute the declarations page of the policy for the producing broker report required by subsection A of that section. The declarations page shall be kept confidential.

C. Each surplus lines broker shall comply with the reporting and affidavit requirements of Section 59A-14-11 NMSA 1978 and shall file the following documents using the forms and electronic format prescribed in this rule:

(1) the quarterly summary report form prescribed in 13 NMAC 19.2.20 [now 13.19.2.20 NMAC];

(2) a diskette containing the following information in the following format:

Item No.	Information required	Type of field	Number of characters or format
1	Name of insurer	Text	80
2	NAIC company code or alien listing code	Text	12
3	Policy number	Text	40
4	Effective date of policy	Date	mm/dd/yyyy
5	Termination date of policy	Date	mm/dd/yyyy
6	Specific description of coverage	Text	160
7	Premium	Number	2 decimal places
8	Additional premium	Number	2 decimal places
9	Cancellation or return premium	Number	2 decimal places
10	Additional fees	Number	2 decimal places
11	Total	Number	2 decimal places
12	State tax (3% of Total)	Number	2 decimal places

(3) two copies of a printout made from the diskette, one of which will be returned to the surplus lines broker as proof of filing the report; the printout shall show totals in each number column;

(4) the declarations page of the policy attached to the producing broker affidavit for each surplus lines insurance policy written, in the order in which they appear on the diskette and printout;

(5) a check for the amount of taxes due.

D. Each surplus lines insurer shall file the following documents with the superintendent on or before March 1 of each year, using the form and the electronic format prescribed in this rule:

(1) The annual summary report prescribed in 13 NMAC 19.2.21 [now 13.19.2.21 NMAC], listing all surplus lines insurance policies written for risks in New Mexico in the preceding calendar year and indicating the surplus lines broker through whom they were placed.

(2) A diskette containing the following information in the following format:

Item No.	Information required	Type of field	Number of characters
1	Policy number	Text	12
2	Effective date of policy	Date	mm/dd/yyyy
3	Termination date of policy	Date	mm/dd/yyyy
4	Kind of insurance	Text	100
5	Zip code of insured	Text	10
6	Premium	Number	2 decimal places
7	Additional premium	Number	2 decimal places
8	Cancellation or return premium	Number	2 decimal places
9	Additional fees	Number	2 decimal places
10	Total	Number	2 decimal places
11	State tax (3% of Total)	Number	2 decimal places

(3) Two copies of a printout made from the diskette, one of which will be returned to the surplus lines insurer as proof of filing the report; the printout shall show totals in each number column.

[1/1/99; Recompiled 11/30/01]

13.19.2.18 SIGNATURE AND SPECIAL ENDORSEMENT OF SURPLUS LINE POLICY:

If the statement required by NMSA 1978 Section 59A-14-5 does not fit on the declarations page of the policy, the superintendent will accept the New Mexico surplus line brokers' countersignature endorsement prescribed in 13 NMAC 19.2.22 [now 13.19.2.22 NMAC] on a separate page containing the statement required by statute.

[1/1/99; Recompiled 11/30/01]

13.19.2.19 PRODUCING BROKER AFFIDAVIT:

This affidavit shall be completed by the producing broker (e.g., the agent selling the product) and submitted to the surplus lines broker within fifteen days of issuance of the policy.

PRODUCING BROKER AFFIDAVIT

(Required by 59A-14-11B NMSA 1978 Section)

Name of producing broker: _____

Address of producing broker: _____

Being duly sworn, I affirm that:

1. I was engaged to obtain the following policy:

Insurer: _____

Policy number: _____

Type of coverage: _____

Effective date: _____

2. (Check **either** A **or** B below, as appropriate)

___ A. After making a diligent search I found that the full amount or type of insurance requested could not be obtained from authorized insurers in New Mexico.

or

___ B. Within the last year, I have tried to place this type of coverage with at least four insurers authorized in New Mexico, including insurers by whom I am not appointed, and therefore know from substantial recent experience that this coverage cannot be obtained from any authorized insurer in New Mexico.

3. I expressly advised the insured prior to placing the insurance, and the insurance policy states, that:

A. the insurer with whom the insurance is placed is not an authorized insurer in New Mexico and is not subject to the supervision of the superintendent of insurance; and

B. in the event the insurer becomes insolvent, claims will not be paid by any New Mexico guaranty association.

4. I have asked the insured and, to the best of my knowledge, this coverage is not replacing existing coverage from an authorized insurer who was willing to continue providing coverage.

5. I certify that I am licensed by the New Mexico department of insurance for the type of coverage provided and that the information in this form is true and correct and is in compliance with the applicable provisions of the New Mexico insurance code and this rule.

_____
_____

SIGNATURE DATE

SUBSCRIBED AND SWORN TO before me

this ____ day of _____, ____.

_____

Notary Public

My commission expires _____

[1/1/99; Recompiled 11/30/01]

13.19.2.20 SURPLUS LINES BROKER QUARTERLY SUMMARY REPORT FORM:

SURPLUS LINES BROKER QUARTERLY SUMMARY REPORT

(Required by NMSA 1978 Section 59A-14-11C & D)

Name of broker: _____

Address of broker: _____

License number: _____

I hereby submit to the New Mexico Department of Insurance this summary of all surplus lines insurance I placed during the quarter beginning ____/____/_____and ending ___/____/_____. All documents required by Section 59A-14-11 NMSA 1978 and 13 NMAC 19.2.17.3 [now Subsection C of 13.9.2.17 NMAC] to be filed with the superintendent are attached.

I certify that the information on this form is true and correct and is in compliance with the applicable provisions of the New Mexico insurance code and that the information on the diskette filed with this form is identical to the information on the printouts made from the diskette and filed with this form.

_____
_____

Signature Date

SUBSCRIBED AND SWORN TO before me

this ____ day of _____, ____.

_____

Notary Public

My commission expires _____

[1/1/99; Recompiled 11/30/01]

13.19.2.21 SURPLUS LINES INSURER ANNUAL SUMMARY REPORT FORM:

SURPLUS LINES INSURER ANNUAL SUMMARY REPORT

Name of insurer _____

Address of insurer: _____

NAIC company code or alien listing code: _____

The insurer hereby submits to the New Mexico department of insurance a summary of all surplus lines insurance provided by the insurer for risks in New Mexico during _____.

I certify that the information on this form is true and correct and is in compliance with the applicable provisions of the New Mexico Insurance Code and that the information on the diskette filed with this form is identical to the information on the printouts made from the diskette and filed with this form.

_____
_____

Signature of authorized officer Date

_____

Title of authorized officer

[1/1/99; Recompiled 11/30/01]

13.19.2.22 SURPLUS LINES BROKERS COUNTERSIGNATURE ENDORSEMENT:

NEW MEXICO SURPLUS LINES BROKER'S COUNTERSIGNATURE ENDORSEMENT

THIS ENDORSEMENT MUST BE ATTACHED TO THE POLICY

AS PART OF THE INSURANCE CONTRACT

This policy provides surplus lines insurance by an insurer not otherwise authorized to transact business in New Mexico. This policy is not subject to supervision, review or approval by the superintendent of insurance. The insurance so provided is not within the protection of any guaranty fund law of New Mexico designed to protect the public in the event of the insurer's insolvency.

POLICY NUMBER:
_____

NAME OF INSURED:
_____

CERTIFICATE NUMBER:
_____

DATE POLICY SIGNED:
_____

UNDERWRITING COMPANY:
_____

_____

Surplus Lines Brokers Signature

[1/1/99; Recompiled 11/30/01]

PART 3: REPORTING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

13.19.3.1 ISSUING AGENCY:

New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.

[7/1/97; Recompiled 11/30/01]

13.19.3.2 SCOPE:

This rule applies to all persons licensed or required to be licensed by the superintendent.

[7/1/97; Recompiled 11/30/01]

13.19.3.3 STATUTORY AUTHORITY:

Sections 59A-2-9 and 59A-15-20 NMSA 1978.

[5/1/92; Recompiled 11/30/01]

13.19.3.4 DURATION:

Permanent.

[7/1/97; Recompiled 11/30/01]

13.19.3.5 EFFECTIVE DATE:

May 1, 1992, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.

[5/1/92, 7/1-97; Recompiled 11/30/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.19.3.6 OBJECTIVE:

The purpose of this rule is to require licensed agents, insurance consultants, insurance administrators and insurers to submit information to the department of insurance prior to assisting in any way the transaction of insurance by certain types of multiple employer arrangements identified in this rule. These reports will help the department identify unauthorized insurance arrangements before the transactions occur. The reports also will help licensees identify unauthorized insurance arrangements so that they can protect themselves from potential liability for assisting in the transaction of unauthorized insurance.

[5/1/92; Recompiled 11/30/01]

13.19.3.7 DEFINITIONS:

A. **"Agent"** has the definition ascribed thereto in Section 59A-12-2A NMSA 1978 of the New Mexico Insurance Code.

B. **"Arrangement"** means a fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits to individuals.

C. **"Authorized insurer"** has the definition ascribed thereto in Section 59A-1-8B NMSA 1978. For purposes of this rule, nonprofit health care plans holding a valid and subsisting certificate of authority, issued by the superintendent under Article 47 of the Insurance Code, and health maintenance organizations holding a valid and subsisting certificate of authority, issued by the superintendent under Article 46 of the Insurance Code, shall also be defined as authorized insurers.

D. **"Collectively bargained arrangement"** means an arrangement which provides or represents that it is providing health care benefits or coverage under or pursuant to one or more collective bargaining agreements.

E. **"Employee leasing arrangement"** means an arrangement, under contract or otherwise, whereby one business or other entity leases all or a significant number of its workers from another business or entity.

F. **"Employee welfare benefit plan"** means any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.

G. **"Fully insured by an authorized insurer"** means that, for all of the health care coverage provided or offered by or through an arrangement:

(1) an authorized insurer is directly obligated by contract to provide all of the coverage to or under the arrangement;

(2) the authorized insurer assumes all of the risk for payment of all covered services or benefits; and

(3) the liability of the authorized insurer for payment of the covered services or benefits is directly to the individual employee, member or dependent receiving the health care services.

H. **"Insurance administrator"** has the definition ascribed thereto in Section 59A-12A-2B NMSA 1978 of the New Mexico Insurance Code.

I. **"Insurance consultant"** has the definition ascribed thereto in Section 59A-11A-1NMSA 1978 of the New Mexico Insurance Code.

J. **"Multiple employer welfare arrangement"** has the meaning given in Section 59A-1-8.1 NMSA 1978 of the New Mexico Insurance Code.

K. **"Reportable MEWA"** means a person or entity that provides health care benefits or coverage to the employees of two or more employers. Reportable MEWA does not include:

(1) an authorized insurer;

(2) an arrangement which is fully insured by an authorized insurer;

(3) a collectively bargained arrangement;

(4) an employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative; or

(5) a multiple employer welfare arrangement that has satisfactorily demonstrated to the superintendent that it is subject to the jurisdiction of another agency of this state or the federal government in accordance with Section 59A-15-17 NMSA 1978 of the Health Care Benefits Jurisdiction Act.

L. **"Rural electric cooperative means":**

(1) any organization which is exempt from tax under Section 501(a) of Title 26 of the United States Code and which is engaged primarily in providing electric service on a mutual or cooperative basis; or

(2) any organization described in Paragraph (4) or (6) of Section 501(c) of Title 26 of the United States Code which is exempt from tax under Section 501(a) of Title 26 and at least eighty percent (80%) of the members of which are organizations described in 13 NMAC 19.3.7.11.1 [now Paragraph (1) of Subsection K of 13.19.3.7 NMAC].

M. **"Rural telephone cooperative"** means an organization described in Paragraph (4) or (6) of Section 501(c) of Title 26 of the United States Code which is exempt from tax under Section 501(a) of Title 26 and at least eighty percent (80%) of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative or other basis.

[5/1/92; Recompiled 11/30/01]

13.19.3.8 AGENTS AND INSURANCE CONSULTANTS PROHIBITED FROM ASSISTING REPORTABLE MEWAS PRIOR TO FILING:

A. No agent or insurance consultant may solicit, advertise, or market in this state health benefits or coverage from, or accept an application for, or place coverage for a person who resides in this state, with a reportable MEWA unless the agent or insurance consultant first files the information required under 13 NMAC 19.3.12 [now 13.19.3.12 NMAC].

B. No agent or insurance consultant may solicit another agent or insurance consultant to enter into an arrangement to solicit, advertise or market services, health benefits or coverage of a reportable MEWA unless the soliciting agent or insurance consultant first files the information required under 13 NMAC 19.3.12 [now 13.19.3.12 NMAC].

[5/1/92; Recompiled 11/30/01]

13.19.3.9 AGENTS AND INSURANCE CONSULTANTS PROHIBITED FROM ASSISTING EMPLOYEE LEASING ARRANGEMENTS PRIOR TO FILING:

A. No agent or insurance consultant may solicit, advertise or market in this state services, health benefits or coverage for an employee leasing arrangement or a person or arrangement which represents itself as an employee leasing arrangement unless the agent or insurance consultant first files the information required under 13 NMAC 19.3.12 [now 13.19.3.12 NMAC].

B. No agent or insurance consultant may solicit another agent or insurance consultant to enter into an arrangement to solicit, advertise or market the health benefits, coverage or services of an employee leasing arrangement unless the soliciting agent or insurance consultant first files the information required under 13 NMAC 19.3.12 [now 13.19.3.12 NMAC].

[5/1/92; Recompiled 11/30/01]

13.19.3.10 AGENTS AND INSURANCE CONSULTANTS PROHIBITED FROM ASSISTING COLLECTIVELY BARGAINED ARRANGEMENTS PRIOR TO FILING:

A. No agent or insurance consultant may solicit, advertise, or market in this state health benefits or coverage from, or accept an application for, or place coverage for a person who resides in this state with, a collectively bargained arrangement or an arrangement which represents itself as a collectively bargained arrangement unless the agent or insurance consultant first files the information required under 13 NMAC 19.3.12 [now 13.19.3.12 NMAC].

B. No agent or insurance consultant may solicit another agent or insurance consultant to enter into an arrangement to solicit, advertise or market the health benefits or coverage of a collectively bargained arrangement unless the soliciting agent or insurance consultant first files the information required under 13 NMAC 19.3.12 [now 13.19.3 12 NMAC].

[5/1/92; Recompiled 11/30/01]

13.19.3.11 INSURANCE ADMINISTRATORS AND AUTHORIZED INSURERS PROHIBITED FROM ASSISTING REPORTABLE MEWAS PRIOR TO FILING:

A. No insurance administrator may solicit or effect coverage of, underwrite for, collect charges or premium for, or adjust or settle claims of a resident of this state for, or enter into any agreement to perform any of those functions for a reportable MEWA which provides coverage to residents to this state unless the insurance administrator first files the information required under 13 NMAC 19.3.12 [now 13.19.3.12 NMAC].

B. No authorized insurer may solicit or effect coverage of, underwrite for, collect charges or premiums for, or adjust or settle claims of a resident of this state for, or enter into any agreement to perform any of those functions for a reportable MEWA which provides coverage to residents of this state unless the insurer first files the information required under 13 NMAC 19.3.12 [now 13.19.3.12 NMAC].

C. An authorized insurer which issues or has issued any insurance coverage to a reportable MEWA which covers residents of this state including, but not limited to, specific or aggregate stop-loss coverage shall file the information required under 13 NMAC 19.3.12 [now 13.19.3.12 NMAC] within thirty (30) days after the coverage is issued or within thirty (30) days after the date the reportable MEWA first provides coverage to a resident of this state, or within thirty (30) days of the effective date of this rule, whichever is later.

[5/1/92; Recompiled 11/30/01]

13.19.3.12 INFORMATION REQUIRED TO BE FILED AND KEPT CURRENT:

A. An agent, insurance consultant, insurance administrator or insurer required to file under 13 NMAC 19.3.8 through 19.3.11 [now 13.19.3.8 NMAC through 13.19.3.11 NMAC], inclusive, shall file all of the following information on a form approved by the superintendent:

(1) a copy of the organizational documents of the reportable MEWA, employee leasing firm or collectively bargained arrangement, including the articles of incorporation and bylaws, partnership agreement or trust instrument;

(2) a copy of each insurance or reinsurance contract which concerns all or any portion of benefits or coverage offered by the reportable MEWA, employee leasing firm or collectively bargained arrangement;

(3) a clear and complete statement describing the extent to which the benefits provided or offered by the reportable MEWA, employee leasing firm or collectively bargained arrangement are insured or reinsured;

(4) the names and addresses of any person performing or expected to perform the functions of an insurance administrator for the reportable MEWA, employee leasing firm or collectively bargained arrangement; and

(5) a copy of the most recent financial statement of the reportable MEWA, employee leasing firm or collectively bargained arrangement, or a sworn statement that no such financial statement is available.

B. A filing under this rule is ineffective and is not in compliance with this rule if:

(1) it is incomplete or inaccurate; or

(2) a change occurs which makes the information filed inaccurate, unless an amended filing is made within sixty (60) days after the date the change occurs and the amended filing accurately reflects the change.

C. The superintendent shall acknowledge receipt of the filing under this rule within sixty (60) days of receipt of such filing. If the superintendent fails to acknowledge receipt within such time period, the filing shall be deemed to be complete and filed.

[5/1/92; Recompiled 11/30/01]

13.19.3.13 LACK OF KNOWLEDGE NOT A DEFENSE:

A. Lack of knowledge or intent with respect to the status, organization or filings of a reportable MEWA, employee leasing firm or collectively bargained arrangement is not a defense to a violation of this rule.

B. A filing under this rule is solely for the purpose of providing information to the superintendent. This rule and filings hereunder do not authorize or license a reportable MEWA, employee leasing firm, collectively bargained arrangement or any other arrangement to engage in business in this state if otherwise prohibited by law.

[5/1/92; Recompiled 11/30/01]

13.19.3.14 LIABILITY FOR VIOLATION OF THIS RULE:

Any agent, insurance consultant, insurance administrator or insurer who or which assists in any way the transaction of insurance with any arrangement and who or which fails to report in accordance with this regulation shall be liable to any insured in the event that an arrangement fails to pay a claim or loss in this state within the terms of the policy or contract with any insured. The licensee's liability in each such instance shall be coextensive with the arrangement's contractual obligation to its insured, subject to proportional contributions from any other licensee(s) involved in the transaction of insurance with an arrangement in violation of this rule.

[5/1/92; Recompiled 11/30/01]

13.19.3.15 PENALTIES:

The superintendent of insurance may revoke, suspend or refuse to continue the license or certificate of authority or other authorization of any person who fails to comply with this rule and may impose such other administrative penalties as may be authorized by the Insurance Code.

[5/1/92; Recompiled 11/30/01]

PART 4: MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

13.19.4.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.19.4.1 NMAC – N, 2/25/2020]

13.19.4.2. SCOPE:

A. Applicability. These rules apply to any group establishing or maintaining a multiple employer welfare arrangement ("MEWA") providing health benefits in accordance with Section 59A-15-16 NMSA 1978 for its participants or their beneficiaries. An unregistered MEWA shall not:

(1) advertise in the state as a benefit of membership for any group health insurance policy available to its members or beneficiaries;

(2) issue a certificate for delivery in New Mexico to any resident of the state; or

(3) solicit membership in the state on the basis of the existence or availability of such health insurance coverage.

B. Exclusions. Notwithstanding Subsection A of this section, these rules do not apply to any multiple employer welfare arrangement that:

(1) establishes or maintains a multiple employer welfare arrangement plan pursuant to one or more agreements that the United States secretary of labor finds to be a collective bargaining agreement;

(2) is a rural electric cooperative or a rural telephone cooperative association as those terms are defined in ERISA; or

(3) has satisfactorily demonstrated to the superintendent that it is subject to the jurisdiction of another agency of this state or the federal government in accordance with Section 59A-15-17 NMSA 1978.

[13.19.4.2 NMAC – N, 2/25/2020]

13.9.4.3 STATUTORY AUTHORITY:

Sections 59A-1-8, 59A-1-18, 59A-2-9, 59A-4-14, 59A-10-3, 59A-15-17, 59A-15-20, 59A-16-1, 59A-16-27, 59A-18-13.2, 59A-18-13.3, 59A-18-13.5, 59A-23-3, 59A-23C-3 NMSA 1978.

[13.19.4.3 NMAC – N, 2/25/2020]

13.19.4.4 DURATION:

Permanent.

[13.19.4.4 NMAC – N, 2/25/2020]

13.19.4.5 EFFECTIVE DATE:

February 25, 2020, unless a later date is cited at the end of a section.

[13.19.4.5 NMAC – N, 2/25/2020]

13.19.4.6 OBJECTIVE:

The purpose of this rule is to establish eligibility requirements, registration, reporting, oversight and transparency requirements for multiple employer welfare arrangements. This rule also applies state and federal statutes protecting consumers' access to care to MEWAs.

[13.19.4.6 NMAC – N, 2/25/2020]

13.19.4.7 DEFINITIONS:

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

A. "Association health plan or association or AHP" means any foreign or domestic association that provides a health benefits plan that covers the employees of multiple employers or union members. All association health plans are multiple employer welfare arrangements.

B. "By laws" means the statements adopted by a MEWA that prescribe its purpose, government and administration.

C. "Discretionary group" means a group that does not meet the standard, eligible group requirements under state or federal law, but have otherwise obtained insurance by the discretion of the superintendent to operate.

D. "Employer" means:

(1) a person who is an employer as that term is defined in Section 3(5) of the federal Employee Retirement Income Security Act of 1974, and who employs two or more employees; and

(2) a partnership in relation to a partner pursuant to Section 59A-23E-17 NMSA 1978.

E. "ERISA" refers to the Employee Retirement Income Security Act of 1974 (29 United States Code Section 1002(4)), and ERISA's implementing regulations, as currently enacted or subsequently amended;

(1) these rules incorporate the definitions in 29 U.S.C.A., § 1002, and in its implementing regulations, as currently enacted or subsequently amended.

(2) unless inconsistent with the definitions in 29 U.S.C.A., § 1002, or in its implementing regulations, these rules incorporate the definitions in the New Mexico Insurance Code.

F. "Fully-insured multiple employer welfare arrangement" means that an authorized insurer is obligated to provide all of the benefits and services owed to a participant in, or beneficiary of, a MEWA and is directly liable to each participant or beneficiary for those services or benefits.

G. "Insurance code" refers to the New Mexico Insurance Code and its implementing rules, as currently enacted or subsequently amended.

H. "M-1 filing" means a Form M-1 report that the federal department of labor requires a MEWA to file annually.

I. "Multiple employer welfare arrangement" or **"MEWA"** refers to any foreign or domestic entity that administers a multiple employer welfare arrangement pursuant to 29 U.S.C.A., § 1002(40)(A) and these rules.

J. "NAIC" means the national association of insurance commissioners.

K. "Plan administrator or third-party administrator" means a person or entity engaged by a self-funded MEWA, to carry out the policies established by the trustees

and to otherwise administer and provide day-to-day management of the health benefits plan;

L. "Self-funded multiple employer welfare arrangement" refers to a MEWA that is not fully-insured. A fully-insured MEWA shall be deemed a self-funded MEWA, subject to all of the laws and regulations pertaining thereto, if, at any time, any of the obligations owed by the MEWA to a participant or beneficiary will not be provided by an authorized insurer.

M. "Self-insure" means to assume primary liability or responsibility for certain risks or benefits, rather than transferring liability or responsibility to some other entity.

N. "SERFF" means the system for electronic rates and forms filings.

[13.19.4.7 NMAC – N, 2/25/2020]

13.19.4.8 ELIGIBILITY TO OPERATE:

A. Eligibility to operate as or offer coverage through a MEWA.

(1) Self-funded MEWA. A self-funded MEWA shall be eligible to offer health benefits plans only after meeting the requirements outlined in this section

(2) Fully-insured MEWA. A fully-insured MEWA shall confirm that its offered coverage conforms with the requirements of this section prior to the sale or delivery of any health benefits plan to MEWA members.

B. Eligibility for status as MEWA. A MEWA shall prove that it:

(1) is a bona fide association, which means that the association:

(a) has membership consisting solely of employers or union members;

(b) has been actively in existence for at least five continuous years;

(c) is engaged in substantial activities for its members, other than the sponsorship of an employee welfare benefit plan, and provides business or professional assistance and benefits to its members who share a common business interest and are primarily engaged in the same trade or business;

(d) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee) and clearly so states in all membership and application materials;

(e) has within its membership the employers who participate in and fund the arrangement;

(f) makes health benefits plan coverage offered through the MEWA available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member) and clearly so states in all marketing and application materials;

(g) does not make health benefits plan coverage offered through the MEWA available other than in connection with a member of the MEWA and clearly so states in all marketing and application materials;

(h) provides and annually updates information necessary for the superintendent to determine whether or not the MEWA meets the definition of a MEWA before qualifying as a bona fide association for the purposes of this rule; and

(i) meets at least one of the following conditions:

(i) is a New Mexico entity;

(ii) includes a member that is a New Mexico entity or who conducts business in New Mexico; or

(iii) has a participant who resides in New Mexico;

(2) shares a commonality of interests, which means that the employers or union members are in the same trade, industry, line of business, or profession; and

(3) does not charge employers or union members membership fees solely to participate in the MEWA and no membership fees are included in the premiums charged for health benefits plans.

C. Limitations of membership. A MEWA may only provide benefits to active or retired owners, officers, directors, or employees (and the domestic partners and family members of any of them) of participating employers or union members, except as may otherwise be limited by provisions of ERISA.

D. MEWAs formed for the purposes of selling insurance, prohibited. No MEWA, shall be formed solely for the purpose of selling insurance.

