BEFORE THE NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE

IN THE MATTER OF REPEALING AND REPLACING RULES CODIFIED AT 13.10.34 NMAC STANDARDS FOR ACCIDENT – ONLY, SPECIFIED DISEASE HOSPITAL INDEMNITY, DISABILITY INCOME, SUPPLEMENTAL, AND NON-SUBJECT WORKER EXCEPTED BENEFITS	)	**Docket No. 2021-0084**

HEARING OFFICER'S FINDINGS, CONCLUSIONS, AND RECOMMENDED DECISION

THIS MATTER comes before the New Mexico Office of Superintendent of Insurance ("Superintendent" or "OSI") following a public hearing for comment pursuant to the Notice of Proposed Rulemaking ("NOPR") filed in this docket and published as required by law in the New Mexico Register on November 30, 2021 and in the *Albuquerque Journal* on November 30, 2021 and distributed via OSI's Newsletter to a list of potentially interested parties.

The Hearing Officer, having reviewed the NOPR and the proposed replacement rules, having conducted a public hearing, having reviewed the written comments and responses submitted to the docket, and being otherwise fully informed in the premises, makes the following findings, conclusions, and recommendations:

FINDINGS:

1. The Superintendent has jurisdiction over the subject matter and the parties pursuant to the New Mexico Insurance Code, NMSA 1978, Sections 59A-1-1 et seq. ("Insurance Code").

2. The Superintendent designated Richard B. Word as the Hearing Officer to preside over this matter.

3. The OSI issued a NOPR and published the NOPR in the New Mexico Register on November 30, 2021 and in the *Albuquerque Journal* on November 30, 2021, and OSI distributed the NOPR via OSI's Newsletter to a list of potentially interested parties.

4. The NOPR gave notice of a public hearing, scheduled for January 7, 2022, to accept oral comments on the repeal and replacement of the rules found at 13.10.34 NMAC.

5. The NOPR informed the parties and the public of the process by which the Hearing Officer would conduct the hearing and how parties and the public could make comments on the proposed rulemaking regarding the establishment of regulatory requirements for subject excepted benefit plans to be at 13.10.34 NMAC and have the comments considered.

6. The NOPR further advised that a copy of the full text of the replacement rules was available on the OSI website or the New Mexico Sunshine portal, or by requesting a copy from OSI.

7. The purpose of these rules is to establish regulatory requirements for the subject excepted benefit plans. The rules will standardize and simplify the terms and coverages; facilitate public understanding and comparison of coverage; eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims and require disclosures in the marketing and sale of subject excepted benefit plans.

8. Statutory authority for adopting and promulgating the proposed rule is found in the Short-Term Health Plan and Excepted Benefit Act ("the Act"), NMSA 1978, Sections 59A-23G-1 through -7 (2019).

9. On September 16, 2021 the Superintendent entered an Emergency Order Adopting an Amendment to 13.10.34 NMAC ("Emergency Order"). The Emergency Order was entered in OSI Docket No 2021-0060 and amended Section 6 of 13.10.34 NMAC extending the time for subject

excepted benefits plans previously approved for sale in New Mexico to come into compliance with the current 13.10.34 from October 1, 2021 to October 1, 2022. This change in the effective date is codified in the curent rule at 13.10.34.6 NMAC. No other provisions of 13.10.34 NMAC were amended by the Emergency Order.

10. The Emergency Order was issued pursuant to NMSA 1978, Section 12-8-4(B) of the Administrative Procedures Act and NMSA 1978, Section 14-4-5.6 of the State Rules Act. Section 14-4-5.6(E) provides in relevant part:

> If no permanent rule is adopted within one hundred eighty days from the effective date of the emergency rule, the emergency rule shall expire and may not be readopted as an emergency rule. If an expired emergency rule temporarily amended or repealed an existing rule, the rule shall revert to what it would have been had the emergency rule not been issued.

Accordingly, if a permanent rule setting the effective date of 13.10.34 NMAC was not adopted within 180 days of the Emergency Order, or March 15, 2022, the rule would revert to its original effective date of October 1, 2021.

11. A Partial Recommended Decision and corresponding Order were issued in this matter on February 24, 2022, solely addressing the effective date of the provisions of the current 13.10.34 NMAC. The issuance of a partial order to amend the effective date of 13.10.34 NMAC was necessitated by the looming extinguishment of an earlier Emergency Order amending the effective date of 13.10.34 NMAC.

12. The Hearing Officer found it is necessary and proper for the Superintendent of Insurance to issue an Order adopting a new effective date for 13.10.34 separate from and prior to issuing a final order on the entire proposed 13.10.34.

13. A partial recommended decision was filed on February 24, 2022 recommending the effective date in the current rule be amended to April 1, 2023, and a final order was issued on that date adopting the recommended decision and amending the effective date of the rule to April 1, 2023.

14. Statutory authority for promulgation of the proposed replacement rule is found at NMSA 1978, Sections 59A-18, 59A-16 and 59A-23G-3.

15. On January 7, 2021, OSI conducted the public hearing.

16. Todd Baran, Life and Health attorney for OSI, Julie Weinberg, Director of the Life and Health Products Division for OSI, Cindy Goff, Vice President of Supplemental Benefits and Group Insurance at the American Council of Life Insurers ("ACLI"), Peiter Williams, General Counsel for Regulatory Insurance Advisors, LLC ("RIA"), on behalf of Aflac, Paul G. Williams, Vice President and Legal Counsel for UNUM, and R. Foster Seaton all made oral comments at the public hearing.

