TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 15 LONG-TERM CARE INSURANCE

13.10.15.1 ISSUING AGENCY: New Mexico Public Regulation Commission, Insurance Division.
[1-1-99; A, 1-1-99; 13.10.15.1 NMAC - Rn & A, 13 NMAC 10.15.1, 1-1-04]

13.10.15.2 SCOPE: This rule applies to all long-term care insurance policies and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after January 1, 1999 by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. Additionally, this rule is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if: 1) the benefits of the disability inicome policy are dependent upon or vary in amount based on the receipt of long-term care services; 2) the disability income policy is advertised, marketed or offered as insurance for long-term care services; or 3) benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.
[1-1-99; A, 1-1-99; 13.10.15.2 NMAC - Rn & A, 13 NMAC 10.15.2, 1-1-04]

13.10.15.3 STATUTORY AUTHORITY: Sections 59A-2-9, 59A-23A-6 and 59A-23A-9 NMSA 1978.
[1-1-99; 13.10.15.3 NMAC - Rn, 13 NMAC 10.15.3, 1-1-04]

13.10.15.4 DURATION: Permanent.
[1-1-99; 13.10.15.4 NMAC - Rn, 13 NMAC 10.15.4, 1-1-04]

13.10.15.5 EFFECTIVE DATE: January 1, 1999, unless a later date is cited at the end of a section.
[1-1-99; 13.10.15.5 NMAC - Rn & A, 13 NMAC 10.15.5, 1-1-04]

13.10.15.6 OBJECTIVE: The purpose of this rule is to implement Chapter 59A, Article 23A NMSA 1978 to promote the public interest and the availability of long-term care insurance coverage, and to facilitate flexibility and innovation in the development of long-term care insurance.
[1-1-99; 13.10.15.6 NMAC - Rn, 13 NMAC 10.15.6, 1-1-04]

13.10.15.7 DEFINITIONS: In additon to the definitions in Section 59A-23A-4 NMSA 1978, the following terms have the meanings given here.

A. "Basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

B. "Basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

C. "Converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Superintendent to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made.

D. "Exceptional increase" means only those increases filed by an insurer as exceptional for which the superintendent determines the need for the premium rate increase is justified: 1) due to a change in laws or rules applicable to long-term care coverage in this state or 2) due to increased and unexpected utilization that affects a majority of insurers of similar products.

E. "Incidental" as used in Subsection J of 13.10.15.33 NMAC, means that the value of the long-term care benefits prpovided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy, measured as of the date of issue.

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

G. **"Managed-care plan"** means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

H. **"Qualified actuary"** means a member in good standing of the American Academy of Actuaries.

I. **"Similar policy forms"** means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Paragraph (1) of Subsection C of Section 59A-23A-4 NMSA 1978 are not considered similar to certificates of policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For the purpose of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits

[1-1-99; 13.10.15.7 NMAC - Rn & A, 13 NMAC 10.15.7, 1-1-04]

13.10.15.8 **USE OF CERTAIN POLICY TERMS:** No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements.

A. **Activities of daily living** means at least bathing, continence, dressing, eating, toileting and transferring.

B. **Acute condition** means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. **Adult day care** means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

D. **Bathing** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

E. **Cognitive impairment** means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. **Continence** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. **Dressing** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

H. **Eating** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

I. **Hands-on assistance** means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

J. **Home health care services** means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. **Medicare** shall be defined as The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended, or Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof, or words of similar import.

L. **Mental or nervous disorder** shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

M. **Personal care** means the provision of hands-on services to assist an individual with activities of daily living (such as bathing, eating, dressing, transferring and toileting).

N. **Skilled nursing care, intermediate care, personal care, home care**, and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

O. **Toileting** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. **Transferring** means moving into or out of a bed, chair or wheelchair.

Q. **All providers of services, including but not limited to skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, personal care facility, and home care agency** shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

[1-1-99; 13.10.15.8 NMAC - Rn, 13 NMAC 10.15.8, 1-1-04]

13.10.15.9 RENEWABILITY: The terms guaranteed renewable and noncancelable shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of 13.10.15.20 NMAC.

A. No policy issued to an individual shall contain renewal provisions other than guaranteed renewable or noncancelable.

B. The term guaranteed renewable may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

C. The term noncancelable may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

D. The term "level premium" may only be used when the insurer does not have the right to change the premium.

[1-1-99; 13.10.15.9 NMAC - Rn & A, 13 NMAC 10.15.9, 1-1-04]

13.10.15.10 LIMITATIONS AND EXCLUSIONS:

A. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) preexisting conditions or diseases;

(2) mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) alcoholism and drug addiction;

(4) illness, treatment or medical condition arising out of:

(a) war or act of war (whether declared or undeclared);

(b) participation in a felony, riot or insurrection;

(c) service in the armed forces or units auxiliary thereto;

(d) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(e) aviation (this exclusion applies only to non-fare-paying passengers).

(5) treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers compensation, employers liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered persons immediate family and services for which no charge is normally made in the absence of insurance.

