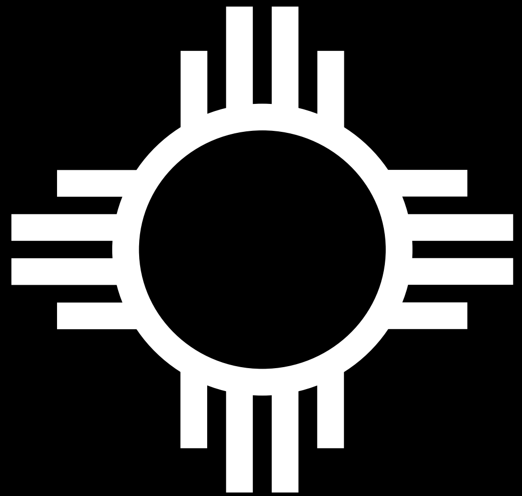
NEW MEXICO REGISTER



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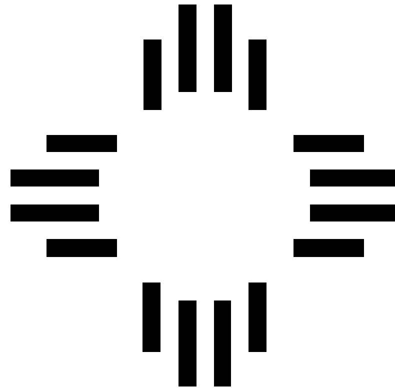

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

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New Mexico Register

Volume XIV, Number 17
September 15, 2003

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Rules published in this issue of the New Mexico Register are effective on the publication date of this issue unless otherwise specified. "No rule shall be valid or enforceable until it is filed with the records center and published in the New Mexico register as provided by the State Rules Act. Unless a later date is otherwise provided by law, the effective date of a rule shall be the date of publication in the New Mexico register." Section 14-4-5 NMSA 1978.

A=*Amended*, E=*Emergency*, N=*New*, R=*Repealed*, Rn=*Renumbered*

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Telephone: (505) 476-7907; Fax (505) 476-7910; E-mail rules@rain.state.nm.us.

Notices of Rulemaking and Proposed Rules

NEW MEXICO BOARD OF EDUCATION

NEW MEXICO STATE BOARD OF EDUCATION
NOTICE OF PROPOSED RULEMAKING

The New Mexico State Board of Education ("State Board") will convene on Wednesday, October 8, 2003. Committees are tentatively scheduled to meet on Wednesday, October 8, 2003 and Thursday, October 9, 2003. Final actions on the proposed rulemaking will be taken at the regular meeting of the State Board on Friday, October 10, 2003. The committee meetings and the regular meeting will be held in Mabry Hall, State Education Building, 300 Don Gaspar, Santa Fe, New Mexico. Information regarding any change in the location of the meetings, the addition or change of meeting days or times, and the agenda for the meeting, will be available at least twenty-four hours prior to the meeting from the Administrative Assistant to the State Board and on the State Board's web page of the State Department of Public Education's website (http://sde.state.nm.us/).

The State Board may consider the following items of rulemaking at the meeting:

Rule Number	Rule Name	Proposed Action
6.19.1 NMAC	PUBLIC SCHOOL ACCOUNTABILITY: GENERAL PROVISIONS	Amend rule*#
6.19.3 NMAC (Proposed NMAC No.)	PERSISTENTLY DANGEROUS SCHOOLS	Amend rule*#
6.30.2.10 NMAC	STANDARDS FOR EXCELLENCE	Amend rule to align with HB 212 requirement for local school board training*+

* Accountability Committee. Copies of the proposed rule change identified with # may be obtained from Ms. Barbara Trujillo at (505) 827-6683. Written comments concerning the rules identified with # should be submitted to Dr. Mel Morgan, Assistant Superintendent for Accountability and Information Services, State Department of Education, 300 Don Gaspar, Santa Fe, NM 87501-2786. Comments may also be telefaxed to Dr. Morgan at (505) 827-6689 or submitted electronically to mmorgan@sde.state.nm.us. Comments will be accepted until 5 p.m. on October 3, 2003; however, submission of written comments as soon as possible is encouraged. Copies of the proposed rule change identified with + may be obtained from Ms. Ruth Williams at (505) 476-0393. Written comments concerning the rule identified with + should be directed to Ms. Williams at the address and telefax shown above or submitted electronically to rwilliams@sde.state.nm.us.

Individuals with disabilities who require this information in an alternative format or need any form of auxiliary aid to attend or participate in this meeting, please contact the State Board of Education Office at (505) 827-6571 as soon as possible.

The Board attempts to follow the order and date of items as listed on the Agenda; however, the order and date of specific items are tentative and may vary from the printed Agenda.

Comments, questions, or requests for copies of the Agenda should be directed to Mary Jo Bradley, State Department of Education, Education Building, 300 Don Gaspar, Santa Fe, New Mexico 87501-2786 or (505) 827-6571.

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

NOTICE OF PUBLIC HEARING

The Human Services Department will hold a public hearing to consider adopting revised rules in the Food Stamp Program and NMW Cash Assistance Program. The hearing will be held at 9:00 am on Wednesday, October 15, 2003. The hearing will be held in the conference room for the Income Support Division of the Human Services Department. The conference room is located in room 120 on the lower level of the Pollon Plaza building, 2009 S. Pacheco St., Santa Fe, NM 87505.

The Department will take action to expand the eligibility of immigrant children to participate in the Food Stamp Program in compliance with the Federal Farm Security and Rural Investment Act of 2002 (the Farm Bill). An immigrant child who is under eighteen years of age will be able to participate in the Food Stamp Program if the child meets one of the definitions of "qualified alien", regardless of the child's date of entry into the United States.

Each year the United States Department of Agriculture-Food and Nutrition Services (USDA-FNS) adjusts the income limits, maximum shelter deduction, standard utility allowances, and the Thrifty Food Plan (the maximum food stamp benefit amount) for the federal Food Stamp Program. The federal adjustments are effective in October of each year. The Human Services Department makes comparable adjustments to the income limits for the NMW Cash Assistance Program, also effective in October of each year.

Because the department received notification of the annual adjustments from the federal government, the Department will implement an interim emergency rule to make effective the federal mandates for the Food Stamp Program and will implement the adjustments to the income limits for the NMW Cash Assistance Program at the same time.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Department toll free at 1-800-432-6217, TDD 1-800-609-4TDD (4833), or through the New Mexico Relay System toll free at 1-800-659-8331. The Department requests at least a 10-day advance notice to provide requested alterna-

tive formats and special accommodations.

Individuals wishing to testify or who would like a copy of the proposed regulation should contact the Income Support Division, P.O. Box 2348, Pollon Plaza, Santa Fe, NM 87505-2348, or by calling toll free 1-800-432-6217.

Individuals who do not wish to attend the hearing may submit written or recorded comments. Written or recorded comments must be received by 5:00 PM on the date of the hearing. Please send comments to:

Pamela S. Hyde, J.D., Secretary
Human Services Department
P.O. Box 2348 Pollon Plaza
Santa Fe, NM 87504-2348

You may send comments electronically to: Sharon.Regensberg@state.nm.us

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) will hold a public hearing at 9:00 a.m., on October 9, 2003, at the State Capitol, Room 305, Santa Fe, New Mexico. The subject of the hearing will be Vision Care Services.

In response to recommendations from the Medicaid Reform Committee, the New Mexico Medicaid program is amending the policy for Vision Services to cover one routine eye exam and one set of corrective lenses for an adult in a twelve-month period, unless a ophthalmologist or optometrist recommends a change in prescription due to a medical condition affecting vision. Medicaid will cover one frame for corrective lenses for an adult in a twenty-four month period.

In addition, clarification was made regarding the replacement of contact lenses and coverage of prisms to prevent diplopia.

Interested persons may submit written comments no later than 5:00 p.m., October 9, 2003, to Pamela S. Hyde, J.D., Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of the Human Services Register are available for review on our Website at www.state.nm.us/hsd/mad.html. or by sending a self-addressed stamped envelope to Medical Assistance Division, Planning & Program Operations Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) will hold a public hearing at 10:30 a.m., on October 9, 2003, at the State Capitol, Room 305, Santa Fe, New Mexico. The subject of the hearing will be Special Rehabilitation Services.

The Special Rehabilitation Services policy (MAD-743), dated March 1,1999, is being revised as a result of HIPAA coding changes. The proposed policy excludes references to billing units. The proposed policy also includes some changes in the language.

Interested persons may submit written comments no later than 5:00 p.m., October 9, 2003, to Pamela S. Hyde, J.D., Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of the Human Services Register are available for review on our Website at www.state.nm.us/hsd/mad.html. or by sending a self-addressed stamped envelope to Medical Assistance Division, Planning & Program Operations Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) will hold a public hearing at 1:30 p.m., on October 9, 2003, at the State Capitol, Room 305, Santa Fe, New Mexico. The subject of the hearing will be Emergency Services for Undocumented Aliens.

The Human Services Department updated language in the policy to reflect changes in labor and delivery services, non-covered services, and eligibility for services under this New Mexico Medicaid program. Labor and delivery has been defined as all labor and delivery except for scheduled cesarean sections. Non-covered services has been expanded to include scheduled cesarean sections. The category of eligibility, Aid to Families with Dependent Children, has been replaced by category of eligibility, JUL Medicaid.

Interested persons may submit written comments no later than 5:00 p.m., October 9, 2003, to Pamela S. Hyde, J.D., Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of the Human Services Register are available for review on our Website at www.state.nm.us/hsd/mad.html. or by sending a self-addressed stamped envelope to Medical Assistance Division, Planning & Program Operations Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) will hold a public hearing at 9:00 a.m., on October 14, 2003, at the State Capitol, Room 321 Santa Fe, New Mexico. The subject of the hearing will be Medicaid Managed Care

A proposed regulation to amend the Medicaid managed care regulations for the purpose of incorporating changes in federal law that address new or revised provisions required by Medicaid managed care organizations. The new federal requirements require amending several sections of the managed care policies.

Interested persons may submit written comments no later than 5:00 p.m., October 14, 2003, to Pamela S. Hyde, J.D., Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of the Human Services Register are available for review on our Website at www.state.nm.us/hsd/mad.html. or by sending a self-addressed stamped envelope to Medical Assistance Division, Planning & Program Operations Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) will hold a public hearing at 9:30 a.m., on October 15, 2003, at the State Library at 1205 Camino Carlos Rey, Santa Fe, New Mexico. The subject of the hearing will be Medically Necessary Services.

In the year 2000 the Medical Assistance Division working in conjunction with several stakeholder groups revised the definition of medical necessity. At this time the Division did not change the definition for medical necessity in regulation for the fee-for-service program. This regulation change clarifies the definition of medical necessity for all Medicaid programs. This policy will provide a more uniform definition for all programs in Medicaid, including the Salud! Medicaid managed care programs.

