

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 25 MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

13.10.25.1 ISSUING AGENCY: Office of Superintendent of Insurance.
[13.10.25.1 NMAC - Rp, 13.10.25.1 NMAC, 1/1/2019]

13.10.25.2 SCOPE:

A. Except as otherwise specifically provided in Sections 10, 19, 20, 23 and 28 of 13.10.25 NMAC this regulation shall apply to:

(1) All Medicare Supplement policies delivered or issued for delivery in this state before or after the effective date of this regulation; and

(2) All certificates issued under group Medicare Supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations

[13.10.25.2 NMAC - Rp, 13.10.25.2 NMAC, 1/1/2019]

13.10.25.3 STATUTORY AUTHORITY: Section 59A-2-9, Subsection D of Section 59A-18-12, Subsection B of Section 59A-18-13, Paragraph (4) of Subsection A of Section 59A-23-3 and Section 59A-24A-1 et seq. NMSA 1978.

[13.10.25.3 NMAC - Rp, 13.10.25.3 NMAC, 1/1/2019]

13.10.25.4 DURATION: Permanent.

[13.10.25.4 NMAC - Rp, 13.10.25.4 NMAC, 1/1/2019]

13.10.25.5 OBJECTIVE: The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare Supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

[13.10.25.5 NMAC - Rp, 13.10.25.5 NMAC, 1/1/2019]

13.10.25.6 EFFECTIVE DATE: January 1, 2019, unless a later date is cited at the end of a section.

[13.10.25.6 NMAC - Rp, 13.10.25.6 NMAC, 1/1/2019]

13.10.25.7 DEFINITIONS: For purposes of this regulation:

A. “**1990 Standardized Medicare Supplement benefit plan,**” “**1990 standardized benefit plan**” or “**1990 Plan**” means a group or individual policy of Medicare Supplement insurance issued on or after July 1, 1992 with an effective date prior to June 1, 2010 and includes Medicare Supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

B. “**2010 Standardized Medicare Supplement benefit plan,**” “**2010 standardized benefit plan**” or “**2010 plan**” means a group or individual policy of Medicare Supplement insurance issued on or after June 1, 2010.

C. “**Activities of daily living**” include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, administration of drugs that are normally self-administered, and changing bandages or other dressings.

D. “**Applicant**” means:

(1) In the case of an individual Medicare Supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare Supplement policy, the proposed certificate holder.

E. “**At-home recovery visit**” means the period of a visit required to provide at-home-recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24 hour period of services provided by a care provider is one visit.

F. “Bankruptcy” means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

G. “Care provider” means a duly qualified or licensed home health aide or homemaker, personal care aide, nurse provided through a licensed home health care agency, referred by a licensed referral agency or by a licensed nurses’ registry.

H. “Certificate” means any certificate delivered or issued for delivery in this state under a group Medicare Supplement policy.

I. “Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer.

J. “Complaint” means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

K. “Continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

L. “Creditable coverage”;
(1) means with respect to an individual, coverage of the individual provided under any of the following:

(a) a group health plan;
(b) health insurance coverage;
(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(d) Title XIX of the Social Security Act (Medicaid), 42 U.S.C. 1396, et seq., other than coverage consisting solely of benefits under section 1928;

(e) Chapter 55 of Title 10 U.S.C. (*Civilian Health and Medical Program of the Uniformed Services – CHAMPUS, TRICARE*);

(f) a medical care program of the Indian Health Service or of a tribal organization;
(g) a state health benefits risk pool;
(h) a health plan offered under Chapter 89 of Title 5 U.S.C. (*Federal Employees Health Benefits Program*);

(i) a public health plan as defined in federal regulation; and
(j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e));

(2) shall not include one or more, or any combination of, the following:
(a) coverage only for accident or disability income insurance, or any combination thereof;

(b) coverage issued as a supplement to liability insurance;
(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers’ compensation or similar insurance;
(e) automobile medical payment insurance;
(f) credit-only insurance;
(g) coverage for on-site medical clinics; and
(h) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(3) shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) limited scope dental or vision benefits;
(b) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) such other similar, limited benefits as are specified in federal regulations;

(4) shall not include the following benefits if offered as independent, non-coordinated benefits:

(a) coverage only for a specified disease or illness; and
(b) hospital indemnity or other fixed indemnity insurance; and

(5) shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) Medicare Supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1));

(b) coverage supplemental to the coverage provided under Chapter 55 of Title 10, U.S.C.; and

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

M. “Grievance” means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

N. “Home” shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured’s place of residence.

O. “Insolvency” exists as to:

(1) any organization, when it is unable to meet its obligations as they mature;

(2) a stock insurer or other stock corporation, when its assets are in amount less than its liabilities, exclusive of paid-in capital stock;

(3) a mutual, reciprocal, or foreign Lloyds insurer, when its assets are in amount less than its liabilities exclusive of the minimum paid-in basic capital required under Section 59A-5-16 NMSA 1978 for its authority to transact insurance; or

(4) a domestic Lloyds insurer, nonprofit health care plan, prepaid dental care plan, motor club, or other corporation other than any referred to in Paragraph (1) of (2) of this subsection, when its assets are in amount less than its liabilities, exclusive of surplus, guaranty fund or deposit required to be maintained under the Insurance Code for its authority to transact insurance in this state.

P. “Issuer” includes insurance companies, fraternal benefit societies, nonprofit health care plans, health maintenance organizations and any other entity offering, delivering, issuing Medicare Supplement policies or certificates for delivery in this state.

Q. “Medicare” has the meaning set forth in Subsection F of 13.10.25.8 NMAC.

R. “Medicare Advantage plan” or previously **“Medicare+Choice”** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

(1) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

S. “Medicare Select issuer” means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

T. “Medicare Select policy” or **“Medicare Select certificate”** mean respectively a Medicare Supplement policy or certificate that contains restricted network provisions.

U. “Medicare Supplement policy” means a group or individual policy of accident and sickness insurance or a subscriber contract of a nonprofit health care plan or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. “Medicare Supplement policy” does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act (42 U.S.C. §1395l(a)(1)(A)).

V. “NAIC” means the national association of insurance commissioners.

W. “Network provider” means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

X. “Pre-standardized Medicare Supplement benefit plan,” “Pre-standardized benefit plan” or **“Pre- standardized plan”** means a group or individual policy of Medicare Supplement insurance issued prior to July 1, 1992.

Y. “Policy form” means the form on which the policy is delivered or issued for delivery by the issuer.

Z. “Restricted network provision,” means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

AA. “Secretary” means the secretary of the United States department of health and human services.

BB. “SERFF” means the NAIC’s system for electronic rate and form filing.

CC. “**Service area**” means the geographic area approved by the superintendent within which an issuer is authorized to offer a Medicare Select policy.

DD. “**Superintendent**” means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent’s official duties and with the superintendent’s authorization.

[13.10.25.7 NMAC - Rp, 13.10.25.7 NMAC, 1/1/2019]

13.10.25.8 POLICY DEFINITIONS AND TERMS: No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

A. “**Accident,**” “**accidental injury,**” or “**accidental means**” shall be defined to employ “result” language and shall not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: “Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.”

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers’ compensation, employer’s liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. “**Benefit period**” or “**Medicare benefit period**” shall not be defined more restrictively than as defined in the Medicare program.

C. “**Convalescent nursing home,**” “**extended care facility,**” or “**skilled nursing facility**” shall not be defined more restrictively than as defined in the Medicare program.