E. Limitations on large group plans. A health benefits plan offered by a MEWA shall not be considered a large group plan exempt from state and federal laws governing individual or small group coverage solely because the aggregate number of lives covered by the MEWA meets the definition of a large group plan.

F. Size of MEWA. A self-funded MEWA proposing to provide a health benefits plan to fewer than 100 covered lives does not meet the criteria for eligibility under this rule, shall not be registered as an authorized MEWA and shall not offer a health benefits plan to any employees or union members.

[13.19.4.8 NMAC – N, 2/25/2020]

13.19.4.9 MULTIPLE EMPLOYER WELFARE ARRANGEMENT OR ASSOCIATION HEALTH PLAN NAME:

A. Name. No MEWA formed pursuant to this rule shall take any name that is the same as or closely resembles the name of any other MEWA possessing registration and doing business in this state. A MEWA must complete its application for registration to transact business under its own name and shall not adopt any assumed name, except that a MEWA by amending its articles may change its name or take a new name with the approval of the superintendent. A MEWA shall clearly state this name on all advertising materials.

B. Legal proceedings. Whenever it shall be necessary in any legal proceeding to prove the existence of a MEWA, a certified copy of the MEWA registration in this state shall be prima facie evidence of the existence of the MEWA.

[13.19.4.9 NMAC – N, 2/25/2020]

13.19.4.10 DUTIES AND COMPENSATION OF TRUSTEES, OFFICERS OR DIRECTORS:

A. Responsibilities of trustees, officers or directors. The trustees, officers or directors of a MEWA shall give the attention and exercise the vigilance, diligence, care and skill that prudent persons use in like or similar circumstances.

B. Authority of trustees, officers or directors. The board of trustees, officers or directors shall select such directors as designated in the articles or bylaws or trust agreement and may appoint agents as deemed necessary for the transaction of the business of the MEWA. All directors and agents shall respectively have such authority and perform such duties in the management of the property and affairs of the MEWA as may be delegated by the board of trustees, officers or directors. Any director or agent may be removed by the board of trustees, officers or directors whenever in their judgment the business interests of the MEWA will be served by the removal. The board of trustees, officers or directors shall secure by bond or otherwise the fidelity of any or all such directors or agents who handle the funds of the MEWA.

C. Duties of the trustees, officers or directors. The trustees, officers or directors of a MEWA are responsible for the operations of the MEWA. The directors shall have, at minimum, the following duties:

(1) fiduciary responsibility for the MEWA operation and financial condition;

(2) selection, supervision, and evaluation of the service company, financial administrator, accountant, insurer, and any other contractors;

(3) on the basis of the plan's overall financial condition, authorizing changes in premium, reserve, or investment practices; and declaring assessments or dividends as appropriate;

(4) approving all reports concerning the plan's operations and status to the superintendent and the members;

(5) monitoring delinquent premiums, loss experience, and the financial condition of individual members; and authorizing disciplinary action or expulsion as appropriate;

(6) authorizing acceptance or rejection of applications for membership;

(7) as permitted by the bylaws, making or recommending changes to the bylaws for the improvement of the plan's operation and financial integrity; and

(8) monitoring the plan's compliance with all statutes and rules governing its operation.

D. Compensation. The compensation of any commissioned sales agent shall not exceed five percent of the premium attributable to that agent.

E. Membership. Members of the MEWA's board of trustees, officers or directors shall include individuals receiving benefits from the MEWA's health plan.

[13.19.4.10 NMAC – N, 2/25/2020]

13.19.4.11 APPLICATION PROCESS FOR MEWAS:

A. Application requirements for registration generally. All MEWAs shall submit an application for registration and receive approval from the superintendent before sale of any plans or products. All application materials shall be provided in the format specified by the superintendent on the office of superintendent of insurance website.

B. Contents of application, generally. An application for registration shall include the MEWA's most current M-1 filing with the United States department of labor. Unless the information in the documents requested below is provided in the M-1 filing, the MEWA must also file:

(1) a certified copy of the formative documents that establish the MEWA entity name and type under which the MEWA will operate, the MEWA's federal employer

identification number (FEIN) and filings which demonstrate that the MEWA is authorized to do business in New Mexico;

(2) copies of all bylaws, operating agreements or similar documents that govern the control of the MEWA;

(3) the name, address, and telephone number for the contact for each association, group, trust, employer or member participating in the MEWA;

(4) the name, address, and telephone number of each officer, director, partner or trustee of the MEWA;

(5) a description of all sources of financing and revenue of the MEWA;

(6) the MEWA's current financial statements including audit reports, a balance sheet, income statement, cash flow statement and detailed listing of assets and debts, each developed according to generally accepted accounting principles;

(7) an affidavit from an officer, director, fiduciary or trustee of the MEWA attesting that, based on the affiant's informed belief, the MEWA is in compliance with all applicable provisions of ERISA;

(8) an affidavit from an officer, director, fiduciary or trustee of the MEWA attesting that, based on the affiant's informed belief, the MEWA is in compliance with all applicable provisions of the Insurance Code and applicable portions of the Affordable Care Act. Such affidavit does not absolve the MEWA from any rate or form filing requirements under 13.19.4.23 NMAC;

(9) an affidavit from an officer, director or trustee of the MEWA certifying that all association members and their employees shall be eligible for participation in the MEWA;

(10) a copy of any document executed by an employer or trust to become a member of the MEWA, including application for membership;

(11) a description of all membership requirements;

(12) the names and license numbers of any third-party benefit administrators administering health benefits offered by the MEWA;

(13) a copy of a binder or policy of stop loss coverage required by 13.19.4.19; and

(14) any additional information requested by the superintendent, including but not limited to any documents required by 13.19.4.23 to establish compliance with 13.19.4.11 NMAC

C. Additional specifications for fully-insured MEWAs. An application for a registration to operate as a fully-insured MEWA shall also include:

(1) the NAIC number of each insurer who will provide benefits on behalf of the MEWA; and

(2) all contracts between the MEWA and each insurer identified in Paragraph (1) of this subsection.

D. Additional specifications for self-insured MEWAs. An application for registration to operate as a self-insured MEWA shall also include:

(1) an actuarial opinion prepared, signed and dated by a person who is a member of the American Academy of Actuaries stating that appropriate loss and loss adjustment reserves have been established and that adequate premiums are being charged;

(2) a copy of an indemnity agreement that jointly and severally binds the MEWA and each member thereof to meet the obligations of the MEWA;

(3) a copy of a document that binds and obligates the board members of the MEWA to replace any funding shortfall relating to the MEWA operations in this state. Such document shall provide for the payment of one hundred percent of any claims covered by the plan in the event the MEWA operates in states other than New Mexico;

(4) a copy of all stop-loss or reinsurance commitments, binders or policies insuring the MEWA or its members for benefits owed under the plan;

(5) any applicable documents required to be filed pursuant to 13.2.7 NMAC; and

(6) all documents necessary to demonstrate its solvency to the superintendent's satisfaction, as set forth in 13.19.4.15 NMAC.

E. Application filing fee. The application filing fee for registration to operate as a MEWA in New Mexico shall be the same as those described under Section 59A-6-1, NMSA 1978.

[13.19.4.11 NMAC – N, 2/25/2020]

13.19.4.12 APPLICATION REVIEW AND APPROVAL PROCESS FOR MEWAS:

A. Application completion requirements. An application is not complete until the MEWA has met all the requirements of this section to the satisfaction of the superintendent. The superintendent shall examine the application and supporting

documents submitted by the applicant and shall conduct any investigation that the superintendent deems necessary. Incomplete applications shall be denied.

B. Application review. The superintendent shall register the MEWA upon finding that:

(1) the persons responsible for the conduct of the MEWA are competent, financially responsible and of good moral character;

(2) the applicant MEWA satisfies the requirements of 13.19.4.14 - 13.19.4.19 NMAC; and

(3) the applicant MEWA satisfies the requirements of 13.19.4.23 NMAC.

C. Material changes. A MEWA that has made an application under this rule shall amend such application within 30 days of the date the MEWA becomes aware, or through the exercise of due diligence should have become aware, of any material change to the information required to be filed. The amended application filing shall accurately reflect material changes to the information originally filed. Any changes made subsequent to the immediately preceding M-1 filing shall be specifically identified.

D. Rate and form filing requirements. A MEWA shall comply with the rate and form and filing requirements described in Chapter 59A, Article 18, NMSA 1978 and its implementing rules, as currently enacted or subsequently amended. All forms, rates and advertisements shall be filed through SERFF prior to use.

[13.19.4.12 NMAC – N, 2/25/2020]

13.19.4.13 REVOCATION:

The superintendent may revoke a MEWA's registration upon determining that the MEWA is no longer in compliance with any applicable provision of federal law, the Insurance Code or these rules, even if the non-compliance pre-dated registration.

[13.19.4.13 NMAC – N, 2/25/2020]

13.19.4.14 SELF-FUNDED MEWA DEPOSIT REQUIREMENTS:

A. **Deposit requirement**. Every self-funded MEWA shall make and maintain deposits in trust of for the benefit and protection of all of its participants and their beneficiaries as specified by the superintendent in the certificate of registration. The deposit shall consist of assets eligible under Section 59A-10-3 NMSA 1978, and shall be deposited with or through the superintendent or in a commercial depository located in the state of New Mexico approved by the superintendent subject to Section 59A-10-1 *et seq*., NMSA 1978.

B. Deposit release conditions. Any such deposit shall be released only in the following instances:

(1) upon extinguishment of all fixed and contingent liabilities of the MEWA secured by the deposit;

(2) upon the assumption by an authorized insurer of the MEWA's fixed and contingent liabilities secured by the deposit; or

(3) upon order of a court of competent jurisdiction, the reserve deposit may be released to the receiver, conservator, rehabilitator or liquidator of the MEWA for whose account the deposit is held.

[13.19.4.14 NMAC – N, 2/25/2020]

13.19.4.15 SELF-FUNDED MEWA MINIMUM SOLVENCY REQUIREMENTS:

A. Net worth requirements. Every self-funded MEWA shall maintain an unallocated reserve level of not less than the greater of twenty percent of the total premiums in the preceding plan year or twenty percent of the total estimated premiums for the current plan year. The superintendent may require a self-funded MEWA to maintain a minimum net worth in an amount lesser or greater than otherwise required in this rule.

B. Reserve accounting principles. Every self-funded MEWA shall establish and maintain loss and loss adjustment reserves determined by sound actuarial principles in a format consistent with that required by the national association of insurance commissioners for commercial health insurers. These principles shall give proper actuarial regard for known claims, paid and outstanding, a history of incurred but not reported claims, claims handling expenses, unearned premium, an estimate for bad debts, a trend factor and a margin for error.

C. Reserve requirements. Reserves shall be maintained in liquid admitted assets.

[13.19.4.15 NMAC – N, 2/25/2020]

13.19.4.16 ACCOUNTING STANDARDS AND REPORTING REQUIREMENTS:

A. Annual statement required. Each self-funded MEWA transacting business in this state shall file annually with the superintendent statements and reports in compliance with 13.2.5 NMAC. Additionally, each annual statement shall be filed:

(1) by June 1st of each year, financial statements audited by a certified public accountant; and

(2) by March 1st of each year, an actuarial opinion prepared and certified by an actuary who is not an employee of the self-funded MEWA and who is a fellow of the society of actuaries, a member of the American academy of actuaries, or an enrolled actuary under the Employee Retirement Income Security Act of 1974 (29 United States Code §§ 1241 and 1242). The actuarial opinion shall include:

(a) a description of the actuarial soundness of the self-funded MEWA, including any recommended actions that the self-funded MEWA should take to improve its actuarial soundness;

(b) the recommended amount of cash reserves the self-funded MEWA should maintain, which shall not be less than the greater of twenty percent of the total contributions in the preceding plan year or twenty percent of the total estimated contributions for the current plan year;

(c) a calculation of cash reserves with proper actuarial regard for known claims, paid and outstanding, a history of incurred but not reported claims, claims handling expenses, unearned premiums, an estimate for bad debts, a trend factor, and a margin for error; and

(d) the recommended level of specific and aggregate stop-loss insurance the MEWA arrangement should maintain.

B. Renewal contingent upon compliance. The superintendent shall review the statements and reports required by Subsection A of this section. Renewal of a self-funded MEWA registration is contingent upon the superintendent finding that the self-funded MEWA meets the requirements of Subsection B of 13.19.4.12 NMAC.

C. Order for actuarial review. On a finding of good cause, the superintendent may order an actuarial review of a self-funded MEWA in addition to the actuarial opinion required by this section. The cost of any such additional actuarial review shall be paid by the self-funded MEWA.

D. Quarterly reports. A self-funded MEWA shall file quarterly financial reports. Quarterly reports shall contain statements for each health benefits plan offered by the self-funded MEWA pursuant to NAIC standards set forth in Model Law 430 Section 25 and Section 26.

E. Examination timeline. The superintendent shall examine the affairs and conduct of a self-funded MEWA at least once every three years in the same manner that applies to domestic and foreign insurers with a certificate of authority to transact insurance in New Mexico. Expenses of examination shall be paid by each MEWA, or its insurers, pursuant to Section 59A-4-14 NMSA 1978.

[13.19.4.16 NMAC – N, 2/25/2020]

13.19.4.17 INVESTMENT REQUIREMENTS OF SELF-FUNDED MEWAS:

Every self-funded MEWA shall comply fully with the investment requirements of Section 59A-9-2 NMSA 1978. In addition, a MEWA must not invest in securities or debt of a member employer, or a member employer's parent, subsidiary, or affiliate; or any person or entity under contract with the MEWA.

[13.19.4.17 NMAC – N, 2/25/2020]

13.19.4.18 FINANCIAL INTEGRITY OF SELF FUNDED-MEWAS:

A. Fidelity bond. All persons who handle MEWA funds or who will have authority to gain access to MEWA funds, including trustees, officers or directors must be covered by a fidelity bond. The bond must cover losses from dishonesty, robbery, forgery or alteration, misplacement, and mysterious and unexplainable disappearance. The amount of coverage for each occurrence must be at least $300,000. The MEWA must submit a fidelity bond covering the required persons, or submit proof of coverage for all required individuals not covered under the MEWAs bond.

B. Integrity of assets. A MEWA's assets:

(1) must not be commingled with the assets of any employer member;

(2) must not be loaned to anyone for any purpose, or used as security for a loan, except as permitted under subsection C of this section for investments.

(3) must be employed solely for the purposes stated in the bylaws, and in compliance with this chapter and related statutes; and

(4) must not be considered the property or right of any member, covered employee, or other covered person, except:

(a) for benefits under the coverage documents;

(b) for dividends declared in accordance with Section 59A-37-22 NMSA 1978.

(c) for a portion of the assets remaining after the plan's dissolution.

C. Sources and uses of funds. A MEWA may expend funds for payment of losses and expenses, and for other costs customarily borne by insurers under conventional insurance policies in New Mexico. A MEWA must not borrow money or issue debt instruments, except to maintain cash flow through a stop-loss policy requiring an insurer to advance funds to the MEWA under conditions approved by the superintendent. A MEWA may bring legal suits to collect legal debts. A MEWA may receive funds only from:

(1) its members as premiums, assessments or penalties;

(2) its insurers or indemnitors pursuant to insurance or indemnification agreements;

(3) dividends, interest, or the proceeds of sale of investments;

(4) refunds of excess payments;

(5) coordination of benefits with automobile coverage, workers' compensation coverage, and other employee health benefit coverage;

(6) collection of money owed to the MEWA; or

(7) subrogation.

D. Separate accounts. A MEWA may establish separate accounts for the payment of claims or certain types of expenses. These accounts must be used only by the MEWA's third-party administrators, its authorized subcontractors or financial administrators as appropriate to the account's purpose. The amount in these special accounts must not exceed the amount reasonably sufficient to pay the claims or expenses for which it is established. All monetary and investment assets not in these accounts must be under the control of the financial administrator.

E. Monitoring financial condition. The trustees, officers or directors must review the MEWA's revenues, expenses, and loss development, and evaluate its current and expected financial condition quarterly. The trustees, officers or directors must attempt in good faith to maintain or restore the MEWA's sound financial condition, using any means at its disposal. These means include but are not limited to adjusting premium rates, underwriting standards, dividend rates, expulsion standards, and other powers granted in this rule and the bylaws. If the superintendent judges that the trustees', officers' or director's actions are inadequate to maintain or restore the plan's sound financial condition, the superintendent shall, as appropriate: order an increase in the premium rates; revoke the MEWA's registration; or order that an assessment be levied against the members.

[13.19.4.18 NMAC – N, 2/25/2020]

13.19.4.19 SELF-FUNDED MEWA STOP-LOSS COVERAGE REQUIREMENTS:

A. Purchase and alteration. A MEWA must inform the superintendent at least 180 days prior to expiration of any required stop-loss insurance policy whether it intends to renew the policy, and whether the insurer is willing to renew the policy. Alteration of a required stop-loss insurance policy midterm with the effect of reducing coverage, and cancellation by the plan midterm, is prohibited. If more than one stop-loss insurance

policy is obtained in fulfillment of this part's requirements, their expiration dates must be the same.

B. Individual excess. A MEWA shall have and maintain individual excess stop-loss insurance, that provides for the insurer to assume all liability in excess of the per person limit per year under all coverages the plan offers. The reporting period under this coverage shall be no less than one year after the fund year's conclusion.

C. Aggregate excess. A MEWA must have and maintain aggregate excess stop-loss insurance that provides for the insurer to assume all liability in excess of a specified amount of claim losses for each fund year. The aggregate excess coverage may be in the form of incurred basis stop-loss insurance or paid basis stop-loss insurance. MEWAs using paid basis stop-loss insurance shall have and maintain extended or runoff aggregate excess stop-loss insurance on an incurred basis. The extended or runoff coverage shall provide for the insurer to assume all liability in excess of a specified amount of claim losses incurred while the paid basis stop-loss insurance was in force, but paid after its termination or nonrenewal. The reporting period under paid basis insurance shall be no less than three months after the fund year's conclusion. The reporting period under incurred basis insurance, including extended or runoff insurance shall be no less than one year after the fund year's conclusion.

D. Contractual Requirements. A MEWA shall have and maintain the following language in its required aggregate excess stop-loss insurance policy, unless the superintendent determines that a policy with that language is not available in the market for stop-loss coverage, in which case, the superintendent may determine the requirements needed to obtain stop-loss coverage and meet solvency requirements: "The insurer shall, at the superintendent's request, assume direct responsibility for the MEWA's coverage and all other responsibilities under this chapter and related statutes, if the MEWA becomes insolvent, ceases operations without authorization, or otherwise fails to fulfill its responsibilities under this chapter and related statutes. The insurer may attempt to collect reimbursement from the MEWA or an employer member on whose behalf the insurer is called upon to pay premium, pay claims, or incur other extraordinary expenses. However, the insurer shall fulfill its responsibilities under this section while any collection attempts are pending. The insurer's responsibilities extend to all matters arising during or attributable to the policy period, and do not terminate with the end of the policy period."

[13.19.4.19 NMAC – N, 2/25/2020]

13.19.4.20 ENDING SELF-FUNDED, RUNOFF PERIOD, AND PLAN DISSOLUTION:

A. Ending self-funded registration. A MEWA may decide to end its self-funded registration and cease to provide coverage, effective at the end of a fund year. The MEWA shall notify the superintendent within 14 days of such a decision. A MEWA may not elect to end its self-funded registration less than 45 days prior to the end of the fund

year in question. Voluntary ending of self-funded registration does not constitute MEWA dissolution under Subsection D of this section.

B. Revocation of self-funded registration. The superintendent shall, by order, revoke the registration of a MEWA to self-insure upon ten days' written notice if any of the following events occur or conditions develop, and if the superintendent judges them to be material:

(1) failure of the MEWA to comply with this rule and all applicable statutes under the Insurance Code;

(2) failure of the MEWA to comply with any lawful order of the superintendent;

(3) commission by the MEWA of an unfair or deceptive practice or fraud as defined in Chapter 59A, Articles 16, 16b, or 16c of the Insurance Code or in related rules; or

(4) a deterioration of the MEWA's financial integrity to the extent that its present or future ability to meet obligations promptly and in full is or will be significantly impaired.

C. Runoff period. A health benefits plan offered by a MEWA shall continue to exist as a runoff plan after its self-funded registration has ended, for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the plan provided coverage. A runoff plan shall continue to comply with all appropriate provisions of this rule, and with all other applicable New Mexico statutes and rules. Authority to exist as a runoff plan is open-ended, and does not require renewal of registration.

D. Dissolution. A MEWA, including a runoff health benefits plan offered by a MEWA, which desires to cease existence shall apply to the superintendent for authorization to dissolve. Applications shall be approved or disapproved within 60 days of receipt. Dissolution without authorization is prohibited and void, and does not absolve a MEWA or runoff plan from fulfilling its continuing obligations, and does not absolve its members from assessment under premium tax law. The MEWA's assets at the time of dissolution shall be distributed to the members and covered employees as provided in the bylaws. The superintendent shall grant authorization to dissolve if either of the following conditions are met:

(1) the MEWA demonstrates that it has no outstanding liabilities, including incurred but not reported liabilities; or

(2) the MEWA has obtained an irrevocable commitment from a licensed insurer that provides for payment of all outstanding liabilities, and for providing all related services, including payment of claims, preparation of reports, and administration of transactions associated with the period when the plan provided coverage.

[13.19.4.20 NMAC – N, 2/25/2020]

13.19.4.21 EFFECT OF REGISTRATION:

A. Deemed to be an insurer. Upon approval of the application for registration, a self-funded MEWA is deemed to be an "insurer" under Subsection A of Section 59A-1-8 NMSA 1978.

B. Deemed to be an authorized issuer. Upon approval of the application for registration, a self-funded MEWA is deemed to be an authorized insurer for purposes of compliance with state and federal law.

C. Plan deemed to be a contract. The health benefits plan of a registered self-funded MEWA is deemed to be a health benefits plan under state and federal law.

[13.19.4.21 NMAC – N, 2/25/2020]

13.19.4.22 RENEWAL OF REGISTRATION:

A. Renewal requirements. A MEWA's registration shall continue in force as long as the MEWA complies with these rules and all other applicable state and federal laws, unless suspended or revoked by the superintendent or terminated at the MEWA's request, subject to continuance of the registration by the MEWA each year by:

(1) payment on or before March 1 of a $200.00 continuation fee;

(2) filing on or before March 1, by the MEWA or its authorized insurer(s), of an audited financial statement for the preceding year;

(3) timely payment by the MEWA, or its authorized insurer(s), of premium taxes for the preceding calendar year;

(4) reporting on demographic information, on a form approved by the superintendent, providing MEWA, and any third party administrator, intermediary, regulatory compliance, and insurer contacts that comply with the following requirements:

(a) the MEWA contact shall be the person responsible for filing all applicable forms and changes in information with the superintendent; and

(b) the regulatory contact shall be the person responsible for receiving notice of laws, rules, bulletins and the like that may affect the plan;

(5) notice of any changes in information previously filed with the superintendent, which shall include, but is not limited to, the following items:

(a) biographical affidavits of any new trustees, officers, directors, or other members of the association's or MEWA's governing body;

(b) the names, addresses, and qualifications of any new individuals responsible for the conduct of the plan's affairs, including third-party administrators;

(c) any new policy or amendment;

(d) any new trust agreement, plan document, plan summary, or bylaws;

(e) any new advertising and marketing material;

(f) any new members of the MEWA; and

(g) any other new agreements.

B. Expiration of registration and cure. A MEWA's registration shall expire under the same conditions and be cured by the same processes as described in Section 59A-5-23, NMSA 1978.

[13.19.4.22 NMAC – N, 2/25/2020]

13.19.4.23 RATE AND FORM FILING REQUIREMENTS:

A. Rate and form filing requirements. A MEWA selling health benefits plans to New Mexico residents or employers, or an insurance company offering coverage through a MEWA, shall set premiums in accordance with sound actuarial methods and the standards outlined below:

(1) All forms of contracts evidencing benefits provided and all premium rates proposed, including any and all amendments, endorsements, riders, certificates or other modifications to contracts or premiums, shall conform to the filing and approval requirements contained in Sections 59A-18-13.2, 59A-18-13.3 and 59A-18-13.5 NMSA 1978, and any other applicable state or federal law.

(2) All MEWAs covering New Mexico residents shall charge premium rates in compliance with state and federal law, consistent with the market in which employer member is part; that is, a self-employed individual will have an individual policy, a small business will have a small group policy, and a large employer will have a large group policy.

(3) All MEWAs covering New Mexico residents shall file forms and rates in compliance with state and federal law, consistent with the market in which employer member is part, that is, a self-employed individual will have an individual policy, a small business will have a small group policy, a large employer will have a large group policy.

(4) All MEWAs covering New Mexico residents shall cover consumer protections in compliance with state and federal law, consistent with the market in which employer member is part, that is, a self-employed individual will have an individual policy, a small business will have a small group policy, a large employer will have a large group policy.

B. Existing group rates use. A fully-insured MEWA offering small or large group coverage may use its existing small or large group rates, as applicable, without making a MEWA-specific rate filing, so long as such group rates have been filed with and approved by the superintendent and meet the requirements of this section.

C. Rate guarantee requirement. A self-insured or fully-insured MEWA offering benefits plans to individuals through sole proprietorship businesses shall guarantee the rates on all such plans for a minimum of 12 months.

D. Medical loss ratio requirements. A self-insured or fully-insured MEWA offering a health benefit plan with covered lives in New Mexico shall comply with respect to those covered lives, with the medical loss ratio and rebating requirements of New Mexico law.