B. This section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

[1-1-99; 13.10.15.10 NMAC - Rn, 13 NMAC 10.15.10, 1-1-04]

13.10.15.11 EXTENSION OF BENEFITS: Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

[1-1-99; 13.10.15.11 NMAC - Rn, 13 NMAC 10.15.11, 1-1-04]

13.10.15.12 CONTINUATION OF COVERAGE OR CONVERSION REQUIRED:

A. Group long-term care insurance issued in this state on or after July 1, 1997 shall provide covered individuals with a basis for continuation or conversion of coverage.

B. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) termination of group coverage resulted from an individuals failure to make any required payment of premium or contribution when due; or

(2) the terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(a) providing benefits identical to or benefits determined by the Superintendent to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(b) the premium for which is calculated in a manner consistent with the requirements of Subsection C of 13.10.15.14 NMAC.

[1-1-99; 13.10.15.12 NMAC - Rn, 13 NMAC 10.15.12, 1-1-04]

13.10.15.13 CONTINUATION OF COVERAGE:

A. Group policies which restrict provision of benefits and services to, or contain incentives to use, certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Superintendent shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

B. Notwithstanding any other provision of Subsection B of 13.10.15.12 NMAC, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

[1-1-99; 13.10.15.13 NMAC - Rn, 13 NMAC 10.15.13, 1-1-04]

13.10.15.14 CONVERSION:

A. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers and/or facilities, the Superintendent, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

B. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy or following payment direction of the insurer, if later. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

C. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

D. Notwithstanding any other provision of Subsection B of 13.10.15.12 NMAC, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

E. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individuals coverage under the group policy remained in force and effect.

[1-1-99; 13.10.15.14 NMAC - Rn, 13 NMAC 10.15.14, 1-1-04]

13.10.15.15 DISCONTINUANCE AND REPLACEMENT: If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to

all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

A. shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

B. shall not vary or otherwise depend on the individuals health or disability status, claim experience or use of long-term care services.

[1-1-99; 13.10.15.15 NMAC - Rn, 13 NMAC 10.15.15, 1-1-04]

13.10.15.16 LIMITATIONS ON PREMIUM RATE INCREASES:

A. The initial premium charged an insured covered by a long-term care policy shall not increase during the initial three (3) years in which the policy is in force.

B. The premium charged to an insured shall not increase due to either:

(1) the increasing age of the insured at ages beyond sixty-five (65); or

(2) the duration the insured has been covered under the policy.

C. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under 13.10.15.43 NMAC, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

D. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under 13.10.15.43 NMAC, the initial annual premium shall be based on the reduced benefits.

[1-1-99; 13.10.15.16 NMAC - Rn, 13 NMAC 10.15.16, 1-1-04]

13.10.15.17 UNINTENTIONAL LAPSE: Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. Designation of person to receive notice.

(1) No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either:

(a) a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium;

(b) or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

(2) The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured.

(3) The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address.

(4) In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

(5) The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

B. Payroll and pension deduction plans. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A of this section need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

C. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A of this section, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

[1-1-99; 13.10.15.17 NMAC - Rn, 13 NMAC 10.15.17, 1-1-04]

13.10.15.18 REINSTATEMENT: In addition to the requirement in 13.10.15.17 NMAC, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policy holder or certificate holder became cognitively impaired or lost functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof for cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.
[1-1-99; 13.10.15.18 NMAC - Rn & A, 13 NMAC 10.15.18, 1-1-04]

13.10.15.19 REQUIRED DISCLOSURE PROVISIONS:

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder. A long-term care insurance policy or certificate, other than the one where the insured does not have the right to change premium, shall include a statement that premium rates may change.

B. Riders and endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and customary or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as Preexisting Condition Limitations.

E. Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Paragraphs (6) and (7) of Section 59A-23A-6C NMSA 1978 shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph Limitations or Conditions on Eligibility for Benefits.

F. Disclosure of tax consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.
[1-1-99; 13.10.15.19 NMAC - Rn & A, 13 NMAC 10.15.19, 1-1-04]

13.10.15.20 REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS:

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2) of this subsection, this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2004.

(2) For certificates issued on or after the effective date of this amended rule under a long-term care insurance policy as defined in Paragraph (1) of Subsection C of Section 59A-23A-4 NMSA 1978, which policy was in force at the time this amended rule became effective, the provisions of this section shall apply on the policy anniversary following July 1, 2004.

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or

enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or the certificate holder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect untill a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective; and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (2) of this subsection if the premium rate or rate schedule is changed;

(5) Information regarding each premium rate increase on this form or similar policy forms over the past ten (10) years for this state that a minimum identifies:

(a) The policy forms for which premium rates have been increased;

(b) The calendar years when the form was available for purchase; and

(c) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(6) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(7) An insurer shall have the right to exclude form the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired form other nonaffiliated insurers when those increases occurred prior to the acquisition.

(8) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four (24) month period following the acquisition of the block or policies, the acquiring insurer may exclude the rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with paragraph (5) of this subsection.