D. “**Health care expenses**” means, for purposes of 13.10.25.20 NMAC, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. “**Hospital**” may be defined in relation to its status, facilities and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the Medicare program.

F. “**Medicare**” shall be defined in the policy and certificate. Medicare may be substantially defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended,” or “Title I, Part I of Public Law 89-97, as enacted by the eighty-ninth congress of the United States of America and popularly known as the *Health Insurance for the Aged Act*, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

G. “**Medicare eligible expenses**” shall mean expenses of the kinds covered by Medicare Part A and Medicare Part B, to the extent recognized as reasonable and medically necessary by Medicare.

H. “**Physician**” shall not be defined more restrictively than as defined in the Medicare program.

I. “**Sickness**” shall not be defined to be more restrictive than the following:

(1) “Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.”

(2) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability or similar law.

[13.10.25.8 NMAC - Rp, 13.10.25.8 NMAC, 1/1/2019]

13.10.25.9 PROHIBITED POLICY PROVISIONS:

A. Except for permitted preexisting condition clauses as described in Paragraph (1) of Subsection A of 13.10.25.10 NMAC, Paragraph (1) of Subsection A of 13.10.25.11 NMAC, and Paragraph (1) of Subsection A of 13.10.25.13 NMAC, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare Supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare Supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D. Outpatient prescription drugs:

(1) Subject to Paragraphs (4) of Subsection A and Subsection B of 13.10.25.10 NMAC and Paragraphs (4) of Subsection A and Subsection B of 13.10.25.11 NMAC, a Medicare Supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

(2) A Medicare Supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare Supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D at the option of the policyholder unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Medicare Part D plan and;

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

[13.10.25.9 NMAC - Rp, 13.10.25.9 NMAC, 1/1/2019]

13.10.25.10 MINIMUM BENEFIT STANDARDS FOR PRE-STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992: No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General standards. The following standards apply to Medicare Supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) **Preexisting conditions.** A Medicare Supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) **Losses from sickness.** A Medicare Supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) **Cost sharing.** A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) **Cancellation and termination.** A "non-cancellable," "guaranteed renewable" or "non-cancellable and guaranteed renewable" Medicare Supplement policy shall not:

(a) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

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

B. Renewal and continuation of coverage for policies or certificates.

(1) **Cancellation by issuer.** Except as authorized by the superintendent, an issuer shall neither cancel nor non-renew a Medicare Supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(2) **Termination by group.** If a group Medicare Supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (4) of this subsection, the issuer shall offer certificate holders an individual Medicare Supplement policy. The issuer shall offer the certificate holder at least the following choices:

(a) an individual Medicare Supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare Supplement policy; and

(b) an individual Medicare Supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection D of 13.10.25.13 NMAC.

(3) **Group membership termination.** If membership in a group is terminated, the issuer shall:

(a) offer the certificate holder the conversion opportunities described in Paragraph (2) of this subsection; or

(b) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) **Replacement.** If a group Medicare Supplement policy is replaced by another group Medicare Supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5) **Coverage of continuous loss.** Termination of a Medicare Supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(6) **Elimination of drug benefit.** If a Medicare Supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

C. **Minimum Benefit Standards.** Medicare Supplement insurance policies shall consist of the following:

(1) **Medicare Part A coinsurance after day 60.** Coverage of eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) **Medicare Part A hospitalization inpatient deductible.** Coverage of either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) **Medicare Part A reserve lifetime days daily charges.** Coverage of eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) **Medicare Part A uncovered hospitalization coverage.** Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) **Medicare Part A blood.** Coverage for or the reasonable cost (as per 42 U.S.C. §1395x(v)) of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Medicare Part B;

(6) **Medicare Part B cost sharing.** Coverage of the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible; and

(7) **Medicare Part B blood.** Effective January 1, 1990, coverage for the reasonable cost (as per 42 U.S.C. §1395x(v)) of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Medicare Part A, subject to the Medicare deductible amount.

[13.10.25.10 NMAC - Rp, 13.10.25.10 NMAC, 1/1/2019]

13.10.25.11 BENEFIT STANDARDS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER JULY 1, 1992 AND PRIOR TO JUNE 1, 2010: The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992 and with an effective date prior to June 1, 2010. For policies issued with an effective date after June 1, 2010, refer to Section 13.10.25.13 NMAC.

A. **General Standards.** The following standards apply to 1990 Benefit Standardized Plan policies and certificates and are in addition to all other requirements of this regulation.

(1) **Preexisting conditions.** Refer to Paragraph (1) of Subsection A of 13.10.25.10 NMAC.

(2) **Loss from sickness.** Refer to Paragraph (2) of Subsection A of 13.10.25.10 NMAC.

(3) **Cost sharing.** Refer to Paragraph (3) of Subsection A of 13.10.25.10 NMAC. An increase in premium shall not be effective without 60 days-notice to the policyholder.

(4) **Termination of spousal coverage.** No Medicare Supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

B. Renewal and continuation of coverage for policies or certificates. Each Medicare Supplement policy shall be guaranteed renewable.

(1) **Cancellation for health status.** The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(2) **Cancellation by issuer.** The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) **Termination by group.** If the Medicare Supplement policy is terminated by the group policyholder and is not replaced as provided under Paragraph (5) of this subsection, the issuer shall offer certificate holders an individual Medicare Supplement policy which (at the option of the certificate holder):

(a) provides for continuation of the benefits contained in the group policy, or

(b) provides for benefits that otherwise meet the requirements of this subsection.

(4) **Group membership termination.** If an individual is a certificate holder in a group Medicare Supplement policy and the individual terminates membership in the group, the issuer shall

(a) offer the certificate holder the conversion opportunity described in Paragraph (3) of this subsection, or

(b) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) **Replacement.** Refer to Paragraph (4) of Subsection B of 13.10.25.10 NMAC.

(6) **Coverage of continuous loss.** Refer to Paragraph (5) of Subsection B of 13.10.25.10 NMAC.

(7) **Elimination of drug benefit.** Refer to Paragraph (6) of Subsection B of 13.10.25.10 NMAC.

C. Coordination with Medical Assistance under Title XIX of the Social Security Act.

(1) **Temporary suspension.** A Medicare Supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(2) **Reinstitution.** If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) **Suspension - other coverage.** Each Medicare Supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss.

(4) **Reinstitution of coverage.** Reinstitution of coverages as described in Paragraphs (2) and (3) of this subsection:

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

(b) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare Supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

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

D. Policy exchanges. If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans to exchange during a specified period from the policyholder's 1990

Standardized Benefit Plan (as described in 13.10.25.12 NMAC) to a 2010 Standardized Benefit Plan (as described in 13.10.25.14 NMAC), the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the superintendent if the insured replaces a 1990 Standardized Benefit Plan policy or certificate with a 2010 Standardized Benefit Plan policy or certificate of identical rate structure and basis, using the insured's identical rating characteristics and classification. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The issuer must file the proposed method electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978.

(2) The rating class of the new policy or certificate shall be the class of the replaced coverage.

(3) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized Benefit Plan policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six months to any added benefits contained in the new 2010 Standardized Benefit Plan policy or certificate not contained in the exchanged policy.

(4) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

E. Standards for basic (core) benefits common to benefit plans A to J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement insurance benefit plans in addition to the basic core package, but not in lieu of it.