E. Commissions and medical loss ratios. Any fees associated with broker services shall not be incorporated into the medical loss ratio under Subsection D of this section, but shall be incorporated into the administrative expense portion of a self-insured or fully-insured MEWA's rate filing.

F. Commission reimbursement. A self-insured or fully-insured MEWA shall not pay commissions or fees higher than the commissions allowed for the same coverage offered as a qualified health plan in the individual or small group market, as applicable.

G. Third party administrator contracts. Prior to sale of any health benefits plan, a self-insured or fully-insured MEWA shall file in SERFF as informational filings all copies of all contracts or agreements between the MEWA and any other entity that govern the management or administration of the MEWA, including any third-party benefit administrators;

H. Approval. No health benefits plan or certificate of coverage shall be delivered or issued for delivery in this state until a copy of the form and of the rules for the classification of risks has been filed with and approved by the superintendent in accordance with state law.

[13.19.4.23 NMAC - N, 2/25/2020]

13.19.4.24 MANAGED HEALTH CARE COMPLIANCE PLAN AND BENEFITS REQUIREMENTS:

A healthcare plan offered by a MEWA, or by an insurer offering coverage through a MEWA, shall comply with all state and federal laws that mandate benefits, that mandate consumer protections and that mandate managed health care requirements.

[13.19.4.24 NMAC – N, 2/25/2020]

13.19.4.25 NOTICE REQUIREMENTS:

A. Notice language. The following notice shall be provided by a MEWA or third-party administrator within the policy documents to employers and employees who obtain coverage from a MEWA:

"Notice

The [Insert the name of the MULTIPLE EMPLOYER WELFARE ARRANGEMENT in all capital letters] IS NOT AN INSURANCE COMPANY. FOR ADDITIONAL INFORMATION ABOUT THE [Insert the name of the MULTIPLE EMPLOYER WELFARE ARRANGEMENT in all capital letters] YOU SHOULD ASK QUESTIONS OF THE ADMINISTRATOR OF THE [Insert the name of the MULTIPLE EMPLOYER WELFARE ARRANGEMENT in all capital letters], OR YOU MAY CONTACT THE NEW MEXICO OFFICE OF THE SUPERINTENDENT OF INSURANCE USING THE CONTACT INFORMATION PROVIDED ON THE OSI WEBSITE."

B. Contact for superintendent. Each MEWA related notice shall include the superintendent's current consumer service telephone number and website in this notice.

C. Notice to individual and small group prospective enrollees. Any MEWA, third-party administrator or agent or producer acting on behalf of a MEWA shall provide the following information to prospective purchasers of an individual or small group health benefits plan:

(1) A statement that the individual or small group has the option of purchasing insurance on the New Mexico Health Insurance Exchange;

(2) Contact information for the New Mexico health insurance marketplace, including website and phone number;

(3) A statement that purchasing a health benefits plan through the MEWA may result in preventing the employer or individual from accessing premium subsidies, cost sharing reductions, or other financial assistance that may otherwise be available through the New Mexico health insurance exchange; and

(4) A table showing current income eligibility guidelines for Medicaid and individual and family marketplace coverage through the New Mexico health insurance exchange.

[13.19.4.25 NMAC – N, 2/25/2020]

13.19.4.26 ENROLLMENT PERIODS:

A self-funded or fully-insured MEWA shall offer open and special enrollment periods consistent with state and federal law and consistent with the market in which the employer member is a part; that is, a self-employed individual will have an individual policy, a small business will have a small group policy, and a large employer will have a large group policy.

[13.19.4.26 NMAC – N, 2/25/2020]

13.19.4.27 RECORD RETENTION:

A MEWA doing business in New Mexico shall maintain its books and records for a minimum period of seven years. Records shall be made available to the superintendent for review upon request.

[13.19.4.27 NMAC – N, 2/25/2020]

13.19.4.28 ENFORCEMENT:

A. Enforcement action for failure to comply with rule. The superintendent may revoke, suspend or refuse to continue the registration of a MEWA that fails to comply with this rule and may impose such other applicable administrative penalties authorized under the Insurance Code.

B. Cease and desist. When the superintendent believes that a MEWA or any other person is operating in this state without a registration or has violated the law or a rule or order of the superintendent, the superintendent may issue an order to cease and desist such violation or take any other action set forth in Section 59A-16-27 NMSA 1978.

C. Penalty. Any person or entity who violates any provision of this rule is subject to the penalties provided in Section 59A-1-18 NMSA 1978.

[13.19.4.28 NMAC – N, 2/25/2020]

13.19.4.29 FRAUD REPORTING REQUIREMENT:

Any regulated entity who knowingly aids, assists or abets violations of these rules is subject to the same penalties as the MEWA.

[13.19.4.29 NMAC – N, 2/25/2020]

13.19.4.30 INSURANCE AGENTS AND BROKERS:

Any person, including a licensed agent, broker or other individual, soliciting, offering or selling a health benefit plan on behalf of a MEWA to a New Mexico employer or a New Mexico resident shall comply with the following requirements:

A. Prior to completing a sale of individual or small group coverage, disclose to the employer or resident that:

(1) the agent or broker is being compensated for the sale of the health benefit plan;

(2) that the small employer or individual has the option of purchasing insurance on the New Mexico health insurance marketplace;

(3) the eligibility guidelines for Medicaid coverage and financial assistance for coverage through the New Mexico health insurance exchange;

(4) contact information for the New Mexico health insurance exchange; and

(5) a comparison table showing the similarities and differences in coverages between a MEWA with qualified health plans sold in the individual and small group market; and

B. Prior to engaging in or assisting any person to engage in selling health benefits plans through a MEWA, shall document appropriate due diligence to establish, at a minimum; the following:

(1) that the MEWA's insurer or third-party administrator is licensed in the state;

(2) that the MEWA has registered, permitting it to operate in the state;

(3) that the disclosures listed in Paragraph (1) are in the policy document; and

(4) that the advertising and marketing materials that the agent or broker is using have been approved by the superintendent.

[13.19.4.30 NMAC – N, 2/25/2020]

13.19.4.31 SHORT TERM LIMITED DURATION AND EXCEPTED BENEFIT PLANS:

Only a fully-insured MEWA shall offer a short-term or excepted benefits plan. A MEWA offering short-term or excepted benefits plans shall comply with all sections of this rule pertaining to fully-insured MEWA plan.

[13.19.4.31 NMAC – N, 2/25/2020]

13.19.4.32 VACCINE PURCHASING

ACT COMPLIANCE: A MEWA offering a major medical health benefits plan shall comply with the reporting requirements under the Vaccine Purchasing Act at 24-5a-1 et seq. NMSA 1978.

[13.19.4.32 NMAC – N, 2/25/2020]

13.19.4.33 PHARMACY BENEFIT MANAGERS:

Any self-funded or fully-insured MEWA offering drug coverage through a pharmacy benefit manager shall comply with Section 59A-61-1 et seq. NMSA 1978.

[13.19.4.33 NMAC – N, 2/25/2020]

13.19.4.34 COMPLIANCE FOR EXISTING MEWAS OR DISCRETIONARY GROUPS:

A MEWA subject to this rule on its effective date shall comply with the provisions of this rule no later than 45 days following its effective date.

[13.19.4.35 NMAC – N, 2/25/2020]

13.19.4.35 DEADLINES:

The superintendent, for good cause, may shorten or extend any deadline set by this rule or under the Insurance Code.

[13.19.4.36 NMAC – N, 2/25/2020]

13.19.4.36 RULE NONCOMPLIANCE:

Failure to comply with any provision of these rules is a violation of the Insurance Code and punishable pursuant to Section 59A-5-30 NMSA 1978.

[13.19.4.37 NMAC – N, 2/25/2020]

13.19.4.37 HEARING RIGHTS:

Any person aggrieved by any action, threatened action, or failure to act by the superintendent shall have the same right to a hearing before the superintendent with respect thereto as provided for in general under Chapter 59A, Article 4 NMSA 1978 and the implementing rules.

[13.19.4.38 NMAC – N, 2/25/2020]

13.19.4.38 SEVERABILITY:

If any provision of this rule, or the application thereof to any person or circumstance, is held invalid, such invalidity shall not affect other provisions or applications of this rule that can be given effect without the invalid provision or application, and to that end the provisions of this rule are severable.

[13.19.4.38 NMAC – N, 2/25/2020]

CHAPTER 20: MISCELLANEOUS INSURANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: BAIL BONDSMEN AND SOLICITORS

13.20.2.1 ISSUING AGENCY:

Office of Superintendent of Insurance (OSI), Post Office Box 1689, Santa Fe, NM 87504-1689.

[13 NMAC 20.2.1; - Rp, 13.20.2.1 NMAC, 7/11/17]

13.20.2.2 SCOPE:

This rule applies to all persons seeking licensure to transact, or all persons transacting bail bond business in New Mexico.

[13 NMAC 20.2.2 - Rp, 13.20.2.2 NMAC, 7/11/17]

13.20.2.3 STATUTORY AUTHORITY:

Sections 59A-2-8, 59A-2-9 NMSA 1978 and 59A-51-1 NMSA 1978 *et seq*.

[13 NMAC 20.2.3 - Rp, 13.20.2.3 NMAC, 7/11/17]

13.20.2.4 DURATION:

Permanent.

[13 NMAC 20.2.4 - Rp, 13.20.2.4 NMAC, 7/11/17]

13.20.2.5 EFFECTIVE DATE:

July 11, 2017

[13 NMAC 20.2.5 - Rp, 13.20.2.5 NMAC, 7/11/17]

13.20.2.6 OBJECTIVE:

The purpose of this rule is to implement the Bail Bondsmen Licensing Law, Section 59A-51-1 NMSA 1978 *et seq*.

[13 NMAC 20.2.6 - Rp, 13.20.2.6 NMAC, 7/11/17]

13.20.2.7 DEFINITIONS:

All of the definitions contained in the bail bondsmen licensing law are applicable in this section. Additionally, as used in this rule:

A. "Accredited provider" means a provider of either continuing education or of the required pre-licensing formal classroom education as described in Sections 13.20.2.11 NMAC and 13.20.2.12 NMAC, who has been awarded official approval by the insurance education committee and the superintendent.

B. "Clock hour" means 50 minutes of continuous formal pre-licensing or continuing education classroom education.

C. "Extraterritorial recovery" means travel outside of a 60-mile radius from the bail bondsman's physical office address for purposes of recovering and delivering an absconder to the court.

D. "Limited surety agent" has the same meaning as defined in Subsection C of Section 59A-51-2 NMSA 1978.

E. "Principal" means a person acting on behalf of the defendant to arrange for or execute a surety bond and who bears the risk upon forfeiture.

F. "Property bondsman" has the same meaning as defined in Subsection D of Section 59A-51-2 NMSA 1978.

G. "Solicitor" has the same meaning as defined in Subsection E of Section 59A-51-2 NMSA 1978.

H. "Sponsoring bondsman" means a licensed bail bondsman that has been accredited and awarded official approval by the insurance education committee and the superintendent to sponsor a solicitor and provide on-the-job training for bail bondsmen and solicitor applicants, as described in Section 13.20.2.12 NMAC.

I. "Superintendent" means the Superintendent of Insurance.

[13 NMAC 20.2.7 - Rp, 13.20.2.7 NMAC, 7/11/17]

13.20.2.8 LICENSING RESTRICTIONS:

A. All applicants.

(1) 18 U.S.C. Sections 1033 and 1034 of the Violent Crime Control and Law Enforcement Act of 1994, and the New Mexico Criminal Offender Employment Act, Section 28-2-1 NMSA 1978 *et seq*., apply to all bail bondsmen and solicitor applicants.

(2) Pursuant to Subsection A of Section 59A-51-3 NMSA 1978, no person shall act as a property bondsman, limited surety agent or solicitor, or perform any functions or duties or exercise any of the powers prescribed for bail bondsmen or solicitors in the bail bondsmen licensing law, unless such person is qualified and licensed.

B. Bail bondsmen.

(1) An individual seeking to transact or transacting both surety and property bail bonds must be licensed as both a limited surety agent and a property bondsman.

(2) A licensed bail bondsman shall not concurrently be licensed as a solicitor.

(3) A bail bondsman shall be a high school graduate or have passed a high school equivalency examination. This requirement is waived for bail bondsmen who were licensed prior to May 21, 2014.

(4) A licensed bail bondsman shall not engage in untrustworthy or incompetent conduct.

C. Solicitors.

(1) A solicitor shall not concurrently be licensed as a bail bondsman.

(2) A solicitor shall not concurrently be employed by more than one bail bondsman and must be registered with the superintendent by the employer bail bondsmen within seven days of employment.

(3) The solicitor's license shall cover the kinds of bail bonds for which the employer bail bondsman is licensed.

(4) A solicitor employed by a limited surety agent shall not sign surety bail bonds.

(5) A licensed solicitor shall not engage in untrustworthy or incompetent conduct.

D. Revocation of license. The superintendent shall suspend or revoke a license of a bondsman or a solicitor if there is a finding of conduct that was a source of injury or loss to the public, including a finding that the bondsman or solicitor licensee:

(1) is unfit to engage in the bail bond business;

(2) has engaged in actions that are detrimental to the public interest;

(3) is no longer engaging in business in good faith;

(4) is guilty of offering a rebate on commissions as surety agent or property bondsman; or

(5) has made false representation regarding the requirements and compliance with the bail bondsmen licensing law.

E. Fines and penalties. The superintendent may impose a fine not to exceed $1,000.00 for each violation and may also impose a penalty pursuant to Section 59A-1-16 NMSA 1978.

[13 NMAC 20.2.8 - Rp, 13.20.2.8 NMAC, 7/11/17]

13.20.2.9 APPLICATION FOR LICENSE:

The requirements in this section are in addition to the requirements of Section 59A-51-5 NMSA 1978.

A. All applicants.

(1) The applicant shall complete pre-licensing education, as described in Subsection B of 13.20.2.11 NMAC.

(2) The applicant shall complete on-the-job training requirements, as described in Subsection B of 13.20.2.12 NMAC.

(3) The applicant shall register for and complete the required examination. Proof of the applicant's identity, including a recent legible credential-sized full-face photograph of the applicant shall be provided by the applicant at the time of the exam and shall be submitted to the superintendent by the exam vendor along with the applicant's exam result.

(4) The applicant shall complete the license application, which shall be signed by the applicant, under oath if required by the form.

(a) The application shall state the type of license applied for.

(b) The application shall be accompanied by the license application filing fee.

(5) The application shall require such information about the applicant as:

(a) the applicant's name, date of birth, social security number, residence address, mailing address, business address and a valid electronic mail (email) address;

(b) the applicant's personal history and business experience;

(c) the applicant's experience or special training or education in the bail bond business;

(d) whether the applicant was ever previously licensed to transact bail bonds or any other insurance business in this state or elsewhere;

(e) whether any bail bondsman, insurance or other professional license of the applicant was ever refused, suspended or revoked;

(f) whether any insurer or bail bondsman claims that the applicant is indebted to it, and if so, the details of the claim;

(g) whether the applicant has ever had an insurance agency contract cancelled and the facts concerning the cancellation; and

(h) such other pertinent information about the applicant as the superintendent may reasonably require.

B. Non-resident applicants.

(1) All non-resident applicants must keep a current business, mailing, residence and email address on file with the superintendent.

(2) All non-resident applicants must irrevocably appoint the superintendent, on a form prescribed and furnished by the superintendent, as agent on whom service of process may be served.

(a) Upon service, the superintendent shall promptly forward a copy by certified mail, return receipt requested to the non-resident licensee at the non-resident licensee's last address of record.

(b) Process served and copy forwarded to the last address of record with the superintendent constitutes personal service upon the non-resident licensee.

(3) A non-resident licensee shall also file a written agreement with the superintendent, to appear before the superintendent pursuant to a notice of hearing, show cause order or subpoena issued by the superintendent and deposited, postage

paid, by certified mail in a letter depository of the United States post office, addressed to the non-resident licensee at the last address of record.

(4) A failure to appear by the non-resident licensee will constitute a consent to subsequent suspension, revocation or refusal by the superintendent to continue the license.

C. Limited surety agents.

(1) The application shall show "bail bonds" as the class of surety insurance business to be transacted.

(2) The application must be accompanied by appointment of the applicant as a limited surety agent by an authorized surety insurer, subject to issuance of the license.

(3) If required by the superintendent, the surety insurer shall certify in writing:

(a) that it has investigated the applicant's experience or training in the bail bond business;

(b) that it has investigated the applicant's business and personal reputation;

(c) that it believes the applicant is trustworthy and worthy of licensing; and

(d) that it believes the applicant intends in good faith to engage in the bail bond business.

D. Property bondsmen.

(1) The application shall show "property bail bonds" as the class of bail bond business to be transacted.

(2) The applicant shall demonstrate financial responsibility by filing a detailed financial statement, signed under oath. All instructions for preparing and submitting a detailed financial statement are available on the OSI website.

(3) Prior to issuance of the license, the applicant shall deposit with the superintendent an acceptable deposit as defined in Section 51A-51-8 NMSA.

E. Solicitors.

(1) The application shall be accompanied by a written appointment of the applicant as a solicitor by a licensed bail bondsman, subject to issuance of the license.

(2) If required by the superintendent, the sponsoring bail bondsman shall certify in writing:

(a) that he has investigated the applicant's experience or training in the bail bond business;

(b) that he has investigated the applicant's business and personal reputation;

(c) that he believes the applicant is trustworthy and worthy of licensing;

(d) that he believes the applicant intends in good faith to engage in the bail bond business; and

(e) that he shall supervise the solicitor's activities on the bondsman's behalf.

F. Approval or denial of license application.

(1) Prior to submission of an application, the applicant shall pass the examination conducted by and under authorization of the superintendent, with a score of seventy percent or higher.

(2) After completing a review of an application for a license as a bail bondsman or solicitor, the superintendent shall notify the applicant in writing whether the application has been approved or denied.

[13 NMAC 20.2.9 - Rp, 13.20.2.9 NMAC, 7/11/17]

13.20.2.10 SCOPE OF EDUCATION AND EXAMINATION:

Pre-licensing and continuing education courses, on-the-job training, and examinations shall be based on the following subjects, laws and rules:

A. Subjects:

(1) ethics;

(2) bond forfeiture procedures;

(3) rights of the accused;

(4) permitted and prohibited rates and charges;

(5) receipt and return of collateral security;

(6) financial management, accounting, trust account maintenance, and fiscal responsibilities;

(7) violations of law and applicable penalties;

(8) procedures for recovering a defendant who fails to appear and for returning a defendant to custody;

(9) record-keeping requirements;

(10) reporting requirements; and

(11) other relevant issues confronting the bail bond business in New Mexico.

B. Laws:

(1) Chapter 59A, Article 51 NMSA 1978, the Bail Bondsmen Licensing Law;

(2) all NMSA 1978 articles and sections cited in the bail bondsmen licensing law;

(3) Chapter 31, Article 3, NMSA 1978, Bail; and

(4) Chapter 46, Article 6 NMSA 1978, Surety Bonds.

C. Rules:

(1) Rule 5-401 *et seq.* NMRA 1999, Rules of Criminal Procedure for the district courts;

(2) Rule 6-401 *et seq.* NMRA 1999, Rules of Criminal Procedure for the magistrate courts;

(3) Rule 7-401 *et seq.* NMRA 1999, Rules of Criminal Procedure for the metropolitan courts;

(4) Rule 8-401 *et seq.* NMRA 1999, Rules of Criminal Procedure for the municipal courts;

(5) Forms 9-302 through 9-311 NMRA 1999, Criminal Forms;

(6) 13.4.7 NMAC, continuing education requirements; and

(7) this rule.

[13 NMAC 20.2.10 - Rp, 13.20.2.10 NMAC, 7/11/17]

13.20.2.11 PRE-LICENSING CLASSROOM EDUCATION:

A. Accreditation. A provider seeking to offer formal pre-licensing classroom education courses for bail bondsmen or solicitors shall be approved and accredited by the insurance education committee as provided in 13.4.7 NMAC, Continuing Education Requirements.

B. Pre-licensing classroom requirements. Each applicant shall complete 10 clock hours of pre-licensing classroom education using a curriculum that has been approved by the superintendent.

C. Curriculum. Once a year, during the month of January but before January 31, an accredited provider shall file a course curriculum with the superintendent for approval. The course curriculum shall be based on the subjects, laws and rules cited in 13.20.2.10 NMAC, shall describe how each subject will be taught to the applicant, and shall indicate the approximate amount of time to be allocated to each subject.

D. Course sites. Accredited providers shall offer formal pre-licensing classroom education courses in at least two geographic areas of the state located not less than 150 miles apart, as measured in driving distance from one course site to the other, until such time as the superintendent determines that sufficient classes are available statewide.

E. Certificate of completion. For each applicant who successfully completes the entire 10 clock hours of required pre-licensing classroom education, the accredited provider shall prepare and furnish to the applicant on the form provided by the superintendent a written certificate stating that the applicant has successfully completed the required formal pre-licensing classroom education in accordance with the approved curriculum. The accredited provider shall specify the number of hours the applicant attended the course.

[13 NMAC 20.2.11 - Rp, 13.20.2.11 NMAC, 7/11/17]

13.20.2.12 PRE-LICENSING ON-THE-JOB TRAINING:

A. On-the-job training plan. Once a year, during the month of January but before January 31, the sponsoring bail bondsman shall file an on-the-job training plan with the superintendent for approval. The on-the-job training plan shall be based on the subjects, laws and rules cited in 13.20.2.10 NMAC, shall describe how each subject will be taught to the applicant, and shall indicate the approximate amount of time to be allocated to each subject.

B. Training requirements. Each applicant shall complete 30 clock hours of on-the-job training under the direct supervision of a sponsoring bail bondsman.

C. Certificate of completion. For each applicant who successfully completes on-the-job training, the sponsoring bail bondsman shall certify in writing to the superintendent that the applicant has been taught the subjects pertinent to the duties

and responsibilities of a bail bondsman, including ethics, all laws and rules related to the bail bond business and that applicant is prepared to take the exam. The sponsoring bail bondsman shall prepare and furnish to the applicant on the form provided by the superintendent a written certificate stating that the applicant has successfully completed on-the-job training in accordance with the approved on-the-job training plan.

[13 NMAC 20.2.12 - Rp, 13.20.2.12 NMAC, 7/11/17]

13.20.2.13 WAIVER OF PRE-LICENSING EDUCATION REQUIREMENTS:

Upon written request from an applicant, the superintendent may, at his discretion, waive the pre-licensing education requirements whenever the applicant's background and experience so warrant.

[13 NMAC 20.2.13 - Rp, 13.20.2.14 NMAC, 7/11/17]

13.20.2.14 ELIGIBILITY FOR LICENSE:

A. Before an applicant may take the examination required for licensure, the applicant shall:

(1) complete the pre-licensing classroom education and on-the-job training required by 13.20.2.11 NMAC and 13.20.2.12 NMAC, unless the pre-licensing education requirement is waived by the superintendent as provided for in 13.20.2.13 NMAC;

(2) submit a written certificate of completion from his sponsoring bail bondsman for on-the-job training; and

(3) submit a written certificate of completion from an accredited provider for formal pre-licensing classroom education, if applicable.

B. Prior to licensure the applicant must successfully pass the examination.

[13 NMAC 20.2.14 - Rp, 13.20.2.15 NMAC, 7/11/17]

13.20.2.15 SPONSORING BAIL BONDSMEN:

A. Certification:

(1) Application: A bail bondsman seeking to be accredited as a sponsoring bail bondsman or as an accredited provider shall file an application with the superintendent on a form prescribed by the superintendent.

(2) Qualifications: The superintendent may certify a person as a sponsoring bail bondsman or an accredited provider if the person:

(a) is a licensed bail bondsman in good standing in this state or elsewhere;

(b) has been actively engaged in the bail bond business in this state or elsewhere for at least three years;

(c) has reasonable knowledge of the bail bond business and the laws and rules governing its transaction in New Mexico; and

(d) has a good business and personal reputation.

(3) Certificate: The superintendent shall issue written authorization to act as a sponsoring bail bondsman or as an accredited provider.

B. Assignment: The superintendent may assign a sponsoring bail bondsman to conduct on-the-job training for an applicant for licensure as a bail bondsman or solicitor.

C. De-certification: The superintendent may decertify a sponsoring bail bondsman for:

(1) refusal or failure to conduct on-the-job training for an applicant for licensure as a bail bondsman or solicitor; or

(2) failure to continue to meet the qualifications set forth in Paragraph (2) of Subsection A of 13.20.2.15 NMAC.

[13 NMAC 20.2.15 - Rp, 13.20.2.16 NMAC, 7/11/17]

13.20.2.16 CONTINUING EDUCATION:

Continuing education for bail bondsmen and solicitors shall be provided in accordance with 13.4.7 NMAC, Continuing Education Requirements. The continuing education hourly requirements in 13.4.7 NMAC shall be completed prior to license renewal for a bail bondsman or solicitor licensee issued a license by the superintendent.

[13 NMAC 20.2.16 - Rp, 13.20.2.17 NMAC, 7/11/17]

13.20.2.17 RESPONSIBILITIES OF BAIL BONDSMEN:

A. Permanent street address of place of business. Every bail bondsman and solicitor shall have and maintain in this state a place of business accessible to the public where the bail bondsman or solicitor principally conducts bail bond transactions. The permanent street address of such place shall appear upon the bail bondsman's or solicitor's license, and the bail bondsman shall notify the superintendent in writing or as otherwise specified by the superintendent within 30 days of any change of address. Nothing in this paragraph shall prohibit the bail bondsman from maintaining his place of business in his residence in this state as long as the residence is properly permitted by

the municipality in which the residence is located. A bondsman with more than one office location must have a permanent street address in each office location.