(9) If the acquiring insurer in Paragraph (8) of this subsection files for a subsequent rate increase, even within the 24 month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Paragraph (8) of this subsection, the acquiring insurer must make all disclosure required by Paragraph (5) of this subsection, including disclosure of the earlier rate increase referenced in Paragraph (8) of this subsection.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection B of this section. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in 13.10.15.50 and 13.10.15.53 NMAC to comply with the requirements of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least sixty (60) days prior to the implementation of the premium rate schedule
increase by the insurer. The notice shall include the information required by Subsection B of this section when the rate increase is implemented.

[13.10.15.20 NMAC - N, 1-1-04]

13.10.15.21 INITIAL FILING REQUIREMENTS:

A. This section applies to any long-term care policy issued in this state on or after January 1, 2004.

B. An insurer shall provide the information listed in this subsection to the superintendent along with the form and rate filing required by law.

(1) A copy of the disclosure documents required by 13.10.15.20 NMAC; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium rate increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include: (i) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held, (ii) a statement that the assumptions used for reserves contain reasonable margins for adverse experience, (iii) a statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted), and (iv) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situation where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the superintendent may request a demonstration under Subsection C of this section based on a standard age distribution.

(e) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences

C. The superintendent may request an actuarial demonstration that benefits are reasonable in relation to premiums.

[13.10.15.21 NMAC - N, 1-1-04]

13.10.15.22 PROHIBITION AGAINST POST-CLAIM UNDERWRITING:

A. All applications for long-term care insurance policies or certificates, except those which are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(1) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

B. Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery: "Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form]/[is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address [insert address]."

(3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

(a) a report of a physical examination;

(b) an assessment of functional capacity;

(c) an attending physicians statement; or

(d) copies of medical records.

C. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

D. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated, and shall annually furnish this information to the Superintendent in the format prescribed by the National Association of Insurance Commissioners in 13.10.15.49 NMAC.
[1-1-99; 13.10.15.22 NMAC - Rn, 13 NMAC 10.15.20, 1-1-04]

13.10.15.23 MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES:

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits by:

(1) requiring that the insured/claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community or institutional setting before home health care services are covered;

(3) limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(5) excluding coverage for personal care services provided by a home health aide;

(6) requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) requiring that the insured/claimant have an acute condition before home health care services are covered;

(8) limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.
[1-1-99; 13.10.15.23 NMAC - Rn, 13 NMAC 10.15.21, 1-1-04]

13.10.15.24 REQUIREMENT TO OFFER INFLATION PROTECTION:

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the offer required by Subsection A of this section shall be made to the group policyholder; except, if the policy is issued to a group defined in Paragraph (1) of Subsection C of Section 59A-24A-4 NMSA 1978 other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

C. The offer required by Subsection A of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. Outline of coverage.

(1) Insurers shall include the following information in or with the outline of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

E. Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. Rejection by the applicant.

(1) The inflation protection required by Paragraph (1) of Subsection A of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

(2) The rejection shall be considered a part of the application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection."

[1-1-99; 13.10.15.24 NMAC - Rn & A, 13 NMAC 10.15.22, 1-1-04]

13.10.15.25 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE:

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced provided, however, that the certificate holder has been notified of the replacement.

(1) "Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?"

(2) "Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?"

(a) "If so, with which company?"

(b) "If that policy lapsed, when did it lapse?"

(3) "Are you covered by Medicaid?"

(4) "Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?"

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

C. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, policy number, and address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

D. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 13.9.6 NMAC, Replacement of Life Insurance and Annuities. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy,

the replacing insurer shall comply with both the long-term care replacement requirements of this section and the life insurance replacement requirements of 13.9.6 NMAC, Replacement of Life Insurance and Annuities.
[1-1-99; 13.10.15.25 NMAC - Rn, 13 NMAC 10.15.23, 1-1-04]

13.10.15.26 SOLICITATIONS OTHER THAN DIRECT RESPONSE: Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above Notice to Applicant was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

[1-1-99; 13.10.15.26 NMAC - Rn, 13 NMAC 10.15.24, 1-1-04]

13.10.15.27 DIRECT RESPONSE SOLICITATIONS: Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the

application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] Within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)

[1-1-99; 13.10.15.27 NMAC - Rn, 13 NMAC 10.15.25, 1-1-04]

13.10.15.28 REPORTING REQUIREMENTS: For purposes of this section, policy means only long-term care insurance and report means on a statewide basis.

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agents total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

C. Each insurer shall report annually by June 30th:

(1) the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A of this section.

(2) the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(3) the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

[1-1-99; 13.10.15.28 NMAC - Rn, 13 NMAC 10.15.26, 1-1-04]

13.10.15.29 LICENSING: No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses.

[1-1-99; 13.10.15.29 NMAC - Rn, 13 NMAC 10.15.27, 1-1-04]

13.10.15.30 DISCRETIONARY POWERS OF SUPERINTENDENT: The Superintendent may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that:

A. The modification or suspension would be in the best interest of the insureds; and

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(1) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(2) the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(3) the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

[1-1-99; 13.10.15.30 NMAC - Rn, 13 NMAC 10.15.28, 1-1-04]

13.10.15.31 RESERVE STANDARDS:

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Section 59A-8-5 NMSA 1978. Claim reserves must also be established in the case when such policy or rider is in claim status.