17. Mr. Seaton, Cindy Goff on behalf of ACLI, and Paul Glyn Williams, Vice President and Legal Counsel for Unum, Barry R. Koonce, Vice President and Chief of Government Affairs Office of American Fidelity, Christopher M. Buzzell, Regulatory Compliance Counsel for Aflac, Pieter Williams, General Counsel and Chief Operating Officer of RIA, on behalf of Aflac, Ryan Chieffo, Director, Regulatory and Government Affairs, The Standard, Devlin Smith, Compliance Director, Securian Financial Group, Inc., filed timely comments to the proposed rule.

18. OSI Staff, Paul G. Williams of Unum, Mr. Seaton, Caren Alvarado, Vice President for Regulatory Affairs at Crum & Foster, on behalf of US Fire Insurance Company ("US Fire"), Ms. Goff of ACLI, Christy Wermuth, Director of Product Development and Implementation, Chubb,

J.P. Wieske, Executive Director, Health Benefits Institute ("HBI"), Karlee Tebutt, Regional Director, State Affairs, Association of Health Insurance Providers ("AHIP") [check], James M. Harrison, Counsel – Government Relations, Principal Financial Group ("Principal"), Jaclyn Davis, Senior Compliance Analyst, Mutual of Omaha, Hilario Cisco Rubio, State President, New Mexico Association of Health Underwriters, Christopher P. Poe, Senior Vice President, CUNA Mutual Group, submitted responses to comments.

19. All comments, oral and written, have been made part of the record.

20. OSI has adopted rules for rulemaking, which are applicable to this proceeding, and which state:

> The superintendent may adopt, amend, or reject the proposed rule. Any amendments to the proposed rule must fall within the scope of the current rulemaking proceeding. Amendments to a proposed rule are within the scope of the rulemaking if the amendments:
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> **(1)** are a logical outgrowth of the rule proposed in the notice; or
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> **(2)** are proposed, or are reasonably suggested, by comments made during the comment period, and the 10 day response period after the close of the comment period has been provided; and
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> **a)** any person affected by the adoption of the rule, if amended, should have reasonably expected that any change from the published proposed rule would affect that person's interest; or
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> **b)** the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule.

13.1.4.13(C) NMAC. The "10 day response period after the close of the comment period" is ten calendar days. 13.1.4.11(B) NMAC.

21. 13.1.4.13(C) NMAC contemplates that OSI may amend a proposed rule if the amendment is a "logical outgrowth" of the proposed rule ***or*** the amendment is proposed during the comment period, with ten calendar days to respond to the proposed amendment.

22. The NOPR informed interested parties that the comment period ended at 4:00 p.m. on January 7, 2021 and that the response comment period ended at 4:00 p.m. on January 17, 2021. Orders extended the time to submit responses to February 15, 2022. Thus, the "10 day response period after the close of the comment period" was provided.

23. Although there appears to be no New Mexico case law addressing the issue, federal courts have recognized that administrative agencies may make changes in the proposed rule after the comment period without a new round of hearings, as long as the final rule is a "logical outgrowth" of the proposed rule. *Market Synergy Group, Inc. v. U.S. Dep't of Labor*, 885 F.3d 676, 681 (10th Cir. 2018); *Zen Magnets, LLC v. Consumer Prod. Safety Comm'n*, 841 F.3d, 1141, 1154 (10th Cir. 2016). "A final rule qualifies as a logical outgrowth if interested parties should have anticipated that the change was possible, and thus reasonably should have filed their comments on the subject during the notice-and-comment period." *Market Synergy* at 681 (internal quotation marks omitted); *Zen Magnets* at 1154.

24. As he did during the rulemaking for the current 10.13.34 NMAC, Mr. Seaton urges that this proposed rule should not be adopted until amendments are made to the authorizing statute. Specifically, Mr. Seaton asserts that the Act prohibits any excepted benefits plans except those sold through a bona fide association. *See* NMSA 1978, §59A-23G-6 ("No insurer shall issue, and no association, trust or multiple employer welfare arrangement shall offer, a short-term or excepted benefits plan to a resident of the state unless through a bona fide association.") Mr. Seaton similarly reprises his argument from the rulemaking for the current rule that the provisions of the Health Insurance Portability Act, NMSA 1978, Sections 59A-23E-1 through – 20 (1998 as amended through 2019) ("HIPA") create conflicts with the Act that interfere with the adoption of the

proposed rule. No other comments raised these issues. OSI Staff's response acknowledged the need for the legislature to amend the Act as well as other parts of the Insurance Code pertaining to health coverage to address inconsistencies and improve clarity. OSI Staff urges that the adoption of the proposed rule with its important consumer protections not be delayed until needed legislative amendments are enacted. OSI Staff recommends that findings of the hearing officer on these issues in the previous excepted benefits rulemaking be accepted and that Mr. Seaton's recommended amendments to the proposed rule not be approved.