(1) **Medicare Part A coinsurance after day 60.** Coverage of eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) **Medicare Part A reserve lifetime days coinsurance.** Coverage of Medicare Part A – eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) **Medicare Part A uncovered hospitalization coverage.** Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one-hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) **Medicare Part A and Medicare Part B blood.** Coverage under Medicare Part A and Medicare Part B for the reasonable cost (as per 42 U.S.C. §1395x(v)) of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) **Medicare Part B cost sharing.** Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

F. Standards for additional benefits. The following additional benefits shall be included in Medicare Part B for Plan B through Plan J only as provided by 13.10.25.12 NMAC:

(1) **Medicare Part A deductible.** Coverage for one-hundred percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) **Skilled nursing facility care.** Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(3) **Medicare Part B deductible.** Coverage of one-hundred percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) **Eighty percent of the Medicare Part B excess charges.** Coverage for eighty percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Medicare Part B charge.

(5) **One-hundred percent of the Medicare Part B excess charges.** Coverage for one-hundred percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Medicare Part B charge.

(6) Basic outpatient prescription drug benefit. Coverage for fifty percent of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare Supplement policy effective after December 31, 2005.

(7) Extended outpatient prescription drug benefit. Coverage for fifty percent of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare Supplement policy effective after December 31, 2005.

(8) Medically necessary emergency care in a foreign country. Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive medical care benefit.

(a) Coverage for the following preventive health services not covered by Medicare:
(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) of this subparagraph and patient education to address preventive health care measures; and

(ii) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(b) Reimbursement shall be for the actual charges up to one-hundred percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in *American Medical Association Current Procedural Terminology* (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-home recovery benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) Coverage requirements and limitations.

(i) At-home recovery services provided must be primarily services that assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(b) Coverage is limited to:

(i) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(ii) the actual charges for each visit up to a maximum reimbursement of \$40 per visit;

(iii) \$1,600 per calendar year;

(iv) seven visits in any one week;

(v) care furnished on a visiting basis in the insured's home;

(vi) services provided by a care provider as defined in Subsection E of

13.10.25.7 NMAC;

(vii) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and

(viii) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) home care visits paid for by Medicare or other government programs; and

(ii) care provided by family members, unpaid volunteers or providers who are not care providers.

G. Standards for Plans K and L.

(1) Plan K. Standardized Medicare Supplement benefit Plan K shall consist of the following:

- (a) **Medicare Part A coinsurance after day 60.** Refer to Paragraph (1) of Subsection E of 13.10.25.11 NMAC;
- (b) **Medicare Part A coinsurance reserves.** Refer to Paragraph (2) of Subsection E of 13.10.25.11 NMAC;
- (c) **Medicare Part A hospital inpatient coverage.** Refer to Paragraph (3) of Subsection E of 13.10.25.11 NMAC;
- (d) **Medicare Part A deductible.** Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;
- (e) **Skilled nursing facility care.** Coverage for fifty percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;
- (f) **Hospice care.** Coverage for fifty percent of cost sharing for all Medicare Part A - eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;
- (g) **Blood.** Coverage for fifty percent, under Medicare Part A or Medicare Part B, of the reasonable cost (as per 42 U.S.C. §1395x(v)) of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;
- (h) **Medicare Part B cost sharing.** Except for coverage provided in Subparagraph (i) of this paragraph, coverage for fifty percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j) of this paragraph;
- (i) **Medicare Part B preventive services.** Coverage of one-hundred percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Medicare Part B deductible; and
- (j) **Cost sharing – out-of-pocket limitation.** Coverage of one-hundred percent of all cost sharing under Medicare Part A and Medicare Part B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Part A and Medicare Part B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.
- (2) **Plan L.** Standardized Medicare Supplement benefit Plan L shall consist of the following:
- (a) the benefits described in Subparagraphs (a), (b) (c) and (i) of Paragraph (1) of this subsection;
- (b) the benefit described in Subparagraphs (d) (e), (f), (g), and (h) of Paragraph (1) of this subsection, but substituting seventy-five percent for fifty percent; and
- (c) the benefit described in Subparagraph (j) of Paragraph (1), but substituting \$2000 for \$4000.

[13.10.25.11 NMAC - Rp, 13.10.25.11 NMAC, 1/1/2019; A/E 1/1/2019; A, 4/23/2019]

13.10.25.12 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JULY 1, 1992 AND PRIOR TO JUNE 1, 2010:

- A.** An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Subsection E of 13.10.25.11 NMAC.
- B.** No groups, packages or combinations of Medicare Supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Subsection G of this section and in 13.10.25.16 NMAC.
- C.** Benefit plans shall be uniform in structure, language, designation and format to the standard benefit *Plans A through L* listed in this section and conform to the definitions in 13.10.25.7 NMAC. Each benefit shall be structured in accordance with the format provided in Subsection B, C or D of 13.10.25.11 NMAC and list the benefits in the order shown in this section. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of a benefit.
- D.** An issuer may use, in addition to the benefit plan designations required in Subsection C of this section, other designations to the extent permitted by law.
- E. Make-up of benefit plans:**

- (1) **Plan A.** Standardized Medicare Supplement benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans, as defined in Subsection E of 13.10.25.11 NMAC.
- (2) **Plan B.** Standardized Medicare Supplement benefit Plan B shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible as defined in Paragraph (1) of Subsection F of 13.10.25.11 NMAC.
- (3) **Plan C.** Standardized Medicare Supplement benefit Plan C shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (2), (3) and (8) respectively of Subsection F of 13.10.25.11 NMAC.
- (4) **Plan D.** Standardized Medicare Supplement benefit Plan D shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Paragraphs (1), (2), (8) and (10) respectively of Subsection F of 13.10.25.11. NMAC.
- (5) **Plan E.** Standardized Medicare Supplement benefit Plan E shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Paragraphs (1), (2), (8) and (9) respectively of Subsection F of 13.10.25.11. NMAC.
- (6) **Plan F.** Standardized Medicare Supplement benefit Plan F shall include only the following: The core benefit as defined Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, the skilled nursing facility care, the Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (2), (3), (5) and (8) respectively of Subsection F of 13.10.25.11 NMAC.
- (7) **High deductible Plan F.** Standardized Medicare Supplement benefit High Deductible Plan F shall include only the following: one-hundred percent of covered expenses following the payment of the annual High Deductible Plan F deductible. The covered expenses include the core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (2), (3), (5) and (8) respectively of Subsection F of 13.10.25.11 NMAC. The annual High Deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement Plan F policy, and shall be in addition to any other specific benefit deductibles. The annual High Deductible Plan F deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the *Consumer Price Index* for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.
- (8) **Plan G.** Standardized Medicare Supplement benefit Plan G shall include only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Paragraphs (1), (2), (4), (8) and (10) respectively of Subsection F of 13.10.25.11 NMAC.
- (9) **Plan H.** Standardized Medicare Supplement benefit Plan H shall consist of only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (2), (6), and (8) respectively of Subsection F of 13.10.25.11 NMAC. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.
- (10) **Plan I.** Standardized Medicare Supplement benefit Plan I shall consist of only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, one-hundred percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Paragraphs (1), (2), (5), (6), (8) and (10) respectively of Subsection F of 13.10.25.11 NMAC. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.
- (11) **Plan J.** Standardized Medicare Supplement benefit Plan J shall consist of only the following: The core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Paragraphs (1), (2), (3), (5), (7), (8), (9) and (10) respectively of Subsection

F of 13.10.25.11 NMAC. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(12) **High deductible Plan J.** Standardized Medicare Supplement benefit High Deductible Plan J shall consist of only the following: one-hundred percent of covered expenses following the payment of the annual High Deductible Plan J deductible. The covered expenses include the core benefit as defined in Subsection E of 13.10.25.11 NMAC, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Paragraphs (1), (2), (3), (5), (7), (8), (9) and (10) respectively of Subsection F of 13.10.25.11 NMAC. The annual High Deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement Plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the *Consumer Price Index* for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(13) **Plan K and Plan L.** Make-up of two Medicare Supplement plans mandated by the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA):

(a) **Plan K.** Standardized Medicare Supplement benefit Plan K shall consist of only those benefits described in Paragraph (1) of Subsection G of 13.10.25.11 NMAC.