Interested persons may submit written comments no later than 5:00 p.m., October 15, 2003, to Pamela S. Hyde, J.D., Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of the Human Services Register are available for review on our Website at www.state.nm.us/hsd/mad.html. or by sending a self-addressed stamped envelope to Medical Assistance Division, Planning & Program Operations Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) will hold a public hearing at 1:30 p.m., on October 15, 2003, at the State Library, room 2022 (1205 Camino Carlos Rey), Santa Fe, New Mexico. The subject of the hearing will be Prior Authorization and Utilization Review Policy.

In order to comply with the Health Insurance Portability and Accountability Act (HIPAA), the Medical Assistance Division has reviewed, updated, and revised Medicaid policies and billing instructions. Language found in current policies and billing instructions are inconsistent and outdated. This proposed regulation has been changed in order to provide consistent language throughout Medicaid policies.

Interested persons may submit written comments no later than 5:00 p.m., October 15, 2003, to Pamela S. Hyde, J.D., Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of the Human Services Register are available for review on our Website at www.state.nm.us/hsd/mad.html. or by sending a self-addressed stamped envelope to Medical Assistance Division, Planning & Program Operations Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO LIVESTOCK BOARD

NOTICE OF RULE MAKING HEARING AND REGULAR BOARD MEETING

NOTICE IS HEREBY GIVEN that a regular Board meeting will be held on Monday September 15, 2003, at New Mexico Livestock Board, 300 San Mateo NE Suite 1000, Albuquerque New Mexico, at 1:30 p.m. The Board will cover matters of general business.

Anyone who requires special accommodations is requested to notify the New Mexico Livestock Board office at (505) 841-6161 of such needs at least five days prior to the meeting.

NEW MEXICO MANUFACTURED HOUSING COMMITTEE

LEGAL NOTICE

PUBLIC HEARING NOTICE

The Manufactured Housing Committee has

scheduled a Public Hearing for the purpose of Rulemaking, at 9:00 a.m., October 22, 2003, at the Department of Labor, 501 Mountain Rd. NE, Albuquerque, New Mexico.

The public is invited to attend and comment on the Division's proposed Rules and Regulation (rules), specifically, New Mexico Administrative Code, Section 14.12.2. The Committee will receive recommendations and written comments on all Sections of 14.12.2 NMAC. Written recommendations, including draft language should be addressed to the Manufactured Housing Committee at the address listed below. These recommendations must be submitted no later than October 10, 2003, to be considered for inclusion in the proposed rule. Written and oral comments will be received on the proposed rule at the Public Hearing. Immediately following the Public Hearing, the State of New Mexico Manufactured Housing Committee will hold its Bimonthly Committee Meeting, and the adoption of the proposed rule change will be on the agenda for that meeting. At the meeting the Committee will vote to approve or disapprove the recommended rule changes. The meeting will be held pursuant to the Open Meetings Act.

Copies of written comments received by October 10, 2003, and the AGENDA may be obtained by making a written or faxed request to the Manufactured Housing Division (MHD), 725 Saint Michael's Drive, P.O. Box 25101, Santa Fe, New Mexico 87504, Phone: (505) 827-7070 or Fax: (505) 827-7074.

Pursuant to the Americans with Disabilities Act, participants with special needs should contact the Manufactured Housing Division no later than October 1, 2003.

John Alejandro Sr., Director
Manufactured Housing Division
PO Box 25101- Santa Fe, New Mexico 87504

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

STATE OF NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

IN THE MATTER OF THE IMPLEMENTATION OF THE CONCEALED HANDGUN CARRY ACT

NOTICE OF HEARING ON PROPOSED RULEMAKING AND PROCEDURAL ORDER

The purpose of this hearing is to obtain input on a proposed rule to implement the Concealed Handgun Carry Act, NMSA 1978 Sections 29-19-1 et seq.

I. SOLICITATION OF COMMENTS

The Secretary of the Department of Public Safety is issuing this Notice to provide an opportunity for public comment and to create a record for a decision on a proposed rule to implement the Concealed Handgun Carry Act. The Secretary requests written and oral comments from all interested persons and entities on the proposed rule.

All relevant and timely comments, including data, views, or arguments, will be considered by the Secretary. In reaching his decision, the Secretary may take into account information and ideas not contained in the comments, providing that such information or a writing containing the nature and source of such information is placed in the public file, and provided that the fact of the Secretary's reliance on such information is noted in the Order the Secretary ultimately issues.

II. ORDER

IT IS THEREFORE ORDERED that this Notice of Hearing on Proposed Rulemaking and Procedural Order be issued.

IT IS FURTHER ORDERED that an informal public hearing be held on October 15, 2003, at 9:00 a.m. in Room 307 of the State Capitol, corner of Paseo de Peralta and Old Santa Fe Trail, Santa Fe, New Mexico for the purpose of receiving oral public comments including data, views, or arguments on the proposed rule. Please note that no food or beverages are permitted in committee rooms in the State Capitol. All interested persons wishing to present testimony may do so at the hearing. Interested persons should contact Sergeant Richard Martinez at the Department of Public Safety at (505) 841-8053, Ext. 1102 ahead of time to confirm the hearing date, time, and place since hearings are occasionally rescheduled.

IT IS FURTHER ORDERED that all interested parties may file written comments on the proposed rule on or before October 8, 2003. All relevant and timely comments, including data, views, or arguments will be considered by the Secretary before final action is taken in this proceeding. An original and four copies of written comments must be filed prior to the hearing with the Department of Public Safety, 6301 Indian School Rd., NE, Suite 310, Albuquerque, NM 87110, Attn: Sergeant Richard Martinez. The caption of this notice must appear on each submittal. Comments will be available for public inspection during regular business hours in the office of David Castaneda of the Department of Public Safety, 4491 Cerrillos Road, Santa Fe, NM, or at the office of Sergeant Richard Martinez, 6301 Indian School Rd., NE, Suite 310, Albuquerque, NM 87110.

IT IS FURTHER ORDERED that the Secretary may require the submission of additional information, make further inquiries, and modify the dates and procedures if necessary to provide for a fuller record and a more efficient proceeding.

IT IS FURTHER ORDERED that Department staff shall cause a copy of this Notice to be published once in the *New Mexico Register* and once in the *Albuquerque Journal*, both on or before to September 15, 2003. To obtain a copy of the proposed rule: (1) write to Sergeant Richard Martinez, 6301 Indian School Rd., NE, Suite 310, Albuquerque, NM 87110 and include the caption on this notice, a self-addressed envelope and a check for $5.00 made payable to the Department of Public Safety to cover the cost of copying and postage; (2) call Sergeant Richard Martinez at (505) 841-8053, Ext. 1102 with the caption on this notice (you will be billed $5.00 to cover the cost of copying and postage); or (3) e-mail Sergeant Richard Martinez at rmartinez@dps.state.nm.us with the caption on this notice (you will receive a copy of the rule in Microsoft WORD format by return e-mail at no charge). The proposed rule is also available for inspection and copying during regular business hours in the office of David Castaneda of the Department of Public Safety, 4491 Cerrillos Road, Santa Fe, NM, or at the office of Sergeant Richard Martinez, 6301 Indian School Rd., NE, Suite 310, Albuquerque, NM 87110.

III. ADVISEMENTS

PLEASE BE ADVISED THAT the New Mexico Lobbyist Regulation Act, NMSA 1978, Section 2-11-1 *et seq.,* regulates lobbying activities before state agencies, officers, boards and commissions in rulemaking and other policy-making proceedings. A person is a lobbyist and must register with the Secretary of State if the person is paid or employed to do lobbying or the person represents an interest group and attempts to influence a state agency, officer, board or commission while it is engaged in any formal process to adopt a rule, regulation, standard or policy of general application. An individual who appears for him or herself is not a lobbyist and does not need to register. The law provides penalties for violations of its provisions. For more information and registration forms, contact the Secretary of State's

Office, State Capitol Building, Room 420, Santa Fe, NM 87503, (505) 827-3600.

PLEASE BE ADVISED THAT individuals with a disability who are in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing, may contact Sergeant Richard Martinez on or before October 8, 2003, at (505) 841-8053, Ext. 1102. Public documents associated with the hearing can be provided in various accessible forms for disabled individuals. Requests for summaries or other types of accessible forms should also be addressed to Sergeant Martinez.

DONE, this 2nd day of September, 2003.

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

____
John Denko, Jr., Secretary

End of Notices and Proposed Rules Section

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Adopted Rules and Regulations

NEW MEXICO CHILDREN, YOUTH AND FAMILIES DEPARTMENT

FAMILY SERVICES DIVISION

This is an emergency amendment to 8.15.2.17 NMAC

8.15.2.17 PAYMENT FOR SERVICES: The department pays child care providers on a monthly basis, according to standard practice for the child care industry. Payment is based upon the child's enrollment with the provider as reflected in the child care placement agreement, rather than daily attendance. As a result, most placements reflect a month of service provision and are paid on this basis. However, placements may be closed at any time during the month. The following describes circumstances when placements may be closed and payment discontinued at a time other than the end of the month:

A. When the eligibility period as indicated by the child care placement agreement expires during the month, including the end of a school semester; or when the provider requests that the client change providers or the provider discontinues services; payment will be made through the last day that care is provided.

B. When the client requests a change of provider, regardless of the reason, payment will be made through the final day of the expiration of the fourteen (14) calendar day notice issued to the provider. Payment to the new provider begins on the day care begins.

C. The amount of the payment is based upon the average number of hours per week needed per child during the certification period. The number of hours of care needed is determined with the parent at the time of certification and is reflected in the provider agreement. Providers are paid according to the units of service needed which are reflected in the child care agreement covering the certification period.

D. The department pays for care based upon the following units of service:

Full time	Part time 1	Part time 2	Part time 3
Care provided for an average of 30 or more hours per week per month	Care provided for an average of 20-29 hours per week per month	Care provided for an average of 6 - 19 hours per week per month	Care provider for an average of 5 or less hours per week per month
Pay at 100% of full time rate	Pay at 75 % of full time rate	Pay at 50 % of full time rate	Pay at 25% of full time rate

E. Out of School Time Care provided by licensed child care providers who provide care for 6-19 hours per week are paid at the 75% rate (Part time 1).

F. Out of School Time Care provided by licensed child care providers who provide care for 20 or more hours per week are paid at the 100% rate (Full time).

G. Out of School Time Care provided for 5 hours or less per week are paid at the 25% rate (Part time 3) regardless of provider type.