B. Affiliation. Any licensee licensed under the bail bond licensing law doing bail bond business in a business entity name, must complete a business entity license application, and must provide business registration documents for the business entity from the New Mexico office of secretary of state, to the superintendent. All bail bond business must be conducted in the business entity name.

C. Display of licenses. The licenses of the bail bondsman and the solicitors employed by him shall be conspicuously displayed in a part of the place of business customarily open to the public.

D. Allowable charges. A bail bondsman shall not accept any charges, fees, reimbursement or other remuneration except as approved by the superintendent.

E. Receipt for premium required. A bail bondsman shall issue a receipt for premium collected that includes the following information:

(1) the name and address of the bail bondsman or solicitor collecting premium;

(2) the face amount of the bond;

(3) the date bond was posted;

(4) the defendant's name, address and date of birth;

(5) the charges against the defendant;

(6) the date of the defendant's release;

(7) the date and time the defendant is required to appear;

(8) the case number;

(9) the name and address of the court at which the defendant must appear; and

(10) the signature of the defendant or principal acknowledging delivery of the receipt for premium.

F. Payment by credit card. A bail bondsman may accept payment by credit card as long as the fee charged by the credit card company is not passed on to the client.

G. Maintenance of bond or deposit. A bond or deposit must be maintained until all bonds that have been posted with all courts becomes exonerated.

H. Restrictions.

(1) A bondsman shall not offer a reduction in rates, charges or premiums or give or promise anything of value to the defendant or principal or anyone on behalf of the defendant or principal.

(2) A bondsman shall not suggest or recommend an attorney to represent the defendant. If pressed to provide a referral, the bondsman may suggest that the defendant or principal contact the local bar association.

(3) A bondsman shall not participate as an attorney at trial or hearing on behalf of a defendant or surety.

I. In relation to solicitors.

(1) Notice of employment. A sponsoring bondsman shall register a licensed solicitor with the superintendent within seven days of employment with the bail bondsman and shall supervise the activities of every solicitor in the bail bondsman's employ.

(2) Records of transactions. A bail bondsman shall maintain all records of his solicitors' bail bond transactions in his principal place of business, provided that a bail bondsman:

(a) may collect the records of solicitors not working out of the bail bondsman's principal place of business monthly; and

(b) shall make all records of bail bond transactions made pursuant to his license available for inspection at his principal place of business within 48 hours of a request from the superintendent.

(3) Annual report. The bail bondsman shall file an annual report with the superintendent on or before March 1 of each year, to include an alphabetic list of all solicitors whose license will be continued and who have met license renewal requirements in accordance with Section 59A-11-1, et seq.

(4) Termination. When the employment relationship between a bail bondsman and solicitor ceases as a result of either discharge or resignation, the bail bondsman shall terminate the appointment as prescribed in Section 59A-51-12B NMSA 1978.

(5) Notice of termination. When a bail bondsman terminates his relationship with a solicitor, the bail bondsman shall file a confidential written notice of the

termination with the superintendent within 30 days. This notice shall include the following:

(a) a statement that the bail bondsman has provided written notice of the termination to the solicitor; and

(b) a statement of the reason, if any, for the termination.

[13 NMAC 20.2.17 - Rp, 13.20.2.18 NMAC, 7/11/17]

13.20.2.18 RESPONSIBILITIES OF SOLICITORS:

A. The transactions of a solicitor under a solicitor's license shall be in the name of the employer bail bondsman.

B. A solicitor shall maintain records of his bail bond transactions.

C. A solicitor shall notify the superintendent and the employer bail bondsman when he ceases employment as a solicitor.

D. A solicitor shall not suggest or recommend an attorney to represent the defendant. If pressed to provide a referral, the bondsman may suggest that the defendant or principal contact the local bar association.

E. A solicitor shall not participate as an attorney at trial or hearing on behalf of a defendant or surety.

[13 NMAC 20.2.18 - Rp, 13.20.2.19 NMAC, 7/11/17]

13.20.2.19 EVIDENCE OF LICENSE AND EMPLOYMENT:

A. When posting a bail bond, a bail bondsman or solicitor transacting bail bond business in New Mexico must show that he has a valid license issued by the superintendent.

B. When countersigning bonds for another bail bondsman, a bail bondsman must show proof that he is employed by the authorizing bail bondsman.

[13 NMAC 20.2.19 - Rp, 13.20.2.20 NMAC, 7/11/17]

13.20.2.20 COLLATERAL SECURITY OR OTHER INDEMNITY:

A. Permissible forms. Collateral security may be in the form of cash or negotiable instruments, a mortgage on real property, personal property, or a lien on personal property.

B. Receipt required. A bail bondsman shall issue a receipt for collateral or security deposited with him or her that includes the following information:

(1) the depositor's name, address and date of birth;

(2) the defendant's name;

(3) a description and the actual or estimated value of the collateral or security deposited;

(4) a description of the condition of the collateral or security at the time it is received by the bail bondsman;

(5) the printed name and the signature of the person receiving the deposited collateral or security; and

(6) an acknowledgement that the collateral or security has been returned to the depositor, the date returned, and to whom.

C. Reasonable amount. A bail bondsman may charge or accept collateral or security or other indemnity that is of reasonable value in relation to the amount of the bond. No collateral or security in tangible property may be retained, sold or otherwise disposed of upon default of the premium payment. The bail bondsman's aggregate interest in any combination of collateral, security or real property shall be limited to one hundred percent of the amount of the bond.

D. Return of collateral. Except for the premium on the bond and any expenses incurred in extraterritorial recovery, a bail bondsman shall return to the client any collateral not forfeited to a court within 10 days of final termination of liability on the bond, as evidenced by receipt of the judgment and sentence in the case, a certificate of discharge, or an order releasing the bond. The client may retrieve the collateral at the bail bondsman's place of business or the bail bondsman may deliver the collateral to the client in a manner or at a location agreeable to the client. A bail bondsman shall not use collateral to pay for expenses of recovering a defendant who fails to appear.

E. Unclaimed collateral. A bail bondsman shall maintain and dispose of any unclaimed collateral in accordance with the Uniform Unclaimed Property Act, Sections 7-8A-1 NMSA 1978 *et seq*.

[13 NMAC 20.2.20 - Rp, 13.20.2.21 NMAC, 7/11/17]

13.20.2.21 RECORDS OF OPERATIONS:

Every bail bondsman shall keep the records required by Subsections A and B of 13.20.2.22 NMAC for at least three years after final termination of liability on the bond

and the records required by Subsection C of 13.20.2.22 NMAC for at least five years after final termination of liability on the bond.

A. Bail bond transactions. The record of bail bond transactions shall show:

(1) the name of the solicitor or bondsman involved in the transaction, if any;

(2) the name and address of the defendant;

(3) the name and address of the person paying the premium for the bail bond;

(4) the court in which the bail bond was posted;

(5) the type of bail bond;

(6) the amount of the premium; and

(7) whether the bond was forfeited.

B. Receipt and return of collateral security in the form of property. The record of property received and returned shall show:

(1) the date the property was received;

(2) the name and address of the person from whom the property was received;

(3) a description of the collateral;

(4) the estimated value of the collateral; and

(5) the date the property was returned.

C. Receipt and return of collateral security in the form of cash or negotiable instruments. Cash and negotiable instruments received as collateral security shall be deposited in one or more trust accounts maintained for that purpose. The record of trust accounts shall show:

(1) the date the cash or negotiable instrument was received;

(2) the amount of the cash or negotiable instrument received;

(3) the name and address of the person from whom the cash or negotiable instrument was received;

(4) the name and address of the financial institution maintaining the trust account;

(5) the date of each disbursement;

(6) the amount of each disbursement;

(7) the name of the person to whom the disbursement was made; and

(8) the reason for the disbursement.

[13 NMAC 20.2.21 - Rp, 13.20.2.22 NMAC, 7/11/17]

13.20.2.22 PROPERTY BONDSMAN'S SCHEDULE OF CHARGES AND RATING PLAN:

Every property bondsman shall maintain records to confirm compliance with the superintendent's published premium rates, schedule of charges and rating plan. The superintendent may, if he deems it necessary to evaluate compliance require the property bondman to submit audited financial statements under oath.

A. The published premium rates, schedule of charges and rating plan shall be available on the OSI website and will be updated periodically, pursuant to a public hearing, as deemed necessary by the superintendent.

B. The published premium rates, schedule of charges and rating plan shall be:

(1) posted in a conspicuous place in the bail bondsman's place of business;

(2) available for public inspection in the offices of the superintendent; and

(3) provided to any court upon request.

[13 NMAC 20.2.22 - Rp, 13.20.2.23 NMAC, 7/11/17]

13.20.2.23 INSTRUCTIONS FOR PREPARING AND SUBMITTING THE ANNUAL FINANCIAL STATEMENT:

Upon the licensee's renewal anniversary date, property bondsman must submit a detailed financial statement to the OSI examinations bureau. All instructions for preparing and submitting a financial statement are posted on the OSI website at: http://www.osi.state.nm.us/. In lieu of submitting the detailed financial statement, the licensee may provide a copy of the most recent federal tax return along with evidence that any funds due pursuant to the return were also submitted.

[13 NMAC 20.2.23 - Rp, 13.20.2.24 NMAC, 7/11/17]

13.20.2.24 – 13.20.2.33 [RESERVED]

CHAPTER 21: PATIENT'S COMPENSATION FUND

PART 1: GENERAL PROVISIONS

13.21.1.1 ISSUING AGENCY:

New Mexico Superintendent of Insurance (the superintendent).

[13.21.1.1 NMAC –Rp, 13.21.1.1 NMAC, 01/01/2022]

13.21.1.2 SCOPE:

The rules of Chapter 21 provide for and govern the organization, administration, and defense of the New Mexico Patient's Compensation Fund (the fund).

[13.21.1.2 NMAC –Rp, 13.21.1.2 NMAC, 01/01/2022]

13.21.1.3 STATUTORY AUTHORITY:

Section 41-5-25 NMSA 1978;

[13.21.1.3 NMAC –Rp, 13.21.1.3 NMAC, 01/01/2022]

13.21.1.4 DURATION:

Permanent.

[13.21.1.4 NMAC –Rp, 13.21.1.4 NMAC, 01/01/2022]

13.21.1.5 EFFECTIVE DATE:

January 1, 2022, unless a later date is cited at the end of a section.

[13.21.1.5 NMAC –Rp, 13.21.1.5 NMAC, 01/01/2022]

13.21.1.6 OBJECTIVE:

The rules of Chapter 21 are adopted and promulgated to ensure that the *Patient's Compensation Fund* is organized, administered, and operated on a financially and actuarially sound basis so as to achieve the purpose for which it was established. The rules adopted in Chapter 21 shall be construed, interpreted, and applied to achieve the purposes and objectives for which the fund was established.

[13.21.1.6 NMAC –Rp, 13.21.1.6 NMAC, 01/01/2022]

13.21.1.7 DEFINITIONS:

This chapter adopts the definitions found in Section 41-5-3 NMSA 1978, in Section 14-4-2 NMSA 1978, in Chapter 59A, Article 1, NMSA 1978, and in 1.24.1.7 NMAC. In addition:

A. "Base coverage" means the medical malpractice liability coverage, as required by the MMA or as determined by the superintendent for a hospital or outpatient health care facility, that must be provided by an insurance policy issued to a health care provider;

B. "Insured" means a health care provider insured under a medical malpractice liability insurance policy;

C. "MMA" means the New Mexico Medical Malpractice Act, Sections 41-5-1 through 41-5-29 NMSA 1978;

D. "Occurrence coverage" means malpractice liability insurance for medical malpractice that occurs during the policy term, regardless of when the claim was reported;

E. "Qualified health care provider" or **"QHP"** means a health care provider, as defined in Subsection A of Section 41-5-1 NMSA 1978, who is admitted to the fund pursuant to these rules;

F. "Self-insured" means a person who satisfies, or seeks to satisfy, the requirements for becoming a "qualified health care provider " by depositing funds with the superintendent;

G. "Slot coverage" means prohibited coverage for more than one part-time health care provider on a "full-time equivalency " (FTE) basis calculated on how many hours, collectively, the part-time health care providers would be working during the period of coverage and calculating the premium as comparable to the one full-time health care provider's premium; and

H. "Third-party administrator" or **"TPA"** means the third-party administrator identified in Section 41-5-25 NMSA 1978.

[13.21.1.7 NMAC –Rp, 13.21.1.7 NMAC, 01/01/2022]

13.21.1.8 RESPONSIBILITIES OF THE THIRD-PARTY ADMINISTRATOR:

The third-party administrator shall demonstrate its qualifications through prior experience fulfilling responsibilities similar to those set forth herein and have the responsibility to

A. receive and process health care provider requests for admission to the fund;

B. determine whether applicants for admission satisfy the standards of financial responsibility and possess the other qualifications for admission specified by these rules;

C. timely collect surcharges from, or paid by insurers on behalf of, health care providers;

D. certify periods of admission of qualified health care providers;

E. process claims against qualified health care providers or the fund in accordance with the MMA and these rules;

F. collect and maintain claims experience and surcharge data;

G. purchase insurance for the fund and its obligations;

H. retain actuarial, legal and claim adjusting services for the fund;

I. negotiate reasonable and appropriate compromises and settlements of the fund's liability respecting any claim against the fund and obtain approval from the superintendent or the superintendent's designee before entering into an agreement involving PCF funds;

J. pay judgments, settlements, arbitration awards, and medical expenses for which the fund is responsible;

K. at the direction of the superintendent, develop and maintain a website linked to the office of superintendent of insurance website;

L. provide an annual audit of the fund to the superintendent;

M. subject to approval from the superintendent, develop methodology for allocating liability for any fund deficit among health care providers; and

N. discharge and perform such other duties, responsibilities, functions, and activities as are expressly or impliedly imposed on the TPA by the MMA, as directed by the superintendent or as specified by these rules.

[13.21.1.8 NMAC –Rp, 13.21.1.8 NMAC, 01/01/2022]

13.21.1.9 EXPENSES OF ADMINISTRATION AND DEFENSE:

All expenses incurred for, by, or on behalf of the superintendent or the TPA in the administration, operation, and defense of the fund shall be borne by the fund.

[13.21.1.9 NMAC –Rp, 13.21.1.9 NMAC, 01/01/2022]

13.21.1.10 REFERENCE TO OTHER DOCUMENTS:

When a rule issued by the superintendent relating to the MMA or the fund refers to another rule, regulation, statute, or other document, the reference, unless stated specifically to the contrary, is continuous and intended to refer to all amendments of the rule, regulation, statute, or document.

[13.21.1.10 NMAC –Rp, 13.21.1.10 NMAC, 01/01/2022]

13.21.1.11 INTERPRETATION OF TERMS:

Unless the context otherwise requires:

A. Singular/plural. Words used in the singular include the plural; words used in the plural include the singular;

B. Gender. Words used in the neuter gender include the masculine and the feminine. The personal pronoun in either gender may be used in these rules to refer to any person, firm or corporation.

C. Permissive/mandatory. May is permissive; shall and must are mandatory.

[13.21.1.11 NMAC –Rp, 13.21.1.11 NMAC, 01/01/2022]

13.21.1.12 USE OF PRESCRIBED FORMS:

The TPA may prescribe forms to carry out certain requirements of Chapter 21 of these rules. Prescribed forms must be used when a form exists for the purpose, unless these rules state otherwise or the TPA waives this requirement. The TPA shall accept filings made on photocopies of prescribed forms, provided they are legible.

[13.21.1.12 NMAC –Rp, 13.21.1.12 NMAC, 01/01/2022]

13.21.1.13 ADDRESS FOR FILING DOCUMENTS:

The TPA shall post filing and contact information on the Patient's Compensation Fund website.

[13.21.1.13 NMAC –Rp, 13.21.1.13 NMAC, 01/01/2022]

13.21.1.14 SEVERABILITY:

If any provision of Chapter 21 of these rules, or the application or enforcement thereof, is held invalid, such invalidity shall not affect other provisions or applications of Chapter

21 these rules which can be given effect without the invalid provisions or applications, and to this end the several provisions of Chapter 21 of these rules are hereby declared severable.

[13.21.1.14 NMAC –Rp, 13.21.1.14 NMAC, 01/01/2022]

PART 2: QUALIFICATIONS AND ADMISSIONS

13.21.2.1 ISSUING AGENCY:

The New Mexico Superintendent of Insurance.

[13.21.2.1 NMAC –Rp, 13.21.2.1 NMAC, 01/01/2022]

13.21.2.2 SCOPE:

The rules in this part govern the qualification and admission of health care providers to the Patient's Compensation Fund (the fund).

[13.21.2.2 NMAC – Rp,13.21.2.2 NMAC, 01/01/2022]

13.21.2.3 STATUTORY AUTHORITY:

Section 41-5-25 NMSA 1978.

[13.21.2.3 NMAC – Rp,13.21.2.3 NMAC, 01/01/2022]

13.21.2.4 DURATION:

Permanent.

[13.21.2.4 NMAC – Rp,13.21.2.4 NMAC, 01/01/2022]

13.21.2.5 EFFECTIVE DATE:

January 1, 2022, unless a later date is cited at the end of a section.

[13.21.2.5 NMAC – Rp,13.21.2.5 NMAC, 01/01/2022]

13.21.2.6 OBJECTIVE:

The rules in this part are intended to ensure that health care providers are qualified for and admitted to the fund on a financially and actuarially sound basis.

[13.21.2.6 NMAC – Rp,13.21.2.6 NMAC, 01/01/2022]

13.21.2.7 DEFINITIONS:

This rule adopts the definitions found in Section 41-5-3 NMSA 1978, in Section 14-4-2 NMSA 1978, in Chapter 59A, Article 1 NMSA 1978, in 1.24.1.7 NMAC, and in 13.21.1.7 NMAC.

[13.21.2.7 NMAC – Rp,13.21.2.7 NMAC, 01/01/2022]

13.21.2.8 BASIC QUALIFICATIONS FOR ADMISSION TO THE FUND:

A. To be eligible for admission to the fund, a person shall:

(1) be a health care provider, as defined by the MMA or by these rules, who is engaged in the provision of health care services within the state of New Mexico, and is not organized solely or primarily for the purpose of qualifying for admission to the fund;

(2) demonstrate and maintain, to the satisfaction of and in the manner specified by the superintendent and in accordance with the standards prescribed by these rules, or as otherwise provided by law, financial responsibility for, and with respect to, malpractice or professional liability claims asserted against the person or institution;

(3) apply for admission pursuant to these rules; and

(4) pay the applicable surcharges and assessments to the fund.

B. Part-time health care providers and locum tenens may be enrolled individually in the fund, paying their class surcharge on a pro rata basis.

C. An independent provider that is a business entity, including solo corporations:

(1) must have at least one qualified health care provider as a member or employee of the entity;

(2) must have all qualifiable health care provider members or employees admitted to the fund to have the business entity eligible for fund coverage; and

(3) shall pay an applicable business entity surcharge to the fund.

D. Slot coverage is not permitted.

E. A health care provider who is a natural person may be qualified as a member or employee of more than one business entity, with the appropriate surcharges paid pro rata. The underlying medical malpractice liability insurance may be provided by different insurers.

[13.21.2.8 NMAC – Rp,13.21.2.8 NMAC, 01/01/2022]

13.21.2.9 FINANCIAL RESPONSIBILITY - INSURANCE:

A. To establish and maintain financial responsibility using insurance, the health care provider, or authorized representative of the health care provider, shall submit proof that the health care provider is or will be insured under a policy of malpractice liability insurance with indemnity limits of $250,000 per occurrence.

B. To be acceptable as evidence of malpractice liability insurance, an insurance policy:

(1) shall be issued by an insurer licensed and admitted in New Mexico by the superintendent or by a licensed risk retention group;

(2) shall, except for a hospital or outpatient health care facility, be on an occurrence coverage form approved by the superintendent;

(3) if on a claims made form issued to a hospital or outpatient health care facility, shall be on a claims made form approved by the superintendent and must include an extended reporting endorsement or equivalent tail to maintain indefinite coverage;

(4) shall provide for the insurer's assumption of the defense of any covered claim, without limitation on the insurer's maximum obligation respecting the cost of defense;

(5) shall, for an independent provider, provide coverage for not more than three separate occurrences; and

(6) shall be nonassessable.

C. Admitted carriers and risk retention groups desiring to provide malpractice liability insurance policies for the qualification of health care providers under the MMA must apply for approval from the superintendent by submitting a copy of the proposed policy forms and proposed rates to the superintendent.

D. The proof required by Subsection A of this section shall be issued and executed by an officer or authorized agent of the applicant health care provider's insurer and shall specifically identify the policyholder, the named insureds under such policy, the policy period, and the limits of coverage. Upon request by the superintendent or the TPA, such certification shall be accompanied by a certified true copy of the policy, or identification of the SERFF numbers of the specific policy form(s) previously filed with and approved by the superintendent.

E. The occurrence coverage required by this rule to demonstrate the requisite financial responsibility for qualification with the fund shall be deemed to be continuing without a lapse in coverage by the fund, provided that the health care provider meets the premium payment conditions of the underlying coverage and timely meets the surcharge payment conditions of these rules, as applicable.

[13.21.2.9 NMAC – Rp,13.21.2.9 NMAC, 01/01/2022]

13.21.2.10 FINANCIAL RESPONSIBILITY - SELF-INSURANCE:

An independent provider may qualify for admission to the fund by having continuously on deposit the sum of $750,000 in cash, as long as the following conditions are met:

A. The deposit shall be conditioned only for, dedicated exclusively to, and held in trust for the benefit and protection of and as security for the prompt payment of all medical malpractice claims arising or asserted against the health care provider.

B. A self-insured health care provider shall be required to execute a pledge agreement for the money on deposit prescribed and supplied by the superintendent.

C. Sums on deposit with the superintendent pursuant to this rule shall not be assigned, transferred, mortgaged, pledged, hypothecated, or otherwise encumbered by the health care provider nor shall any such deposit be subject to writ of attachment, sequestration, or execution except pursuant to a final judgment or court-approved settlement issued or made in connection with and arising out of a malpractice claim against the health care provider.

D. To maintain financial responsibility for continuing qualification with the fund, a self-insured health care provider shall at all times maintain the sum on deposit provided for by this rule at not less than $750,000. The value of the health care provider's deposit shall be deemed impaired when any portion is seized or released pursuant to judicial process.

E. In the event that a self-insured health care provider's deposit provided for by this rule becomes impaired, the superintendent shall give written notice of such impairment to the self-insured health care provider, and the self-insured health care provider shall, unless a longer period is provided for by the superintendent, have five days from receipt of such notice to make such additional deposit as will restore the minimum deposit value prescribed by this rule. A self-insured health care provider's qualification with the fund shall terminate on and as of the later of the last day set by these rules or, if applicable, by the superintendent, if the self-insured health care provider has not on or prior to such date restored the minimum deposit value prescribed by this rule. In the case of multiple self-insured health care providers approved by the superintendent to post one deposit, as set forth in Subsection B of this section, the admission to the fund of each member of the group or each related entity shall terminate on and as of the last day set by these rules or, if applicable, by the superintendent, if the self-insured health

care provider has not on or prior to such date restored the minimum deposit value prescribed by this rule.

F. A self-insured health care provider shall, within 120 days of receiving notice of a request for review of a malpractice claim, submit a report to the superintendent and the TPA of the anticipated exposure to the fund and the self-insured health care provider and containing sufficient details supporting the anticipated exposure. In addition, said self-insured heath care provider shall provide updates to the superintendent and the TPA when significant changes in anticipated exposure occur.

G. A self-insured health care provider who has evidenced financial responsibility pursuant to this rule may withdraw the deposit prescribed by this rule upon authorization of the superintendent. All money shall remain on deposit and pledged to the fund during the term of the health care provider's admission as a self-insured health care provider with the fund and for the longer of a three-year period following termination of such admission or as long as any medical malpractice claim is pending, whether with the medical review commission or in a court of competent jurisdiction. After this time period, authorization may be given when the health care provider files with the superintendent and the TPA, not less than 30 days prior to the date such withdrawal is to be effected, a certificate signed by the health care provider, certifying:

(1) the date the health care provider terminated admission to the fund as a self-insured health care provider;

(2) that there are no medical malpractice claims pending with the medical review commission or in a court of competent jurisdiction;

(3) that there are no unpaid final judgments or settlements against or made by the health care provider in connection with or arising out of a malpractice claim; and

(4) that there are no unasserted medical malpractice claims which are probable of assertion against the health care provider.

H. Effective as of the date on which a self-insured health care provider's deposit is withdrawn pursuant to this rule, the health care provider's admission to and qualification with the fund shall be terminated.

I. The deposit with the superintendent shall provide coverage for not more than three separate occurrences, and the limit that shall be paid from the deposit for each occurrence is $250,000.

J. The acceptance by the superintendent of the self-insurance deposit described in this rule does not create in the superintendent, the TPA, or the fund a duty to defend any health care provider making a deposit under this rule.

[13.21.2.10 NMAC – Rp,13.21.2.10 NMAC, 01/01/2022]

13.21.2.11 ADDITIONAL QUALIFICATIONS FOR HOSPITALS AND OUTPATIENT HEALTH CARE FACILITIES:

A. The superintendent shall perform a risk assessment for each applicant hospital or outpatient health care facility. If the hospital or outpatient care facility will establish and maintain financial responsibility with medical malpractice liability insurance, the superintendent may consider as the risk assessment the information and documents that the applicant submitted to its insurer, all of which shall be provided to the superintendent by, or on behalf of, the applicant, along with all other information that the superintendent has or requests of the applicant. If the hospital or outpatient care facility will be self-insured, the risk assessment shall be based on information requested by the superintendent upon forms prescribed and supplied by the superintendent. The superintendent may request and consider any additional information pertinent to a risk assessment.