25. The Hearing Officer overseeing the earlier rulemaking process leading to the adoption of the current 13.10.34 NMAC addressed these same arguments from Mr. Seaton in Findings 18-20 of his Findings, Conclusions, and Recommendation, filed in OSI Docket No. 2020-00043. These findings were subsequently adopted by the Superintendent of Insurance in his Final Order Adopting Rule filed into that docket on September 17, 2020. The Hearing Officer takes administrative notice of both of those filings in OSI Docket No. 2020-00043 and specifically adopts the conclusions of the previous Hearing Officer in Findings 18-20 in that matter. The Act provides in Section 59A-23G-2(B)(12) that "'excepted benefits' means benefits furnished pursuant to . . . other similar individual or group insurance coverage or arrangement designated by the superintendent." The Hearing Officer agrees with the previous Hearing Officer that this provision must mean something and finds that the Act is not limited solely to plans offered by bona fide associations. The Hearing Officer similarly rejects Mr. Seaton's contention that HIPA creates conflicts with the Act that necessitate a delay in the adoption of the proposed rule. As was found in Recommended Decision and Order adopting the current 13.10.34 NMAC, the Hearing Officer

finds that the two acts do not conflict. The Hearing Officer therefore recommends that the proposed rule in this matter not be postponed.

26. Both at the public hearing and in written comments, several commentators referred to discussions and workshops between OSI, industry and other interested parties regarding the preparation and drafting the proposed rules. Those discussions, meetings and any materials exchanged as part of the preparation of the proposed 13.10.34 are not a part of the record and have not been considered by the Hearing Officer in the preparation of this Recommended Decision. The Hearing Officer notes that he had no part in those discussions or meetings, nor any role in the preparation of the proposed 13.10.34.

27. Mr. Seaton comments that the use of the plural form "these rules" or "rules" in the proposed 13.10.34.2 and elsewhere in 13.10.34 is incorrect and should be changed to the singular form "this rule" or "rule". No other comments address this point. In its response, OSI Staff defers to the Hearing Officer. The Hearing Officer agrees with Mr. Seaton and finds that the entirety of the proposed 13.10.34 is properly referred to as "the rule", and the sections of Part 34 are themselves not separate rules. Accordingly, the Hearing Officer recommends that references to the plural form of "rule" be changed to the singular form throughout the proposed 13.10.34 together with corresponding changes of the demonstrative pronouns from "these" to the singular "this".

28. Although not identified in the comments, the Hearing Officer notes that the phrase "and applicability exceptions" at the end of the first sentence of the proposed 13.10.34.2 appears to be a typographical error. The Hearing Officer recommends that the word "applicable" be substituted for "applicability" in that sentence so that it read, with the above-recommended change to the singular of "rule": "SCOPE: This section identifies the excepted benefits products that are subject

to this rule, and applicable exceptions:". The Hearing Officer finds that this is a stylistic and not a substantive change. The Hearing Officer's change to the proposed rule meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible.

29. Aflac, ACLI[1], AHIP, HBI and Mutual of Omaha[2] all express concern over the treatment of "other fixed indemnity" products in the proposed rule. These comments all approve of the proposed rule's listing of "other fixed indemnity" as one of seven types of excepted benefits products to which the proposed rule applies in the proposed 10.13.34.2(A)(4). However, these commentators recommend changes to other sections of the rule to clarify the distinction between "other fixed indemnity" products and other types of excepted benefits throughout the proposed rule. OSI Staff responds that it was the intent of the proposed rule to regulate "other fixed indemnity benefits as well as products. To that end, OSI Staff's response recommends an amendment to the introductory sentence of the proposed 13.10.34.2 to add the words "and excepted benefits", so that this sentence, as modified to use the singular "this rule" as recommended in Finding No. 27 above, would read: "SCOPE: This section identifies the excepted benefits and excepted benefits products that are subject to this rule and applicable exceptions." Staff's position is supported by the legislative directive to the Superintendent of Insurance to adopt and promulgate this rule contained in the Act. Under the heading "**Benefits; minimum standards**", Section 59A-23G-4(A) states: "The superintendent shall adopt and promulgate rules to establish minimum

[1] The comments of both American Fidelity and The Standard state that they endorse the comments and recommendations of ACLI in this matter. Accordingly, their support for ACLI's position is noted by the Hearing Officer even if not expressly reported in every finding in this Recommended Decision.

[2] Mutual of Omaha filed comments on the proposed Rule on February 7, 2022. Pursuant to 13.1.4.11(C) NMAC and as noted in the NOPR for this matter, written comments were due on January 7, 2022. While extensions were granted by the Hearing Officer for the submission of responses to comments, no extension was granted for the filing of comments.

standards for benefits provided by short-term plan and excepted benefit plans that are subject to the Short-Term Health Plan and Excepted Benefits Act." The Hearing Officer finds that this proposed amendment is logically consistent with the clear language of this statute. The Hearing Officer also finds that this change to the proposed rule meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible. The Hearing Officer recommends that OSI Staff's change should be adopted and recommends it be adopted

30. Aflac, ACLI, RIA, Securian, HBI, Mutual of Omaha and AHIP all take issue with the application of the proposed rule to out-of-state issued group plans covering employees who reside in New Mexico. The proposed 13.10.34.2(B), as modified to use the singular "this rule" as recommended in Finding No. 27 above, states:

> **B. Extraterritorial plans.** This rule applies to every subject individual, group and blanket contract of insurance, including any certificate, delivered in this state, and to any subject contract issued to a group located outside of this state, if any covered person resides in this state, except:
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> > **(1)** a group plan, and certificates of insurance relating to that plan, issued to an out-of-state employer with fewer than 21 New Mexico residents enrolled in the plan; or
> >
> > **(2)** a group or blanket plan issued to an out-of-state entity that resides in a state whose laws offer protections that, in the discretion of the superintendent, are equivalent to or more protective than New Mexico law.