H. Monthly Reimbursement Rates

	Licensed Child Care Centers							
	Full Time		Part Time 1		Part Time 2		Part Time 3	
	Metro	Rural	Metro	Rural	Metro	Rural	Metro	Rural
Infant	$467.84	$352.60	$350.88	$264.45	$233.92	$176.30	$116.96	$88.15
Toddler	$417.19	$345.00	$312.89	$258.75	$208.60	$172.50	$104.30	$86.25
Pre-School	$386.48	$322.50	$289.86	$241.88	$193.24	$161.25	$96.62	$80.63
School Age	$337.11	$311.75	$252.83	$233.81	$168.56	$155.88	$84.28	$77.94

	Licensed Group Homes (Capacity: 7-12)							
	Full Time		Part Time 1		Part Time 2		Part Time 3	
	Metro	Rural	Metro	Rural	Metro	Rural	Metro	Rural
Infant	$370.48	$324.38	$277.86	$243.29	$185.24	$162.19	$92.62	$81.10
Toddler	$335.40	$320.00	$251.55	$240.00	$167.70	$160.00	$83.85	$80.00
Pre-School	$329.55	$315.00	$247.16	$236.25	$164.78	$157.50	$82.39	$78.75
School Age	$325.00	$305.00	$243.75	$228.75	$162.50	$152.50	$81.25	$76.25

	Licensed Family Homes (Capacity: 6 or less)							
	Full Time		Part Time 1		Part Time 2		Part Time 3	
	Metro	Rural	Metro	Rural	Metro	Rural	Metro	Rural
Infant	$365.20	$320.00	$273.90	$240.00	$182.60	$160.00	$91.30	$80.00
Toddler	$325.08	$315.00	$243.81	$236.25	$162.54	$157.50	$81.27	$78.75
Pre-School	$324.17	$310.00	$243.13	$232.50	$162.09	$155.00	$81.04	$77.50
School Age	$319.28	$300.00	$239.46	$225.00	$159.64	$150.00	$79.82	$75.00

	Registered Homes and In-Home Child Care							
	Full Time		Part Time 1		Part Time 2		Part Time 3	
	Metro	Rural	Metro	Rural	Metro	Rural	Metro	Rural
Infant	$278.74	$258.00	$209.06	$193.50	$139.37	$129.00	$69.69	$64.50
Toddler	$264.00	$217.69	$198.00	$163.27	$132.00	$108.85	$66.00	$54.42
Pre-School	$242.00	$220.00	$181.50	$165.00	$121.00	$110.00	$60.50	$55.00
School Age	$242.00	$198.00	$181.50	$148.50	$121.00	$99.00	$60.50	$49.50

I. The department pays a differential rate according to the location of the provider, license or registration status of the provider, national accreditation status of the provider if applicable, and in accordance with the rate established for metro or rural location of the provider. Providers located in the three metropolitan statistical areas of the state as determined by the U.S. census bureau receive the metropolitan rate. These include Bernalillo, Sandoval, Valencia, Santa Fe, Los Alamos, Dona Ana, and San Juan counties. All other providers receive the rural rate.

J. The department pays a differential rate to former gold and silver licensed providers and providers holding national accreditation status. Former gold and silver licensed providers receive an additional $66.00 per month and $33.00 per month, respectively, for full time care above the base reimbursement standard. In order to continue at these reimbursement rates a provider must meet and maintain former gold and silver licensing requirements. If a former gold or silver licensed provider fails to meet the former gold and silver licensing requirements this could result in the provider reimbursement reverting to a lower level of reimbursement. Providers holding national accreditation status receive an additional $75.00 per child per month for full time care above the metro rate for type of child care (licensed center, group home or family home) and age of child. All licensed nationally accredited providers will be paid at the metro rates for the appropriate age group and type of care. In order to continue at this accredited reimbursement rate, a provider holding national accreditation status must meet and maintain licensing standards and maintain national accreditation status without a lapse. If a provider holding national accreditation status fails to maintain these requirements, this will result in the provider reimbursement reverting to a lower level of reimbursement.

K. AIM HIGH is a voluntary quality child care improvement pilot program that is open to all registered and licensed child care providers. The department pays a differential rate to providers achieving AIM HIGH levels as follows: Level 3 at [~~$16.50~~] **$25.50** per month per child for full time care above the base reimbursement rate; Level 4 at [~~$33.00~~] **$42.00** per month per child for full time care above the base reimbursement rate, and Level 5 at $75.00 per child per month for full time care above the base reimbursement rate.

L. The department pays a differential rate equivalent to 10% of the applicable full-time rate to providers who provide full-time care during non-traditional hours. Providers who provide part-time care during non-traditional hours will be paid a differential rate subject to the proration schedule delineated in 8.15.2.17 (D) NMAC.

M. If a significant change occurs in the client's circumstances, (for example, an increase or decrease in income or a change in work schedule) the child care placement agreement is modified and the rate of payment is adjusted. The department monitors attendance and reviews the placement at the end of the certification period when the child is re-certified.

N. The department may conduct provider or parent audits to assess that the approved service units are consistent with usage. Providers found to be defrauding the department are sanctioned. Providers must provide all relevant information requested by the department during an audit.

O. Payments are made to the provider for the period covered in the placement agreement or based on the availability of funds, which may be shorter than the usual six month certification period. The client's certification period may be established for a period less than six months, if applicable to their need for care.

[8.15.2.17 NMAC - Rp 8.15.2.17 NMAC, 11-01-02; A, 03/01/03; A, 07/16/03; A, 08/26/03]

NEW MEXICO DEPARTMENT OF GAME AND FISH

Explanatory paragraph: This is an amendment to Subsection G of 19.31.8.13 NMAC. The season ending date for Bow, Muzzleloader or Rifle has been extended from January 31 to February 29. The season ending date for GMU 4 remains January 31. The effective date is September 15, 2003.

19.31.8.13 ELK (2003 - 2004):

G. Private land elk hunts for ranches designated as **"RANCH ONLY"** shall be limited to the following season dates and weapon types: August 30 – September 22, **BOW ONLY,** in GMU's 2, 4, 5A, 5B, 6A, 6C, 7, 9, 10, 12, 13, 15, 16A, 16B, 16C, 16D, 16E, 17, 18, 21A, 21B, 22A, 23, 24, 34, 36, 37, 42, 44/45, 46, 47, 48, 49, 50, 51, 52, 53, 54 (except northeast portion), 55A, 56A, 57, 58; **BOW or MUZZLELOADER,** October 4 through [~~January 31~~] **February 29** in GMU's 2, 6A,

6C, 7, 9, 10, 34, 36, 37, 44/45, 48, 52, and 53 shall be limited to any consecutive 5 days, October 11 through [~~January 31~~] **February 29** in GMU's 13, 15, 16E, 17, 22A, 22B, 23, and 24, shall be limited to any consecutive 5 days; **BOW, MUZZLE-LOADER or RIFLE, October 4 through January 31 in GMU 4; BOW, MUZZLE-LOADER or RIFLE,** October 4 through [~~January 31~~] **February 29** in GMU's [~~4,~~] 5A, 5B, 12, 41, 42, 43, 46, 47, 49, 51, 54 (except northeast portion), 55A, 56A, 56 (Sierra Grande portion), 57, and 58 shall be limited to any consecutive 5 days, October 11 through [~~January 31~~] **February 29** in GMU's 2, 6A, 6C, 7, 10, 16A, 16B, 16C, 16D, 21A, 21B, 36, 37, 44/45, 50, 52, and 53, shall be limited to any consecutive 5 days, October 18 through [~~January 31~~] **February 29** in GMU's 16E, 22A, 22B, 23, 24, 34, and 48 shall be limited to any consecutive 5 days. November 8 through [~~January 31~~] **February 29** in GMU 9 shall be limited to any consecutive 5 days; **HANDICAP HUNTERS ONLY,** September 27 through October 1 in GMU's 16A, 16D, and 34, October 4 -8 in GMU 50, and November 8-12 in GMU 9 (including Water canyon, but not Marquez WMA). All private land handicap hunters must satisfy licensing requirements as stated in 19.31.3 NMAC, in order to hunt during the "Handicap Hunters" hunt periods.
[19.31.8.13 NMAC - Rp 19.31.8.13 NMAC, 4-1-2003; A, 9-15-2003]

NEW MEXICO DEPARTMENT OF GAME AND FISH

This is an amendment to 19.31.10 NMAC, Section 17

19.31.10.17 USE OF VEHICLES AND ROADS IN HUNTING:

A. Roads: It shall be unlawful to shoot at, wound, take, attempt to take, or kill any protected species on, from, or across any graded and including the areas lying within right-of-way fences or 40 feet from the edge of the pavement or maintained surface, in absence of right-of-way fences.

B. Vehicles, boats, aircraft: It shall be unlawful to shoot at any protected species from within a motor vehicle, power boat, sailboat, or aircraft. EXCEPTION - Migratory birds may be taken from a motor-driven boat (or other craft with attached motor) or sailboat when resting at anchor or fastened within or immediately alongside a fixed hunting blind or is used solely as a means of picking up dead birds.

C. Harassing protected wildlife: It shall be unlawful, at any time, to pursue, harass, harry, drive, or rally any protected species by use of or from a motor-driven vehicle, powerboat, sailboat, or aircraft.

D. Hunting after air travel: It shall be unlawful for anyone to hunt for or take any protected species until after the start of legal hunting hours on the day following any air travel except by regularly scheduled commercial airline flights or legitimate direct flight to the final destination.

E. Use of aircraft for spotting game: It shall be unlawful to use aircraft to spot or locate and relay the location of any protected species to anyone on the ground by any means of communication or signaling device or action.

F. Using information gained from air flight: It shall be unlawful to hunt for or to take, or assist in the hunting for or taking of, any protected species with the use of information regarding location of any protected species gained from the use of any aircraft until 48 hours after such aircraft use.

G. Vehicle off of established road: During the seasons established for any protected species, it shall be unlawful to drive or ride in a motor vehicle which is driven off an established road when the vehicle bears a licensed hunter, fisherman or trapper. EXCEPTION: 1) Snowmobiles; 2) To retrieve lawfully taken game not in an area closed to vehicular traffic. 3) All landowners, lessees or their employees, while on their owned or leased lands in connection with legitimate agricultural activities.

H. Closed roads: [~~It shall be unlawful for licensed hunters, anglers, or trappers to drive on closed roads during established seasons for protected species~~] **During the seasons established for any protected species, it shall be unlawful to knowingly occupy, drive, or cause to be driven any motor vehicle on a closed road when the vehicle bears a licensed hunter, angler or trapper**.

I. Handicapped license:

(1) Shooting from a vehicle: The holder of a handicap license is authorized to shoot at and kill protected species during their respective open seasons from a stationary motor-driven vehicle that is not on a public road or highway. The director may issue permits to shoot from a stationary vehicle to applicants who provide certification that the applicant is permanently disabled in accordance with the American Disability Act. Such certification shall be signed by an M.D. or O.D. licensed to practice in the applicant's state of residence.