B. Reserves for policies and riders should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is

immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

C. In the development and calculation of reserves, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) definition of insured events;
(2) covered long-term care facilities;
(3) existence of home convalescence care coverage;
(4) definition of facilities;
(5) existence or absence of barriers to eligibility;
(6) premium waiver provision;
(7) renewability;
(8) ability to raise premiums;
(9) marketing method;
(10) underwriting procedures;
(11) claims adjustment procedures;
(12) waiting period;
(13) maximum benefit;
(14) availability of eligible facilities;
(15) margins in claim costs;
(16) optional nature of benefit;
(17) delay in eligibility for benefit;
(18) inflation protection provisions; and
(19) guaranteed insurability option.

D. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

E. When long-term care benefits are provided other than as described in this section, reserves shall be determined in accordance with Sections 59A-8-6 and 59A-8-7 NMSA 1978.

[1-1-99; 13.10.15.31 NMAC - Rn, 13 NMAC 10.15.29, 1-1-04]

13.10.15.32 LOSS RATIO: This section does not apply to policies or certificates providing nonforfeiture benefits in accordance with Subsection C of 13.10.15.43 NMAC based on acceptance of the offer of non-forfeiture benefits required by Subsection A of 13.10.15.43 NMAC. This section shall not apply to long-term care insurance policies or certificates covered by 13.10.15.20 and 13.10.15.33 NMAC.

A. Effective January 1, 1999, benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums, provided the expected lifetime loss ratio and future expected loss ratio is at least sixty-five percent (65%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(1) statistical credibility of incurred claims experience and earned premiums;
(2) the period for which rates are computed to provide coverage;
(3) experienced and projected trends;
(4) concentration of experience within early policy duration;
(5) expected claim fluctuation;
(6) experience refunds, adjustments or dividends;
(7) renewability features;
(8) all appropriate expense factors;
(9) interest;
(10) experimental nature of the coverage;
(11) policy reserves;
(12) mix of business by risk classification; and
(13) product features such as long elimination periods, high deductibles and high maximum limits.

B. Issuers of a life insurance policy that funds long-term care benefits are exempted from the requirements of Subsection A of 13.10.15.32 NMAC if they comply with the requirements of 13.10.15.35 NMAC. [1-1-99; 13.10.15.32 NMAC - Rn & A, 13 NMAC 10.15.30, 1-1-04]

13.10.15.33 PREMIUM RATE SCHEDULE INCREASES:

A. This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2004.

(2) For certificates issued on or after the effective date of this amended rule under a group policy as defined in Paragraph (1) of Subsection C of Section 59A-23A-4 NMSA 1978, which policy was in force at the time this amended rule became effective, the provisions of this section shall apply on the policy anniversary following July 1, 2004.

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the superintendent at least thirty (30) days prior to the notice to the policyholders and shall include:

(1) Information required by 13.10.15.20 NMAC;

(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing iss in compliance with the provisions of this section.

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the methods and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale. Annual values for the five (5) years preceeding the three (3) years following the valuation date shall be provided separately. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase. The projections shall demonstrate compliance with Subsection C of this section. For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and in the event the superintendent determines that offsets exist, the insurer shall use appropriate net projected experience.

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates.

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for benefits attributable to benefits, unless sufficient justification is provided to the superintendent; and

(5) Sufficient information for review and approval of the premium rate schedule increase by the superintendent.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times fifty-eight percent (58%);

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) of this paragraph on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in Subsection A of 13.10.14.24 NMAC. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review by the superintendent updated projections, as defined in Subparagraph (a) of Paragraph (3) of Subsection B of this section, annually for the next three (3) years and include a comparison of actual results to projected values. The superintendent may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the superintendent.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium rate schedule, lifetime projections, as defined in Subparagraph (a) of Paragraph (3) of Subsection B of this section, shall be filed for review by the superintendent every five (5) years following the end of the required period in Subsection D of this section. For group insurance policies that meet the conditions of Subsection K of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the superintendent.

F. The following applies:

(1) If the superintendent has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C of this section, the superintendent may require the insurer to implement any of the following:

(a) premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

(2) In determining whether the actual experience adequately matches projected experience, consideration should be given to Subparagraph (e) of Paragraph (3) of Subsection B of this section, if applicable.

G. If a majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to superintendent approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate the appropriate administration and claims processing have been implemented or are in effect; otherwise the superintendent may impose the conditions in subsection H; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C of this section had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subparagraphs (a) and (c) of Paragraph (1) of Subsection C of this section.