These commentators assert that such employer-sponsored plans have not been a source of regulatory concern and argue that the proposed maximum number of New Mexico residents enrolled in a plan before it is subject to the rule was both far too low and arbitrary. RIA and Securian contend that basing an exemption on a set number of New Mexico resident enrollees

would create compliance issues for insurers and employees because of natural fluctuations in the number of employees and their eligible dependents. RIA, Mutual of Omaha and others request a complete exemption for out-of-state employer groups plans regardless of the number of New Mexico residents enrolled in the plan, or alternatively that the minimum number of resident enrollees be increased to 500. In his comments, Mr. Seaton opposes all exemptions for insurance contracts otherwise covered by the proposed rule. In his response, he notes the difficulty of setting the number of New Mexico resident enrollees that would trigger exemption and argued that instead of exempting all such plans the proposed rule should have no exemptions and should apply to all out-of-state plans in which any New Mexico residents are enrolled, as in the current rule.

31. OSI Staff's response begins by noting that the Insurance Code provides the OSI with authority to regulate out-of-state insurance plans to the extent that they provide coverage to New Mexico residents. Staff acknowledges that the proposed rule will present compliance challenges for some employers but points out that there are many out-of-state employers with large numbers of New Mexico-based employees. Staff also points out that there are many instances where an employer offers different insurance plans for its out-of-state employees. Staff argues that when possible, "New Mexico residents who are employees of out-of-state companies deserve the same consumer protections as those who work for New Mexico-based employers." OSI Staff supports the threshold number of New Mexico employees used in the rule as a balancing of the interest of extending the protections of the rule to all New Mexicans and the relative administrative burden on employers. In an apparent effort to clarify the applicability of the rule and ease the potential administrative burden of compliance, OSI Staff recommends amending this subsection to make clear that it applies to out of state companies that employ 20 or more New Mexico residents at any

time during a calendar year. The Hearing Officer finds that the Superintendent of Insurance possesses authority under the Insurance Code to regulate subject extraterritorial plans in which excepted benefit products and benefits are provided to New Mexico residents. The Hearing Officer also finds that setting a minimum threshold number of employees employed in New Mexico during the calendar year below which the rule does not apply is reasonable and justified to balance the administrative burden on employees and consumer protections for New Mexico residents. The Hearing Officer further finds that the threshold number described in the proposed rule and in OSI Staff's recommended amendment is too low and recommends that it be raised to 100. This number more accurately reflects a fair balancing of the interests of protecting consumers and avoiding excessive administrative burdens on employers. Accordingly, the Hearing Officer finds that amending the threshold number of employees to 100 is not arbitrary but is reasonable and supported by the record in this matter. The Hearing Officer finds that the amendment to the subsection proposed by OSI Staff's to specify that the threshold is based on the number of New Mexico residents employed by the out of state employer in a calendar year adds clarity while reducing the administrative burden on employers. Therefore, the Hearing Officer recommends that the proposed 13.10.34.2(B)(1) be amended to read: "(1) a group plan, and certificates of insurance relating to that plan, issued to an out-of-state employer that employs 100 or fewer New Mexico residents at any time during the calendar year; or". The Hearing Officer's recommended change to the proposed subsection meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible.

32. The proposed 13.10.34.2(C) would exclude certain excepted benefit plans from compliance with the proposed rule if they were issued prior to the effective date of the rule. Several

comments and responses were received on this issue. In his comments, Mr. Seaton originally appears to suggest that no exemptions be granted. In his response, however, he urges that the proposed 13.10.34.2(C) be greatly simplified to read simply: "**C. Grandfathered plans.** This rule does not apply to any non-cancellable or guaranteed renewable plan issued prior to the effective date of this rule, so long as the plan is continually in force with neither any lapse nor any change in the provisions of the plan." The Hearing Officer recommends against the adoption of Mr. Seaton's proposed language.

33. ACLI comments request clarification on the applicability of the exemption to disability income insurance under the proposed 13.10.34.2(C)(1)(a), and requests this subsection include a reference to conditionally renewable plans. OSI Staff's response concludes that ACLI's request to include conditionally renewable disability income plans that otherwise meet the requirement for an exemption under the proposed 13.10.34.2(C)(1) is reasonable. OSI Staff recommends amending 13.10.34.2(C)(1)(a) to read: "(a) the plan is guaranteed renewable, non-cancellable, guaranteed renewable through a specified age, or conditionally renewable in the case of disability income plans;". The Hearing Officer finds that proposed amendment is reasonable, justified, and in the best interest of consumers. The Hearing Officer also finds that this change to the proposed rule meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible. The Hearing Officer recommends that OSI Staff's change should be adopted and recommends it be adopted.

34. ACLI's comments also recommend that this grandfathered plan exemption be expanded to expressly include coverage currently in force that is offered through labor unions, suggesting this be accomplished by amending the first sentence of 13.10.34.2(C)(2). ACLI also notes the apparent

inadvertent omission of the word "and" at the end of the proposed 13.10.34.2(C)(2)(c). Securian's comments similarly suggest amending (C)(2) to add "credit union" to the list of entities providing excepted benefit plans that would be grandfathered under the proposed rule. CUNA Mutual's comments also seek inclusion of plans offered by credit unions, noting that a credit union, as a cooperative association, is a "bona fide association".