(2) Driving off established roads: Holders of a handicap license may, with permission of the landowner, lessee, or land management agency, drive off established roads to hunt for or take squirrels or game birds, excluding turkey, during open seasons.

(3) Assistance for handicapped hunter: The holder of a handicapped license may be accompanied by another person to assist in reducing to possession any big game animal which has clearly been wounded by the licensed handicapped hunter.
[6-25-90; 4-1-95; 19.31.1.17 NMAC - Rn, 19 NMAC 31.1.17, 4-14-2000; 19.31.10.17 NMAC - Rn, 19.31.1.17 NMAC, 9-29-00; A, 12-14-01; A, 09-15-03]

NEW MEXICO DEPARTMENT OF LABOR
EMPLOYMENT SECURITY DIVISION

This is an amendment to 11.3.400 NMAC, Section 415. The amendment was enacted as an emergency measure and is effective August 27, 2003.

11.3.400.415 EXPERIENCE RATING OF EMPLOYERS: This rule shall govern the experience rating provisions of NMSA 1978 Section 51-1-11.

A. DEFINITIONS: For purposes of 11.3.400.415 NMAC, the following definitions shall apply:

(1) The "total assets in the fund" means all contributions collected, all payments in lieu of contributions collected or due from nonprofit organizations or governmental units and accounts receivable for federal shareable benefits for periods through the computation date of June 30.

(2) "Last annual payrolls" means the total payrolls as reported by all employers subject to contributions for the twelve-month period ending December 31 prior to the computation date except that, for rate year 2004, "last annual payrolls" means total payrolls as reported by all employers subject to contributions for the twelve-month period ending December 31, 2000.

(3) The "reserve" for each employer shall be the excess of employer's total contributions paid less total benefit charges computed as a percentage of the employer's "average payroll" reported for contributions. Each employer's reserve account percentage ("excess reserve ratio") shall be rounded to the nearest one-tenth of one percent.

B. ELIGIBILITY OF EMPLOYER'S ACCOUNT FOR COMPUTED RATE BASED ON BENEFIT EXPERIENCE. For purposes of the interpretation and application of NMSA 1978 Section 51-1-11E, no employer's experience rating account shall be deemed to have been

chargeable with benefits throughout the preceding thirty-six consecutive calendar month period ending on a computation date as defined in NMSA 1978 Section 51-1-11H(3)(d), unless as of such computation date, the department finds that the employer paid wages in employment during any part of the first calendar quarter of the three and one-half year period ending on such computation date and that the payment of such wages was not interrupted for nine or more consecutive calendar quarters, or by termination of coverage under NMSA 1978 Section 51-1-18; provided, all quarterly wage and contribution reports received by the department by July 31 following the computation date will be considered in computing the rate for the succeeding calendar year.

C. The amendment to Paragraph 2 of Subsection A of 11.3.400.415 NMAC, "except that, for rate year 2004, "last annual payrolls" means total payrolls as reported by all employers subject to contributions for the twelve-month period ending December 31, 2000" is adopted as an emergency measure to implement legislative changes enacted by the New Mexico Legislature in 2003. The emergency provision will remain in place indefinitely, but its effect will be for the calendar years 2003 and 2004. Notice and hearing on the promulgation of the emergency measure shall occur after the enactment as required by Sections 201 and 205 of 11.3.200 NMAC in that the amended rule shall be published on the department's website within seven days of the effective date and in the next available publication of the New Mexico Register.

[7-15-98; 11.3.400.415 NMAC - Rn & A, 11 NMAC 3.400.415, 9-1-2001; A, 01-01-2003; A, 8-27-2003]

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.4.17 NMAC effective 09-30-03.

16.19.4.17 PHARMACIST CLINICIAN:

A. PURPOSE: The purpose of these regulations is to implement the Pharmacist Prescriptive Authority Act, Sections 61-11B-1 through 61-11B-3 NMSA 1978 by providing minimum standards, terms and conditions for the certification, practice, and supervision of pharmacist clinicians. These regulations are adopted pursuant to Section 61-11B-3 of the Pharmacist Prescriptive Authority Act.

B. DEFINITIONS:

(1) Board means the New Mexico Board of Pharmacy.

(2) "dangerous drug" means a drug that, because of any potentiality for harmful effect or the methods of its use or the collateral measures necessary to its use, is not safe except under the supervision of a practitioner licensed by law to direct the use of such drug and the drug prior to dispensing is required by federal law and state law to bear the manufacturer's legend "Caution: Federal law prohibits dispensing without a prescription".

(3) "guidelines or protocol" means a written agreement between a pharmacist clinician or group of pharmacist clinicians and a practitioner or group of practitioners that delegates prescriptive authority.

(4) "monitor dangerous drug therapy" means to review the dangerous drug therapy regimen of patients by a pharmacist clinician for the purpose of evaluating and rendering advice to the prescribing practitioner regarding adjustment of the regimen. "Monitor dangerous drug therapy" includes:

(a) collecting and reviewing patient dangerous drug histories;

(b) measuring and reviewing routine patient vital signs including pulse, temperature, blood pressure and respiration;

(c) ordering and evaluating the results of laboratory tests relating to dangerous drug therapy, including blood chemistries and cell counts, controlled substance therapy levels, blood, urine, tissue or other body fluids, culture and sensitivity tests when performed in accordance with guidelines or protocols applicable to the practice setting; and

(d) evaluating situations that require the immediate attention of a physician and instituting or modifying treatment procedures when necessary.

(5) "oversight committee" means a joint committee made up of four (4) members to hear issues regarding pharmacist clinicians' prescriptive authority activities and supervising practitioners' direction of these activities.

(6) "pharmacist" means a person duly licensed by the Board to engage in the practice of pharmacy pursuant to the Pharmacy Act, Sections 61-11-1, 61-11-2, 61-11-4 to 61-11-28 NMSA 1978.

(7) "pharmacist clinician" means a pharmacist with additional training required by regulations adopted by the Board in consultation with the New Mexico Board of Medical Examiners and the New Mexico Academy of Physician Assistants, who exercises prescriptive authority in accordance with guidelines or protocol.

(8) "practitioner" means a physician duly authorized by law in New Mexico to prescribe dangerous drugs including controlled substances in Schedules II through V.

(9) "prescriptive authority" means the authority to prescribe, administer, monitor or modify dangerous drug therapy.

(10) "supervising practitioner" means a doctor, or group of doctors, of medicine or osteopathy approved by the respective Board to supervise a pharmacist clinician; "supervising practitioner" includes a practitioner approved by the respective Board as an alternate supervising practitioner.

(11) "scope of practice" means those duties and limitations of duties placed upon a pharmacist clinician by the supervising practitioner, the Board, and applicable law, and includes the limitations implied by the specialty practiced by the supervising practitioner.

C. INITIAL CERTIFICATION:

(1) The Board may certify a pharmacist as a pharmacist clinician upon completion of an application for certification and satisfaction of the requirements set forth in these regulations.

(2) A pharmacist who applies for certification as a pharmacist clinician shall complete application forms as required by the Board and shall pay a fee. The fee shall be set by the Board to defray the cost of processing the application, which fee is not returnable.

(3) To obtain initial certification as a pharmacist clinician, an applicant must provide proof that the applicant has satisfied one of the following:

(a) if the applicant is an actively licensed pharmacist, achievement of national certification as a physician assistant; or

(b) satisfactory completion of an academic curriculum which includes a minimum of sixty (60) hours of physical assessment training followed by nine (9) months of supervised clinical experience involving assessment skills; or

(c) satisfactory completion of a 60-hour physical assessment course approved by the Board and a 150-hour, 300 patient contact preceptorship supervised by a physician and approved by the Board, and achievement of a passing score as defined by the Board on an appropriate exam approved by the Board, or

(d) if the applicant is certified by the Indian Health Service's Pharmacist Practitioner Program, documentation of 600 patient contacts within the past two years as a pharmacist practitioner, accompanied by a supporting affidavit from the supervising physician.

(4) The Board shall issue a document of certification to each pharmacist certified as a pharmacist clinician. A copy of the document of certification shall at all times be maintained at each place of practice of the pharmacist clinician. **The initial**

certification will expire on the same date as the clinician's pharmacist license. The Board may prorate the fee based on the number of months of certification from the date of issue to the date of expiration.

(5) Upon certification by the Board, the name and address of the pharmacist clinician, name of the supervising practitioner, and other pertinent information shall be enrolled by the Board on a roster of pharmacist clinicians.

(6) No person shall represent that he or she is certified as a pharmacist clinician without maintaining current certification with the Board.

D. [~~ANNUAL~~] RENEWAL OF CERTIFICATION:

(1) Every pharmacist clinician certified to practice in New Mexico shall apply during the month of his or her birth **[~~each year~~]** to the Board for renewal of certification as a pharmacist clinician for the ensuing **two** year **period**.

(2) Applications for renewal must include:

(a) statement of the pharmacist clinician's name and current address;

(b) guidelines or protocol, if the pharmacist clinician seeks to exercise prescriptive authority;

(c) **[~~annual~~]** documentation of continuing education hours, including proof of completion of **[~~ten (10)~~]** **twenty (20)** hours of American Council of Pharmaceutical Education approved (ACPE) or Category I of the American Medical Association approved live continuing education (meeting, seminar, workshop, symposium), beyond the required hours in 16.19.4.10 NMAC (as amended), as required by the Board; and

(d) other additional information as requested by the Board.

E. PRESCRIPTIVE AUTHORITY, GUIDELINES OR PROTOCOL:

(1) No pharmacist clinician may exercise prescriptive authority unless guidelines or protocol from the current supervising practitioner are on file with the Board.

(2) A certified pharmacist clinician seeking to exercise prescriptive authority shall submit an application to the Board. The application must include the supervising practitioner's name and current medical license, guidelines or protocol and other information requested by the Board. A pharmacist may submit the application with the initial application for certification or as a separate application after becoming certified as a pharmacist clinician.

(3) The guidelines or protocol will be established and approved by the supervising practitioner as set forth in these regulations and will be kept on file at each practice site of the pharmacist clinician and with the Board.

(4) The guidelines or protocol must include:

(a) name of the practitioner authorized to prescribe dangerous drugs and name of the pharmacist clinician;

(b) statement of the types of prescriptive authority decisions the pharmacist clinician is authorized to make, including, but not limited to:

(i) types of diseases, dangerous drugs or dangerous drug categories involved and the type of prescriptive authority authorized in each case;

(ii) procedures, decision criteria or plan the pharmacist clinician is to follow when exercising prescriptive authority;

(c) activities to be followed by the pharmacist clinician while exercising prescriptive authority, including documentation of feedback to the authorizing practitioner concerning specific decisions made; documentation may be made on the prescriptive record, patient profile, patient medical chart or in a separate log book;

(d) description of appropriate mechanisms for reporting to the supervising practitioner; and

(e) description of the scope of practice of the pharmacist clinician.