H. Further considerations:

(1) For a rate increase filing that meets the following criteria, the superintendent shall review, for all policies included in the filing, the projected lapse rates during the twelve (12) months following each rate increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(2) In the event significant adverse lapsation has occurred, is anticipated in the filings or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the superintendent may determine that a rate spiral exists. Following the determination that a rate spiral exists, the superintendent may require the insurer to offer, without underwriting, to all in force insureds subject to

the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall (i) be subject to the approval of the superintendent, (ii) be based on actuarially sound principles, but not be based on attained age, and (iii) provide that maximum benefits under any new policy accepted by the insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lessor of: (i) the maximum rate increase determined based on combined experience, and (ii) the maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the superintendent determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the superintendent may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following provisions:

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I of this section shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection E of 13.10.15.7 NMAC, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides for insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(a) Section 59A-20-31 NMSA 1978;

(b) Section 59A-20-33 NMSA 1978; and

(c) 13.9.3.17 NMAC.

(3) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by 13.9.15 NMAC, Life Insurance Illustrations;

(b) Disclosure requirements in 13.9.12 NMAC, Annuity and Deposit Fund Disclosure; and

(c) Disclosure requirements in 13.9.3 NMAC, Variable Annuity Contracts.

(4) An actuarial memorandum is filed with the superintendent that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on age of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning
a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H of this section shall not apply to group insurance policies as defined in Paragraph (1) of Subsection C of Section 59A-23A-4 NMSA 1978 where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

[13.10.15.33 NMAC - N, 1-1-04]

13.10.15.34 FILING REQUIREMENTS:

A. An insurer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the superintendent in accordance with filing requirements and procedures prescribed in Chapter 59A, Articles 18, 44, 46 and 47 NMSA 1978. Policies and certificates of a master policy issued as a result of solicitations of individuals by agents, or through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies for the purpose of this section.

B. An insurer shall not use or change premium rates for a long-term care policy or certificate unless the rating schedule and supporting documentation have been filed with and approved by the Superintendent in accordance with the filing requirements and procedures of this rule and Chapter 59A, Articles 18, 44, 46 and 47 NMSA 1978 in a form acceptable to the Superintendent.

C. An insurer or a similar organization offering group long-term care insurance to a resident of this state pursuant to Section 59A-23A-5 NMSA 1978 shall file with the Superintendent evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

[1-1-99; 13.10.15.34 NMAC - Rn, 13 NMAC 10.15.31, 1-1-04]

13.10.15.35 EXEMPTION FROM LOSS RATIO REQUIREMENTS: Issuers of a life insurance policy that funds long-term care benefits entirely by accelerating the death benefit are exempted from 13.10.15.32 NMAC if they provide to the Superintendent:

A. a statement that the interest credited to determine cash value accumulations, including long-term care, if any, are guaranteed to be not less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy.

B. a statement that the life insurance policy meets the requirements of the standard non-forfeiture law, Section 59A-20-31NMSA 1978.

C. a statement that the life insurance policy reserves are set based upon Section 59A-8-5 NMSA 1978.

D. a statement that the policy meets the disclosure requirements of this rule and Section 59A-23A NMSA 1978.

E. a statement that any policy illustration used meets the requirements of rules adopted by the superintendent.

F. an actuarial memorandum which shall include:

(1) a description of the basis on which the long-term care rates were determined;

(2) a description of the basis for the reserves;

(3) a summary of the type of policy benefits, renewability, general marketing method and limits on ages of issuance;

(4) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium, dollars per policy and dollars per unit of benefits, if any;

(5) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; and

(6) the estimated average annual premium per policy and the average issue age;

G. a statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

H. a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy both for active lives and those in long-term care claim status.

I. a certification by an actuary who is a member of the American Academy of Actuaries that the information contained in the memorandum is proper to the best of the actuary's knowledge and judgment.

[1-1-99; 13.10.15.35 NMAC - Rn, 13 NMAC 10.15.32, 1-1-04]

13.10.15.36 FILING REQUIREMENTS FOR ADVERTISING:

A. Every issuer shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Superintendent for review or approval by the Superintendent as required under Section 59A-23A-11 NMSA 1978. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

B. The Superintendent may exempt from these requirements any advertising form or material when, in the Superintendent's opinion, this requirement may not be reasonably applied.

[1-1-99; 13.10.15.36 NMAC - Rn, 13 NMAC 10.15.33, 1-1-04]

13.10.15.37 STANDARDS FOR MARKETING: Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

A. establish marketing procedures and agent training requirements to assure that:

(1) any marketing activities, including any comparison of policies by its agents or other producers will be fair and accurate; and .