(b) **Plan L.** Standardized Medicare Supplement benefit Plan L shall consist of only those benefits described in Paragraph (2) of Subsection G of 13.10.25.11 NMAC.

F. New or innovative benefits: An issuer may, with the prior approval of the superintendent, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare Supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare Supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

[13.10.25.12 NMAC - Rp, 13.10.25.12 NMAC, 1/1/2019]

13.10.25.13 BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010: The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare Supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare Supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare Supplement policies and certificates issued with an effective date of coverage before June 1, 2010 remain subject to the requirements of 13.10.25.11 NMAC.

A. General standards. The following standards apply to 2010 Standardized Benefit Plan policies and certificates and are in addition to all other requirements of this regulation.

(1) **Preexisting conditions.** Refer to Paragraph (1) of Subsection A of 13.10.25.11 NMAC.

(2) **Losses from sickness.** Refer to Paragraph (2) of Subsection A of 13.10.25.11 NMAC.

(3) **Cost sharing.** Refer to Paragraph (3) of Subsection A of 13.10.25.11 NMAC.

(4) **Termination of spousal coverage.** Refer to Paragraph (4) of Subsection A of 13.10.25.11

NMAC.

B. Renewal and continuation of coverage for policies or certificates. Each Medicare Supplement policy shall be guaranteed renewable.

(1) **Cancellation for health status.** Refer to Paragraph (1) of Subsection B of 13.10.25.11 NMAC.

(2) **Cancellation by issuer.** Refer to Paragraph (2) of Subsection B of 13.10.25.11 NMAC.

(3) **Termination by group.** Refer to Paragraph (3) of Subsection B of 13.10.25.11 NMAC.

(4) **Group membership termination.** Refer to Paragraph (4) of Subsection B of 13.10.25.11

NMAC.

(5) **Replacement.** Refer to Paragraph (5) of Subsection B of 13.10.25.11 NMAC.

(6) **Coverage of continuous loss.** Refer to Paragraph (6) of Subsection B of 13.10.25.11

NMAC.

C. Coordination with medical assistance under Title XIX of the Social Security Act.

Refer to Subsection C of 13.10.25.11 NMAC.

D. Standards for basic (core) benefits common to Medicare Supplement insurance benefit plans

A, B, C, D, F, F with high deductible, G, M and N: Every issuer shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement insurance benefit plans in addition to the basic core package, but not in lieu of it.

(1) **Medicare Part A coinsurance after day 60.** Refer to Paragraph (1) of Subsection E of 13.10.25.11 NMAC;

(2) **Medicare Part A reserve lifetime days coinsurance.** Refer to Paragraph (2) of Subsection E of 13.10.25.11 NMAC;

(3) **Medicare Part A uncovered hospitalization coverage.** Refer to Paragraph (3) of Subsection E of 13.10.25.11 NMAC;

(4) **Medicare Part A and Medicare Part B blood.** Refer to Paragraph (4) of Subsection E of 13.10.25.11 NMAC;

(5) **Medicare Part B cost sharing.** Refer to Paragraph (5) of Subsection E of 13.10.25.11 NMAC; and

(6) **Hospice care cost sharing.** Coverage of cost sharing for all Medicare Part A-eligible hospice care and respite care expenses.

E. Standards for additional benefits: The following additional benefits shall be included in Medicare Supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by 13.10.25.14 NMAC.

(1) **Medicare Part A deductible, one-hundred percent.** Refer to Paragraph (1) of Subsection F of 13.10.25.11 NMAC;

(2) **Medicare Part A deductible, fifty percent.** Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) **Skilled nursing facility care.** Refer to Paragraph (2) of Subsection F of 13.10.25.11 NMAC.

(4) **Medicare Part B deductible.** Refer to Paragraph (3) of Subsection F of 13.10.25.11 NMAC;

(5) **One-hundred percent of the Medicare Part B excess charges.** Refer to Paragraph (5) of Subsection F of 13.10.25.11 NMAC; and

(6) **Medically necessary emergency care in a foreign country.** Refer to Paragraph (8) of Subsection F of 13.10.25.11 NMAC.

F. Standards for Plans K and L.

(1) **Plan K.** Plan K as mandated by the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*, shall include only the following:

(a) **Medicare Part A coinsurance after day 60.** Refer to Subparagraph (a) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(b) **Medicare Part A hospital coinsurance, 91st through 150th days.** Refer to Subparagraph (b) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(c) **Medicare Part A hospitalization after lifetime reserve days are exhausted.** Refer to Subparagraph (c) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(d) **Medicare Part A deductible.** Refer to Subparagraph (d) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC

(e) **Skilled nursing facility care.** Refer to Subparagraph (e) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(f) **Hospice Care.** Refer to Subparagraph (f) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(g) **Blood.** Refer to Subparagraph (g) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(h) **Medicare Part B Cost sharing.** Refer to Subparagraph (h) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(i) **Medicare Part B preventive services.** Refer to Subparagraph (i) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC;

(j) **Cost sharing after out-of-pocket limits.** Refer to Subparagraph (j) of Paragraph (1) of Subsection G of 13.10.25.11 NMAC.

(2) **Plan L.** Plan L as mandated by the *Medicare Prescription Drug Improvement and Modernization Act of 2003*, shall include only the following:

(a) The benefits described in Subparagraphs (a), (b), (c) and (i) of the preceding paragraph;

(b) The benefit described in Subparagraphs (d), (e), (f), (g) and (h) of the preceding paragraph, but substituting seventy-five percent for fifty percent; and

(c) The benefit described in Subparagraph (j) of the preceding paragraph, but substituting \$2000 for \$4000.

[13.10.25.13 NMAC - Rp, 13.10.25.13 NMAC, 1/1/2019]

13.10.25.14 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010: The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare Supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare Supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of 13.10.25.12 NMAC.

A. Benefit requirements:

(1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in Subsection D of 13.10.25.13 NMAC of this regulation.

(2) If an issuer makes available any of the additional benefits described in Subsection E of 13.10.25.13 NMAC, or offers standardized benefit Plans K or L (as described in Paragraphs (8) and (9) of Subsection E of this section), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Paragraph (1) of this subsection, a policy form or certificate form containing either standardized benefit Plan C (as described in Paragraph (3) of Subsection E of this section) or standardized benefit Plan F (as described in Paragraph (5) of Subsection E of this section).

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Subsection F of this section and 13.10.25.16 NMAC.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in 13.10.25.7 NMAC. Each benefit shall be structured in accordance with the format provided in Subsections D and E of 13.10.25.13 NMAC; or, in the case of Plans K or L, in Paragraphs (8) and (9) of Subsection E of this section and list the benefits in the order shown. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

E. Make-up of 2010 standardized benefit plans:

(1) **Plan A.** Standardized Medicare Supplement Benefit Plan A shall include only the following: The basic (core) benefits as defined in Subsection D of 13.10.25.13 NMAC.