F. SCOPE OF PRACTICE:

(1) A pharmacist clinician shall perform only those services that are delineated in the guidelines or protocol and are within the scope of practice of the supervising practitioner.

(2) A pharmacist clinician may practice in a health care institution within the policies of that institution.

(3) A pharmacist clinician may prescribe controlled substances provided that the pharmacist clinician (i) has obtained a New Mexico Controlled Substances registration and a Drug Enforcement Agency registration, and (ii) prescribes controlled substances within the parameters of written guidelines or protocols established under these regulations and Section 3, A. of the Pharmacist Prescriptive Authority Act.

(4) The Board may, in its discretion after investigation and evaluation, place limitations on the tasks a pharmacist clinician may perform under the authority and direction of a supervising practitioner.

G. RELATIONSHIP OF PHARMACIST CLINICIANS TO DESIGNATED SUPERVISING PRACTITIONERS:

(1) The direction and supervision of pharmacist clinicians may be rendered by approved supervising practitioners and not through intermediaries.

(2) A pharmacist clinician must meet in person with the supervising practitioner or the supervising practitioner's Board-approved alternate at least once every two (2) weeks to discuss patient management. Supervising practitioners must provide direction to pharmacist clinicians to specify the pharmacotherapeutic services to be provided under the circumstances in each case. This may be done by written guidelines or protocol or by oral communications in person, over the phone or by other electronic means. It is the responsibility of the supervising practitioner to assure that the appropriate directions are given and understood.

(3) The supervising practitioner must visit the premises of the pharmacist clinician's practice at least once every sixty (60) days in a nursing home setting and once every fourteen (14) days in the primary place of practice of the pharmacist clinician, and evaluate the quality of all pharmacotherapeutic services rendered by the pharmacist clinician by reviewing not less than twenty percent (20%) of all medical records to assure compliance with the guidelines or protocol and directions.

(4) If the supervising practitioner is of the opinion that circumstances warrant exceptions to the requirements set forth in paragraphs A, B or C [1, 2 or 3] above, the supervising practitioner must specify the circumstances in writing and deliver the same to the Secretary of the State of New Mexico Board of Medical Examiners or the State of New Mexico Board of Osteopathic Medical Examiners. The respective Board will review, grant or deny requests for exceptions or waivers, in the Board's discretion.

(5) Documentation of the supervising practitioner's reviews must be retained by the pharmacist clinician and be available for Board inspection for a period of not less than five (5) years from the date of review.

(6) The pharmacist clinician must function in reasonable proximity to the supervising practitioner and must have prompt access to the practitioner by telephone or two-way radio or two-way television or other electronic means for advice and direction. "Reasonable proximity" means a location not more than 120 miles or two hours, whichever is greater, from the supervising practitioner.

(7) If the supervising practitioner plans to be or is absent from his or her practice for any reason, the supervising practitioner cannot designate a pharmacist clinician to take over those duties or cover the practice during such absence. The supervising practitioner may designate an alternate supervising practitioner, approved by the respective Board, to cover the practice and perform the duties of supervising practitioner. The alternate supervising practitioner

will then supervise the pharmacist clinician and will be responsible for the pharmacist clinician's actions or omissions in exercising prescriptive authority or other duties as a pharmacist clinician.

(8) Upon any change in supervising practitioner between annual renewals of certification, a pharmacist clinician shall submit to the Board within ten (10) working days, the new supervising practitioner's name, current medical license, and guidelines or protocol. This notice requirement does not apply to an alternate supervising practitioner who is designated to cover during the absence of the supervising practitioner.

(9) The Chair of the Board will appoint two (2) members of the Board, and the President of the supervising practitioner's respective Board will appoint two (2) members of the respective Board to the oversight committee. The oversight committee will make a report that may include non-binding recommendations to both the Board and respective Board regarding disciplinary action. Each Board can accept or reject the recommendations.

H. APPEALS; Any applicant for certification or any certified pharmacist clinician may appeal a decision of the Board in accordance with the provisions of the Uniform Licensing Act, Sections 61-1-1 to 61-1-33 NMSA 1978.

[03-14-98; 16.19.4.17 NMAC - Rn, 16 NMAC 19.4.17, 03-30-02; 16.19.4.17 NMAC - Rn, 16.19.4.18 NMAC, 12-15-02; A, 09-30-03]

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.6 NMAC, Sections 17 and 21, effective 09-30-03.

16.19.6.17 SIGNS TO BE REMOVED WHEN PHARMACY DISCONTINUES OPERATION: When a pharmacy discontinues operation, the permit issued by the board shall be immediately surrendered to the board office, all drug signs and symbols, either within or without the premises, shall be immediately removed; all drugs, devises, poisons shall be removed or destroyed:

A. **SIGNS**: Any store, shop, laboratory or place of business which has upon it or in it a sign or words "pharmacist", "pharmaceutical chemist", "apothecary", "druggist", "pharmacy", "drug store", "drugs", "drug sundries", "prescriptions", or any of these words, or words of similar import either in English or any other language, or which is advertised by any sign containing any of these words, is defined by law to be a drug store **[~~of~~] or** pharmacy and must obtain a license from the board of pharmacy. Any such place of business not licensed by the board shall remove any such sign **[~~of~~] or** words which it may have upon or in it.

B. Waiver: The board may waive this requirement pursuant to a petition for waiver. Waivers granted by the board are limited to use by the party and business specified in the waiver document and other limitations set forth. Such petitions shall include:

(1) name of the party;

(2) address of the business;

(3) type of business;

(4) reason for waiver request;

(5) supporting documents; and

(6) photographs of the business demonstrating the use of the sign or words in question.

C. Use of pharmacy, pharmacist and other names: Any "advertiser", as defined by Paragraph (2) of Subsection A of 16.19.21 NMAC, using the names "pharmacist", "pharmacy", "apothecary", "apothecary shop", "drug store", "druggist", "drug sindries", "prescriptions", or any other combination of these words or any other words of similar import that indicate to the public that the advertiser is a pharmacy, is prohibited unless the following occurs:

(1) the advertiser is or has a licensed pharmacy in New Mexico; or

(2) the advertiser is or has a non-resident pharmacy licensed in New Mexico; or

(3) the advertiser has a clear statement, included with such advertisement, stating to the effect, "the advertiser is not a licensed pharmacy and does not fill prescriptions or practice pharmacy"; and

(4) the advertiser must disclose the name of the licensed pharmacy where prescriptions are filled for New Mexico residents and such disclosure would be clear and concise; and

(5) any "confidential information", as defined by NMSA 61-11-2D, is obtained by persons authorized by law to receive such information.

(6) pharmacists registered in this state may advertise their professional services except such advertisement shall not solicit prescription drug (dangerous drug) sales unless in conjunction with a licensed pharmacy.

[16.19.6.17 NMAC - Rp 16 NMAC 19.6.17, 03-30-02; A, 09-30-03]

16.19.6.21 GUIDELINES TO PREVENT FALSE AND MISLEADING ADVERTISING:

A. Definitions as used in this section:

(1) "advertising" or "to advertise" means to inform customers by any means such as, but not limited to, shelf tags, preticketing, display card, handbills, billboards, and advertisements in the newspapers, magazines, **the internet,** radio and television or by mail;

(2) "advertiser" means any person or firm which advertises **dangerous drug** prices **or services, defined as the practice of pharmacy (NMSA 61-11-2BB),** to consumers **in this state.**.

(3) "article" includes services as well;

(4) "price disclosure" is defined as in-store verbal disclosure of price, disclosure of prices by telephone, price lists, posters in-store containing retail prices for selected drugs indicating "our price".

B. Guidelines:

(1) An advertisement shall in no way stimulate demand or promote overuse or abuse of a dangerous drug or drugs. Prescription drugs are so intimately related to the public health that any ad which tends to promote overuse or abuse of a drug would have an adverse effect on public health, safety and welfare.

(2) The advertiser who does more than state his asking price must tell the truth in such a way that it cannot be misunderstood. Truthful price advertising, offering real bargains may be a benefit to all. But the advertiser must shun sales "gimmicks" and/or adverbs which infer exclusively when they are not factual, i.e., "cheapest", "lowest", which lure customers into a belief that they are getting bargains when in fact they are not.

(3) No comparisons should be made or implied between the price at which an article is offered for sale and some other reference price unless the nature of the reference price is explicitly identified and the advertiser has a reasonable basis to substantiate the reference price.

(4) Comparative pricing is generally defined as the practice whereby a firm or business displays, states, or advertises, directly or by implication two or more prices for his product or services; the actual current prices and another reference price. A reference price may not be implied by a statement such as "save 40%" unless it is substantiated pursuant to Paragraph (3) of Subsection B of 16.19.6.21 NMAC..

(5) No advertisement should be made expressly or impliedly offering lowered prices as a result of some unusual circumstances, unless the circumstances are true and the prices are actually lower than the advertiser's usual prices (i.e., clearance or special purchases, etc.)

(6) A firm should not advertise a "sale" or other temporary change in prices

without disclosing as explicitly as possible, the terms of quantities available, and the period in which the advertised prices will be available.

(7) An advertised price for an article should not be compared with a price for another article unless the price for the article is explicitly identified, and the advertiser has a reasonable basis to substantiate the existence of that price. In addition, one of the following conditions must be met:

(a) the comparability of the two articles can be established by reference to established standards of identity or performance; or

(b) the advertiser has otherwise established that the two articles are substantially identical in all significant respects; or

(c) the article is specifically identified.

(8) A retailer can be reasonably certain that his product is substantially identical to other products if he knows that all are made by the same manufacturer to the same specifications.

C. PRESCRIPTION DRUG ADVERTISING: Every advertisement other than price disclosure of a prescription drug shall contain the following information:

(1) the proprietary or trade name of the drug product;

(2) the established name of the drug product;

(3) the established name and quantity of each active ingredient in the drug product;

(4) the declaration of the established name and quantity of each active ingredient is optional if the drug product contains more than three active ingredients. However, this option does not apply to drug products containing aspirin, phenacetin, and caffeine in combination with one or two other active ingredients;

(5) the name of the manufacturer, packager or distributor;

(6) the dosage form;

(7) the price charged for a specific number of dosage units or quantity of the drug product;

(8) the price is to include all charges to the customer;

(9) the following services are considered to be included in the price to the consumer. If any of these services are not included in the price, the advertisement shall indicate those not provided:

(a) professional fees or cost or product and mark-up;

(b) patient Rx records;

(c) delivery services;

(d) charge privileges;

(e) pharmaceutical counseling;

(f) emergency after hours service;

(g) tax or insurance information;

(h) the hours pharmaceutical services are available to the customer.