35. OSI Staff's response to the comments also deems reasonable the requests by ACLI and Securian to specifically include plans provided through labor unions and credit unions in the proposed 13.10.34.2(C)(2). OSI Staff recommends amending Subsection 2(C)(2)(c) to read: "**c.** eligibility for the plan is limited to employees, union group, credit union, or association members and their dependents;". In addition to addressing the concerns raised by ACLI, Securian and CUNA Mutual, the Hearing Officer finds that this proposed amendment is reasonable, justified, and in the interests of consumers. However, the Hearing Officer recommends the term "labor group" be changed for the sake of clarity to "labor union". The Hearing Officer also agrees with ACLI that a word is missing after the semicolon at the end of (C)(2)(c) and finds that the addition of the conjunctive "and" in that place is logical and consistent with the structure of 13.10.34.2(C)(1) immediately above. The Hearing Officer recommends that the proposed 13.10.34.2(C)(2)(c) be amended to read: "**c.** eligibility for the plan is limited to employees, labor union, credit union, or association members and their dependents; and". The Hearing Officer further finds that this change requires similar changes elsewhere in the proposed 13.10.34.2(C)(2) so that it remain internally consistent and logical, and recommends the following additional amendments to (C)(2) so that it read in relevant part:

"**(2)** An employer group, labor union, credit union, or bona fide association if:

(a) the carrier began offering the plan through the employer, labor union, credit union, or association prior to the effective date of these rules;

(b) the plan is in continually in force without any lapse;

(c) eligibility for the plan is limited to employees or labor union, credit union or association members and their dependents; and"

The Hearing Officer finds that these changes to the proposed rule meet the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the Hearing Officer recommends they be adopted.

36. ACLI's comments suggest that a definition of "bona fide association" be included in the proposed rule to provide guidance. OSI Staff's response notes that a definition of "bona fide association" is found at NMSA 1978, 59A-23G-2(A) and recommends it be referenced in the proposed rule. The Hearing Officer agrees, and recommends the proposed rule be amended to add the phrase ", as defined in NMSA 1978, 59A-23G-2(A)," immediately after "bona fide association" in the first line of the proposed 13.10.34.2(C)(2). The Hearing Officer finds that this change to the proposed rule meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the Hearing Officer recommends it be adopted.

37. Chubb filed comments questioning the applicability of the proposed rule to out of state issued blanket insurance policies that are fully funded by the policy holder and where the individual insureds are not identified and their state of residency is not known to the policyholder or the insurer. To illustrate its concern Chubb points to blanket policies obtained by out-of-state common carriers such as airlines providing coverage meeting the definition of excepted benefits to all its passengers. Chubb notes that such policies do not and could not identify each individual passenger-insured. The Hearing Officer notes that Chubb's comments were filed outside of the official comment period set forth in 13.1.4.11 and the Notice of Proposed Rulemaking issued in

this matter, and that they do not refer to other comments on the proposed rule or otherwise take the form of a response. OSI Staff's response acknowledges some confusion about Chubb's concerns but asserts that scope of the proposed rule encompasses such plans where New Mexico residents are among the individual insured. The Hearing Officer finds it significant that the Insurance Code already imposes certain requirements and restrictions on blanket policies fully funded by the sponsor/policyholder on behalf of a class of insured who are otherwise not identified as individuals. See NMSA 1978, 59A-23-1 through 16 (1984 as amended through 2019) Accordingly, the Hearing Officer finds no basis to completely exempt this type of blanket insurance policy that Chubb appears to recommend.

38. Although not the subject of comments, the Hearing Officer observes that the list of statutory authorities for the proposed rule is incomplete. While Section 3 of the Act ("**Short-term plans; excepted benefits; standards for policy provisions**") is included, Section 4 of the Act is not. Section 59A-23G-4 ("**Benefits; minimum standards**") provides: "The superintendent shall adopt and promulgate rules to establish minimum standards for benefits provided by short-term plans and excepted benefits plans that are subject to the Short-Term Health Plan and Excepted Benefits Act." The Hearing Officer finds that Section 4 of the Act provides another source of statutory authority for the adoption of this rule and should thus be added to those statutory provisions listed in the proposed 13.10.34.3. This change meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible. The Hearing Officer finds that this change should be adopted and recommends that it be adopted.

39. The Hearing Officer takes notice that the issue of the effective date of the current rule was addressed in the Partial Recommended Decision and Partial Order issued on February 24, 2022 in

this matter. Several concerns were expressed about the effective date of the proposed rule. Unum's comments requests that the effective date of the proposed rule be changed to June 1, 2023. Unum explained that a full year would be needed to implement the changes required by the proposed rule. Mr. Seaton comments that he sees no reason to change the effective date from the October 1, 2022 date imposed by the emergency order. In its response, ACLI disagrees with Mr. Seaton's comment and asserts that more time was needed for the preparation and submission to OSI of new products under the rule, for OSI review of such products, and for the implementation of new systems by insurers for newly approved products and rates. ACLI questions whether the January 1, 2023 effective date in the proposed rule provided sufficient time, and suggests OSI consider an effective date of June 1, 2023. In its response, OSI Staff agrees with Unum regarding the lead time needed to design new plans and obtain review and approval from OSI and recommends setting the effective date at the earlier of 12 months after the rule is finalized, or June 1, 2023. The Hearing Officer finds that extending the effective date to April 1, 2023 is reasonable and provides adequate time for insurers to comply with the rule. Accordingly, the Hearing Officer recommends deleting "January 1" form the proposed 13.10.34.5 and inserting in its place "April 1". This change to the proposed rule meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible.

40. Mr. Seaton's comments recommend that the definition of "Accident only plan" in the proposed 13.10.34.7(A) be amended to delete the words "fixed indemnity" because the proposed 13.10.34.10(C) already restricts compensation under such plans to a fixed indemnity basis. OSI Staff's response disagrees with the proposed amendment. The Hearing Officer finds that Mr.