(2) excessive insurance is not sold or issued;

B. display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and the policy the following: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations;"

C. provide copies of the disclosure forms required by Subsection C of 13.10.15.20 NMAC to the applicant;

D. inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance;

E. establish auditable procedures for verifying compliance with this section;

F. if the Superintendent approves a senior insurance counseling program for New Mexico, provide written notice at solicitation to the prospective policyholder and certificate holder that such a program is available and the name, address and telephone number of the program;

G. use the terms noncancelable or level premium for long-term care health insurance policies and certificates only when the policy or certificate conforms to Subsection C of 13.10.15.9 NMAC; and

H. provide an explanation of contingent benefit upon lapse provided for in Subsection B of 13.10.15.43 NMAC.

[1-1-99; 13.10.15.37 NMAC - Rn & A, 13 NMAC 10.15.34, 1-1-04]

13.10.15.38 PROHIBITED MARKETING PRACTICES: In addition to the practices prohibited in Chapter 59A, Article 16 NMSA 1978, the following acts and practices are prohibited

A. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

B. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

C. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

[1-1-99; 13.10.15.38 NMAC - Rn, 13 NMAC 10.15.35, 1-1-04]

13.10.15.39 ASSOCIATIONS:

A. The primary responsibility of an association endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

B. The insurer shall file with the Superintendent the following material:

(1) the policy and certificate as required herein,

(2) a corresponding outline of coverage,

(3) the premium rates as required herein, and

(4) all advertisements requested by the Superintendent.

C. The association shall disclose in any long-term care insurance solicitation:

(1) the specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members, and

(2) a brief description of the process under which such policies and the insurer issuing such policies were selected.

D. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose such fact to its members.

E. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve such insurance policies as well as the compensation arrangements made with the insurer.

F. The association shall also:

(1) at the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update such examination thereafter in the event of material change;

(2) actively monitor the marketing efforts of the insurer and its agents; and

(3) review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding such policies or certificates.

G. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the Superintendent the information required by this rule.

H. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements of this section.

I. Failure to comply with the filing and certification requirements of 13.10.15.36 through 10.13.15.39 NMAC constitutes an unfair trade practice in violation of Chapter 59A, Article 16 NMSA 1978.
[1-1-99; 13.10.15.39 NMAC - Rn, 13 NMAC 10.15.36, 1-1-04]

13.10.15.40 SUITABILITY: This section shall not apply to life insurance policies that accelerate benefits for long-term care.

A. Every issuer shall:

(1) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the Superintendent.

B. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

C. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

D. The issuer shall provide the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" at the same time as the personal worksheet is provided to the applicant. The form shall be in the format contained in 13.10.15.51 NMAC, in not less than twelve (12) point type.

E. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to proved the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to 13.10.15.49 NMAC. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

F. The issuer shall report annually to the Superintendent the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

[1-1-99; 13.10.15.40 NMAC - Rn, 13 NMAC 10.15.37, 1-1-04]

13.10.15.41 REQUIREMENTS FOR LONG-TERM CARE INSURANCE PERSONAL WORKSHEETS:

A. To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(1) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(3) the values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

B. The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Subsection A of of this section. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in 13.10.15.50 NMAC, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Superintendent.

C. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

D. No issuer or agent may sell or disseminate outside the company or any information obtained through the personal worksheet in in 13.10.15.50 NMAC.

[1-1-99; 13.10.15.41 NMAC - Rn, 13 NMAC 10.15.38, 1-1-04]

13.10.15.42 PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES: If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

[1-1-99; 13.10.15.42 NMAC - Rn, 13 NMAC 10.15.39, 1-1-04]

13.10.15.43 NONFORFEITURE BENEFIT REQUIREMENT: This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

A. Offer required. No policy or certificate may be delivered or issued for delivery in this state unless a policy or certificate providing for nonforfeiture benefits to the defaulting or lapsing policyholder or certificate holder has been offered to the applicant.

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility requirements, benefit triggers and benefit length that are the same as coverage offered without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Subsection C of this section.

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(3) If the offer required to be made pursuant to this subsection is rejected, the insurer shall provide the contingent benefit upon lapse described in Subsection B of this section.

B. Contingent benefit upon lapse.

(1) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Paragraph (2) of this subsection based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the increased premium. Unless otherwise required, policyholders shall be notified at least sixty (60) days prior to the due date of the premium reflecting the rate increase.

(2) Triggers for a substantial premium increase:

ISSUE AGE	**PERCENT INCREASE OVER INITIAL PREMIUM**
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(3) On or before the effective date of a substantial premium increase as defined in Paragraph (1) of Subsection B of this section, the insurer shall:

(a) offer to reduce the policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(b) offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection C of this section. This option may be elected at any time during the 120-day period referenced in Subsection A of this section; and

(c) notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced Paragraph (1) of Subsection B of this section shall be deemed to be the election of the offer to convert in Subparagraph (b) of Paragraph (3) of Subsection B of this section.

(4) To determine whether contingent benefit upon lapse provisions are triggered under Paragraph (1) of Subsection B of this section, a replacing insurer that purchased or otherwise assumed a block of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

C. Nonforfeiture benefits. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases with increasing age:

(a) at least one percent (1%) plus the scheduled percentage increase in benefits per year prior to age fifty (50); and

(b) at least three percent (3%) plus the scheduled percentage increase in benefits per year beyond age fifty(50).

(2) For purposes of this subsection, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3) of Subsection B of this section.

(3) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits and premiums waived. Except as provided in Paragraph (1) of Subsection C of this section, benefits paid during premium paying status will not reduce the standard nonforfeiture credit. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Paragraph (1) of Subsection C of this section.