D. PROHIBITED DRUG ADVERTISING

(1) There shall be no advertising, other than price disclosure, of a prescription drug or OTC drug which is a controlled substance regulated by the New Mexico Controlled Substances Act.

(2) There shall be no advertising, other than price disclosure, of a prescription drug product that is required by the federal Food and Drug Administration to contain a box warning statement on the label indicating there is evidence of significant incidence of fatalities or serious damage associated with the use of the drug product.

(3) Advertisements are not permitted for a drug evaluated by the Drug Efficacy Study Group, and for which no claim has been evaluated as higher than "possibly effective".

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.12 NAMC, Sections 9, 12, 13, 14 and 15, effective 09-30-03.

16.19.12.9 REGISTRATION FEES:

A. Registration by Examination $200.00

B. Registration by Reciprocity $200.00

C. Registration as an Intern **[~~$15.00~~] $30.00**

D. Registration as a Pharmacy Technician **[~~$15.00~~] $30.00**

[03-07-80…08-27-90; A, 07-15-97; A, 07-31-98; 16.19.12.9 NMAC - Rn, 16 NMAC 19.12.6, 03-30-02; A, 12-15-02; A, 09-30-03]

16.19.12.12 LICENSE/REGISTRATION RENEWAL:

A. Pharmacist license renewal for Active $200.00

B. Pharmacist license renewal for In-Active $70.00

C. Intern Renewal **[~~$10.00~~] $30.00 per year**

D. Duplicate License for Interns and Pharmacists $10.00

E. Controlled Substance Registration $60.00

F. Duplicate License for Controlled Substance $10.00

G. Pharmacy Technician Renewal **[~~$5.00~~] $30.00 bi-ennialy**

H. Manufacturer Representative $100.00 bi-ennialy

I. Pharmacist Clinician $70.00 bi-ennialy

[03-07-80...08-27-90; A, 07-31-98; A, 11-14-98; 16.19.12.12 NMAC - Rn, 16 NMAC 19.12.12, 03-30-02; A, 12-15-02; A, 09-30-03]

16.19.12.13 LICENSE FEES:

A. License fee for Drug Manufacturer $300.00

B. Wholesale Drug Distributor $300.00

C. Drug Manufacturer/Repackager $300.00

D. Repackager $300.00

E. Retail Pharmacy License **[~~$150.00~~] $300.00 bi-ennialy**

F. Hospital Pharmacy License **[~~$150.00~~] $300.00 bi-ennialy**

G. Hospital Drug Room pursuant to Section 61-11-7 of Pharmacy Act $60.00

H. Duplicate License $10.00

I. Nonresident Pharmacies **[~~$150.00~~] $400.00 bi-ennialy**

J. Seller or Dispenser of Contact Lens' $400.00 bi-ennialy

[03-07-80...05-01-93; 16.19.12.13 NMAC - Rn, 16 NMAC 19.12.13, 03-30-02; A, 09-30-03]

16.19.12.14 DRUG ROOM PERMIT:

A. Drug Room Permit in Adult Shelter Care or Custodial Care Facility:

[~~(1) from two through five beds $35.00~~]

[~~(2) from six through ten beds $50.00~~]

[~~(3) more than 10 beds $75.00~~]

(1) 10 or fewer beds: $100.00 bi-ennialy

(2) 11 or more beds: $200.00 bi-ennialy

B. Drug Room Permit in an Intermediate Nursing Home Facility **[~~$100.00~~] $200.00 bi-ennialy**

C. Drug Room Permit in a Skilled Nursing Home Facility **[~~$100.00~~] $200.00 bi-ennialy**

D. Duplicate License $10.00

[03-07-80...08-27-90; 16.19.12.14 NMAC - Rn, 16 NMAC 19.12.14, 03-30-02; A, 09-30-03]

16.19.12.15 CLINIC LICENSE FEES: Clinic license fees shall be:

A. Limited Clinic **[~~$150.00~~] $300.00 bi-ennialy**

B. Intermediate Clinic **[~~$150.00~~] $300.00 bi-ennialy**

C. Major Clinic

[~~$150.00~~] $300.00 bi-ennialy
D. Duplicate License
$10.00
E. Animal Control Clinics
[~~$50.00~~] $100.00 bi-ennialy
[03-07-80...08-06-94; 12-15-99; 16.19.12.15 NMAC - Rn, 16 NMAC 19.12.15, 03-30-02; A, 09-30-03]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

Notice of Repeal

1.18.308 NMAC, Executive Records Retention and Disposition Schedule for the Office of the State Auditor, is being repealed and replaced with the new 1.18.308 NMAC, Executive Records Retention and Disposition Schedule for the Office of the State Auditor, effective September 26, 2003. The New Mexico Commission of Public Records at their August 26, 2003 meeting repealed the current rule. The New Mexico Commission of Public Records at their August 26, 2003 meeting approved the new rule.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

August 28, 2003

Donald L. Padilla, Records Management Division Director
NM Commission of Public Records
1205 Camino Carlos Rey
Santa Fe, New Mexico 87505

Mr. Padilla:

You recently requested to publish a synopsis in lieu of publishing the full content of the following listed rules:
* 1.18.765 NMAC ERRDS, New Mexico Juvenile Parole Board (amendment; and
* 1.18.308 NMAC ERRDS, Office of the State Auditor (repeal and replace).

A review of these rules shows that their most impact is limited to the individual agencies to which they pertain, and they are "unduly cumbersome, expensive or otherwise inexpedient" to publish. Therefore, your request to publish a synopsis for each is approved.

Sincerely,

Sandra Jaramillo
State Records Administrator

SJ/dlp

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.308 NMAC ERRDS, Office of the State Auditor

1. Subject matter: 1.18.308 NMAC, Executive Records Retention and Disposition Schedule for the Officer of the State Auditor. This rule is new and replaces 1.18.308 NMAC ERRDS, Office of the State Auditor an outdated re-numbered version that was filed on 7/22/2002. This records retention and disposition schedule is a timetable for the management of specific records series of the Office of the State Auditor. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the office as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the Office of the State Auditor.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Office of the State Auditor. Persons and entities normally subject to the rules and regulations of the Office of the State Auditor may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Office of the State Auditor.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Office of the State Auditor. Any person or entity outside the covered geographical area that conducts business with or through the Office of the State Auditor may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 were used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: September 26, 2003.

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.308 NMAC ERRDS, Office of the State Auditor.

____
Roberta D. Joe ___________
Date
Assistant Attorney General

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.18.569 NMAC ERRDS, NM ORGANIC COMMODITY COMMISSION, Sections 8 and 13.

1.18.569.8 ABREVIATIONS AND ACRONYMS:
A. "CFR" stands for code of federal register.
B. "ERRDS" stands for executive records retention and disposition schedule.
C. "GRRDS" stands for general records retention and disposition schedule.
D. "ISO" stands for international organization for standardization. [This acronym stands for the european version.]
[~~**D.**~~] **E. "NMAC"** stands for New Mexico administrative code.
[~~**E.**~~] **F. "NMSA"** stands for New Mexico statutes annotated.
G. "NOP" stands for the national organic program.
[~~**F.**~~] **H. "OCC"** stands for organic commodity commission.
[1.18.569.8 NMAC - N, 2/18/2003; A, 9/29/2003]

1.18.569.13 OCC ACCREDITA-

TION FILE:

A. **Program:** certification and enforcement

B. **Maintenance system:** alphabetical by accrediting entity

C. **Description:** records concerning the accreditation of the OCC to certify operations and products as organic. The file may contain application for accreditation, audit report with accreditation decision or accreditation conditions, annual audits, findings, annual checklists, updates, correspondence, memoranda, etc. [The references to "accreditation" as used herein include but are not limited to NOP accreditation or ISO guide 65 accreditation.]

D. **Retention:**

(1) accreditation approved. 10 years after accreditation expired, suspended, or revoked

(2) accreditation denied. five years after accreditation denied

[1.18.569.13 NMAC - N, 9/29/2003]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.18.630 NMAC, Sections 343 and 345.

1.18.630.343 PAYMENT TRANSMITTAL LOG:

A. **Program:** CSED, program support

B. **Maintenance system:** [~~chronological by payment date~~] chrono-numeric by payment date then, case number

C. **Description:** record [~~concerns a log~~] of payments made for child support paid and deposited at local county offices with data entry and processing at the central office. Log may show region, transmittal date, case number, payer's identification number, payer's full name, check, money order or cash receipt number, payment amount, total number of checks, grand total dollar amount, etc.

D. **Retention:** three years after youngest child in support case reaches 18 years of age

E. **Confidentiality:** Portions of record may be confidential per 45 CFR 205.50.

[1.18.630.343 NMAC - Rp, 1.18.630.64 NMAC, 09/30/02; A, 09/29/03]

1.18.630.345 DAILY CASH RECEIPTS [~~PRINTOUT~~] BATCH FILE:

A. **Program:** CSED, program support

B. **Maintenance system:** [~~chronological by year~~] chrono-numeric by day, then batch number

C. **Description:** [~~record concerns cash receipts for CSED. Printout may show payment code, check number, amount, case number, payer's full name, total number of receipts, and total amount received, etc.~~] record of daily cash receipts received and processed by CSED central office. File may contain transaction document (t-doc); non-custodial payment (ncp) order; copies of application for child support; copies of wage withholding report; correspondence; original envelopes; copies of the CSED payment tracking system screens showing payment code, payment method code, and payment source code; copies of checks with check number, amount, case number, payer's full name; total number of receipts, and total dollar amount received, etc.

D. **Retention:** [~~three years~~] five years after the close of the federal fiscal year in which created

E. **Confidentiality:** Portions of record may be confidential per 45 CFR 205.50

[1.18.630.345 NMAC - Rp, 1.18.630.66 NMAC, 09/30/02; A, 09/29/03]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

[*The synopsis approval letter for 1.18.765 NMAC appears on page 596*]

SYNOPSIS
1.18.765 NMAC ERRDS, Juvenile Parole Board

1. Subject matter: 1.18.765 NMAC, Executive Records Retention and Disposition Schedule for the Juvenile Parole Board. This rule is an amendment to 1.18.765 NMAC ERRDS, Juvenile Parole Board an outdated re-numbered version that was filed on 7/22/2002. This records retention and disposition schedule is a timetable for the management of specific records series of the Juvenile Parole Board. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the board as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the Juvenile Parole Board.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Juvenile Parole Board. Persons and entities normally subject to the rules and regulations of the Juvenile Parole Board may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Juvenile Parole Board.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Juvenile Parole Board. Any person or entity outside the covered geographical area that conducts business with or through the Juvenile Parole Board may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 were used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: September 26, 2003.

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.765 NMAC ERRDS, Juvenile Parole Board.