Seaton's proposed change does not add clarity and that there is otherwise not a sufficient basis to adopt Mr. Seaton's suggested amendment and recommends against it.

41. Mr. Seaton's comments recommend amendments to the definitions of "Certificate", "Disability income plan", and "Hospital indemnity plan" in the proposed 13.10.34.7(B), (D), and (F) respectively. OSI Staff did not respond to these suggestions and no other comments or responses addressed these definitions. The Hearing Officer finds that there is not a sufficient basis for the suggested amendments and recommends against their adoption.

42. ACLI, RIA and Aflac suggest substantial amendments to the definition of "other fixed indemnity" in the proposed 13.10.34.7(H). The proposed amendment corresponds with ACLI's contention, asserted multiple times in its comments, that "other fixed indemnity" is a distinct product type and that restrictions placed on that product type in the proposed rule should not apply to other types of products covered by the rule that pay benefits on a fixed indemnity basis. Mr. Seaton's response recommends that the defined term be changed to "other fixed indemnity plan" and that the definition specify that under such plan the payment of benefits be "conditioned on the occurrence of a covered person receiving care or treatment unrelated to hospital confinement as specified in this rule." OSI Staff's response rejects ACLI, RIA and Aflac's contention and reasserts the position that regulating other fixed indemnity benefits as benefits and not as a separate product is the best way to limit the number of fixed indemnity benefits available for purchase. Staff states this is consistent with the policy goal of discouraging consumers from purchasing multiple health-related excepted benefit products in lieu of major medical insurance coverage. The Hearing Officer notes that the definition is clear in its intent to define "other fixed indemnity" in terms of a fixed cash benefit and not in terms of an insurance product or type, and that this approach is consistent

with the overall structure of the proposed rule. The Hearing Officer finds that there is not a sufficient showing of the need to amend the definition of "other fixed indemnity" in the proposed rule and recommends against any amendment.

43. Mr. Seaton's comments also suggest amendments to the definitions of "Plan", "Non-contributory", and "Supplemental plan" in the proposed 13.10.34.7(I), (J), and (L) respectively. OSI Staff did not respond specifically to these suggestions and no other comments or responses addressed these definitions. OSI Staff did respond generally to the lengthy "Technical Issues" section of Mr. Seaton's comments containing these suggestions and recommended they all be rejected. OSI Staff believes Mr. Seaton's proposals in that section are technical and mostly address the form and not the substance of the proposed rule, and notes that other commentators did not join in these suggested changes. The Hearing Officer finds that there is not a sufficient basis for the suggested amendments and recommends against their adoption, with one exception. Mr. Seaton's comments correctly point out that the proposed 13.10.34.7 contains two subsections marked "(J)". The Hearing Officer recommends that the second subsection "(J)", providing a definition of "Non-subject worker plan", be renumbered 13.10.34.7(K), and that the remaining two definitions be renumbered "(L)" and "(M)" accordingly.

44. ACLI in both its comments and responses requests clarification regarding the applicability of the notice requirements imposed by the proposed 13.10.34.8(C) regarding the exclusion of coverage for a loss due to a preexisting condition. Subsection 8(C) requires a clear and conspicuous notice of the scope and applicability of any exclusion of coverage based on a preexisting condition. ACLI's comments suggests concern that the notice requirement applies to employer-provided group coverage offered to employees. OSI Staff responds that there is no need for clarification as

the language of the proposed subsection is clear about the types of policies to which it applies. The Hearing Officer agrees with OSI staff. The proposed Subsection 8(C) affirmatively imposes the notice requirement only on "[a]n individual plan, or plan sold through an association or group described in Paragraph (2) or (4) of Subsection A of Section 59A-23-3 NMSA 1978", and then only where the plan "excludes coverage for a loss due to a preexisting condition". The Hearing Officer recommends that no changes be made to the proposed 13.10.34.8(C).

45. ACLI, AHIP and Mutual of Omaha request that "purely elective" cosmetic surgery be added to the list of permitted exclusions in the proposed 13.10.34.8(E). OSI Staff responds that the term "purely elective" is overly broad and open to interpretation. Illustrating its position, Staff describes a scenario where a covered person elects cosmetic surgery to repair arguably minor disfigurement caused by a covered accident, while the insurer deems the choice purely elective. Staff recommends no changes be made to this subsection. The Hearing Officer agrees with OSI Staff that an exclusion for "purely elective" or similarly described surgeries would be too open to interpretation that would likely not favor the insured and could otherwise also discourage an insured from obtaining otherwise legitimate and much needed medical treatment. The Hearing Officer also points out that the proposed 13.10.34.8(E)(11) provides a "catch-all" exclusion for "any other type, circumstance or cause of loss if the carrier satisfies the superintendent that the exclusion promotes a legitimate underwriting or policy objective or is required to comply with any state or federal law." The Hearing Officer finds that there is not a sufficient basis for the proposed change and recommends against it.

46. Although not the subject of comments, the Hearing Officer observes that the proposed 13.10.34.8(G) requires clarification. This subsection currently reads: "**G. Marketing of blanket**

or coverages. A carrier shall not sell any blanket coverage to a group that is not described in Section 59A-23-2 NMSA 1978 or group coverage that is not identified in Section 59A-23-3 NMSA 1978." Under 59A-23-2, blanket health insurance covers special groups of no less than 10 persons under a contract of insurance issued to a common carrier, employer, organization utilizing volunteers, or similar organizations which is deemed the policyholder. A blanket coverage policy is thus not sold to the group of insureds but to the common carrier, employer or organization. The Hearing Officer recommends deleting the words "to a group" following" blanket coverage" in the proposed 8(G). The Hearing Officer's recommended change meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible.