B. The superintendent shall arrange for an actuarial study before determining base coverage or deposit and surcharges. If the data available for a hospital or outpatient health care facility is insufficient for actuarial analysis, due to sample size or similar inadequacies, the actuarial study may aggregate data among similar hospitals or outpatient health care facilities to achieve actuarial significance.

C. Based on the risk assessment and actuarial study the superintendent shall determine each hospital's or outpatient health care facility's base coverage and coverage terms, or, if self-insured, the required deposit, pursuant to the procedures of this section.

D. The risk assessment and actuarial study for each hospital or outpatient health care facility shall be required when the hospital or outpatient health care facility applies the first time for admission to the fund, and may be required at any other time the superintendent deems it necessary or advisable.

E. A hospital or outpatient health care facility seeking admission to the fund must apply by April 1 of the year prior to their first admission to the fund.

[13.21.2.11 NMAC – Rp,13.21.2.11 NMAC, 01/01/2022]

13.21.2.12 CONFIDENTIAL INFORMATION:

Information from any health care provider who seeks qualification and admission to the fund shall be kept confidential pursuant to the requirements of Paragraph D of Section 41-5-25 NMSA 1978.

[13.21.2.12 NMAC – Rp,13.21.2.12 NMAC, 01/01/2022]

13.21.2.13 ADMISSION PROCEDURE:

A. An application for admission to the fund shall be made to the third-party administrator through the patient's compensation fund website, which shall require the applicant to provide a legal name; professional license, certification, or registration number; information relating to the nature and scope of the applicant's practice sufficient to identify the class or category of the practitioner; information on malpractice claims previously concluded or then pending against the applicant; and such other information as the superintendent or the TPA may require.

B. The application shall be accompanied by evidence of financial responsibility in the form prescribed by these rules and the applicable surcharge as determined by the **superintendent with the advice of the advisory board.**

C. The advisory board will provide advice to the superintendent and carry out its additional obligations as set forth in Paragraph E of Section 41-5-25.1 NMSA 1978.

D. If the third-party administrator determines that an applicant does not meet the qualifications for admission to the fund set forth in the MMA and these rules, the third-party administrator shall issue a notice to that effect and notify the applicant within 15 days of receipt of the completed application. The applicant may within 15 days of receipt of the notice, appeal the determination to the superintendent by delivering a notice of appeal to the superintendent. The provisions of 13.21.4 NMAC shall apply to the appeal.

[13.21.2.13 NMAC – Rp,13.21.2.13 NMAC, 01/01/2022]

13.21.2.14 ORDER OF ADMISSION:

A. Periodically, after health care providers have been approved for admission into the fund, the TPA shall notify the superintendent, who shall issue an order of admission to the fund, which shall:

(1) identify the health care providers who have been admitted;

(2) state that the health care providers have qualified for admission to the fund pursuant to Section 41-5-5 NMSA 1978;

(3) specify the effective date and term of each admission; and

(4) for a hospital or outpatient health care facility for whom a base coverage or surcharge has been set, the amount of the base coverage or surcharge.

B. Duplicate or additional orders of admission shall be available to and upon the request of a qualified health care provider or the qualified health care provider's attorney, or professional liability insurance underwriter, when such certification is required to evidence admission to or qualification with the fund in connection with an actual or proposed malpractice claim against the health care provider.

C. A copy of each order of admission shall be available for public inspection at the main office of the superintendent on the day it is issued, and a copy of the order shall be posted on the patient's compensation fund website as soon as practicable. Posting the order on the patient's compensation fund website shall constitute delivery to the health care provider and any other interested person. Any person aggrieved by the admission of any qualified health care provider to the fund or by the conditions of the health care provider's admission may, within 15 days of issuance of the order, appeal the admission to the superintendent by delivering a notice of appeal to the superintendent. The filing of an appeal shall not operate to stay the order of admission or suspend the conditions of admission. The provisions of 13.21.4 NMAC shall apply to the appeal.

[13.21.2.14 NMAC – Rp,13.21.2.14 NMAC, 01/01/2022]

13.21.2.15 EXPIRATION OF ADMISSION AND RENEWAL OF ADMISSION:

A. Admission to the fund expires:

(1) as to a health care provider evidencing financial responsibility other than by self-insurance, on and as of:

(a) the effective date and time of termination or cancellation of the policy of the health care provider's malpractice liability coverage; or

(b) the last day of the applicable period for which the prior annual surcharge applied in the event that the annual surcharge for renewal coverage is not paid by the health care provider to the insurer on or before 30 days following the expiration of the prior admission period.

(2) as to a self-insured health care provider on and as of:

(a) the effective date and time of termination, cancellation or impairment of the health care provider's financial responsibility; or

(b) the last day of the applicable period for which the prior surcharge applied in the event that the surcharge for renewal coverage is not paid by the health care provider to the superintendent on or before 30 days following the expiration of the prior admission period.

B. Admission to the fund must be renewed by each qualified health care provider on or before expiration of the admission period in accordance with these rules.

[13.21.2.15 NMAC – Rp,13.21.2.15 NMAC, 01/01/2022]

13.21.2.16 TERMINATION OF ADMISSION:

A. A health care provider's admission to the fund shall terminate:

(1) as to a health care provider evidencing financial responsibility by proof of insurance pursuant to these rules, on and as of the effective date of cancellation of the health care provider's insurance coverage;

(2) as to a self-insured health care provider on and as of any date on which:

(a) the health care provider ceases to maintain financial responsibility in the amount and form prescribed by these rules; or

(b) the health care provider fails, within the allowed time after notice by the TPA, to provide additional security for financial responsibility when existing financial responsibility security is impaired as provided in these rules.

(3) on any date that the health care provider's professional or institutional license, certification, or registration is suspended or revoked or that the health care provider ceases to be a health care provider as defined by the MMA or these rules or otherwise ceases to be eligible for admission to the fund.

B. Upon written notice to a health care provider, or such provider's authorized representative, the TPA may terminate a health care provider's admission to the fund, effective 30 days following the mailing by registered or certified mail, return receipt requested, or giving of such notice in the event that a qualified health care provider has failed or refused to timely provide any reports or submit any information or data required to be reported or submitted by these rules. If, within 30 days of receipt of such a notice, a health care provider furnishes to the TPA any and all delinquent reports, information, and data, as specified by such notice, the health care provider's admission to the fund may be continued in effect, provided that the health care provider remains otherwise qualified for admission to the fund.

C. If the TPA terminates a health care provider's admission to the fund, the TPA shall notify the provider within 15 days of receipt of the cancellation or termination. The health care provider may, within 15 days of receipt of the notice, appeal the determination by delivering a notice of appeal to the superintendent. The provisions of 13.21.4 NMAC shall apply to the appeal.

[13.21.2.16 NMAC – Rp,13.21.2.16 NMAC, 01/01/2022]

13.21.2.17 PATIENT'S COMPENSATION FUND ACTUARY:

A. In accordance with the provisions of law applicable to contracting for personal, professional, or consulting services, the superintendent, in consultation with the advisory board, may employ or hire one or more qualified and competent actuaries to advise and consult the superintendent, the advisory board, and the TPA on all aspects of the administration, operation, and defense of the fund which require application of actuarial science.

B. An actuary may be asked to evaluate or recommend:

(1) the claims experience data required for risk assessments;

(2) the establishment, maintenance, and adjustment of reserves on individual claims against the fund and the establishment, maintenance, and adjustment of reserves for incurred but not reported claims;

(3) surcharges, rated and classified according to the classes or risks against which the fund provides compensation, that shall reasonably ensure that the fund is sufficiently funded so as to be and remain financially and actuarially capable of providing the compensation for which it is organized;

(4) each hospital's or outpatient health care facility's base coverage and coverage terms upon initial admission into the fund, and whether additional charges need to be made for initial admission to the fund; and

(5) any other actuarial questions affecting the administration, operation, and defense of the fund.

[13.21.2.17 NMAC – Rp,13.21.2.17 NMAC, 01/01/2022]

13.21.2.18 ANNUAL ACTUARIAL STUDY:

A. Annually, as required by Section 41-5-25 NMSA 1978, the superintendent shall cause an independent actuary to perform an actuarial study of the fund, and of the surcharges necessary and appropriate to ensure that it is and remains financially and actuarially sound.

B. In the performance of the actuarial study, the independent actuary shall employ sound actuarial principles.

[13.21.2.18 NMAC – Rp,13.21.2.18 NMAC, 01/01/2022]

13.21.2.19 SURCHARGES:

A. For a health care provider other than a hospital or outpatient care facility, the superintendent, with the advice of the advisory board, shall determine surcharges based on classifications and categories of medical malpractice liability risks underwritten by the fund with respect to practice type or specialties as determined and specified in the annual actuarial study pursuant to this rule.

B. For a hospital or outpatient care facility, the superintendent, with the advice of the advisory board, shall determine surcharges based on the annual actuarial study using the information specified in Paragraph D of Section 41-5-25 NMSA 1978.

[13.21.2.19 NMAC – Rp,13.21.2.19 NMAC, 01/01/2022]

13.21.2.20 PAYMENT OF SURCHARGES:

A. An insured health care provider must pay the applicable surcharge to the medical malpractice liability insurer within 30 days of the inception of coverage, and within 30 days of the inception of each period of renewal coverage.

B. A self-insured health care provider must pay the applicable surcharge within 30 days of the requested date for admission into the fund, and within 30 days of the inception of each renewal period.

[13.21.2.20 NMAC – Rp,13.21.2.20 NMAC, 01/01/2022]

13.21.2.21 ADMISSION DATE:

A. A health care provider who applied for admission to the fund prior to the effective date of these rules, and who was approved for admission prior to the effective date of these rules, shall be admitted to the fund as of the date of the prior application.

B. A health care provider whose first application for admission to the fund is made after the effective date of these rules, and who is approved for admission pursuant to these rules, will be admitted to the fund as of the date of initial application.

C. Under Sections A and B of this section, the admission date for an insured health care provider who applies to participate in the fund, and who pays all applicable surcharges to the fund, within 60 days of the inception of the base coverage, shall relate back to the inception date of the base coverage.

D. The admission of all health care providers in the fund as of December 31, 2021 shall expire at the end of December 31, 2021. The admission of any health care provider renewed or admitted to the fund on or after January 1, 2022 shall expire at the end of December 31 of the year of renewal or admission.

[13.21.2.21 NMAC – Rp,13.21.2.21 NMAC, 01/01/2022]

PART 3: PROCEDURAL RULES FOR PUBLIC RULE HEARINGS

13.21.3.1 ISSUING AGENCY:

New Mexico Superintendent of Insurance.

[13.21.3.1 NMAC – N/E, 3/01/2019; Rp, 13.21.3.1 NMAC, 4/30/2019]

13.21.3.2 SCOPE:

This rule applies to all proceedings relating to the Patient's Compensation Fund (the fund) in which the superintendent adopts rules as required by law.

[13.21.3.2 NMAC – N/E, 3/01/2019; Rp, 13.21.3.2 NMAC, 4/30/2019 A, 01/01/2022]

13.21.3.3 STATUTORY AUTHORITY:

Section 14-4-5.8 NMSA 1978.

[13.21.3.3 NMAC – N/E, 3/01/2019; Rp, 13.21.3.3 NMAC, 4/30/2019]

13.21.3.4 DURATION:

Permanent.

[13.21.3.4 NMAC – N/E, 3/01/2019; Rp, 13.21.3.4 NMAC, 4/30/2019]

13.21.3.5 EFFECTIVE DATE:

April 30, 2019, unless a later date is cited at the end of a section.

[13.21.3.5 NMAC – N/E, 3/01/2019; Rp, 13.21.3.5 NMAC, 4/30/2019]

13.21.3.6 OBJECTIVE:

To provide procedural rules for public rule hearings for use by the superintendent consistent with the State Rules Act in the organization, administration, and defense of the fund and to facilitate public engagement with the superintendent's rulemaking process in a transparent, organized, and fair manner.

[13.21.3.6 NMAC – N/E, 3/01/2019; Rp, 13.21.3.6 NMAC, 4/30/2019; A, 01/01/2022]

13.21.3.7 DEFINITIONS:

This rule adopts the definitions found in Section 41-5-3 NMSA 1978, in Section 14-4-2 NMSA 1978, in Chapter 59A, Article 1 NMSA 1978, in 1.24.1.7 NMAC, and in 13.21.1.7 NMAC. In addition:

A. "Final order" also means "concise explanatory statement" as described in Section 14-4-5.5 NMSA 1978;

B. "Logical outgrowth" occurs when a final rule differs from the proposed rule if interested parties should have anticipated that the change was possible, and thus reasonably should have filed their comments on the subject during the notice-and-comment period;

C. "Recommended decision" means the written decision of any designated hearing officer which contains a description of the rulemaking proceeding, a summary of any written comments submitted to the superintendent, a summary of any oral comments made at the public hearing, any analysis or conclusions of the designated hearing officer, and recommendations to the superintendent concerning adoption, rejection, or amendment of the proposed rule.

[13.21.3.7 NMAC – N/E, 3/01/2019; Rp, 13.21.3.7 NMAC, 4/30/2019 A, 01/01/2022]

13.21.3.8 INITIATION OF THE RULEMAKING PROCESS BY THE SUPERINTENDENT:

A. The rulemaking process may be initiated by the superintendent through a notice for a rule hearing that is publicly posted pursuant to this rule.

B. The superintendent shall proceed with the rulemaking process by posting public notice, publishing the proposed rule for comment, and setting a public rule hearing in accordance with the State Rules Act and any other applicable law.

C. Once the superintendent initiates the rulemaking process, the superintendent must maintain a record as prescribed in Section 14-4-5.4 NMSA 1978.

[13.21.3.8 NMAC – N/E, 3/01/2019; Rp, 13.21.3.8 NMAC, 4/30/2019]

13.21.3.9 INITIATION OF THE RULEMAKING PROCESS BY THE PUBLIC:

A. Any person may file a petition for rulemaking with the superintendent.

B. A petition for rulemaking shall be made in writing and include an explanation of the purpose or statement of reasons for the proposed rule. A petition shall include a citation to the legal authority authorizing the superintendent to adopt the rule and a copy of or citation to technical information, if any, that serves as the basis for the proposed rule. A petition should be as clear as possible and may include the proposed rule in underline and strikethrough format, consistent with requirements of the state records administrator.

C. The superintendent shall, if required by law, consider the petition and make a determination within 30 calendar days whether to grant or deny the petition. If the superintendent denies the petition, the superintendent shall issue a final order explaining the reason for denial. No affirmative duty to respond to a public petition is created by these rules. If a public right to petition the superintendent exists under the MMA, the superintendent must follow all timelines or responses governed by the MMA.

D. Once the superintendent initiates the rulemaking process, the superintendent must maintain a record as prescribed in Section 14-4-5.4 NMSA 1978.

[13.21.3.9 NMAC – N/E, 3/01/2019; Rp, 13.21.3.9 NMAC, 4/30/2019]

13.21.3.10 RULEMAKING NOTICE:

The superintendent shall provide to the public, as defined in Section 14-4-2 NMSA 1978, notice of the proposed rulemaking a minimum of 30 calendar days prior to the public rule hearing and in accordance with requirements of Section 14-4-5.2 NMSA 1978.

[13.21.3.10 NMAC – N/E, 3/01/2019; Rp, 13.21.3.10 NMAC, 4/30/2019]

13.21.3.11 WRITTEN COMMENT PERIOD:

A. The public comment period must be at least 30 calendar days, beginning after publication of the notice in the New Mexico register and issuance of the rulemaking notice. The superintendent shall not adopt a proposed rule before the end of the public comment period.

B. As long as the public comment period is at least 30 calendar days, the public comment period will close for initial comments at 4:00 p.m. on the day of the public hearing, or on the last day of the public hearing if the public hearing extends for more than one day. For purposes only of responses to written comments or oral comments at the public hearing, the public comment period will extend at least 10 calendar days beyond the public hearing or close of the 30 day comment period, whichever is later, unless the necessity of adopting or publishing the rule by a certain date makes the extension of the public comment period impractical.

C. A person may submit, by mail or in electronic form, written comments or responses to comments on a proposed rule, and those comments or responses shall be made part of the record. Written comments may be submitted through the end of the public comment period, and responses to comments may be submitted for an additional 10 days, unless the necessity of adopting or publishing the rule by a certain date makes a response period impractical.

D. The superintendent may decide to amend the comment period, or response period, if the superintendent provides to the public, as defined in Section 14-4-2 NMSA 1978, notice of the changes.

E. The superintendent shall post all written comments and responses on the patient's compensation fund website, as soon as practicable, and no more than three business days following receipt to allow for public review. All written comments and responses received by the superintendent shall also be available for public inspection at the main office of the superintendent.

[13.21.3.11 NMAC – Rp, 13.21.3.11 NMAC, 4/30/2019 A, 01/01/2022]

13.21.3.12 PUBLIC HEARING:

A. Prior to adopting a proposed rule, the superintendent must hold a public rule hearing. The purpose of the hearing is to provide all interested persons a reasonable opportunity to submit data, views or arguments orally or in writing on the proposed rule. The superintendent, at the superintendent's discretion, directly or through a designated hearing officer, may determine whether to hold more than one hearing.

B. The superintendent may act as the hearing officer or designate an individual hearing officer to preside over the hearing. The hearing officer may ask questions and provide comments for clarification purposes only, but should refrain from providing opinions or engaging in discussion regarding the merits of the proposed rule or any public comment presented. All written comments submitted during the public comment period, as well as any written comments submitted during the hearing, will be made part of the record.

C. Individuals wishing to provide public comment or submit information at the hearing must state their name and any relevant affiliation for the record and be recognized before presenting. Public comment shall not be taken under oath unless required by law or separate rule. Any individual who provides public comment at the hearing may be questioned by the superintendent or hearing officer or, at the discretion of the superintendent or hearing officer, or as otherwise provided by law, by other persons at the hearing.

D. The hearing shall be conducted in a fair and equitable manner. The superintendent or hearing officer may determine the format in which the hearing is conducted (e.g. introduction of each part or section one at a time for comment), but the hearing will be conducted in a simple and organized manner that facilitates public comment and a clear rulemaking record.

E. The rules of evidence do not apply to public rule hearings and the superintendent or hearing officer may, in the interest of efficiency, exclude or limit comment or questions deemed irrelevant, redundant, or unduly repetitious.

F. The superintendent must hold the hearing in a venue that reasonably accommodates all persons who wish to participate or observe, and appropriate audio equipment should be secured to ensure all in attendance can hear the proceeding and be heard when presenting comment. Reasonable efforts shall be made to accommodate the use of audio and video recording devices. Hearings shall be open to the public, but are not subject to the New Mexico Open Meetings Act.

G. The hearing shall be recorded by any stenographic method in use in the district court or by audio recording.

[13.21.3.12 NMAC – N/E, 3/01/2019; Rp, 13.21.3.12 NMAC, 4/30/2019]

13.21.3.13 RULEMAKING RECORD AND ADOPTION OF RULE:

A. The superintendent shall maintain a record of the rulemaking proceeding as required in Section 14-4-5.4 NMSA 1978, and any written comment, document, or other exhibit entered into the record during the rule hearing shall be labeled clearly. Pre-filed written comments are part of the rulemaking record without the need for formal admission. Pre-filed comments include, but are not limited to: the petition; public notices of the rulemaking, including any lists of individuals to whom notice was mailed or sent electronically; the proposed rule in underline and strikethrough format; and any written comment submitted during the comment period prior to the rule hearing. Written comments or other documents introduced during the hearing should be admitted into the record after being marked as an exhibit.

B. If the rule hearing is conducted by a designated hearing officer, the complete rulemaking record, including any memoranda summarizing the contents of the hearing, if written, shall be compiled and forwarded to the superintendent with sufficient time to review. The superintendent shall review the rulemaking record or the hearing officer's recommended decision before rendering a final decision on the proposed rule.

C. The superintendent may adopt, amend, or reject the proposed rule. Any amendments to the proposed rule must fall within the scope of the current rulemaking proceeding. Amendments to a proposed rule are within the scope of the rulemaking if the amendments:

(1) are a logical outgrowth of the rule proposed in the notice; or

(2) are proposed, or are reasonably suggested, by comments made during the comment period, and the 10 day response period after the close of the comment period has been provided, and

(a) any person affected by the adoption of the rule, if amended, should have reasonably expected that any change from the published proposed rule would affect that person's interest; or

(b) the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule.

D. The date of adoption of the proposed rule shall be the date the final order is signed by the superintendent, unless otherwise specified in the final order.

E. The final order may adopt by reference some or all of any recommended decision and shall include by reference or otherwise, but not be limited to, the following:

(1) citation to specific statutory or other authority authorizing the rule;

(2) effective date of the rule;

(3) date of adoption of the rule, if different than the date of the final order;

(4) reasons for adopting the rule, including any findings otherwise required by law of the superintendent, and a summary of any independent analysis done by the superintendent;

(5) reasons for any change between the published proposed rule and the final rule; and

(6) reasons for not accepting substantive arguments made through public comment.

[13.21.3.13 NMAC – N/E, 3/01/2019; Rp, 13.21.3.13 NMAC, 4/30/2019]

13.21.3.14 FILING AND PUBLICATION; EFFECTIVE DATE:

A. Within 15 calendar days after the date of adoption of a rule, the superintendent shall file the adopted rule with the state records administrator and shall provide to the public the adopted rule and final order in accordance with the State Rules Act.

B. Unless another date is stated in the superintendent's final order, or otherwise provided by law, the effective date of the rule shall be the date of publication in the New Mexico register.

[13.21.3.14 NMAC – N/E, 3/01/2019; Rp, 13.21.3.14 NMAC, 4/30/2019]

13.21.3.15 EMERGENCY RULES:

The superintendent shall comply with the rulemaking procedures in Section 14-4-5.6 NMSA 1978, regarding the promulgation of emergency rules.

[13.21.3.15 NMAC – N/E, 3/01/2019; Rp, 13.21.3.15 NMAC, 4/30/2019]

PART 4: ADMINISTRATIVE HEARINGS

13.21.4.1 ISSUING AGENCY:

New Mexico Superintendent of Insurance.

[13.21.4.1 NMAC – Rp, 13.21.4.1 NMAC, 4/30/2019]

13.21.4.2 SCOPE:

Except as otherwise provided, the rules in this part govern every adjudicatory proceeding, except any surcharge rate proceeding conducted pursuant to a notice of hearing issued by the superintendent on any matter delegated to the superintendent

under the Medical Malpractice Act (MMA) or the rules adopted in Chapter 21 of Title 13 of the New Mexico Administrative Code, and to any request for hearing submitted to the superintendent, unless a more specific statutory or regulatory provision applies to the specific hearing type being conducted.

[13.21.4.2 NMAC – N/E, 3/01/2019; Rp, 13.21.4.2 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.3 STATUTORY AUTHORITY:

Section 41-5-25 NMSA 1978.

[13.21.4.3 NMAC – Rp, 13.21.4.3 NMAC, 4/30/2019]

13.21.4.4 DURATION:

Permanent.

[13.21.4.4 NMAC – Rp, 13.21.4.4 NMAC, 4/30/2019]

13.21.4.5 EFFECTIVE DATE:

April 30, 2019, unless a later date is cited at the end of a section.

[13.21.4.5 NMAC – Rp, 13.21.4.5 NMAC, 4/30/2019]

13.21.4.6 OBJECTIVE:

The purpose of this rule is to provide procedures to govern administrative hearings held before the superintendent in his capacity administering the MMA.

[13.21.4.6 NMAC – Rp, 13.21.4.6 NMAC, 4/30/2019]

13.21.4.7 DEFINITIONS:

This rule adopts the definitions found in Section 41-5-3 NMSA 1978, in Section 14-4-2 NMSA 1978, in 1.24.1.7 NMAC, and in 13.21.1.7 NMAC. In addition:

A. "Attorney" means only an individual who is licensed to practice law in New Mexico or who has requested temporary licensure under the New Mexico supreme court's *pro hac vice* rules.

B. "Day or days" shall be interpreted as follows, unless otherwise specified:

(1) "Business day" means Monday through Friday, excluding any days that state offices are officially closed;

(2) one to five days means only business days; and

(3) six days or more means calendar days, including weekends and state holidays.

C. "Hearing" means an on-the-record adjudicatory proceeding before the superintendent or the before a hearing officer appointed by the superintendent.

D. "Hearing officer" is the superintendent, or a person designated by the superintendent, to serve as a neutral decision maker in a proceeding.

E. "Order" means any directive, command, determination of a disputed issue, or ruling on a disputed matter issued by the superintendent or a hearing officer in a proceeding governed by these rules.

F. "OSI" means the New Mexico office of superintendent of insurance.

G. "Party" means an entity who participates in a proceeding governed by these rules by order of the superintendent.

H. "Pleading" means any written request, motion, or proposed action filed by a party in a docketed proceeding, as set forth in 13.21.4.10 NMAC.

I. "Proceeding" means any formal adjudicatory proceeding, case, or hearing conducted by the superintendent pursuant to these rules.

J. "Request for hearing" means a formal written request for an opportunity to appear before the superintendent and offer testimony, to call witnesses, present evidence and ask questions, that is submitted by a person with respect to a particular matter where the superintendent has statutory or regulatory authority to conduct an adjudicatory proceeding.