____
Roberta D. Joe ____________
Date
Assistant Attorney General

NEW MEXICO PUBLIC REGULATION COMMISSION
INSURANCE DIVISION

13 NMAC 2.6, Actuarial Opinions and Memoranda (filed 5-27-97), was repealed effective September 30, 2003.

13 NMAC 9.5, Life Insurance Disclosure (filed 05-27-97), is repealed effective December 31, 2003 and re-promulgated as 13.9.5 NMAC, Life Insurance Disclosure effective 1-1-04.

13 NMAC 9.6, Replacement of Life Insurance and Annuities (filed 5/27/97), was repealed effective December 31, 2003.

13 NMAC 10.14, Minimum Reserve Standards For Individual & Group Health Insurance Contracts (filed 12/03/96), was repealed effective September 30, 2003.

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 2 INSURANCE COMPANY LICENSING AND OPERATION
PART 6 ACTUARIAL OPINION AND MEMORANDA

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) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) 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]

HISTORY OF 13.2.6 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records - state records center and archives.
SCC 93-5-IN, Actuarial Opinions and Memoranda, filed 12-01-93.

History of Repealed Materials:
13 NMAC 2.6, Actuarial Opinion and Memoranda, filed 5-27-97, was repealed 9-30-03.

Other History:
SCC 93-5-IN, Actuarial Opinions and Memoranda, filed 12-01-93, renumbered, reformatted and replaced by 13 NMAC 2.6, Actuarial Opinion and Memoranda, effective 7-1-97;
13 NMAC 2.6, Actuarial Opinion and Memoranda, filed 5-27-97 replaced by 13.2.6 NMAC, Replacement of Life Insurance and Annuities, effective 10-1-03]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 9 LIFE INSURANCE AND ANNUITIES
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.

Reprinted by. . .

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]

HISTORY OF 13.9.5 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records - state records center and archives.
INS Rule 80-3, Life Insurance Solicitation Rule, filed 9-12-80.

History of Repealed Material: 13 NMAC 9.5, Life Insurance Disclosure (filed 5-27-97), repealed 12-31-03.

Other History:
INS Rule 80-3, Life Insurance Solicitation Rule, filed 9-12-80, renumbered, reformatted and replaced by 13 NMAC 9.5, Life Insurance Disclosure, effective 7-1-97. 13 NMAC 9.5, Life Insurance Disclosure, filed 5-27-97, was replaced by 13.9.5 NMAC, Life Insurance Disclosure, effective 1-1-04.

NEW MEXICO PUBLIC REGULATION COMMISSION
INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 9 LIFE INSURANCE AND ANNUITIES
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 EXIST-

ING 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

[Please see *Appendix A* on page 614.]

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]

HISTORY OF 13.9.6 NMAC
Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records - state records center and archives.
INS Rule 80-4, Life Insurance Replacement Rule, filed 9-12-80.

History of Repealed Material:
13 NMAC 9.6, Replacement of Life Insurance and Annuities, filed 5-27-97, was repealed 12-31-03.

Other History: INS Rule 80-4, Life Insurance Replacement Rule, filed September 12, 1980, renumbered, reformatted and replaced by 13 NMAC 9.6, Replacement of Life Insurance and Annuities, effective 7-1-97;
13 NMAC 9.6, Replacement of Life Insurance and Annuities, filed 5-27-97 replaced by 13.9.6 NMAC, Replacement of Life Insurance and Annuities, effective 1-1-04.

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 9 LIFE INSURANCE AND ANNUITIES
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]

HISTORY OF 13.9.16 NMAC: [RESERVED]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
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 commis-

sions, 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]

HISTORY OF 13.10.14 NMAC:
Pre-NMAC History: None.

History of Repealed Material:
13 NMAC 10.14, Minimum Reserve Standards For Individual & Group Health Insurance Contracts (filed 12-03-96), repealed effective 9-30-03.

Other History:
13 NMAC 10.14, Minimum Reserve Standards For Individual & Group Health Insurance Contracts, filed 12-03-96 replaced by 13.10.14 NMAC, Minimum Reserve Standards For Individual and Group Health Insurance Contracts, effective 10-1-03.

NEW MEXICO PUBLIC REGULATION COMMISSION
INSURANCE DIVISION

This is an amendment to 13.10.8 NMAC, Sections 1, 5, 7, 11, 17, 20, 31, 32, 47 and 58. This action also renumbers and reformats 13 NMAC 10.8 to 13.10.8 NMAC in accordance with the current New Mexico Administrative Code (NMAC) requirements.

13.10.8.1 ISSUING AGENCY: Public Regulation Commission, Insurance Division[~~, Post Office Box 1269, Santa Fe, NM 87504-1269~~].
[7-1-98; A, 1-1-99; 13.10.8.1 NMAC - Rn & A, 13 NMAC 10.8.1, 1-1-04]

13.10.8.5 EFFECTIVE DATE: July 1, 1998, unless a later date is cited at the end of a section[~~ or paragraph~~].
[7-1-98; 13.10.8.5 NMAC - Rn & A, 13 NMAC 10.8.5, 1-1-04]

13.10.8.7 DEFINITIONS [~~As used in this rule~~]:

A. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

B. "Applicant" means:

(1) in the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(2) in the case of a group medicare supplement policy the proposed certificateholder.

C. "At-home recovery benefit" means coverage for services to provide short term at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

D. "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 4 hours in a 24-hour period of services provided by a care provider is one visit.

E. "Bankruptcy" means that a medicare+choice 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.

F. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

G. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

H. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

I. "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select issuer or its network providers.

J. "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 sixty-three (63) days.

K. "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), other than coverage consisting solely of benefits under section 1928;

(e) Chapter 55 of Title 10 United States Code (CHAMPUS);

(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 United States Code (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 United States Code 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, noncoordinated benefits:

(a) coverage only for a specified disease or illness; and

(b) hospital indemnity or other fixed indemnity insurance.

(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;

(b) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

(c) similar supplemental coverage provided to coverage under a group health plan.

L. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

M. "Form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

N. "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.

O. "Home" shall mean any place used by the insured as a place of residence, provided that such 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.

P. "Issuer" 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.

Q. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

R. "Medicare+choice plan" means a plan of coverage for health benefits under medicare part C as defined in [~~[refer to definition of medicare+choice plan in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33]~~] 42 U.S.C. 1395w-28(b)(1), and includes:

(1) coordinated care plans which 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) medicare medical savings account plans coupled with a contribution into a medicare+choice medical savings account; and

(3) medicare+choice 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" means respectively, a medicare supplement policy or certificate that contains restricted network provisions.

U. "Medicare supplement policy" means (unless defined to the contrary in this rule) a group policy issued pursuant to Chapter 59A, Article 23 NMSA 1978, group and blanket health insurance contracts, or an individual policy issued pursuant to Chapter 59A, Article 22 NMSA 1978, health insurance contracts, or a group or individual certificate of health insurance or a subscriber contract issued pursuant to Chapter 59A, Article 47 NMSA 1978, nonprofit health care plans, or Chapter 59A, Article 46 NMSA 1978, health maintenance organizations, or by a hospital and medical service association 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 as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare.

V. "Network provider" means a provider of health care, or a group of providers of health cares which has entered into a written agreement with the issuer to provide benefits insured under a medicare select policy.

W. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

X. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

Y. "Secretary" means the secretary of the United States department of health and human services.

Z. "Service area" means the geographic area approved by the superintendent within which an issuer is authorized to offer a medicare select policy.

AA. "Structure, language, and format" means style, arrangement and overall content of a benefit.

[7-1-98; 13.10.8.7 NMAC - Rn & A, 13 NMAC 10.8.7, 1-1-04]

13.10.8.11 GENERAL STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992: The standards prescribed in 13.10.8.11 and 13.10.8.12 NMAC apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

A. A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) 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 (6) months before the effective date of coverage.

B. A medicare supplement policy or certificate shall not indemnify against losses resulting from a sickness on a different basis than losses resulting from accidents.

C. A medicare supplement policy or certificate shall contain a provision which provides that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes[~~, and in accordance with Part L of this rule~~].

D. A "non-cancelable," "guaranteed renewable," or "non-cancelable and guaranteed renewable" medicare supplement policy shall not:

(1) 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 non-payment of premium; or

(2) be canceled or non-renewed by the issuer solely on the grounds of deterioration of health.

[7-1-98; 13.10.8.11 NMAC - Rn & A, 13 NMAC 10.8.11, 1-1-04]

13.10.8.17 COORDINATION WITH MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT:

A. 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 certificateholder for the period (not to exceed twenty-four months) in which the policyholder or certificateholder 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 certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.[~~[see Footnote 1]~~]

B. [~~Footnote 1:~~]If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certifications provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for the period 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 such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

[~~B.~~]D. Reinstitution of such coverages:

(1) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(2) shall provide for coverage which is equivalent to coverage in effect before the date of such suspension; and

(3) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

[7-1-98; 13.10.8.17 NMAC - Rn & A, 13 NMAC 10.8.17, 1-1-04]

13.10.8.20 PREVENTIVE MEDICAL CARE BENEFIT: Coverage for the following preventive health services:

A. An annual clinical preventive medical history and physical examination that may include tests and services from Subsection B of 13.10.8.20 NMAC and patient education to address preventive health care measures.

B. Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(1) [~~fecal-occult blood test and/or~~]digital rectal examination;

[~~(2) mammogram;~~]

[~~(3)~~](2) dipstick urinalysis for hematuria, bacteriuria and proteinuria;

[~~(4)~~](3) pure tone (air only) hearing screening test, administered or ordered by a physician;

[~~(5)~~](4) serum cholesterol screening (every five (5) years);

[~~(6)~~](5) thyroid function test; [~~and/or~~]

[~~(7)~~](6) diabetes screening.

C. [~~Influenza vaccine administered at any appropriate time during the year and~~]Tetanus and diphtheria booster every ten (10) years.

D. Any other tests or preventive measures determined appropriate by the attending physician.

E. Reimbursement shall be for the actual charges up to one hundred percent (100 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 one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

[7-1-98; 13.10.8.20 NMAC - Rn & A, 13 NMAC 10.8.20, 1-1-04]

13.10.8.31 GUARANTEED ISSUE:

A. Eligible persons are those individuals described in 13.10.8.32 NMAC who, subject to Subparagraph (2) of Paragraph B of 13.10.8.32 NMAC, apply to enroll under the policy not later than sixty-three days after the date of the termination of enrollment described in 13.10.8.32 NMAC, and who submit evidence of the date of termination or disenrollment with the application for a medicare supplement policy.

B. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in 13.10.8.33 NMAC 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.