47. ACLI and AHIP expressed concern about the applicability of the 30-day termination notice requirement in the proposed 13.10.34.8(U) in cases where a carrier seeks to terminate coverage based on fraud. OSI Staff's response acknowledges that a carrier may not wish to continue coverage of an insured for 30 days after uncovering potential fraud but points out that an insured who seeks to dispute such a determination would have thirty days to obtain other coverage while the dispute is resolved. OSI Staff also notes that a carrier can delay payments where it concludes fraud occurred. The Hearing Officer agrees with the analysis of OSI Staff and recommends that no changes be made to the proposed 13.10.34.8(T) or (U).

48. ACLI's comments request more specific language on the termination of coverage requirement for group plans found in the first paragraph of the proposed 13.10.34.8(V). ACLI notes that a carrier may not have the necessary contact information to provide an insured with the required notice. ACLI offered amendments in the form of additional language to the proposed Subsection 8(V). AHIP and HIB concur with ACLI's comments. In its response, OSI Staff agrees

with the need for clarification and concurs in the amendments offered by ACLI but also recommends the addition of another sentence requiring the attestation by the party responsible for providing the notice that it was given. The Hearing Officer finds that these amendments add needed clarity to this subsection. ACLI's suggested changes were made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended proposed subsection or the issues determined by that subsection are the same as those in the published proposed rule. OSI Staff's change meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible. The Hearing Officer finds that amendments proposed by ACLI and OSI Staff may be adopted and the Hearing Officer recommends that they be adopted. With these recommended amendments, the proposed 13.10.34.8(V) would now read:

> **V. Notice required upon termination of coverage for group plans.** A group plan shall specify that either the carrier or the group master policyholder shall provide notice to the party responsible for providing notice to each group certificate holder of any plan expiration, lapse or termination at least 30 days in advance. Except where the group policyholder or the employer is replacing a group plan with another carrier's plan, a carrier shall not terminate a group plan unless it provides written notice to the party responsible for providing notice to each certificate holder 30 days prior to the certificate holder's intended termination date. The party responsible for providing notice to each certificate holder shall attest that notice was provided 30 days prior to the intended termination date.

49. ACLI, AHIP, HBI and Securian recommend changes to the requirements for submission and approval of plans with variable benefits in the proposed 13.10.34.8(Y). All three, as well as Mutual of Omaha in its late-filed comments, assert that this subsection would impose an excessive administrative burden by requiring a carrier to submit an outline of coverage or plan design of each

possible combination in a variable filing and that an outline of coverage for each plan design is not possible before the insured has selected their coverage. Aflac seeks clarification of the intent of this subsection, stating that it is difficult for a carrier to file outlines of coverage representing a final plan design before a customer has selected its desired coverage. ACLI requests "the removal of the requirement that a carrier must submit for approval an outline of coverage or certificate for each possible plan design and instead follow common protocols that allow for filing bracketed outlines of coverage and certificates with a general statement of variability that describes the variable elements of each bracket." AHIP and HBI agree with ACLI's position. Mutual of Omaha made similar observations and suggestions in its untimely-filed comments. HBI questioned the impact of the requirements in this subsection on the use of "smart" electronic forms by carriers.

50. OSI Staff's response acknowledges that the requirement for individual plans in the proposed 13.10.34.8(Y) that carriers "submit for approval an outline of coverage that illustrates final plan design available to a prospective covered person" could be construed to require carriers to submit the final plan that every individual purchaser has chosen to buy. OSI Staff states that this is not the intent of this subsection, and that its goal is to obtain review of the base outline of coverage illustrating the range of benefit types and levels. OSI Staff recommends the first sentence of this subsection be amended to read: "A carrier who offers an individual plan with variable benefit types and levels shall submit for approval the outline of coverage and benefits that illustrates the plan design that would be available to a prospective covered person." OSI Staff does not offer clarifying language for the second sentence of the subsection, which imposes a similar filing requirement for group plans. Staff recommends no changes to this sentence, noting that there are fewer group plans than individual plans and that carriers can submit plans that have already

been vetted by prospective policyholders. OSI Staff also states that the requirements of this subsection would not limit the use of "smart" policy documents that are completed at least partially in electronic form. The Hearing Officer finds that the changes proposed by OSI Staff reasonably address the concerns of the commentators. The Hearing Officer also finds that the requirements of this subsection, as amended, do not impose unreasonable administrative burdens on carriers. The changes proposed by OSI Staff meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible. The Hearing Officer finds that these changes should be adopted and recommends that they be adopted.

51. ACLI and RIA urge the removal in the proposed 13.10.34.8(Z) of the prohibition on conditioning the provision of benefits on the insured's receipt of treatment from a medical provider. ACLI asserts that carriers rely on an insured's receipt of treatment to substantiate a claim based on injury. Aflac contends that absent the ability to condition benefits on health care services or treatment insurers will be more susceptible to claim fraud. OSI Staff responds that this subsection would ensure that the benefit trigger is the covered event, such as a covered accident or the diagnosis of a covered disease or illness, and not treatment. Staff notes that an exception is granted that allows for the conditioning of the receipt of other fixed indemnity medical benefits on the receipt of medical care in the proposed 13.10.34.12. The Hearing Officer recognizes that there are clearly circumstances where an insured may reasonably decline treatment following the occurrence of a covered event. The Hearing Officer finds that the commentators have failed to show a sufficient basis for amending the proposed 8(Z) and recommends against doing so.