(2) **Plan B.** Standardized Medicare Supplement Benefit Plan B shall include only the following: The basic (core) benefit as defined in Subsection d of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible as defined in Paragraph (1) of Subsection E of 13.10.25.13 NMAC.

(3) **Plan C.** Standardized Medicare Supplement Benefit Plan C shall include only the following: The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, one-hundred percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3), (4), and (6) respectively of Subsection E of 13.10.25.13 NMAC.

(4) **Plan D.** Standardized Medicare Supplement Benefit Plan D shall include only the following: The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Paragraphs (1), (3) and (6) respectively of Subsection E of 13.10.25.13 NMAC.

(5) **Plan F.** Standardized Medicare Supplement Benefit Plan F shall include only the following: The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the

Medicare Part A deductible, the skilled nursing facility care, one-hundred percent of the Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3), (4), (5) and (6) respectively of Subsection E of 13.10.25.13 NMAC.

(6) High Deductible Plan F. Standardized Medicare Supplement Benefit Plan F with High Deductible shall include only the following: one-hundred percent of covered expenses following the payment of the annual deductible set forth in Subparagraph (b) of this paragraph.

(a) The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, one-hundred percent of the Medicare Part B deductible, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3), (4), (5) and (6) respectively of Subsection E of 13.10.25.13 NMAC.

(b) The annual deductible in Plan F with High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

(7) Plan G. Standardized Medicare Supplement Benefit Plan G shall include only the following: The basic (core) benefit as defined in Subsection D of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, one-hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3), (5) and (6) respectively of Subsection E of 13.10.25.13 NMAC. Effective January 1, 2020, the standardized benefit plans described in Paragraph (4) of Subsection A of 13.10.25.15 NMAC (Redesignated Plan G With High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Plan K. Standardized Medicare Supplement Benefit Plan K shall consist of only those benefits described in Paragraph (1) of Subsection F of 13.10.25.13 NMAC.

(9) Plan L. Standardized Medicare Supplement Benefit Plan L shall consist of only those benefits described in Paragraph (2) of Subsection F of 13.10.25.13 NMAC.

(10) Plan M. Standardized Medicare Supplement Benefit Plan M shall include only the following: The basic (core) benefit as defined in Subsection B of 13.10.25.13 NMAC, plus fifty percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs (2), (3) and (6) of Subsection C of 13.10.25.13 NMAC, respectively.

(11) Plan N. Standardized Medicare Supplement Benefit Plan N shall include only the following: The basic (core) benefit as defined in Subsection B of 13.10.25.13 NMAC, plus one-hundred percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs (1), (3) and (6) Subsection C of 13.10.25.13 NMAC, respectively, with co-payments in the following amounts:

(a) the lesser of \$20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

(b) the lesser of \$50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

F. New or innovative benefits: An issuer may, with the prior approval of the superintendent, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare Supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare Supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

[13.10.25.14 NMAC - Rp, 13.10.25.14 NMAC, 1/1/2019]

13.10.25.15 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020: The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) requires the following standards are applicable to all

Medicare Supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare Supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare Supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of 13.10.25.11 NMAC.

A. Benefit Requirements. The standards and requirements of 13.10.25.14 NMAC shall apply to all Medicare Supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare Supplement Benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Paragraph (3) of Subsection E of 13.10.25.14 NMAC but shall not provide coverage for one-hundred percent or any portion of the Medicare Part B deductible.

(2) Standardized Medicare Supplement Benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Paragraph (5) of Subsection E of 13.10.25.14 NMAC but shall not provide coverage for one-hundred percent or any portion of the Medicare Part B deductible.

(3) Standardized Medicare Supplement Benefit Plan F with High Deductible is redesignated as Plan G with High Deductible and shall provide the benefits contained in Paragraph (6) of Subsection E of 13.10.25.14 NMAC but shall not provide coverage for one-hundred percent or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(4) Standardized Medicare Supplement Benefit Plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(5) The reference to Plans C or F contained in Paragraph (2) of Subsection A of 13.10.25.14 NMAC is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to certain individuals. This section, applies to only individuals who are newly eligible for Medicare on or after January 1, 2020:

(1) by reason of attaining age 65 on or after January 1, 2020; or

(2) by reason of entitlement to benefits under Medicare Part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

C. Guaranteed issue for eligible persons. For purposes of Subsection E of 13.10.25.18 NMAC, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare Supplement policy Plans C or F (including Plan F with High Deductible) shall be deemed to be a reference to Medicare Supplement Plans D or G (including Plan G with High Deductible), respectively that meet the requirements of this Subsection A of this section.

D. Offer of redesignated plans to individuals other than newly eligible. On or after January 1, 2020, the standardized benefit plans described in Paragraph (4) of Subsection A of this section may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Subsection E of 13.10.25.14 NMAC of this regulation.

[13.10.25.15 NMAC - Rp, 13.10.25.15 NMAC, 1/1/2019]

13.10.25.16 MEDICARE SELECT POLICIES AND CERTIFICATES:

A. Applicability.

(1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. Authorization. The superintendent may authorize a Medicare Select issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the *Omnibus Budget Reconciliation Act (OBRA) of 1990* if the superintendent finds that the issuer has satisfied all of the requirements of this regulation.

C. Approval required. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the superintendent.

D. Filing of plan of operation. A Medicare Select issuer shall file a proposed plan of operation with the superintendent in accordance with the requirements set forth in 13.10.30 NMAC, "Network Access Plans, Network Adequacy and Provider Directories." The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are

available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available 24 hours per day and seven days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) the formal organizational structure;

(b) the written criteria for selection, retention and removal of network providers; and

(c) the procedures for evaluating quality of care provided by network providers, and

the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with

Subsection I of this section.

(7) Any other information requested by the superintendent.

E. Plan updates.

(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the superintendent prior to implementing the changes. Changes shall be considered approved by the superintendent after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the superintendent at least quarterly.

F. Payment of non-network providers.

(1) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(a) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or condition; and

(b) it is not reasonable to obtain services through a network provider.

(2) A Medicare Select policy or certificate shall not restrict payment for covered services that are not available through network providers.

G. Required disclosures. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) other Medicare Supplement policies or certificates offered by the issuer; and

(b) other Medicare Select policies or certificates;

(2) a description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L;

- (4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;
- (5) a description of limitations on referrals to restricted network providers and to other providers;
- (6) a description of the insured's rights to purchase any other Medicare Supplement policy or certificate otherwise offered by the issuer; and
- (7) a description of the Medicare Select issuer's quality assurance program and grievance procedure.

H. Signed acknowledgment. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

I. Complaint and grievance procedure. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the insureds. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

- (1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.
- (2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the insured describing how a grievance may be registered with the issuer.
- (3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.
- (4) If a grievance is found to be valid, corrective action shall be taken promptly.
- (5) All concerned parties shall be notified about the results of a grievance.
- (6) The issuer shall report no later than each March 1 to the superintendent regarding its grievance procedure. The report shall be in a format prescribed by the superintendent and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

J. Alternate policies. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare Supplement policy or certificate otherwise offered by the issuer.

K. Offering non-network policies.

- (1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare Supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.
- (2) For the purposes of this subsection, a Medicare Supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.

L. Continuation of coverage. Medicare select policies and certificates shall provide for continuation of coverage in the event the secretary determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

- (1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare Supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.
- (2) For the purposes of this subsection, a Medicare Supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

M. Data calls. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purpose of evaluating the Medicare Select Program.

[13.10.25.16 NMAC - Rp, 13.10.25.16 NMAC, 1/1/2019]

13.10.25.17 OPEN ENROLLMENT:

A. Plan availability. An issuer shall not deny or condition the issuance or effectiveness of any Medicare Supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare Supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B. Period of creditable coverage.