K. "Sua Sponte" means any determination of the superintendent or of his designee made without prompting of the parties.

L. "Superintendent" means the superintendent of insurance, the office of superintendent of insurance, or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

[13.21.4.7 NMAC – N/E, 3/01/2019; Rp, 13.21.4.7 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.8 REVISION OF STANDING ORDERS:

The superintendent may issue or withdraw standing procedural orders addressing general practice issues and filing protocols for the handling of matters to be adjudicated

before the superintendent. Such standing orders will be available for public inspection at OSI office facilities, on the OSI website, and in any applicable information provided with a notice of hearing. Parties appearing before the superintendent are expected to comply with standing orders.

[13.21.4.8 NMAC – N/E, 3/01/2019; Rp, 13.21.4.8 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.9 REQUESTING A HEARING:

A. Written request required. Any person seeking a hearing before the superintendent shall file a written request for a hearing to the OSI's electronic docket or as otherwise directed by the superintendent. The request shall include all of the following:

(1) a brief summary identifying the nature of the dispute;

(2) the applicable statute, rule, bulletin, or order in dispute in the matter;

(3) a statement of the jurisdictional basis for the superintendent to adjudicate the matter;

(4) the triggering action of the superintendent, such as an order, denial, suspension, revocation, penalty, fine, rule, or interpretative publication;

(5) the requestor's reason for challenging that action or inaction; and

(6) the mailing address of the requestor.

B. Request rejected. The superintendent may reject any request for hearing if the superintendent lacks jurisdiction to adjudicate the matter; the matter is moot; or the request for hearing is procedurally or substantively deficient.

(1) If a request for hearing is rejected, the superintendent will issue an order denying the request with an explanation.

(2) If the request for hearing is deficient for any reason other than lack of subject matter jurisdiction of mootness, the requestor may correct any deficiency and resubmit the request for hearing.

C. Designation of hearing officer. Upon receipt of a request for hearing that contains all information required by Subsection A of this section and over which the superintendent has jurisdiction, the superintendent may designate a hearing officer to preside in the matter based on the knowledge, expertise, experience, efficiency, and staffing needs of the office. The superintendent may subsequently reassign the matter to a different hearing officer, if necessary. The superintendent shall assign a docket

number to be referenced in all subsequent communications and filings concerning the matter.

D. Intervenors. Any person who claims an interest relating to the subject of a notice of hearing, and is so situated that the hearing may impair or impede the person's ability to protect that interest, may apply to intervene in the proceeding.

(1) In determining whether to allow or deny intervention, the superintendent shall consider the nature of the claimed interest of the applicant, the potential impact of the superintendent's decision on the applicant's ability to protect that interest, the timeliness of the application, the potential disruption of the proceedings and prejudice to existing parties if intervention were allowed.

(2) Whether to allow intervention at the sole discretion of the superintendent.

(3) OSI staff may intervene in any proceeding as a matter of right by filing a notice of intervention.

[13.21.4.9 NMAC – N/E, 3/01/2019; Rp, 13.21.4.9 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.10 REPRESENTATION AT HEARING, FORMAL ENTRY OF APPEARANCE, SUBSTITUTION OF COUNSEL, AND WITHDRAWAL FROM REPRESENTATION:

A. Representation. Unless otherwise expressly authorized by statute, only the person challenging the action or a bona fide majority owner if the party is a business entity, or that person's attorney may represent the person in a proceeding.

B. Entry of appearance. Any attorney wishing to represent a party must file a formal written entry of appearance in the docket of the proceeding. The entry of appearance must list the attorney's mailing address, phone and fax number (if any), and an email address (if any). Any attorney wishing to substitute in for a previous attorney must file a substitution of counsel containing the same information required in the initial entry of appearance.

C. Withdrawal. An attorney who intends to withdraw from representation of a party must do so in accordance with the rules of professional conduct.

(1) Withdrawing counsel must file in the docket a written request to withdraw from representation that indicates when counsel notified the party of the withdrawal, and of the date and time of the scheduled hearing.

(2) The superintendent may deny a request to withdraw from representation only when withdrawal would have a clear, materially adverse effect on the represented party's interests and impede the conduct of a full, fair, and efficient hearing.

[13.21.4.10 NMAC – Rp, 13.21.4.10 NMAC, 4/30/2019]

13.21.4.11 FILING OF PLEADINGS:

A. Electronic docket. Individuals or their counsel may access OSI's free electronic docket to view cases and filed pleadings. Registration of a free user account is required to file pleadings into a docket or to request a hearing. Every written document that is submitted to a hearing officer or exchanged between parties for consideration, including pleadings, such as motions, responses and objections, all evidentiary documents and any other filings shall include the caption and shall be filed to the electronic docket.

B. Opening the docket. A docket shall be opened by the superintendent at the superintendent's discretion or by request for hearing filed in the OSI's electronic docket.

C. Public access. Unless otherwise determined by the superintendent upon consideration of a request by a party for confidentiality, all dockets shall be open for public inspection.

D. Filing restrictions and service.

(1) The OSI docket administrator will review all filings for compliance with these rules. Non compliance with filings will be returned to submitter for correction.

(2) The OSI's electronic docket does allow for electron service. All parties of record shall be listed on the initial request for hearing and shall be selected for service with each additional filing.

(3) All filings shall include a certificate of service that documents the method of service used. A represented party shall only be served through counsel.

(4) In-person filing shall be accepted on business days between 8:00 am. and 4:00 pm. In-person pleadings will be marked as filed on the business day that the OSI receives the pleading.

E. Filing requirements.

(1) All motions, except motions made on the record during the hearing or a continuance request made in a genuine unforeseen emergency circumstance (such as an unexpected accident, force majeure, or major medical emergency occurring in such close proximity to the date of the scheduled hearing that a written motion could not be completed), shall be in writing and shall state with particularity the grounds and the relief sought.

(2) Absent any order to the contrary, no pleading shall exceed 10 pages, excluding the caption and certificate of service, of double-spaced (except for block quotations), 12-point font. Only relevant excerpts of a motion exhibit shall be filed, with

the pertinent portions highlighted, underlined, or otherwise emphasized. All exhibits and attachments shall identify the total number of pages, and consecutive page numbers (*e.g.*, "Page 1 of 10 "). Only single-sided documents will be accepted for filing or into a record at a hearing.

F. Request for concurrence. Before submission of any motion, request for relief or request for continuance, the requesting party should make reasonable efforts to consult with each other party about that party's position on the motion unless the nature of the pleading is such that it can be reasonably assumed the requested relief would be opposed. The moving party shall state the position of each other party in the pleading.

G. Responses to pleadings.

(1) Unless a different deadline has been established by the hearing officer, each non-moving party shall have 10 calendar days to file a written response to a pleading.

(2) If a deadline for filing falls on a non-business day, the deadline falls on the next business day.

(3) The hearing officer has the discretion to extend or shorten the response deadline.

(4) Failure to file a response in opposition may be presumed to be consent to the relief sought.

(5) The hearing officer is not required to make a default ruling on any motion if the relief sought could be contrary to the facts or law on the issues.

H. In the event of a procedural defect or other error with the manner, method, or content of a submitted pleading, the hearing officer or records manager may communicate such error to the filing party and withhold filing of the pleading until the moving party remedies the procedural defect. Examples of a procedural defect include, but are not limited to, failure to certify service, failure to comply with the page limitations, failure to confer with other parties, failure to use the form or follow the specific filing method required by the OSI, submission of double-sided documents, failing to properly number pages, failure to use the correct caption of reference the assigned docket number, or failure to comply with an applicable standing order.

[13.21.4.11 NMAC – N/E, 3/01/2019; Rp, 13.21.4.11 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.12 PREHEARING CONFERENCES, STATUS CONFERENCES, AND STATUS CHECKS:

A. Purpose of prehearing conferences. The hearing officer may direct representatives for all parties to meet together or with the hearing officer present for a prehearing conference to consider any or all of the following:

(1) simplify, clarify, narrow or resolve the pending issues;

(2) stipulations and admissions of fact and of the contents and authenticity of documents;

(3) expedition in the discovery and presentation of evidence, including, but not limited to, restriction on the number of exhibits and expert, economic or technical witnesses;

(4) matters of which administrative notice will be taken; and

(5) such other matters as may aid in the orderly and expeditious disposition of the proceeding, including disclosure of the names of witnesses and the identity of documents or other physical exhibits which will be introduced in evidence in the course of the proceeding.

B. Conduct of prehearing conferences.

(1) Prehearing conferences conducted by the hearing officer may be electronically, but not stenographically, recorded. Should a party request that the recording be transcribed, that party shall pay any costs of transcription.

(2) The hearing officer may issue a written order that recites the results of the conference. Such order shall include rulings upon matters considered at the conference, together with appropriate directions to the parties. The order shall control the subsequent course of the proceeding, unless superseded by a subsequent order.

C. Status conferences.

(1) The hearing officer may require the parties to submit a written report of any conference ordered to be conducted between the parties updating the status of the proceeding in light of the conference.

(2) The hearing officer may conduct a status conference upon the request of either party or on the hearing officer's own initiative, at which time the hearing officer may require the parties, attorneys, or authorized representatives, to provide information regarding the status of a proceeding.

[13.21.4.12 NMAC – Rp, 13.21.4.12 NMAC, 4/30/2019]

13.21.4.13 HEARING LOCATION, TIME AND PLACE, NOTICE OF HEARING:

A. Location.

(1) In the absence of any statutory requirements to the contrary, all hearings conducted by the superintendent shall occur in Santa Fe, at the office of superintendent of insurance, unless the hearing officer orders the parties to appear at another location in New Mexico.

(2) The parties may express a mutual preference for location of the hearing in their request for hearing.

(3) In selecting a location other than Santa Fe, the hearing officer shall consider and give weight to the location and wishes of the parties, witnesses, access for a hearing officer with expertise in the matter, and the scheduling and staffing needs of the OSI,

(4) If selecting a location other than Santa Fe would cause an unreasonable, undue burden to any party, that party may file a written objection to the selected location within 10 days of issuance of the notice of hearing, articulating the reasons supporting the objection. The hearing officer will promptly review the objection and, upon a showing of an unreasonable, undue burden, may move the hearing to another more reasonable location and the superintendent may designate another hearing officer if necessary.

B. Notice. The superintendent will notify the parties to the hearing of the date, time and place scheduled for the hearing at least seven days before the scheduled hearing. This notice will be directed to the party's attorney, or to the last known address of any unrepresented party. Notice will be sent via US mail unless the parties have requested an alternate method of notification that is acceptable to the superintendent.

[13.21.4.13 NMAC – N/E, 3/01/2019; Rp, 13.21.4.13 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.14 TELEPHONIC, VIDEOCONFERENCE AND OTHER EQUIVALENT ELECTRONIC METHOD HEARINGS:

A. If not otherwise prohibited by statute, rule, or court ruling, the hearing officer may conduct the hearing in person or by telephone, videoconference, or other equivalent electronic method. The hearing officer shall cause a stenographic or audio recording to be made of all proceedings involving the presentation of evidence, points, authorities or argument pertaining to the merits of the matter before the hearing officer.

B. If the hearing is to be conducted by telephone, videoconference or other equivalent electronic method, the notice shall so inform the parties. Either party may file a written objection to conducting the hearing by telephone, videoconference, or other equivalent electronic method within 10 days of the notice of hearing. Failure to timely object to the conduct of a telephone, videoconference, or other equivalent electronic

method hearing constitutes consent to the hearing proceeding in that manner and waiver of any other applicable statutory in-county hearing requirement.

C. Upon receipt of a timely objection, the hearing officer shall consider the applicable legal requirements, the location of the parties and witnesses, the complexity of the particular matter, the availability of necessary electronic equipment for conduct of a full and fair hearing by telephone, videoconference, or other equivalent electronic method, and the basis of the objection in determining whether the hearing should occur at a specific location rather than via telephone, videoconference, or other equivalent electronic method.

D. Provided that the requesting party has not previously demanded an in-person hearing or otherwise objected to conducting the matter via telephone, videoconference, or other equivalent electronic methods, any party may request to appear directly or have a witness on their behalf appear via telephone, videoconference, or alternative electronic means by filing a request at least three business days before the scheduled hearing. The filing of a request to appear via telephone, videoconference, or other alternative electronic method shall be deemed as a total and complete waiver of any in-person, in-county hearing requirement and deemed as consent for all parties, all witnesses, and the hearing officer to appear via telephone, videoconference, or other equivalent electronic methods.

E. All parties appearing via telephone, videoconference, or other electronic method shall provide the hearing officer with a working email address or facsimile number for the exchange of all documentary evidence before or during the hearing.

F. Failure to follow the hearings officer's instructions for participating in the hearing via telephone, videoconference, or other equivalent electronic method will be treated as a non-appearance at the hearing.

G. Any technical issues shall be promptly reported to the hearing officer.

H. In the event that technical or other computer problems prevent a hearing by videoconference or other electronic method from occurring or otherwise interfere with maintaining or developing a complete record at the hearing, the parties agree and consent that the assigned hearing officer may continue the matter to a different time before expiration of the statutory deadline, may order the parties to appear for an in-person hearing, or may conduct the remaining portion of the hearing via telephone.

I. If the assigned hearing officer determines during the course of the hearing, either *sua sponte* or upon argument of a party, that an in-person hearing is necessary to adequately complete the record, address credibility issues, or is otherwise necessary to ensure a full or fair hearing process, the hearing officer may recess a hearing occurring by telephone, videoconference, or other equivalent electronic method and reconvene the proceeding as an in-person hearing.

[13.21.4.14 NMAC – Rp, 13.21.4.14 NMAC, 4/30/2019]

13.21.4.15 CONTINUANCES:

A. At the request of a party, a witness, or upon the hearing officer's own determination, a hearing may be continued for good cause. The hearing officer shall consider only written continuance requests made at least three working days prior to the scheduled hearing absent extraordinary, unforeseen circumstances that the requesting party or witness could not have known earlier. An order to grant or deny the request may be issued prior to the scheduled hearing or if there is insufficient time to issue an order prior to the scheduled hearing, the hearing officer may grant or deny the request on the record at the hearing. No continuance request may be granted unless there is adequate time to provide notice to the parties, subpoena witnesses and conduct the rescheduled hearing before expiration of any statutory jurisdictional deadline.

B. Within the jurisdictional time limits set by statute, the superintendent or hearing officer may *sua sponte* continue any matter as necessary to address OSI, staffing needs, to ensure efficient and adequate use of state resources, and to manage the hearing docket. To this end, the hearing officer may contact the parties to inquire about the status of a scheduled case.

C. No case shall be continued, even with a showing of good cause or an emergency circumstance, beyond any mandatory, applicable jurisdictional time limit on the case.

[13.21.4.15 NMAC – N/E, 3/01/2019; Rp, 13.21.4.15 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.16 ATTIRE AT HEARING:

All attorneys and other authorized representatives must be attired in a dignified, professional manner at all times during the hearing. Witnesses shall dress in a respectful manner. No attire or dress so flamboyant, disheveled, inflammatory, obscene, offensive or revealing as to create a distraction to the orderly conduct of the hearing will be permitted.

[13.21.4.16 NMAC – Rp, 13.21.4.16 NMAC, 4/30/2019]

13.21.4.17 BURDEN OF PROOF, PRESENTATION OF CASE, EVIDENCE:

A. Burden of proof. Unless otherwise specified by statute, the burden of proof in a proceeding is the preponderance of evidence.

B. Presentation order. The party with the burden of proof in the case will ordinarily present their case first, followed by the opposing party, if any, unless the hearing officer makes reasonable exceptions related to the availability of the witnesses and representatives or other scheduling concerns.

C. Opening statements. The hearing officer may require or allow opening statements as the circumstances justify. Opening statements are not ordinarily evidence, but without objection, may be adopted as evidence by sworn oath of the party-witness who made the opening statement.

D. Testimony under oath. All testimony must be given under oath and will be subject to questioning of each other party. The hearing officer may also ask questions of the witness as appropriate. At the hearing officer's discretion, redirect and re-cross may be allowed.

E. Closing arguments. The parties may make closing arguments, either orally at the conclusion of the case or, upon order of the hearing officer, in writing after conclusion of the hearing.

F. Post-hearing briefs. The hearing officer may also order the parties to submit further briefing on any issue in the case, and to submit proposed findings of fact and conclusions of law. The hearing officer will establish a timeline for submission of any post-hearing pleadings, including time for the parties to exchange briefs, as the hearing officer finds necessary. No decision-writing deadline commences until the parties have submitted any ordered post-hearing briefing or submission.

G. Rules of evidence.

(1) Formal rules of evidence and civil procedure shall not apply in a proceeding unless otherwise expressly and specifically required by statute, regulation, or order of the hearing officer.

(2) Relevant and material evidence shall be admissible. Irrelevant, immaterial, unreliable, or unduly repetitious evidence may be excluded.

(3) A party may offer exhibits, such as records of transactions.

(a) The party shall have the exhibits numbered by the stenographer prior to the hearing.

(b) The party shall provide copies of the evidence to the stenographer, all parties and to the hearing officer.

(c) Exhibits must be introduced and explained by a witness, who must be prepared to answer questions from the parties and the hearing officer.

(d) The hearing officer shall be asked by the party offering an exhibit to accept the exhibit into evidence. The hearing officer may be asked to consider all exhibits introduced by a witness at the conclusion of that witness's testimony or at the conclusion of that party's case.

(e) The stenographer shall retain copies of all exhibits that are admitted and shall make them a part of the record.

(4) The hearing officer shall consider and give appropriate weight to all relevant and material evidence admitted in rendering a final decision on the merits of a matter.

H. Hearsay evidence. Hearsay evidence may be admitted in a proceeding.

I. Taking notice.

(1) The hearing officer may take administrative notice of facts not subject to reasonable dispute that are generally known within the community, capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably disputed, or as provided by an applicable statute.

(2) The hearing officer may take administrative notice at any stage in the proceeding, whether *sua sponte* or at the request of a party.

(3) A party may dispute the propriety of taking administrative notice, including the opportunity to refute a noticed fact.

J. Objections.

(1) A party objecting to evidence, qualifications of an expert, a line of questioning, or the response shall timely and briefly state the grounds for the objection.

(2) Rulings on objections may be addressed on the record at the time of the objection, reserved for ruling in a subsequent written order, or noted as a continuing, ongoing objection for which ruling is reserved to later in the proceeding.

K. Audio or video evidence. Any party wishing to submit a video or audio recording into the record must provide a complete tangible, playable copy that can be retained as part of the record.

L. Size of exhibits. In general, documentary evidence should be no larger than 8.5 inches by 11 inches unless expressly allowed by the hearing officer. The hearing officer may admit larger documentary exhibits presented at hearing, provided the proponent of such exhibits provides the hearing officer with a copy of the exhibit reduced to 8.5 inches by 11 inches. After the hearing at which the exhibit was admitted, the reduced copy shall be substituted for the larger exhibit and made part of the record of the hearing. Arrangements to provide a reduced copy of a large exhibit shall be undertaken in advance of the hearing. Failure by the proponent to provide a reduced copy shall be deemed a withdrawal of the exhibit.

M. Substitutions for objects. In lieu of the introduction of tangible objects as exhibits, the hearing officer may require the moving party to submit a photograph, video, or other appropriate substitute such as a verbal description of the pertinent characteristics of the object for the record.

[13.21.4.17 NMAC – Rp, 13.21.4.17 NMAC, 4/30/2019]

13.21.4.18 WITNESSES, EXPERT WITNESSES, AND INVOCATION OF THE RULE:

A. Use of witnesses. Any person having relevant, material knowledge related to one of the issues in a hearing may testify as a witness under oath in a proceeding. Upon affirming the oath, the witness may be questioned by any party and by the hearing officer.

B. Method of appearance. Unless a more specific provision applies, witnesses are ordinarily expected to appear in the same manner or by the same method as the parties in a proceeding, absent express preapproval of the hearing officer allowing an appearance by a different method. For example, if the hearing is scheduled to be conducted in person in a specific place, the witnesses are also ordinarily expected to appear in person at that same place; however, if the matter is set to occur by telephone or videoconference, then the witnesses may ordinarily appear by telephone of videoconference.

C. Hearing officer as a witness. The current or previously assigned hearing officer in a matter shall not be called and shall not be a witness in the proceeding.

D. Use of expert witnesses.

(1) If either party intends to call and treat a particular witness as an expert witness in the proceeding, the party must identify the purported expert to the other parties and to the hearing officer at least seven days before the scheduled hearing, or with sufficient time before completion of the discovery deadline specified in a scheduling order to allow for deposition.

(2) The party shall include the scope of that expert's purported testimony relative to the proceeding, the expert's credentials, and a listing of any materials the expert reviewed as part of reaching his or her expert opinion.

(3) The opposing party may file a response in opposition before the hearing or challenge the designation of the witness as an expert during the course of the hearing.

E. Use of exclusionary rule. At the hearing, any party can invoke the exclusionary rule, excluding all witnesses other than the real party in interest, their representative, one main case agent, and any designated expert witness from the proceeding until the time of their testimony. If the rule has been invoked, the witnesses shall not discuss

their testimony with each other until the conclusion of the proceeding. When the rule has been invoked, any witness who remains in the hearing after conclusion of their testimony may not be recalled as a witness in the proceeding, except that any witness may observe the testimony of an expert witness and be recalled to provide any subsequent rebuttal testimony.

F. OSI staff as experts.

(1) The hearing officer may request one or more members of OSI staff to be present at the hearing to assist the hearing officer with any matters within the expertise of the staff person.

(2) The staff person may be called as a witness by the hearing officer and examined by the parties and the hearing officer.

(3) Any party may call the staff person as a witness.

(4) Each other party will have the opportunity to cross-examine a staff person who is called as a witness. In the discretion of the hearing officer, the hearing officer may permit re-direct or re-cross examination of the staff person.

(5) The hearing officer shall not discuss the case with the staff person outside the hearing or off the record.

(6) Any staff person requested to be present by the hearing officer shall not be subject to the exclusionary rule.

[13.21.4.18 NMAC – Rp, 13.21.4.18 NMAC, 4/30/2019]

13.21.4.19 HEARING OFFICER POWERS AND RESPONSIBILITIES:

A. General authority. The superintendent may preside over OSI, hearings or may designate a hearing officer to preside instead.

B. Duties of the hearing officer. The hearing officer shall conduct fair and impartial hearings, take all necessary action to avoid delay in the proceedings and maintain order. The hearing officer shall have the powers necessary to carry out these duties, including the following:

(1) to administer or have administered oaths and affirmations;

(2) to cause depositions to be taken;

(3) to require the production or inspection of documents and other items;

(4) to require the answering of interrogatories and requests for admissions;

(5) to rule upon offers of proof and receive evidence;

(6) to regulate the course of the hearings and the conduct of the parties and their representatives therein;

(7) to issue a scheduling order, schedule a prehearing conference for simplification of the issues, or any other proper purpose;

(8) to schedule, continue and reschedule hearings;

(9) to consider and rule upon all procedural and other motions appropriate in proceeding, including qualification of expert witnesses and admission of exhibits;

(10) to require the filing of briefs on specific legal issues prior to or after the hearing;

(11) to cause a docket to be opened and a complete record of a hearing to be made;

(12) to make and issue decisions and procedural orders;

(13) to issue subpoenas in the name of the superintendent;

(14) if acting on behalf of the superintendent, to issue a recommendation to the superintendent regarding the final resolution of the matter; and

(15) to appropriately sanction, up to exclusion, indecorous, obstinate, recalcitrant, obstreperous, unethical, unprofessional or other improper conduct that interferes with the conduct of a fair and orderly hearing or the development of a complete record.

C. Independence of the hearing officer. In the performance of these functions, the hearing officer shall not be responsible to or subject to the direction of any other officer, employee or agent of OSI or the TPA, except that a hearing officer appointed by the superintendent shall be subject to the direction of the superintendent.

D. Ex parte communication. In the performance of these functions, the hearing officer is prohibited from engaging in any improper *ex parte* communications about the substantive issues with any party on any matter. An improper *ex parte* communication occurs when the hearing officer discusses or otherwise communicates regarding the substance of a case without the opposing party being present, except that it is not an improper *ex parte* communication for the hearing officer to go on the record with only one party when the other party has failed to appear at a scheduled hearing.

E. Final order. After a thorough review of the record and any recommendation prepared by a designated hearing officer, the superintendent shall issue a final order.

No party or member of OSI or TPA staff shall engage in any *ex parte* communication with the superintendent in an attempt to influence his final decision.

[13.21.4.19 NMAC – N/E, 3/01/2019; Rp, 13.21.4.19 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.20 CLOSED OR PUBLIC HEARING, SEALED RECORDS, AND DELIBERATIVE NOTES OF HEARING OFFICER:

A. Closed hearings. Unless otherwise provided by law, ordered by the hearing officer for good cause, or required to prevent disclosure of confidential information, all hearings and the record are open to the public. Any party to a proceeding may submit a written request to close the hearing and the record to the public, which shall be granted if authorized by statute, regulation, to preserve confidentiality or to protect a party from harassment or reprisal. Any proceedings and records that involve an individual's medical issues shall be closed to the public.

B. Open hearings. If the hearing is open to the public, members of the public and the media may attend the hearing so long as they do not interrupt, interfere with, or impede the orderly, fair, and efficient hearing process. With prior consent of the hearing officer, media members may record the proceeding from a fixed location in the hearing room. The hearing officer may direct any member of the public, including media members, to leave the proceeding if they engage in any conduct that interferes with the hearing officer's ability to maintain order, develop the record, and provide a fair and efficient hearing process. The proceedings shall be made available telephonically to members of the public, including the media, upon prior request.