[7-1-98; 13.10.8.31 NMAC - Rn & A, 13 NMAC 10.8.31, 1-1-04]

13.10.8.32 ELIGIBLE PERSONS: An eligible person is an individual described in any of the following paragraphs:

A. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare; and the plan terminates, or the plan ceases to

provide all such supplemental health benefits to the individual;

B. The individual is enrolled with a medicare+choice organization under a medicare+choice plan under part c of medicare, 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 1984 of the Social Security Act, 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+choice plan:

(1) [~~The organization's or plan's certification (under this part)~~]The certification of the organization or plan under this part has been terminated, or the organization or plan has [~~terminated or otherwise discontinued providing the plan in the area in which the individual resides~~]notified the individual of an impending termination of such certificate;

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan;

[~~(2)~~](3) 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 (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;

[~~(3)~~](4) The individual demonstrates, in accordance with guidelines established by the secretary, that:

(a) The organization offering the plan substantially violated a material provision of the organizations 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

(b) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plans provisions in marketing the plan to the individual; or

[~~(4)~~](5) The individual meets such other exceptional conditions as the secretary may provide.

C. An individual described in Subparagraph (1) of Paragraph B of 13.10.8.32 NMAC may elect to apply 13.10.8.31 NMAC by substituting for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

D. In the case of an individual making the election in Subsection C of 13.10.8.32 NMAC, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under 13.10.8.31 NMAC shall only become effective upon termination of coverage under the Medicare+Choice plan involved.

[~~C.~~]E. The individual is enrolled with one of the following organizations and the enrollment ceases under the same circumstances that would permit discontinuance of an individuals election of coverage under Subsection B of 13.10.8.32 NMAC:

(1) an eligible organization under a contract under Section 1876 (medicare risk or cost);

(2) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(3) an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

(4) an organization under a medicare select policy.

[~~D.~~]F. The individual is enrolled under a medicare supplement policy and the enrollment ceases because:

(1) of an order issued in a delinquency proceeding held pursuant to Chapter 59A, Article 41 NMSA 1978, or the bankruptcy of the nonissuer organization;

(2) of other involuntary termination of coverage or enrollment under the policy;

(3) the issuer of the policy substantially violated a material provision of the policy;

(4) 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.

[~~E.~~]G. The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any medicare+choice organization under a medicare+choice plan under part c of medicare, any eligible organization under a contract under Section 1876 (medicare risk or cost), any similar organization operating under demonstration project authority, any PACE program under Section 1984 of the Social Security Act, an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a medicare select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first twelve 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).

[~~F.~~]H. The individual, upon first becoming eligible for benefits under Part A of medicare at age 65, enrolls in a medicare+choice plan under part c of medicare, or in a PACE program under Section 1984, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.

[7-1-98; A, 1-1-99; 13.10.8.32 NMAC - Rn & A, 13 NMAC 10.8.32, 1-1-04]

13.10.8.47 REQUIRED DISCLOSURE PROVISIONS:

A. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such 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.

B. 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 this 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, unless the benefits are required by the minimum standards for medicare supplement policies, be agreed to in writing and signed by the insured, except 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, such premium charge shall be set forth in the policy.

C. 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 "unusual and customary" or words of similar import.

D. 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."

E. 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 certificateholder shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded within thirty days after its return if, after examination of the policy or certificate, the insured is not satisfied for any reason.

F. Issuers of health insurance policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person(s) eligible for medicare shall provide to all applicants a guide to health insurance for people with medicare in the form developed jointly by the national association of insurance commissioners and the health care financing administration and in a type size no smaller than 12 point type. Delivery of the guide shall be made whether or not such policies or certificates are advertised, solicited or issued as medicare supplement policies or certificates as defined in the rule. Except in the case of direct response issuers delivery of the guide shall be made to the applicant at the time of application and acknowledgment of the guide shall be obtained by the issuer. Direct response issuers shall deliver the [~~buyer's~~] guide to the applicant upon request but no later than at the time the policy is delivered.
[7-1-98; 13.10.8.47 NMAC - Rn & A, 13 NMAC 10.8.47, 1-1-04]

13.10.8.58 OUTLINE OF COVERAGE:

(COMPANY NAME)

Outline of Medicare Supplement Coverage -- Cover Page

Benefit Plan(s) ____ *(insert letter(s) of plan(s) being offered)*

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in all Plans.
HOSPITALIZATION: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
MEDICAL EXPENSES: Part B coinsurance (generally 20% of Medicare-approved expenses, or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments).
BLOOD: First three pints of blood each year.

A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 limit)	Basic Drugs ($1,250 limit)	Extended Drugs ($3,000 limit)
				Preventive Care					Preventive Care

*** Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [$1500] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.**

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.

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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 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.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "[~~The Medicare Handbook~~]Medicare and You" for more details.

[for agents:] Neither [*insert company name*] nor its agents are connected with Medicare.

[for direct response:] [*insert company name*] is not connected with Medicare.

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 need 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 shown in the charts in 13.10.8.59 and 13.10.8.68 NMAC. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to Subsection D of 13.10.8.23 NMAC.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Superintendent.]
[7-1-98; A, 10-15-99; 13.10.8.58 NMAC - Rn & A, 13 NMAC 10.8.58, 1-1-04]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

This action renumbers and reformats 13 NMAC 10.15 to 13.10.15 NMAC in accordance with the current New Mexico Administrative Code (NMAC) requirements. This action also amends Sections 1, 2, 5, 7, 9, 18, 19, 24, 32, 37, 43, 46, 50 and adds new sections 20, 21, 33 and 53.

13.10.15.1 ISSUING AGENCY: New Mexico Public Regulation Commission, Insurance Division~~[, Post Office Drawer 1269, Santa Fe, NM 87504-1269~~].
[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]

13.10.15.5 EFFECTIVE DATE: January 1, 1999, unless a later date is cited at the end of a section [~~or paragraph~~.]
[1-1-99; 13.10.15.5 NMAC - Rn & A, 13

NMAC 10.15.5, 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.

[~~D~~]F. "Issuer" means an insurer, health care service plan, or other entity marketing or providing long-term care insurance or benefits in this state.

[~~E~~]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]

13.10.15.9 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]

13.10.15.18 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[~~: 1)~~] the policy holder or certificate holder became cognitively impaired or lost functional capacity before the grace period contained in the policy expired[~~; and 2) that cognitive impairment or loss of functional capacity caused the unintentional default in the premium payment~~]. 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 [~~the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.~~] 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 anticipat-

ed 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~~]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]

[~~13.10.15.30~~]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 superintend-

ent 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~~]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 .

[~~**B.** establish marketing procedures to assure that~~]

(2) excessive insurance is not sold or issued;

[~~**C**~~]**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]

[~~13.10.15.40~~]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 [~~thirty (30)~~]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, [~~except~~]for a policy or certificate [~~with a contingent benefit upon lapse or 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]

[*Continued on page 637.*]

[~~13.10.15.43~~]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.

[~~3~~]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;]

[~~D. [State whether or not the company has a right to change premium, and if such right exists, describe clearly and concisely each circumstance under which premium may change.]~~]

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.]

[4]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.]

[~~5~~]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.

[~~6~~]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.]

[~~7~~]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.]

[~~8~~]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 [~~(6)~~] (8) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

[~~9~~]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.]

[10]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.]

[11]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.

[12]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]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. [State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.]

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 last rate increase for this policy in this state was in [year], when premiums went up by an average of ____%]. [The company has not raised its rates for this policy].] [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).]

[Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

Questions Related to Your Income

[~~Where will you get the money to pay each year's premiums?~~]

How will you pay each years' premiums?

___ From My Income ___ From My Savings\Investments ___ My Family [~~members~~] 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 ____]

[[~~Note:~~]]
[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]

13.10.15.53 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]

NEW MEXICO RACING COMMISSION

Explanatory Paragraph: This is an amendment to Subsection K Paragraph (2) (b) of 15.2.7.12 NMAC changing the payout and distribution of the trifecta pool and to Subsection L Paragraph (8), Subsection O Paragraph (7) and Subsection P Paragraph (7) allowing coupled entries and mutuel fields in the superfecta, tri-superfecta and twin superfecta pools effective 09/15/2003.

15.2.7.12 CALCULATION OF PAYOUTS AND DISTRIBUTION OF POOLS:

K. TRIFECTA POOLS:

(1) The trifecta requires selection of the first three finishers, in their exact order, for a single contest.

(2) The net trifecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(a) as a single price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then

(b) **[~~the following sequence, based on the official order of finish shall be used to determine the winning combination: first, second, and fourth; first, third, and fourth; second, third, and fourth; first, second, and fifth; first, third, and fifth; and sequentially thereafter;~~]** **as a single price pool to those whose combinations included, in correct sequence, the first two betting interest; but if there are no such wagers, then**

(c) as a single price pool to those whose combinations correctly selected the first-place betting interest only; but if there are no such wagers, then

(d) the entire pool shall be refunded on trifecta wagers for that contest

[~~(c)~~] **(e)** where only two horses finish in the race on which trifecta wagering is conducted, the pool shall be calculated so that the net pool should be divided by the value of tickets sold in the pool on horses selected to finish first and second in the exact order of the official result coupled with any other horse that started in the race;

[~~(d)~~] **(f)** where only one horse finishes in a race on which trifecta wagering is conducted, the pool shall be calculated so that the net pool shall be divided by the value of the tickets sold in the trifecta pool selecting that horse to finish first, coupled with any two other horses started in the race.

L. SUPERFECTA POOLS:

(8) Coupled entries and mutuel fields **[~~shall be prohibited in superfecta contests.~~]** **may be permitted in superfecta contests with the prior written approval of the commission.**

O. TRI-SUPERFECTA POOLS:

(7) Coupled entries and mutuel fields **[~~shall be prohibited in tri-superfecta contests.~~]** **may be permitted in tri-superfecta contests with the prior written approval of the commission.**

P. TWIN SUPERFECTA POOLS:

(7) Coupled entries and mutuel fields **[~~shall be prohibited in twin superfecta contests.~~]** **may be permitted in twin superfecta contests with the prior written approval of the commission.**

End of Adopted Rules Section

SUBMITTAL DEADLINES AND PUBLICATION DATES

2003

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Issue Number 20	October 16	October 30
Issue Number 21	October 31	November 13
Issue Number 22	November 14	November 26
Issue Number 23	December 1	December 15
Issue Number 24	December 16	December 30

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Issue Number 7	April 1	April 15
Issue Number 8	April 16	April 30
Issue Number 9	May 3	May 14
Issue Number 10	May 17	May 28
Issue Number 11	June 1	June 15
Issue Number 12	June 16	June 30
Issue Number 13	July 1	July 15
Issue Number 14	July 16	July 30
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Issue Number 20	October 15	October 29
Issue Number 21	November 1	November 15
Issue Number 22	November 16	November 30
Issue Number 23	December 1	December 14
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