(1) If an applicant qualifies under Subsection A of this section and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A of this section and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

C. Exclusion of benefits. Except as provided in Subsection B of this section and 13.10.25.18 NMAC and 13.10.25.29 NMAC, Subsection A of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective. [13.10.25.17 NMAC - Rp, 13.10.25.17 NMAC, 1/1/2019]

13.10.25.18 GUARANTEED ISSUE FOR ELIGIBLE PERSONS:

A. Guaranteed issue.

(1) **Eligibility.** Eligible persons, as defined in the *Balanced Budget Act of 1997*, are those individuals described in Subsection B of this section who seek to enroll under the policy during the period specified in Subsection C of this section, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare Supplement policy.

(2) **Discrimination, denial and exclusion.** With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare Supplement policy described in Subsection E of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare Supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare Supplement policy.

B. Eligible persons. An eligible person is an individual described in any of the following paragraphs:

(1) **Employee welfare benefit plan.** The individual is enrolled under an employee welfare benefit plan, as defined in 29 U.S.C. Section 1002, that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all of such supplemental health benefits to the individual;

(2) **Medicare Advantage or PACE.** The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a *Program of All-Inclusive Care for the Elderly* (PACE) provider under Section 1894 of the Social Security Act (42 U.S.C. §1395eee), and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) the certification of the organization or plan has been terminated;

(b) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (42 U.S.C. §1395w-21(g)(3)(B)), where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all

individuals within a residence area;

(d) the individual demonstrates, in accordance with guidelines established by the secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

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

(e) the individual meets such other exceptional conditions as the secretary may provide.

(3) Eligible organization.

(a) The individual is enrolled with:

(i) an eligible organization under a contract under Section 1876 of the Social Security Act (42 U.S.C. §1395mm, Medicare cost);

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

(iii) an organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (42 U.S.C. §1395l(a)(1)(A), health care prepayment plan); or

(iv) an organization under a Medicare Select policy; and

(b) the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph (2) of this subsection.

(4) Enrollment ceases. The individual is enrolled under a Medicare Supplement policy and the enrollment ceases because:

(a) of the insolvency of the issuer or bankruptcy of the non-issuer organization or of other involuntary termination of coverage or enrollment under the policy;

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

(c) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) Termination of enrollment with Medicare Advantage.

(a) the individual was enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the Social Security Act (42 U.S.C. §1395mm, Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act (42 U.S.C. §1395eee) or a Medicare Select policy; and

(b) the subsequent enrollment under Subparagraph (a) of this paragraph is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act, 42 U.S.C. §1395w-21(e));

(6) Disenrollment with Medicare Advantage. The individual, upon first becoming eligible for benefits under Medicare Part A at age 65, enrolls in a Medicare Advantage plan under Medicare Part C, or with a PACE provider under Section 1894 of the Social Security Act (42 U.S.C. §1395eee), and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment; or

(7) Duplicate drug plan enrollment. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Medicare Part D, was enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph (4) of Subsection E of this section.

C. Guaranteed issue time periods.

(1) In the case of an individual described in Paragraph (1) of Subsection B of this section, the guaranteed issue period begins on the later of:

(a) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or

(b) the date that the applicable coverage terminates or ceases, and ends 63 days

thereafter.

(2) In the case of an individual described in Paragraphs (2), (3), (5) or (6) of Subsection B of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in Subparagraph (a) of Paragraph (4) of Subsection B of this section, the guaranteed issue period begins on the earlier of:

(a) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and

(b) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in Paragraph (2), (5) or (6) or Subparagraphs (b) of (c) of Paragraph (4) of Subsection B of this section, who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in Paragraph (7) of Subsection B of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act (42 U.S.C. §1395ss(v)(2)(B)) from the Medicare Supplement issuer during the 60 day period immediately preceding the initial Medicare Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in Subsection B of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

D. Extended Medigap access for interrupted trial periods.

(1) In the case of an individual described in Paragraph (5) of Subsection B of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subparagraph (a) of Paragraph (5) of Subsection B of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Paragraph (5) of Subsection B of this section;

(2) In the case of an individual described in Paragraph (6) of Subsection B of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Paragraph (6) of Subsection B of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described Paragraph (6) of Subsection B of this section; and

(3) For purposes of Paragraph (5) and (6) of Subsections B of this section, no enrollment of an individual with an organization or provider described in Subparagraph (a) of Paragraph (5) of Subsection B of this section, or with a plan or in a program described in Paragraph (6) of Subsection B of this section, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to which eligible persons are entitled. The Medicare Supplement policy to which eligible persons are entitled under:

(1) Paragraphs (1), (2), (3) and (4) of Subsection B of this section is a Medicare Supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2) Subject to Subparagraph (b) of Paragraph (5) of Subsection B of this section is the same Medicare Supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (1) of this section and after December 31, 2005, if the individual was most recently enrolled in a Medicare Supplement policy with an outpatient prescription drug benefit, a Medicare Supplement policy described in this paragraph is:

(a) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(b) at the election of the policyholder, a Plan A, B, C, F (including F with a high deductible), K or L that is offered by any issuer.

(3) Paragraph (6) of Subsection B of this section shall include any Medicare Supplement policy offered by any issuer.

(4) Paragraph (7) of Subsection B of this section is a Medicare Supplement policy that has a

benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare Supplement policy with outpatient prescription drug coverage.

F. Notification provisions.

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare Supplement policies under Subsection A of this section. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare Supplement policies under Subsection A of this section. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

[13.10.25.18 NMAC - Rp, 13.10.25.18 NMAC, 1/1/2019]

13.10.25.19 STANDARDS FOR CLAIMS PAYMENT:

A. An issuer shall comply with section 1882(c)(3) of the Social Security Act (42 U.S.C. §1395ss(c)(3)), as enacted by section 4081(b)(2)(C) of the *Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987*, Pub. L. No. 100-203) by:

(1) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A of this section shall be certified on the Medicare Supplement insurance experience reporting form.

[13.10.25.19 NMAC - Rp, 13.10.25.19 NMAC, 1/1/2019]

13.10.25.20 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM:

A. Loss ratio standards.

(1) Return of premiums.

(a) A Medicare Supplement policy form or certificate form shall not be delivered unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, i.e., are guaranteed, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies;

(b) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) home office and overhead costs;

(ii) advertising costs;

(iii) commissions and other acquisition costs;

(iv) taxes;

- (v) capital costs;
- (vi) administrative costs; and
- (vii) claims processing costs.

(2) **Rate filings.** All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage, i.e., are guaranteed, can be expected to meet the appropriate loss ratio standards.

(3) **Solicited policies.** For purposes of applying Paragraph (1) of this subsection and Paragraph (3) of Subsection C of 13.10.25.21 NMAC only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be group policies.

(4) **Combining experience.** For policies issued prior to July 1, 1992, expected claims in relation to premiums shall meet:

- (a) The originally filed anticipated loss ratio when combined with the actual experience since inception;
- (b) The appropriate loss ratio requirement from items (i) and (ii) of Subparagraph (a) of Paragraph (1) of this subsection when combined with actual experience beginning with July 1, 1992 to date; and
- (c) The appropriate loss ratio requirement from items (i) and (ii) of Subparagraph (a) of Paragraph (1) of this subsection over the entire future period for which the rates are computed to provide coverage, i.e., are guaranteed.