C. Sealed records. Upon request of any party, and upon a showing of good cause, the hearing officer may seal a particular exhibit, document, or portions of a witness's testimony from public disclosure if such items contain statutorily-protected confidential information, privileged information, or otherwise contain private identification information of a party or third party that is immaterial to a substantive issue in the proceeding or if its materiality is substantially outweighed by the prejudice of public release of the information. Upon issuance of an order sealing such documents or exhibits, these records will remain under seal throughout the proceeding and shall be returned to the submitting party at the conclusion of the appeal period or the appeal. The opposing party shall be entitled to promptly review these documents in preparing for the hearing, and may rely on those documents during the hearing as necessary to ensure a fair hearing process; however, the opposing party shall not maintain its own copy of the sealed document after conclusion of the hearing nor reveal, discuss, or disclose the contents of these sealed documents to any other party outside of the hearing process.

D. Notes of deliberation. The hearing officer's notes taken during the course of the hearing, notes generated during the decision-making process, and any draft orders or draft decisions are confidential as part of the deliberative process and are not subject to public disclosure.

[13.21.4.20 NMAC – RP, 13.21.4.20 NMAC, 4/30/2019]

13.21.4.21 SUBPOENAS:

Any request for issuance of subpoenas in matters subject to these rules shall be guided by Rule 45 of the rules of civil procedure for the district courts of New Mexico, except where provisions of that rule conflict with the powers of the superintendent. Any subpoena issued shall be in the name of the superintendent. The party requesting the subpoena shall prepare a proposed subpoena, submit the proposed subpoena to each other party and to the hearing officer for approval, and shall timely and reasonably serve the subpoena on the person or entity subject to the subpoena. Unless good cause is shown for a shorter period, a subpoena shall provide at least 10 days-notice before compelled attendance at a hearing or deposition, and at least 10 days-notice before compelled production of materials. All returns or certificates of service on served subpoenas shall be filed in the docket of the proceeding, copied to the opposing party, and shall be made part of the record of the proceeding.

[13.21.4.21 NMAC – Rp, 13.21.4.21 NMAC, 4/30/2019]

13.21.4.22 LANGUAGE INTERPRETERS:

A party to a proceeding who needs language interpreter services for translation of one language into another is responsible for arranging such service for the hearing. While the person serving as an interpreter need not be a court-certified interpreter in order to provide interpretation at a hearing, any person serving as an interpreter in a matter before the superintendent must be approved by the hearing officer and must affirm the interpreter's oath applicable in New Mexico courts. Upon reasonable notice by the party, any interpreter required to be provided under the Americans with Disabilities Act shall be provided for by the superintendent.

[13.21.4.22 NMAC – Rp, 13.21.4.22 NMAC, 4/30/2019]

13.21.4.23 FAILURE TO APPEAR:

A. Entry of default order. If a party fails to appear for a properly noticed hearing, either in person, through a permissible representative or telephonically with prior approval of the hearing officer, the person waives the right to protest or challenge superintendent's action that is the subject of the hearing notice. The matter shall go on the record for the limited purpose of addressing notice and non-appearance, and a final order shall be entered based on the waiver of the hearing by failing to appear.

B. Evidence of notice. In considering the non-appearance and whether the person received appropriate notice necessitating issuance of the order, the hearing officer may consider the contents of the docket, information conveyed to or known by the superintendent, information related to mailing, including mail tracking, returned receipt information, and notes written on returned envelopes of the United States postal service

or other mail tracking services, and arguments offered by any present party, all of which may be addressed on the record of the hearing or in any subsequent order.

C. Written order required. Oral rulings based on a party's failure to appear are not final until reduced to writing. The hearing officer may issue a different written order as new information arises after the hearing regarding whether the notice of hearing was properly sent to the correct address or otherwise properly served.

[13.21.4.23 NMAC – Rp, 13.21.4.23 NMAC, 4/30/2019]

13.21.4.24 RECONSIDERATION:

A. Time to file. A party may file a motion for reconsideration within 15 days after the date of the final order. Any other party may file a response no more than 15 days after the motion for reconsideration was filed. Motions for reconsideration that are not filed within this deadline may be denied automatically. A timely filed motion for reconsideration should be decided based on the merits, whether or not a response is filed.

B. Posture. The prevailing party shall not file a motion for reconsideration. However, if a requested action is granted in part and denied in part, either party may file a motion for reconsideration.

C. Basis for motion. Motions for reconsideration shall not endeavor to present new evidence previously available, or discoverable through reasonable diligence, to the parties before the hearing. Motions for reconsideration shall not reargue the weight of evidence already ruled upon and shall not reiterate legal arguments already ruled upon. However, a motion for reconsideration may address gross factual or legal errors or omissions contained in the final decision and order.

[13.21.4.24 NMAC – Rp, 13.21.4.24 NMAC, 4/30/2019]

13.21.4.25 APPEALS FOLLOWING HEARING:

Any party who has exhausted all administrative remedies available under these rules and who is adversely affected by a final order or decision in an adjudicatory proceeding may appeal pursuant to the provisions of Section 39-3-1.1 NMSA 1978. Each order issued by the superintendent after an adjudicatory proceeding shall include information about the appeal process for the type of case at issue. Once the appeal is filed in the appropriate court, the appealing party shall promptly provide a court-endorsed copy of the appeal to the superintendent so that the OSI records manager can prepare and submit the proper record.

[13.21.4.25 NMAC – N/E, 3/01/2019; Rp, 13.21.4.25 NMAC 4/30/2019; A, 01/01/2022]

13.21.4.26 REQUESTING COPIES OF EXHIBITS, AUDIO, OR THE ADMINISTRATIVE RECORD:

Any party may access and copy any written document filed to the docket. Copies of an audio recording or written transcript of the proceeding shall be arranged through the stenographic service. The OSI may charge a reasonable fee for copies made, consistent with OSI's fee schedule under the Inspection of Public Records Act. The superintendent may also require the requesting party to submit a computer storage device, such as a compact disc, dvd disc, blu-ray disc, or usb drive, or other tangible device for copying of any audio or video recording that is part of the administrative record.

[13.21.4.26 NMAC – N/E, 3/01/2019; Rp, 13.21.4.26 NMAC 4/30/2019; A, 01/01/2022]

PART 5: SURCHARGE RATE HEARINGS

13.21.5.1 ISSUING AGENCY:

New Mexico Superintendent of Insurance.

[13.21.5.1 NMAC – N, 01/01/2022]

13.21.5.2 SCOPE:

Except as otherwise provided, the rules in this part govern every surcharge rate proceeding conducted pursuant to Paragraph D and Paragraph F of Section 41-5-25 NMSA 1978.

[13.21.5.2 NMAC – N, 01/01/2022]

13.21.5.3 STATUTORY AUTHORITY:

Section 41-5-25 NMSA 1978.

[13.21.5.3 NMAC – N, 01/01/2022]

13.21.5.4 DURATION:

Permanent.

[13.21.5.4 NMAC – N, 01/01/2022]

13.21.5.5 EFFECTIVE DATE:

January 1, 2022, unless a later date is cited at the end of a section.

[13.21.5.5 NMAC – N, 01/01/2022]

13.21.5.6 OBJECTIVE:

The purpose of this rule is to provide procedures to govern surcharge rate hearings required by the Medical Malpractice Act.

[13.21.5.6 NMAC – N, 01/01/2022]

13.21.5.7 DEFINITIONS:

This rule adopts the definitions found in Section 41-5-3 NMSA 1978, in Section 14-4-2 NMSA 1978, in Chapter 59A, Article 1 NMSA 1978, in 1.24.1.7 NMAC, in 13.21.1.7 NMAC, and in 3.21.4.7 NMAC.

[13.21.5.7 NMAC – N, 01/01/2022]

13.21.5.8 REVISION OF STANDING ORDERS:

The superintendent may issue or withdraw standing procedural orders addressing general practice issues and filing protocols for the handling of surcharge rate hearings. Such standing orders will be available for public inspection at OSI office facilities, on the *Patient's Compensation Fund* website, and in any applicable information provided with a notice of hearing. Parties appearing at surcharge rate hearings are expected to comply with standing orders.

[13.21.5.8 NMAC – N, 01/01/2022]

13.21.5.9 ADVISORY BOARD AS HEARING OFFICER:

A. General authority. The advisory board is the hearing officer for surcharge rate hearings. The advisory board may conduct any hearing *en banc*, may designate any number of members less than its whole to conduct any hearing, or may designate a single member to conduct any hearing.

B. Duties of the advisory board. The advisory board shall conduct fair and impartial hearings, take all necessary action to avoid delay in the proceedings and maintain order. The advisory board shall have the powers necessary to carry out these duties, including the following:

(1) to administer or have administered oaths and affirmations;

(2) to cause depositions to be taken;

(3) to require the production or inspection of documents and other items;

(4) to require the answering of interrogatories and requests for admissions;

(5) to rule upon offers of proof and receive evidence;

(6) to regulate the course of the hearings and the conduct of the parties and their representatives therein;

(7) to issue a scheduling order, schedule a prehearing conference for simplification of the issues, or any other proper purpose;

(8) to schedule, continue and reschedule hearings;

(9) to consider and rule upon all procedural and other motions appropriate in the proceeding, including qualification of expert witnesses and admission of exhibits;

(10) to require the filing of briefs on specific legal issues prior to or after the hearing;

(11) to cause a complete record of a hearing to be made;

(12) to make and issue decisions and procedural orders;

(13) to issue subpoenas in the name of the superintendent;

(14) to issue a recommendation to the superintendent regarding the final resolution of the matter; and

(15) to appropriately sanction, up to exclusion, indecorous, obstinate, recalcitrant, obstreperous, unethical, unprofessional or other improper conduct that interferes with the conduct of a fair and orderly hearing or the development of a complete record.

C. Independence of the advisory board. In the performance of these functions, the advisory board shall not be responsible to or subject to the direction of any officer, employee or agent of OSI or the TPA. Pursuant to Paragraph A of Section 41-5-25.1 NMSA 1978, OSI shall provide staff services to the advisory board to assist in the administration of the hearing.

D. Ex parte communication. In the performance of these functions, the advisory board is prohibited from engaging in any improper *ex parte* communications about the substantive issues with any party on any matter. An improper *ex parte* communication occurs when the advisory board, or any of its members, discusses or otherwise communicates regarding the substance of a case without the opposing party being present, except that it is not an improper *ex parte* communication for the advisory board to go on the record with only one party when the other party has failed to appear at a scheduled hearing.

E. Recommended decision. Upon conclusion of the surcharge rate hearing, the advisory board, or a quorum thereof, shall meet to determine the surcharge rates to recommend to the superintendent. The advisory board shall base its determination upon substantial evidence in the whole record. The advisory board shall provide a written recommended decision to the superintendent on or before October 21 of each year, which shall set forth the recommended surcharge rates and a summary of the evidence supporting those rates.

F. Final order. After a thorough review of the record and the recommendation prepared by the advisory board, the superintendent shall issue a final order. No party or member of OSI or TPA staff shall engage in any *ex parte* communication with the superintendent in an attempt to influence a final decision. The superintendent may seek counsel from OSI's office of legal counsel.

[13.21.5.9 NMAC – N, 01/01/2022]

13.21.5.10 INITIATION OF THE SURCHARGE RATE HEARING:

A. Selection of actuary. No later than March 1 of each year, the advisory board shall meet with the superintendent to consult on the selection of an independent actuary to perform the independent actuarial study of the fund. The actuarial study is to be completed by August 1 of the year in which the actuary is selected.

B. Opening the docket. No later than March 15 of each year, the superintendent shall open a docket in OSI's electronic docket system for that year's surcharge rate hearing. A docket number shall be assigned and referenced in all subsequent communications and filings concerning the surcharge rate hearing.

(1) The superintendent shall file an initial order setting the surcharge rate hearing between September 15 and September 30 of each year.

(2) The superintendent shall establish the caption for the docket, which caption shall be used thereafter for any matters pertaining to the hearing. The caption shall state the nature of the matter and shall include the docket number.

(3) Every written document that is submitted to the superintendent or advisory board or exchanged between the parties for consideration, including pleadings such as motions, responses and objections, all evidentiary documents and any other filings shall include the caption and shall be filed to the docket.

C. Designation of advisory board as hearing officer. The superintendent's initial order shall designate the advisory board as the hearing officer in the surcharge rate hearing.

D. Intervenors. Any person who claims an interest relating to the surcharge rate hearing, and is so situated that the hearing may impair or impede the person's ability to protect that interest, may apply to intervene in the proceeding.

(1) In determining whether to allow or deny intervention, the advisory board shall consider the nature of the claimed interest of the applicant, the potential impact of the advisory board's decision on the applicant's ability to protect that interest, the timeliness of the application, the potential disruption of the proceedings and prejudice to existing parties if intervention were allowed.

(2) Whether to allow intervention is at the sole discretion of the advisory board.

[13.21.5.10 NMAC – N, 01/01/2022]

13.21.5.11 REPRESENTATION AT HEARING, FORMAL ENTRY OF APPEARANCE, SUBSTITUTION OF COUNSEL, AND WITHDRAWAL FROM REPRESENTATION:

A. Representation. Unless otherwise expressly authorized by statute, only a person made a party or a bona fide majority owner if the party is a business entity, or that person's attorney may represent the person in the surcharge rate proceeding.

B. Entry of appearance. Any attorney wishing to represent a party must file a formal written entry of appearance in the docket of the proceeding. The entry of appearance must list the attorney's mailing address, phone and fax number (if any), and an email address (if any). Any attorney wishing to substitute in for a previous attorney must file a substitution of counsel containing the same information required in the initial entry of appearance.

C. Withdrawal. An attorney who intends to withdraw from representation of a party must do so in accordance with the rules of professional conduct.

(1) Withdrawing counsel must file in the docket a written request to withdraw from representation that indicates when counsel notified the party of the withdrawal, and of the date and time of the scheduled hearing.

(2) The advisory board may deny a request to withdraw from representation only when withdrawal would have a clear, materially adverse effect on the represented party's interests and impede the conduct of a full, fair, and efficient hearing.

[13.21.5.11 NMAC – N, 01/01/2022]

13.21.5.12 ELECTRONIC DOCKET AND FILING OF DOCUMENTS:

A. Electronic docket. Individuals or their counsel may access OSI's free electronic docket to view cases and filed pleadings. Registration of a free user account is required to file pleadings into a docket. Every written document that is submitted to a hearing officer or exchanged between parties for consideration, including pleadings, such as motions, responses and objections, all evidentiary documents and any other filings shall include the caption and shall be filed to the electronic docket

B. Public access. Unless the document contains information protected under Paragraph D of Section 41-5-25 NMSA 1978, all documents filed in the docket for the surcharge rate proceeding shall be open for public inspection. Any protected information will be filed under seal or redacted in publicly available documents, in a manner ensuring the greatest possible public access to non-confidential information.

C. Filing restrictions and service.

(1) The OSI docket administrator will review all filings for compliance with these rules. Non-compliance with filings will be returned to submitter for correction.

(2) The OSI's electronic docket does allow for electron service. All parties of record shall be listed on the initial request for hearing and shall be selected for service with each additional filing.

(3) All filings shall include a certificate of service that documents the method of service used. A represented party shall only be served through counsel.

(4) In-person filing shall be accepted on business days between 8:00 am and 4:00 pm. In-person pleadings will be marked as filed on the business day that the OSI receives the pleading.

D. Filing requirements.

(1) All motions, except motions made on the record during the hearing or a continuance request made in a genuine unforeseen emergency circumstance (such as an unexpected accident, force majeure, or major medical emergency occurring in such close proximity to the date of the scheduled hearing that a written motion could not be completed), shall be in writing and shall state with particularity the grounds and the relief sought.

(2) Absent any order to the contrary, no pleading shall exceed 10 pages, excluding the caption and certificate of service, of double-spaced (except for block quotations), 12-point font. Only relevant excerpts of a motion exhibit shall be filed, with the pertinent portions highlighted, underlined, or otherwise emphasized. All exhibits and attachments shall identify the total number of pages, and consecutive page numbers (*e.g.*, "Page 1 of 10 "). Only single-sided documents will be accepted for filing or into a record at a hearing.

E. Request for concurrence. Before submission of any motion, request for relief or request for continuance, the requesting party should make reasonable efforts to consult with each other party about that party's position on the motion unless the nature of the pleading is such that it can be reasonably assumed the requested relief would be opposed. The moving party shall state the position of each other party in the pleading.

F. Responses to filings.

(1) Unless a different deadline has been established by the advisory board, each non-moving party shall have 10 calendar days to file a written response to a pleading.

(2) If a deadline for filing falls on a non-business day, the deadline falls on the next business day.

(3) The advisory board has the discretion to extend or shorten the response deadline.

(4) Failure to file a response in opposition may be presumed to be consent to the relief sought.

(5) The advisory board is not required to make a default ruling on any motion if the relief sought could be contrary to the facts or law on the issues.

G. In the event of a procedural defect or other error with the manner, method, or content of a submitted filing, the advisory board or records manager may communicate such error to the filing party and withhold filing of the pleading until the moving party remedies the procedural defect. Examples of a procedural defect include, but are not limited to, failure to certify service, failure to comply with the page limitations, failure to confer with other parties, failure to use the form or follow the specific filing method required by the Patient's Compensation Fund, submission of double-sided documents, failing to properly number pages, failure to use the correct caption of reference the assigned docket number, or failure to comply with an applicable standing order.

[13.21.5.12 NMAC – N, 01/01/2022]

13.21.5.13 PREHEARING CONFERENCES, STATUS CONFERENCES, AND STATUS CHECKS:

A. Purpose of prehearing conferences. The advisory board may direct representatives for all parties to meet together or with the advisory board present for a prehearing conference to consider any or all of the following:

(1) simplify, clarify, narrow or resolve the pending issues;

(2) stipulations and admissions of fact and of the contents and authenticity of documents;

(3) expedition in the discovery and presentation of evidence, including, but not limited to, restriction on the number of exhibits and expert, economic or technical witnesses;

(4) matters of which administrative notice will be taken; and

(5) such other matters as may aid in the orderly and expeditious disposition of the proceeding, including disclosure of the names of witnesses and the identity of documents or other physical exhibits which will be introduced in evidence in the course of the proceeding.

B. Conduct of prehearing conferences.

(1) Prehearing conferences conducted by the advisory board may be electronically, but not stenographically, recorded. Should a party request that the recording be transcribed, that party shall pay any costs of transcription.

(2) The advisory board may issue a written order that recites the results of the conference. Such order shall include rulings upon matters considered at the conference, together with appropriate directions to the parties. The order shall control the subsequent course of the proceeding, unless superseded by a subsequent order.

C. Status conferences.

(1) The advisory board may require the parties to submit a written report of any conference ordered to be conducted between the parties updating the status of the proceeding in light of the conference.

(2) The advisory board may conduct a status conference upon the request of either party or on the advisory board's own initiative, at which time the advisory board may require the parties, attorneys, or authorized representatives, to provide information regarding the status of a proceeding.

[13.21.5.13 NMAC – N, 01/01/2022]

13.21.5.14 HEARING LOCATION, TIME AND PLACE, NOTICE OF HEARING:

A. Location.

(1) In the absence of any statutory requirements to the contrary, all hearings conducted by the advisory board shall occur in Santa Fe, at the office of superintendent of insurance, unless the advisory board orders the parties to appear at another location in New Mexico.

(2) The parties may express a mutual preference for location of any hearing.

(3) In selecting a location other than Santa Fe, the advisory board shall consider and give weight to the location and wishes of the parties, witnesses, and access for members of the advisory board.

(4) If selecting a location other than Santa Fe would cause an unreasonable, undue burden to any party, that party may file a written objection to the selected location within 10 days of issuance of the notice of hearing, articulating the reasons supporting the objection. The advisory board will promptly review the objection and, upon a showing of an unreasonable, undue burden, may move the hearing to another more reasonable location.

B. Notice. Except for the evidentiary hearing to establish surcharge rates set by the superintendent's initial order (unless the advisory board determines to change the date of that hearing), the advisory board will notify the parties to the hearing of the date, time and place scheduled for any hearing at least seven days before the that hearing. This notice will be directed to the party's attorney, or to the last known address of any unrepresented party. Notice will be provided in a manner calculated to provide actual notice.

[13.21.5.14 NMAC – N, 01/01/2022]

13.21.5.15 TELEPHONIC, VIDEOCONFERENCE AND OTHER EQUIVALENT ELECTRONIC METHOD HEARINGS:

A. If not otherwise prohibited by statute, rule, or court ruling, the advisory board may conduct any hearing in person or by telephone, videoconference, or other equivalent electronic method. The advisory board shall cause a stenographic or audio recording to be made of all proceedings involving the presentation of evidence, points, authorities or argument pertaining to the merits of the matter before the advisory board.

B. If the hearing is to be conducted by telephone, videoconference or other equivalent electronic method, the notice shall so inform the parties. Either party may file a written objection to conducting the hearing by telephone, videoconference, or other equivalent electronic method within 10 days of the notice of hearing. Failure to timely object to the conduct of a telephone, videoconference, or other equivalent electronic method hearing constitutes consent to the hearing proceeding in that manner and waiver of any other applicable statutory in-county hearing requirement.

C. Upon receipt of a timely objection, the advisory board shall consider the applicable legal requirements, the location of the parties and witnesses, the complexity of the particular matter, the availability of necessary electronic equipment for conduct of a full and fair hearing by telephone, videoconference, or other equivalent electronic method, and the basis of the objection in determining whether the hearing should occur

at a specific location rather than via telephone, videoconference, or other equivalent electronic method.

D. Provided that the requesting party has not previously demanded an in-person hearing or otherwise objected to conducting the matter via telephone, videoconference, or other equivalent electronic methods, any party may request to appear directly or have a witness on their behalf appear via telephone, videoconference, or alternative electronic means by filing a request at least three business days before the scheduled hearing. The filing of a request to appear via telephone, videoconference, or other alternative electronic method shall be deemed as a total and complete waiver of any in-person, in-county hearing requirement and deemed as consent for all parties, all witnesses, and the advisory board to appear via telephone, videoconference, or other equivalent electronic methods.

E. All parties appearing via telephone, videoconference, or other electronic method shall provide the advisory board with a working email address or facsimile number for the exchange of all documentary evidence before or during the hearing.

F. Failure to follow the advisory board's instructions for participating in the hearing via telephone, videoconference, or other equivalent electronic method will be treated as a non-appearance at the hearing.

G. Any technical issues shall be promptly reported to the advisory board.

H. In the event that technical or other computer problems prevent a hearing by videoconference or other electronic method from occurring or otherwise interfere with maintaining or developing a complete record at the hearing, the parties agree and consent that the advisory board may continue the matter to a different time before expiration of the statutory deadline, may order the parties to appear for an in-person hearing, or may conduct the remaining portion of the hearing via telephone.

I. If the advisory board determines during the course of the hearing, either *sua sponte* or upon argument of a party, that an in-person hearing is necessary to adequately complete the record, address credibility issues, or is otherwise necessary to ensure a full or fair hearing process, the advisory board may recess a hearing occurring by telephone, videoconference, or other equivalent electronic method and reconvene the proceeding as an in-person hearing.

[13.21.5.15 NMAC – N, 01/01/2022]

13.21.5.16 CONTINUANCES:

A. At the request of a party, a witness, or upon the advisory board's own determination, a hearing may be continued for good cause. The advisory board shall consider only written continuance requests made at least three working days prior to the scheduled hearing absent extraordinary, unforeseen circumstances that the requesting

party or witness could not have known earlier. An order to grant or deny the request may be issued prior to the scheduled hearing or if there is insufficient time to issue an order prior to the scheduled hearing, the advisory board may grant or deny the request on the record at the hearing. No continuance request may be granted unless there is adequate time to provide notice to the parties, subpoena witnesses and conduct the rescheduled hearing before expiration of any statutory deadline.

B. Within the time limits set by statute, the superintendent or advisory board may *sua sponte* continue any matter as necessary to address OSI or TPA staffing needs, to ensure efficient and adequate use of state resources, and to manage the hearing docket. To this end, the advisory board may contact the parties to inquire about the status of a scheduled case.

C. No case shall be continued, even with a showing of good cause or an emergency circumstance, beyond any mandatory, applicable time limit on the case.

[13.21.5.16 NMAC – N, 01/01/2022]

13.21.5.17 ATTIRE AT HEARING:

All attorneys and other authorized representatives must be attired in a dignified, professional manner at all times during the hearing. Witnesses shall dress in a respectful manner. No attire or dress so flamboyant, disheveled, inflammatory, obscene, offensive or revealing as to create a distraction to the orderly conduct of the hearing will be permitted.

[13.21.5.17 NMAC – N, 01/01/2022]

13.21.5.18 BURDEN OF PROOF, PRESENTATION OF CASE, EVIDENCE:

A. Burden of proof. Unless otherwise specified by statute, the burden of proof in a proceeding is the preponderance of evidence.

B. Presentation order. The party with the burden of proof in the case will ordinarily present their case first, followed by the opposing party, if any, unless the advisory board makes reasonable exceptions related to the availability of the witnesses and representatives or other scheduling concerns.

C. Opening statements. The advisory board may require or allow opening statements as the circumstances justify. Opening statements are not ordinarily evidence, but without objection, may be adopted as evidence by sworn oath of the party-witness who made the opening statement.

D. Testimony under oath. All testimony must be given under oath and will be subject to questioning of each other party. The advisory board may also ask questions

of the witness as appropriate. At the advisory board's discretion, redirect and re-cross may be allowed.

E. Closing arguments. The parties may make closing arguments, either orally at the conclusion of the case or, upon order of the advisory board, in writing after conclusion of the hearing.

F. Post-hearing briefs. The advisory board may also order the parties to submit further briefing on any issue in the case, and to submit proposed findings of fact and conclusions of law. The advisory board will establish a timeline for submission of any post-hearing pleadings, including time for the parties to exchange briefs, as the advisory board finds necessary. No decision-writing deadline commences until the parties have submitted any ordered post-hearing briefing or submission.