(4) Where more than one individual is covered under an individual policy or group certificate, the method of allocation of the nonforfeiture credit to each of the individuals shall be based on:

(a) the ratio of the premium that would have been paid had the individual purchased coverage separately to the total premium that would have been paid for all individuals assuming each had purchased coverage separately; or

(b) any reasonable actuarial method, provided such method has been described in the policy form filing.

(5) The nonforfeiture benefit and the contingent benefit upon lapse shall begin not later than the end of the third year following the policy or certificate issue date.

(6) Notwithstanding Paragraph (5) of Subsection B of this section, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(a) the end of the tenth year following the policy or certificate issue date; or

(b) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(7) For policies or certificates issued on limited payment plans, nonforfeiture benefits shall begin not later than the first year following the policy or certificate issue date for limited pay periods shorter than 10 years. Nonforfeiture benefits for plans with limited pay periods less than 20 years but at least 10 years shall begin not later than the second year.

(8) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(9) No nonforfeiture option may include the offering of a cash surrender benefit or a loan value

D. General provisions.

(1) All benefits paid by the insurer while the policy or certificate is in premium paying status and in paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

(2) There shall be no difference in the minimum nonforfeiture benefits required by this section for group and individual policies.

(3) The requirements of this section apply to all long-term care insurance policies issued on or after January 1, 1998.

(4) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the lifetime loss ratio requirements of 13.10.15.32 NMAC treating the policy as a whole.

[1-1-99; 13.10.15.43 NMAC - Rn & A, 13 NMAC 10.15.40, 1-1-04]

13.10.15.44 STANDARDS FOR BENEFIT TRIGGERS: The requirements of this section apply to all long-term care insurance policies issued on or after January 1, 1999.

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

B. Activities of daily living.

(1) Activities of daily living shall include at least the following as defined in 13.10.15.8 NMAC and in the policy:

(a) bathing;
(b) continence;
(c) dressing;
(d) eating;
(e) toileting; and
(f) transferring.

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) of Subsection B of this section as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B of this section.

D. For purposes of this section the determination of a deficiency shall not be more restrictive than:

(1) requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

F. Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

[1-1-99; A, 1-1-99; 13.10.15.44 NMAC - Rn, 13 NMAC 10.15.41, 1-1-04]

13.10.15.45 CONTENTS OF OUTLINE OF COVERAGE:

A. The outline of coverage shall be a free-standing document, using no smaller than ten point type.

B. The outline of coverage shall contain no material of an advertising nature.

C. Text which is capitalized or underscored in the standard format for outline of coverage provided in 13.10.15.46 NMAC may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

D. Use of the text and sequence of text of the standard format for outline of coverage provided in 13.10.15.46 NMAC is mandatory, unless otherwise specifically indicated.

[1-1-99; 13.10.15.45 NMAC - Rn, 13 NMAC 10.15.42, 1-1-04]

13.10.15.46 STANDARD FORMAT FOR OUTLINE OF COVERAGE:

[Company Name]
[Address City & State]
[Telephone Number]

LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. TYPE OF POLICY. This policy is [an individual policy of insurance] [a group policy which was issued in the (indicate jurisdiction in which group policy was issued)].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY][CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of the [POLICY][CERTIFICATE]. This [POLICY][CERTIFICATE] is not intended to be a federally tax-qulified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Benefits received under this [POLICY][CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

A. [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions

i. Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy,[certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

ii. [Policies and certificates that are noncancelable shall contain the following statement] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

B. [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

C. [Describe waiver of premium provisions or state that there are not such provisions;]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has the right to change the premium, and if a right exists, describe clearly and voncisely each circumstance under which thepremium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

A. [Provide a brief description of the right to return free look provision of the policy.]

B. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the insurance company.

A. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

B. [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

A. [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

B. [Institutional benefits, by skill level.]

C. [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

10. LIMITATIONS AND EXCLUSIONS. Describe:

A. Preexisting conditions;

B. Non-eligible facilities/provider;

C. Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

D. Exclusions/exceptions;

E. Limitations.

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (8) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH

YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following

A. That the benefit level will not increase over time;

B. Any automatic benefit adjustment provisions;

C. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

D. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

E And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

A. State the total annual premium for the policy;

B. If the premium varies with an applicants choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

14. ADDITIONAL FEATURES.

A. Indicate if medical underwriting is used;

B. Describe other important features.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IS YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

[1-1-99; 13.10.15.46 NMAC - Rn & A, 13 NMAC 10.15.43, 1-1-04]

13.10.15.47 REQUIREMENT TO DELIVER SHOPPER'S GUIDE:

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Superintendent, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide must be sent with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the shopper's guide, but shall furnish the policy summary required by Section 59A-23A-6 NMSA 1978.