B. Refund or credit calculation.

(1) **Filing Appendix A.** Pursuant to Subsection A of 13.10.26.31 NMAC, for each type in a standard Medicare Supplement benefit plan, the issuer shall collect and file with the superintendent by May 31 of each year the data contained in the applicable reporting form contained in Appendix A as provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

(2) **Refund calculation.** If on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare Supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) **Calculation of older policies.** For the purposes of this section, policies or certificates issued prior to July 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1996. The first report shall be due by May 31, 1998.

(4) **Refund interest and distribution.** A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for thirteen-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of premium rates. An issuer of Medicare Supplement policies and certificates issued before or after July 1, 1992, shall annually file its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the superintendent electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed, i.e., are guaranteed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare Supplement policies or certificates in this state shall file for approval electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978:

- (1) **Premium adjustments.**

(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare Supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare Supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the superintendent, the superintendent may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) **Eliminating duplications.** Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare Supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare Supplement benefits provided by the policy or certificate.

D. Public hearings. The superintendent may, at the superintendent's discretion, conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after July 1, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the superintendent.

[13.10.25.20 NMAC - Rp, 13.10.25.20 NMAC, 1/1/2019]

13.10.25.21 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES:

A. Filing policies and certificates. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed and approved electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978.

B. Filing riders and amendments. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* only with the superintendent in the state in which the policy or certificate was issued.

C. Filing rate change requests. An issuer shall not use or change premium rates for a Medicare Supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed and approved electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978.

D. Restrictions on number of forms filed.

(1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each combination of type and series for each standard Medicare Supplement benefit plan.

(2) An issuer may offer, with the approval of the superintendent, up to four additional policy forms or certificate forms of the same type for the same standard Medicare Supplement benefit plan, one for each of the following cases:

- (a) The inclusion of new or innovative benefits;
- (b) The addition of either direct response or agent marketing methods;
- (c) The addition of either guaranteed issue or underwritten coverage;
- (d) The offering of coverage to individuals eligible for Medicare by reason of

disability.

(3) For the purposes of this subsection, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy; "series" means the separate sets of 1990, 2010, and 2020 Standardized Medicare Supplement Benefit Plans defined in Sections 13.10.25.12, 13.10.25.14, and 13.10.25.15 NMAC respectively.

E. Availability of approved forms.

(1) Except as provided in Subparagraph (a) of this paragraph, an issuer shall continue to make available for purchase any policy form or certificate form issued after July 1, 1992, that has been approved by the

superintendent, unless constrained by law from doing so. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the superintendent in writing its decision at least 60 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the superintendent, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) of this paragraph shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare Supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the superintendent of the discontinuance. The period of discontinuance may be reduced if the superintendent determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare Supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) of this subsection.

F. Combining experience for refund calculation.

(1) Except as provided in Paragraph (2) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare Supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 13.10.25.20 NMAC.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

G. An issuer shall not present for filing or approval a rate structure for its Medicare Supplement policies or certificates issued after the effective date of the amendment of this regulation based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

[13.10.25.21 NMAC - Rp, 13.10.25.21 NMAC, 1/1/2019]

13.10.25.22 PERMITTED COMPENSATION ARRANGEMENTS:

A. First year. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare Supplement policy or certificate only if the first year commission or other first year compensation is no more than two-hundred percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. Subsequent years. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

C. Replacement policies. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. Compensation defined. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

[13.10.25.22 NMAC - Rp, 13.10.25.22 NMAC, 1/1/2019]

13.10.25.23 REQUIRED DISCLOSURE PROVISIONS:

A. General rules.

(1) **Renewal or continuation.** Medicare Supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) **Riders or endorsements.** Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare Supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare Supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase

in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare Supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) **Payment standards.** Medicare Supplement policies or certificates issued or delivered after July 1, 1992 shall not provide for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import.

(4) **Disclosure of preexisting condition limitations.** If a Medicare Supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as “Preexisting Condition Limitations.”

(5) **Return and refund period.** Medicare Supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded within 30 days after its return if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) **Delivery of guide.**

(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the NAIC and Center for Medicare and Medicaid Services (CMS) and in a type size no smaller than 12 point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare Supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application and acknowledgement of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, “form” means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.

(1) **Benefit changes.** As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare Supplement insurance policies or certificates in a format acceptable to the superintendent. The notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare Supplement policy or certificate, and

(b) inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) **Required format.** The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) **No solicitation.** The notices shall not contain or be accompanied by any solicitation.

C. MMA notice requirements. Issuers shall comply with any notice requirements of the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*.

D. Outline of coverage requirements.

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare Supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.”

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12 point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or

immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

[Insert “Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010” provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PREMIUM INFORMATION [Boldface Type]

We [insert issuer’s name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy’s most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer’s address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and will return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

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

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

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph must not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as listed below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum*

Standards Model Act – NAIC Model #651, as adopted in 2017. An issuer may use additional benefit plan designations on these charts pursuant to Subsection D of 13.10.25.14 NMAC.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the superintendent.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare Supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

[Use the Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2020 provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan A (Part A) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan A (Part B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan A (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan B (Part A) charts, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan B (Part B) charts, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan B (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan C (Part A) charts, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan C (Part B) charts, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan C (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan C chart, chart notes and associated values for Other Benefits – Not Covered by Medicare provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan D (Part A) chart, chart notes, and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan D (Part B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan D (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan D chart, chart notes and associated values for Other Benefits – Not Covered by Medicare provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan F or High Deductible Plan F (Part A) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan F or High Deductible Plan F (Part B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan F or High Deductible Plan F (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan F or High Deductible Plan F chart and associated values for Other Benefits – not covered by Medicare provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan G or High Deductible Plan G (Part A) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan G or High Deductible Plan G (Part B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan G or High Deductible Plan G (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan G or High Deductible Plan G chart, chart notes and associated values for Other Benefits – not covered by Medicare provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN K

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan K (Part A) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan K (Part B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan K (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN L

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan L (Part A) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan L (Part B) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan L (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan M (Part A) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan L (Part B) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan M (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan M chart, chart notes and associated values for Other Benefits – not covered by Medicare provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

[Use the Plan N (Part A) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

[Use the Plan N (Part B) chart, chart notes and associated values provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

PARTS A & B

[Use the Plan N (Parts A& B) chart, chart notes and associated values provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

OTHER BENEFITS—NOT COVERED BY MEDICARE

[Use the Plan N chart, chart notes and associated values for Other Benefits – not covered by Medicare provided in the Model Regulation To Implement the *NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.]

E. Notice Regarding Policies or Certificates Which are not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare Supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 et seq.), disability income policy; or other policy identified in Subsection B of 13.10.25.3 NMAC, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare Supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the company.”

(2) Pursuant to Subsection B of 13.10.25.31 NMAC, applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph (1) of Subsection D of this section

shall be disclosed, using the applicable statement in Appendix C as provided in the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

[13.10.25.23 NMAC - Rp, 13.10.25.23 NMAC, 1/1/2019]

13.10.25.24 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE:

A. Statements and questions. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare Supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare Supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low- Income Medicare Beneficiary (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an “X”]

To the best of your knowledge,

1. (a) Did you turn age 65 in the last 6 months?
Yes _____ No _____
- (b) Did you enroll in Medicare Part B in the last 6 months?
Yes _____ No _____
- (c) If yes, what is the effective date? _____
2. Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a “Spend-Down Program” and have not met your “Share of Cost,” please answer NO to this question.]