G. Rules of evidence.

(1) Formal rules of evidence and civil procedure shall not apply in a proceeding unless otherwise expressly and specifically required by statute, regulation, or order of the advisory board.

(2) Relevant and material evidence shall be admissible. Irrelevant, immaterial, unreliable, or unduly repetitious evidence may be excluded.

(3) A party may offer exhibits, such as records of transactions.

(a) The party shall have the exhibits numbered by the stenographer prior to the hearing.

(b) The party shall provide copies of the evidence to the stenographer, all parties and to the advisory board.

(c) Exhibits must be introduced and explained by a witness, who must be prepared to answer questions from the parties and the advisory board.

(d) The advisory board shall be asked by the party offering an exhibit to accept the exhibit into evidence. The advisory board may be asked to consider all exhibits introduced by a witness at the conclusion of that witness's testimony or at the conclusion of that party's case.

(e) The stenographer shall retain copies of all exhibits that are admitted and shall make them a part of the record.

(4) The advisory board shall consider and give appropriate weight to all relevant and material evidence admitted in rendering a final decision on the merits of a matter.

H. Hearsay evidence. Hearsay evidence may be admitted in a proceeding.

I. Taking notice.

(1) The advisory board may take administrative notice of facts not subject to reasonable dispute that are generally known within the community, capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably disputed, or as provided by an applicable statute.

(2) The advisory board may take administrative notice at any stage in the proceeding, whether *sua sponte* or at the request of a party.

(3) A party may dispute the propriety of taking administrative notice, including the opportunity to refute a noticed fact.

J. Objections.

(1) A party objecting to evidence, qualifications of an expert, a line of questioning, or the response shall timely and briefly state the grounds for the objection.

(2) Rulings on objections may be addressed on the record at the time of the objection, reserved for ruling in a subsequent written order, or noted as a continuing, ongoing objection for which ruling is reserved to later in the proceeding.

K. Audio or video evidence. Any party wishing to submit a video or audio recording into the record must provide a complete tangible, playable copy that can be retained as part of the record.

L. Size of exhibits. In general, documentary evidence should be no larger than 8.5 inches by 11 inches unless expressly allowed by the advisory board. The advisory board may admit larger documentary exhibits presented at hearing, provided the proponent of such exhibits provides the advisory board with a copy of the exhibit reduced to 8.5 inches by 11 inches. After the hearing at which the exhibit was admitted, the reduced copy shall be substituted for the larger exhibit and made part of the record of the hearing. Arrangements to provide a reduced copy of a large exhibit shall be undertaken in advance of the hearing. Failure by the proponent to provide a reduced copy shall be deemed a withdrawal of the exhibit.

M. Substitutions for objects. In lieu of the introduction of tangible objects as exhibits, the advisory board may require the moving party to submit a photograph, video, or other appropriate substitute such as a verbal description of the pertinent characteristics of the object for the record.

[13.21.5.18 NMAC – N, 01/01/2022]

13.21.5.19 WITNESSES, EXPERT WITNESSES, AND INVOCATION OF THE RULE:

A. Use of witnesses. Any person having relevant, material knowledge related to one of the issues in a hearing may testify as a witness under oath in a proceeding. Upon affirming the oath, the witness may be questioned by any party and by the advisory board.

B. Method of appearance. Unless a more specific provision applies, witnesses are ordinarily expected to appear in the same manner or by the same method as the parties in a proceeding, absent express preapproval of the advisory board allowing an appearance by a different method. For example, if the hearing is scheduled to be conducted in person in a specific place, the witnesses are also ordinarily expected to appear in person at that same place; however, if the matter is set to occur by telephone or videoconference, then the witnesses may ordinarily appear by telephone of videoconference.

C. Advisory board as a witness. The current or previously assigned advisory board in a matter shall not be called and shall not be a witness in the proceeding.

D. Use of expert witnesses.

(1) If either party intends to call and treat a particular witness as an expert witness in the proceeding, the party must identify the purported expert to the other parties and to the advisory board at least seven days before the scheduled hearing, or with sufficient time before completion of the discovery deadline specified in a scheduling order to allow for deposition.

(2) The party shall include the scope of that expert's purported testimony relative to the proceeding, the expert's credentials, and a listing of any materials the expert reviewed as part of reaching his or her expert opinion.

(3) The opposing party may file a response in opposition before the hearing or challenge the designation of the witness as an expert during the course of the hearing.

E. Use of exclusionary rule. At the hearing, any party can invoke the exclusionary rule, excluding all witnesses other than the real party in interest, their representative, one main case agent, and any designated expert witness from the proceeding until the time of their testimony. If the rule has been invoked, the witnesses shall not discuss their testimony with each other until the conclusion of the proceeding. When the rule has been invoked, any witness who remains in the hearing after conclusion of their testimony may not be recalled as a witness in the proceeding, except that any witness may observe the testimony of an expert witness and be recalled to provide any subsequent rebuttal testimony.

F. OSI staff as experts.

(1) The advisory board may request one or more members of OSI staff to be present at the hearing to assist the advisory board with any matters within the expertise of the staff person.

(2) The staff person may be called as a witness by the advisory board and examined by the parties and the advisory board.

(3) Any party may call the staff person as a witness.

(4) Each other party will have the opportunity to cross-examine a staff person who is called as a witness. In the discretion of the advisory board, the advisory board may permit re-direct or re-cross examination of the staff person.

(5) The advisory board shall not discuss the case with the staff person outside the hearing or off the record.

(6) Any staff person requested to be present by the advisory board shall not be subject to the exclusionary rule.

[13.21.5.19 NMAC – N, 01/01/2022]

13.21.5.20 CLOSED OR PUBLIC HEARING, SEALED RECORDS, AND DELIBERATIVE NOTES OF ADVISORY BOARD:

A. Closed hearings. Unless otherwise provided by law, ordered by the advisory board for good cause, or required to prevent disclosure of confidential information, all hearings and the record are open to the public. Any party to a proceeding may submit a written request to close the hearing and the record to the public, which shall be granted if authorized by statute, regulation, to preserve confidentiality or to protect a party from harassment or reprisal.

B. Open hearings. If the hearing is open to the public, members of the public and the media may attend the hearing so long as they do not interrupt, interfere with, or impede the orderly, fair, and efficient hearing process. With prior consent of the advisory board, media members may record the proceeding from a fixed location in the hearing room. The advisory board may direct any member of the public, including media members, to leave the proceeding if they engage in any conduct that interferes with the advisory board's ability to maintain order, develop the record, and provide a fair and efficient hearing process. The proceedings shall be made available telephonically to members of the public, including the media, upon prior request.

C. Sealed records. Upon request of any party, and upon a showing of good cause, the advisory board may seal a particular exhibit, document, or portions of a witness's testimony from public disclosure if such items contain statutorily-protected confidential information, privileged information, or otherwise contain private identification information of a party or third party that is immaterial to a substantive issue in the proceeding or if its

materiality is substantially outweighed by the prejudice of public release of the information. Upon issuance of an order sealing such documents or exhibits, these records will remain under seal throughout the proceeding and shall be returned to the submitting party at the conclusion of the appeal period or the appeal. The opposing party shall be entitled to promptly review these documents in preparing for the hearing, and may rely on those documents during the hearing as necessary to ensure a fair hearing process; however, the opposing party shall not maintain its own copy of the sealed document after conclusion of the hearing nor reveal, discuss, or disclose the contents of these sealed documents to any other party outside of the hearing process.

D. Notes of deliberation. The advisory board's notes taken during the course of the hearing, notes generated during the decision-making process, and any draft orders or draft decisions are confidential as part of the deliberative process and are not subject to public disclosure.

[13.21.5.20 NMAC – N, 01/01/2022]

13.21.5.21 SUBPOENAS:

Any request for issuance of subpoenas in matters subject to these rules shall be guided by Rule 45 of the rules of civil procedure for the district courts of New Mexico, except where provisions of that rule conflict with the powers of the superintendent. Any subpoena issued shall be in the name of the superintendent. The party requesting the subpoena shall prepare a proposed subpoena, submit the proposed subpoena to each other party and to the advisory board for approval, and shall timely and reasonably serve the subpoena on the person or entity subject to the subpoena. Unless good cause is shown for a shorter period, a subpoena shall provide at least 10 days-notice before compelled attendance at a hearing or deposition, and at least 10 days-notice before compelled production of materials. All returns or certificates of service on served subpoenas shall be filed in the docket of the proceeding, copied to the opposing party, and shall be made part of the record of the proceeding.

[13.21.5.21 NMAC – N, 01/01/2022]

13.21.5.22 LANGUAGE INTERPRETERS:

A party to a proceeding who needs language interpreter services for translation of one language into another is responsible for arranging such service for the hearing. While the person serving as an interpreter need not be a court-certified interpreter in order to provide interpretation at a hearing, any person serving as an interpreter in a matter before the superintendent must be approved by the advisory board and must affirm the interpreter's oath applicable in New Mexico courts. Upon reasonable notice by the party, any interpreter required to be provided under the Americans with Disabilities Act shall be provided for by the superintendent.

[13.21.5.22 NMAC – N, 01/01/2022]

13.21.5.23 FAILURE TO APPEAR:

A. Entry of default order. If a party fails to appear for a properly noticed hearing, either in person, through a permissible representative or telephonically with prior approval of the advisory board, the person waives the right to protest or challenge any action that is the subject of the hearing notice. The matter shall go on the record for the limited purpose of addressing notice and non-appearance, and the advisory board shall enter an appropriate order based on the waiver of the hearing by failing to appear.

B. Evidence of notice. In considering the non-appearance and whether the person received appropriate notice necessitating issuance of the order, the advisory board may consider the contents of the docket, information conveyed to or known by the advisory board, information related to mailing, including mail tracking, returned receipt information, and notes written on returned envelopes of the United States postal service or other mail tracking services, and arguments offered by any present party, all of which may be addressed on the record of the hearing or in any subsequent order.

C. Written order required. Oral rulings based on a party's failure to appear are not final until reduced to writing. The advisory board may issue a different written order as new information arises after the hearing regarding whether the notice of hearing was properly sent to the correct address or otherwise properly served.

[13.21.5.23 NMAC – N, 01/01/2022]

13.21.5.24 RECONSIDERATION:

A. Time to file. A party may file a motion for reconsideration within 15 days after the date of the final order. Any other party may file a response no more than 15 days after the motion for reconsideration was filed. Motions for reconsideration that are not filed within this deadline may be denied automatically. A timely filed motion for reconsideration should be decided based on the merits, whether or not a response is filed.

B. Posture. The prevailing party shall not file a motion for reconsideration. However, if a requested action is granted in part and denied in part, either party may file a motion for reconsideration.

C. Basis for motion. Motions for reconsideration shall not endeavor to present new evidence previously available, or discoverable through reasonable diligence, to the parties before the hearing. Motions for reconsideration shall not reargue the weight of evidence already ruled upon and shall not reiterate legal arguments already ruled upon. However, a motion for reconsideration may address gross factual or legal errors or omissions contained in the final decision and order.

[13.21.5.24 NMAC – N, 01/01/2022]

13.21.5.25 APPEALS FOLLOWING HEARING:

Any person who is adversely affected by a final order or decision in a surcharge rate proceeding may appeal pursuant to the provisions of Section 39-3-1.1 NMSA 1978. Each order issued by the superintendent after a surcharge rate proceeding shall include information about the appeal process for the type of case at issue. Once the appeal is filed in the appropriate court, the appealing party shall promptly provide a court-endorsed copy of the appeal to the superintendent so that the OSI records manager can prepare and submit the proper record.

[13.21.5.25 NMAC – N, 01/01/2022]

13.21.5.26 REQUESTING COPIES OF EXHIBITS, AUDIO, OR THE ADMINISTRATIVE RECORD:

Any party may access and copy any written document filed to the docket. Copies of an audio recording or written transcript of the proceeding shall be arranged through the stenographic service. The OSI may charge a reasonable fee for copies made, consistent with OSI's fee schedule under the Inspection of Public Records Act. The superintendent may also require the requesting party to submit a computer storage device, such as a compact disc, dvd disc, blu-ray disc, or usb drive, or other tangible device for copying of any audio or video recording that is part of the administrative record.

[13.21.5.26 NMAC – N, 01/01/2022]

CHAPTER 22: AUTOMOBILE THEFT PREVENTION AUTHORITY

PART 2: BOARD AND GRANT ADMINISTRATION

13.22.2.1 ISSUING AGENCY:

Office of Superintendent of Insurance ("OSI").

[13.22.2.1 NMAC – N, 1/1/2023]

13.22.2.2 SCOPE:

This rule applies to the activities of the New Mexico Automobile Theft Prevention Authority ("NMATPA") board and to its review, approval and administration of grants pursuant to Section 59A-16C-17 NMSA 1978.

[13.22.2.2 NMAC – N, 1/1/2023]

13.22.2.3 STATUTORY AUTHORITY:

Sections 59A-16C-5, 59A-16C-16 and 59A-16C-17 NMSA 1978.

[13.22.2.3 NMAC – N, 1/1/2023]

13.22.2.4 DURATION:

Permanent.

[13.22.2.4 NMAC – N, 1/1/2023]

13.22.2.5 EFFECTIVE DATE:

January 1, 2023, unless a later date is cited at the end of a section.

[13.22.2.5 NMAC – N, 1/1/2023]

13.22.2.6 OBJECTIVE:

This rule establishes definitions and procedures for the conduct of business by the NMATPA board and for the review, approval and administration of grants made by that board pursuant to Section 59A-16C-17 NMSA 1978.

[13.22.2.6 NMAC – N, 1/1/2023]

13.22.2.7 DEFINITIONS:

A. "Automobile theft prevention authority" or **"ATPA"** has the meaning provided in Section 59A-16C-17 NMSA 1978.

B. "Automobile" means a motor vehicle or vehicle.

C. "Board of directors" or **"board"** means the board of directors of the automobile theft prevention authority that is appointed in accordance with Subsection A of Section 59A-16C-17 NMSA 1978.

D. "Executive director" means a supervising prosecuting attorney of the OSI, as designated by the superintendent of insurance.

E. "Grant announcement" means an announcement by the board or executive director that grant funding is available. The announcement shall include a reference to all required application materials and the deadline for submission of grant applications.

F. "Grant award" means a final decision of the NMATPA board to award a grant to a qualified applicant.

G. "Grant award contract" means a written contract that arises as the direct result of a grant award and sets out the respective duties and obligations of NMATPA and a grant awardee. An attorney designated by the superintendent of insurance shall review every grant award contract before the contract is signed. The reviewing attorney shall not be the executive director of NMATPA.

H. "Grant awardee" means a qualified applicant whose grant application has been approved by the board and to whom notification of a grant award has been sent in accordance with this rule.

I. "Grant cycle" means the period of time between the grant announcement and a grant award.

J. "Grant managers guidance manual" or **"GMG"** means the most current publicly available version of the guidance manual approved by the board for providing information on grant application requirements and processes. The ATPA board shall update the GMG annually.

K. "Grant recipient" means a grant awardee.

L. "Motor vehicle" has the meaning provided in the Motor Vehicle Code, Chapter 66, Article 1 NMSA 1978.

M. "New Mexico automobile theft prevention authority" or **"NMATPA"** means the automobile theft prevention authority established for the state of New Mexico by Section 59A-16C-17 NMSA 1978.

N. "NMATPA administration" means the OSI staff responsible for the day-to-day operations and support of the board.

O. "Qualified applicant" means a state, local or regional law enforcement agency or task force that demonstrates that its proposed program satisfies grant requirements and addresses a significant aspect of automobile theft prevention.

P. "Vehicle" has the meaning provided in the Motor Vehicle Code, Chapter 66, Article 1 NMSA 1978.

[13.22.2.7 NMAC – N, 1/1/2023]

13.22.2.8 BOARD OF DIRECTORS:

A. Board responsibilities. The main responsibility of the board is to administer and manage grants made in accordance with Section 59A-16C-17 NMSA 1978. The duties of the board include, without limitation:

(1) reviewing grant applications;

(2) awarding grants consistent with the criteria set forth in this rule;

(3) reviewing grant reports and compliance by grantees; reporting on the work of the board as required by law; and

(4) other duties consistent with Section 59A-16C-17 NMSA 1978, as may be from time to time determined by a majority vote of the board. The executive director may request that the board undertake additional duties on a temporary basis in order to facilitate the orderly implementation of this rule.

B. Board meetings. All meetings of the board shall be held in compliance with the Open Meetings Act, Chapter 10, Article 15 NMSA 1978. The board shall meet at least once every three months, except that the board may, at the call of the chair or at the request of the executive director, or by majority vote, decide to meet more frequently. All meetings of the board shall be recorded and transcribed, and NMATPA will post the transcriptions on the official OSI website. A board meeting may be held in person or virtually. A quorum of the board shall consist of five members of the board and may be achieved through participation in a virtual meeting.

C. Board actions. A quorum of the board shall review the grant applications. A majority of the board shall approve the grant awards. The board may adopt additional policies and procedures governing its processes.

[13.22.2.8 NMAC – N, 1/1/2023]

13.22.2.9 EXECUTIVE DIRECTOR:

The executive director of the NMATPA shall serve ex officio in an official capacity as a supervising prosecuting attorney of OSI.

A. Duties of executive director. The executive director shall have the following duties:

(1) directing the NMATPA administration, as defined in Section 7 of this rule;

(2) preparing the agenda for board meetings, in consultation with the members of the board;

(3) posting meeting agendas as required by the Open Meetings Act; and

(4) other duties not inconsistent with the executive director’s general scope of work as may from time to time be conferred by the board.

B. Authority of executive director. The executive director shall have the following authority:

(1) calling a meeting of the board;

(2) signing grant award contracts, as defined in Section 7 of this rule, on behalf of the NMATPA; and

(3) such other authority as may be necessary to carry out the duties of the executive director.

[13.22.2.9 NMAC – N, 1/1/2023]

13.22.2.10 GRANT MANAGERS GUIDANCE MANUAL ("GMG"):

The board shall annually review, approve and adopt the NMATPA GMG during one or more board meetings. As soon as practicable after the board's annual review, approval and adoption of the GMG, the executive director will publish the GMG by posting a copy of the GMG on the official OSI website.

A. GMG content. The board shall use its best judgment to determine the content of the NMATPA GMG with the following goals in mind:

(1) Clarity of purpose;

(2) Completeness of content;

(3) Ease of comprehension; and

(4) Ease of use.

B. GMG designation. The board may designate an existing GMG for continued use by clearly designating an existing GMG as the most current version. The board may adopt one or more GMGs from other states and jurisdictions that have adopted a GMG, consistent with applicable copyrights and authorship laws. The board may adopt a complete version of the GMG, an abridged version, or both in order to facilitate outreach to intended audiences as the board may deem appropriate. If more than one version is adopted, then each version shall be clearly marked as to its intended use.

C. Current version of GMG. The board shall designate which version of a complete GMG is the most current version and shall post only that version on the official OSI website. The most current GMG shall control for purposes of reviewing, approving and awarding grants; reviewing and reporting compliance with grants; and in case of a discrepancy between versions.

D. Conflict between GMG and Rule. In the event of a conflict between the GMG and this rule, this rule shall control. All editions of the GMG adopted by the board shall state that this rule takes precedence over the GMG in the event of conflict.

[13.22.2.10 NMAC – N, 1/1/2023]

13.22.2.11 GRANT APPLICATIONS – SUBMISSION AND CONTENT:

A. Application submission period. The board will announce annually in writing the availability of grant funding and the start of the application submission period. OSI will publish the notice on the official OSI website and distribute the notice via email to all entities that have signed up for OSI's newsletter email listserv.

B. Application format and required content. An application shall be in the form required by the grant announcement, consistent with the requirements set forth in Section 59A-16C-17 NMSA 1978, this rule and the NMATPA GMG. Grant application and approval forms shall be the most current version adopted by the board.

(1) A grant application shall describe, at minimum, the specific type of automobile theft prevention, enforcement, specialized training, prosecution or first-time offender rehabilitation program proposed.

(2) A grant application shall include or address all required information, forms, and instructions provided in the NMATPA GMG.

C. Method and delivery of application submission. Applications shall be filed with the board electronically as directed in the grant application, notice, or instructions.

D. Scope of grants. Possible funding categories for NMATPA grants include, without limitation:

(1) equipment for law enforcement;

(2) law enforcement services, including overtime pay;

(3) public awareness campaigns; and

(4) other goods or services that meet the objectives of Chapter 59A, Article 16C NMSA 1978.

[13.22.2.11 NMAC – N, 1/1/2023]

13.22.2.12 GRANT AWARDS:

The NMATPA board shall award grants on a competitive basis, subject to available funding, and in accordance with the priorities described in this rule. There shall be no automatic entitlement to a grant, and the board shall not be required to award a grant if no application satisfies the criteria set forth in the applicable grant announcement.

A. Use of the NMATPA GMG. The board shall review applications consistent with Section 59A-16C-17 NMSA 1978, these rules, and the guidance set out in the most current version of the NMATPA GMG.

B. Multi-jurisdictional priority. The board shall give priority to those grant applications representing multi-jurisdictional programs. Applicants representing multiple jurisdictions may submit joint applications.

C. Minimum description required. An application shall, at a minimum, provide a thorough description of the type of automobile theft prevention, enforcement, specialized training, prosecution, or first-time offender rehabilitation program proposed. The minimum description shall include staffing, objectives, measurable goals and costs.

D. Applicable review guidelines. The board shall review each application to determine whether the submitting entity meets the definition of a qualified applicant. The board will then further review the applications received pursuant to the following guidelines:

(1) Whether the application identifies an automobile theft problem clearly, is measurable, and is supported by relevant statistical evidence;

(2) whether the application minimizes duplicative or overlapping existing programs;

(3) whether the application provides a design wherein activities and goals are realistic and attainable;

(4) whether the application displays innovation in its concept, design, or operation. A project is considered innovative if it provides a new and different strategy or approach that prevents, deters, intervenes or reduces the occurrence of automobile theft-related activity;

(5) whether the application demonstrates a realistic cost structure as compared to its goals (cost compared to benefit);

(6) whether the application includes a proposed evaluation design supported by relevant data to measure the effectiveness of the project and a plan for completing said evaluation consistent with applicable grant reporting requirements; and

(7) whether the application was submitted timely and in the prescribed format in accordance with the applicable grant announcement.

E. Equitable review. The board will apply relevant statutes, this rule and the NMATPA GMG to ensure equitable review of grant applications received from law enforcement agencies and other qualified applicants.

F. Geographic distribution. The board will approve grants in a variety of geographic areas of the state to the extent that it is practicable to do so.

[13.22.2.12 NMAC – N, 1/1/2023]

13.22.2.13 GRANT AWARDS AND NOTIFICATION:

Subject to available funds, the board will approve grants in accordance with Section 59A-16C-17 NMSA 1978, this rule and the guidance set forth in the most current version of the NMATPA GMG.

A. Approval criteria. In approving grants, the board shall consider the following criteria:

(1) available funds;

(2) existing activities or programs addressing the same or substantially similar automobile theft problem;

(3) statistical analyses of automobile theft problems in the identified project area;

(4) cooperation and coordination with other agencies and projects to address automobile theft problems;

(5) proposed plan for automobile theft crime prevention, enforcement, prosecution and training;

(6) number of personnel involved in the proposed project; and

(7) the applicant’s experience, qualifications and past performance demonstrating ability to operate a proposed project successfully.

B. Grant awards. A quorum of the board shall review grant applications. A majority vote of the board shall be required for approval of a grant application.

C. Notification. Within 10 business days of a grant award, the executive director will notify each applicant in the current grant cycle of the board’s decision to approve or deny an application.

(1) The board may condition a grant award on an applicant’s satisfaction of reasonable requirements in addition to those identified in the grant announcement and the NMATPA GMG.

(2) The board shall not require as a condition of receipt of a grant that an agency, political subdivision, or other qualified applicant provide any additional monies to operate a recommended program.

(3) An applicant may accept or decline a grant award consistent with the schedule set forth in the NMATPA GMG.

[13.22.2.13 NMAC – N, 1/1/2023]

13.22.2.14 GRANT EVALUATION PROCEDURES:

So that the board can evaluate program success and compliance, all grant recipients must submit quarterly program and financial reports to the board following grant application approval and fund disbursement.

A. Reporting forms provided. The board will provide grant recipients with forms necessary to submit required quarterly financial and program progress/achievement reports.

B. Board review criteria. Board review of quarterly reports submitted by the grant recipients shall be consistent with identified goals and objectives of the NMATPA.

C. Program monitoring. The board will monitor program implementation, financial administration, and achievement of declared program objectives consistent with Section 59A-16C-17 NMSA 1978, this rule and the NMATPA GMG as applicable.

D. Board feedback. The board will provide feedback to grant recipients submitted or failing to submit required quarterly reports, or as is appropriate and consistent with statute, the goals and objectives of the NMATPA, this rule and the NMATPA GMG.

E. Failure to perform. A program that is failing to perform will be given written notice at least 30 days prior to implementation of any remedies identified in this subsection and may request board review of the contemplated action. In the event that a grant recipient fails to perform or complete required quarterly financial and program progress and achievement reports, the board may:

(1) elect to apply a program improvement plan to the recipient to rehabilitate performance;

(2) recommend to the superintendent or the superintendent’s designee for revocation or suspension of recipient’s grant agreement; or

(3) recommend to the superintendent or the superintendent’s designee that reimbursement for expenses be denied.

F. Future consideration: Failure to perform or rehabilitate may affect future consideration of applications submitted to the board by the same applicant.

[13.22.2.14 NMAC – N, 1/1/2023]