[1-1-99; 13.10.15.47 NMAC - Rn, 13 NMAC 10.15.44, 1-1-04]

13.10.15.48 PENALTIES: In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care

insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.
[1-1-99; 13.10.15.48 NMAC - Rn, 13 NMAC 10.15.45, 1-1-04]

13.10.15.49 APPENDIX A:

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF NEW MEXICO FOR THE REPORTING YEAR [ ]

Company Name:_____
Address: _____
_____
Phone Number:_____
Due: March 1 annually

INSTRUCTIONS
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form	Policy and Certificate Number	Name of Insured	Date of Policy Issuance	Date(s) Claim(s) Submitted	Date of Rescission

Detailed reason for rescission:
_____

_____

_____

_____
Signature

_____
Name and Title (please type)

_____
Date

[1-1-99; 13.10.15.49 NMAC - Rn, 13 NMAC 10.15.46, 1-1-04]

13.10.15.50 APPENDIX B:

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long term care insurance can be expensive, and is not appropriate for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the insurance company decide if you should buy this policy.

Premium Information

Policy Form Number(s)_____

The premium for the coverage you are considering will be [$_____ per month, or $____per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable):_____

The Company's Right to Increase Premiums:_____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).]

Questions Related to Your Income

How will you pay each years' premiums?

___ From My Income ___ From My Savings\Investments ___ My Family will Pay

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

What is your annual income? (check one)
___ Under $10,000 ___ $10-20,000 ___ $20-30,000 ___ $30-50,000 ___ Over $50,000

How do you expect your income to change over the next 10 years? (check one)
___ No change ___ Increase ___ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ____ yes ____ no
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
___ From My Income ___ From My Savings\Investments ___ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What elimination period are you considering? Number of days _____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period?
___ From My Income ___ From My Savings\Investments ___ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)
___ Under $20,000 ___ $20-30,000 ___ $30-50,000 ___ Over $50,000

How do you expect your assets to change over the next ten years?
___ Stay about the same ___ Increase ___ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement
___ The answers to the questions above describe my financial situation.
or
___ I choose not to complete this information.

___ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium rate increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and the potential for premium rate increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed:_____ Date: _____
(Applicant)

[___ I explained to the applicant the importance of completing this information.

Signed:_____ Date:_____
(Agent)

Agent's printed name _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.]

Signed:_____ Date:_____
(Applicant)

The company may contact you to verify your answers.

[1-1-99; 13.10.15.50 NMAC - Rn & A, 13 NMAC 10.15.47, 1-1-04]

13.10.15.51 APPENDIX C:

THINGS YOU SHOULD KNOW BEFORE YOU BUY: LONG-TERM CARE INSURANCE

Long-term Care Insurance A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare Medicare does **not** pay for most long-term care.

Medicaid Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid. Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services. When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets. Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide Make sure the insurance company or agent gives you a copy of a book called National Association of Insurance Commissioners" "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

[1-1-99; 13.10.15.51 NMAC - Rn, 13 NMAC 10.15.48, 1-1-04]

13.10.15.52 APPENDIX D:

LONG-TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]

Your recent application for long-term care insurance included a personal worksheet which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.
___ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.
___ **No**, I have decided not to buy a policy at this time.

Signed: _____
Applicant

Date: _____

[1-1-99; 13.10.15.52 NMAC - Rn, 13 NMAC 10.15.49, 1-1-04]

13.10.15.53 APPENDIX E

POTENTIAL RATE INCREASE DISCLOSURE FORM

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurer shall provide all of the following information to the applicant:

Long-term care Insurance
Potential rate Increase Disclosure Form

1. **[Premium Rate][Premium Rate Schedules]:** [Premium Rate][Premium Rate Schedules] that [is][are] applicable to you and that will be in effect until a request is made and approved for an increase [is][are] [on the application][$_____]

2. **The [premium][premium rate schedule] for this policy [will be shown on the schedule page of][will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (fill in the blank):_____.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise a least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This optionis available for purchase for additioonal premium.)
- Exercise your contingent nonforfeiture rights* (This option may be available if you do not purchase a separate nonforfeiture option.)

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of

premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $ 1,000 annual premium for 10 years, so you have paid a total of $ 10,000 in premium.
- In the eleventh year, you received a rate increase of 50%, or $ 500 for a new annual premium of $ 1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $ 10,000 (provided you have at least $ 10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from the date of original issue. It does NOT represent a one-time increase)

ISSUE AGE	PERCENT INCREASE OVER INITIAL PREMIUM
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%

82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[13.10.15.53 NMAC - N, 1-1-04]

HISTORY OF 13.10.15 NMAC
Pre-NMAC History: None.

History of Repealed Material:
13 NMAC 10.15, Long-term Care Insurance (filed 12-03-96), was repealed effective 12-31-98;
13 NMAC 10.15, Long-term Care Insurance, (filed 06-15-98), was repealed effective 12-31-03.

Other History:
13 NMAC 10.15, Long-term Care Insurance (filed 12-03-96), replaced by 13 NMAC 10.15, Long-term Care Insurance, effective 1-1-99;
13 NMAC 10.15, Long-term Care Insurance (filed 06-15-98), replaced by 13.10.15 NMAC, Long-term Care Insurance, effective 1-1-04.