- Yes _____ No _____
- If yes,
- (a) Will Medicaid pay your premiums for this Medicare Supplement policy?
Yes _____ No _____
- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
Yes _____ No _____
3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END: blank."
START /_/_/___ END /_/_/_____
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?
Yes _____ No _____
- (c) Was this your first time in this type of Medicare plan?
Yes _____ No _____
- (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?
Yes _____ No _____
4. (a) Do you have another Medicare Supplement policy in force?
Yes _____ No _____
- (b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

- (c) If so, do you intend to replace your current Medicare Supplement policy with this policy?
Yes _____ No _____
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)
Yes _____ No _____
- (a) If so, with what company and what kind of policy?

- (b) What are your dates of coverage under the other policy?
START /_/_/___ END /_/_/_____
(If you are still covered under the other policy, leave "END" blank.)

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

- (1) List policies sold which are still in force.
(2) List policies sold in the past five years that are no longer in force.

C. Signed form. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Replacement notice. Upon determining that a sale will involve replacement of Medicare Supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare Supplement policy or certificate, a notice regarding replacement of Medicare Supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare Supplement coverage.

E. Format for notice. The notice required by the preceding Subsection for an issuer shall be provided in substantially the following form in no less than 12 point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT

**OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]
- Other. (please specify)

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph must not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

F. Paragraph (2) of the replacement notice (applicable to preexisting conditions) must be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

[13.10.25.24 NMAC - Rp, 13.10.25.24 NMAC, 1/1/2019]

13.10.25.25 FILING REQUIREMENTS FOR ADVERTISING: An issuer shall provide a copy of any Medicare Supplement advertisement intended for use in this state whether through written, radio or television medium to the superintendent for review and approval electronically in SERFF or as otherwise designated by the superintendent, pursuant to Subsection D of Section 59A-17-9, Subsection D of Section 59A-18-12 and Subsection B of Section 59A-18-13 NMSA 1978. Advertisements must comply with the requirements set forth in 13.10.4 NMAC. [13.10.25.25 NMAC - Rp, 13.10.25.25 NMAC, 1/1/2019]

13.10.25.26 STANDARDS FOR MARKETING:

A. Issuer's procedures. An issuer, directly or through its producers, shall:

- (1) establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;
- (2) establish marketing procedures to assure excessive insurance is not sold or issued;
- (3) display prominently by type, stamp or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses"
- (4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare Supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and
- (5) establish auditable procedures for verifying compliance with this Subsection A of this section.

B. Unfair trade practices prohibited. In addition to the practices prohibited in Section 59A-16-1 et seq. NMSA 1978 and Section 57-12-1 et seq. NMSA 1978 and accompanying regulations, the following acts and practices are prohibited:

- (1) **High pressure tactics.** Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
- (2) **Cold lead advertising.** Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. Use of terms. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

[13.10.25.26 NMAC - Rp, 13.10.25.26 NMAC, 1/1/2019]

13.10.25.27 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE:

A. Agent's responsibility. In recommending the purchase or replacement of any Medicare Supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Duplicate policies prohibited. Any sale of a Medicare Supplement policy or certificate that will provide an individual more than one Medicare Supplement policy or certificate is prohibited.

C. Duplicate Part C prohibited. An issuer shall not issue a Medicare Supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

[13.10.25.27 NMAC - Rp, 13.10.25.27 NMAC, 1/1/2019]

13.10.25.28 REPORTING OF MULTIPLE POLICIES:

A. Appendix B due date. On or before March 1 of each year, an issuer shall report to the superintendent the following information for every individual resident of this state for which the issuer has in force

more than one Medicare Supplement policy or certificate using the form referenced in Subsection B of 13.10.26.31 NMAC:

- (1) policy and certificate number; and
- (2) date of issuance.

B. Report organization. The items set forth in Subsection A of this section must be grouped by individual policyholder.

[13.10.25.28 NMAC - Rp, 13.10.25.28 NMAC, 1/1/2019]

13.10.25.29 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES:

A. If a Medicare Supplement policy or certificate replaces another Medicare Supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare Supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare Supplement policy or certificate replaces another Medicare Supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

13.10.25.30 PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING:

This Section applies to all policies with policy years beginning on or after May 21, 2009.

A. Use of genetic testing – exclusion and discrimination. An issuer of a Medicare Supplement policy or certificate;

(1) Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

(2) Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

B. Use of disease or disorder in setting group premium rates. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

(1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

C. Request for genetic testing prohibited. An issuer of a Medicare Supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

D. Permitting use of genetic testing. Subsection C of this section shall not be construed to preclude an issuer of a Medicare Supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the *Health Insurance Portability and Accountability Act of 1996*, as may be revised from time to time) and consistent with Subsection A.

E. For purposes of carrying out Subsection D of this section, an issuer of a Medicare Supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C of this section, an issuer of a Medicare Supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

- (a) compliance with the request is voluntary; and

(b) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

G. An issuer of a Medicare Supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

H. An issuer of a Medicare Supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

I. If an issuer of a Medicare Supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H of this section if such request, requirement, or purchase is not in violation of Subsection G of this section.

J. For the purposes of this section only:

(1) **“Issuer of a Medicare Supplement policy or certificate”** includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) **“Family member”** means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) **“Genetic information”** means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research, which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual.

(4) **“Genetic services”** means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) **“Genetic test”** means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) **“Underwriting purposes”** means,

(a) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(b) The computation of premium or contribution amounts under the policy;

(c) The application of any pre-existing condition exclusion under the policy; and

(d) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

[13.10.25.30 NMAC - Rp, 13.10.25.30 NMAC, 1/1/2019]

13.10.25.31 SEPARABILITY:

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

[13.10.25.31 NMAC - Rp, 13.10.25.31 NMAC, 1/1/2019]

13.10.26.32 APPENDICES:

A. Appendix A - medicare supplement refund calculation form. For the required *Medicare Supplement Refund Calculation Form* for each calendar year, use the form so named and instructions provided in Appendix A of the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017, except that on line 7, in place of “(see worksheet for Ratio 1)” use “(sixty-five percent for Individual, seventy-five percent for Group)”.

B. Appendix B - form for reporting medicare supplement policies. Use the *Form For Reporting Medicare Supplement Policies* provided in Appendix B of the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

C. Appendix C - disclosure statements.

(1) Instructions for use of the disclosure statements for health insurance policies sold to Medicare beneficiaries that duplicate Medicare.

(a) Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary’s other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

(b) All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

(c) State and federal law prohibits insurers from selling a Medicare Supplement policy to a person that already has a Medicare Supplement policy except as a replacement policy.

(d) Property/casualty and life insurance policies are not considered health insurance.

(e) Disability income policies are not considered to provide benefits that duplicate Medicare.

(f) Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

(g) The federal law does not preempt state laws that are more stringent than the federal requirements.

(h) The federal law does not preempt existing state form filing requirements.

(i) Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

(2) For the required disclosure statements refer to the various options that are provided in Appendix C of the *Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act – NAIC Model #651*, as adopted in 2017.

[13.10.25.32 NMAC - Rp, 13.10.25.32 NMAC, 1/1/2019]

HISTORY OF 13.10.25 NMAC:

13.10.25 NMAC - 2010 Medicare Supplement Insurance Standards, filed 8/13/2009 was repealed and replaced by 13.10.25 NMAC - Medicare Supplement Insurance Minimum Standards, effective 1/1/2019.