52. ACLI's comments recommend deleting the proposed 8(AA), which sets limits on the portability or continuation of coverage. OSI Staff responds that the proposed section of the rule

gives covered persons sufficient time to either obtain similar coverage from a new employer or purchase an individual policy. The Hearing Officer is unconvinced of the need to delete 8(AA) and recommends against doing so.

53. The proposed 13.10.34.8(BB) states: "A carrier who offers or pays a fixed indemnity benefit shall not claim, assert or pursue subrogation." ACLI's comments recommend that the proposed 8(BB) not be applicable to disability income policies or benefits. OSI Staff responds that this subsection only prohibits a carrier from seeking payment from a third party or parties deemed responsible for the covered person's disabling injuries or illness and does not prevent the carrier from pursuing offsets. The Hearing Officer finds no sufficient basis for narrowing the proposed rule to exclude disability income policies and recommends against any change to this subsection.

54. Securian's comments request clarification of the proposed 13.10.34.8(CC) to recognize that a plan could include both contributory and non-contributory coverage and requests that in such a case the non-contributory portion of the coverage not be subject to benefit minimums. OSI Staff responds that this request is reasonable and recommends the addition of the following sentence at the end of the subsection: "Benefit minimums are applicable to the non-contributory portion of a plan that has both contributory and non-contributory portions." Given OSI Staff's response that the request that the non-contributory portion of such a plan <u>not</u> be subject to benefit minimums was reasonable, Staff's proposed additional language stating that the non-contributory portion <u>is</u> subject to benefit minimums appears contradictory. The Hearing Officer assumes that OSI Staff's response unintentionally omitted the word "not" immediately preceding "applicable" in its proposed additional language. The Hearing Officer finds that OSI Staff's proposed language to address Securian's concern, so modified, is reasonable. The Hearing Officer recommends the

addition of the following sentence at the end of the proposed 13.10.34.8(CC): "Benefit minimums are not applicable to the non-contributory portion of a plan that has both contributory and non-contributory portions." This change to the proposed rule meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the Hearing Officer recommends it be adopted.

55. In its comments, ACLI recommends amending the description of "partial disability" in the proposed 13.10.34.9(C)(1) to align with the definition of total disability in the proposed 13.10.34.9(E)(2). ACLI suggests striking the phrase ""major", "important", or "essential"" immediately before the word "duties" and substituting the phrase "substantial and material". ACLI also suggests adding the phrase "or words of similar import" immediately before "duties". OSI Staff responds that it finds these suggested amendments reasonable and recommends their adoption. ACLI's suggested amendments were made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule and that the proposed amendments may be adopted. The Hearing Officer also finds that the proposed amendments provide greater clarity and recommends that they be adopted. Therefore, the Hearing Officer recommends that proposed 13.10.34.9(C)(1) be changed to state: "(1) is unable to perform one or more but not all of the substantial and material duties or words of similar import, of the individual's employment or existing occupation or work a specified percentage of time, or a specified number of hours, or earn a specified amount of compensation; and".

56. ACLI's comments assert that the 30 and 60-day maximum elimination periods specified in the proposed 13.10.34.9(G) may result in insurer's inadvertent noncompliance because many

disability income policies use months rather than days and seven months of the year contain 31 days. ACLI recommends that the 30 and 60-day elimination periods be changed to 31 and 62 days. ACLI also urges that the elimination period for coverage providing benefits for less than five years be increased from 90 to 180 days, arguing that in many cases the shorter period would require significant premium increases. OSI Staff responds that extending the elimination periods to 31 and 62 days would exceed the days in 30, 28 or 29-day months and thus advantage some insureds and disadvantage others. OSI Staff's response also notes that extending the 90-day elimination period to 180 days would double the wait time proposed.

57. OSI Staff response states that upon review Staff concludes the proposed 13.10.34.9(G) lacked clarity and recommended a revision to read:

> A disability income plan shall not include an elimination period greater than one month in the case of coverage providing a benefit duration of one year or less; two months in the case of coverage providing a benefit duration of greater than one year and no more than two years; three months in the case of coverage providing a benefit duration of greater than two years and no more than three years; six months in the case of coverage providing a benefit duration of greater than three years and no more than five years; or 365 days in all other cases.

The Hearing Officer generally agrees that the changes to the expression of the benefit duration period in the form of "greater than x year and no more than y years" adds needed clarity to this subsection. However, OSI Staff's proposed change from days to months in the case of elimination periods for coverage providing a benefit duration of five years or less would have the opposite effect. The Hearing Officer notes that this change could create confusion given that months can have 31, 30, 28 and even 29 days. It is for this reason that statutes, court rules and administrative rules typically refer to 30, 60, 90 or 180 days and not one, two, three or six months, in setting

critical, enforceable deadlines. See, e.g. NMSA 1978, Section 59A-11-8(C) ("Within thirty days of the date of issuance of denial, ...") Given the widespread and longstanding practice of specifying legal deadlines in this fashion, the Hearing Officer finds that to do so in this subsection is both reasonable and fair and should not create the risk of inadvertent noncompliance. In its proposed revision, OSI Staff apparently concedes the reasonableness of extending the elimination period from 90 to 180 days in the case of coverage providing a benefit duration of greater than three years and no more than 5 years, and the Hearing Officer concurs. The Hearing Officer finds that OSI Staff's revisions the proposed 13.10.34.9(G), as modified to express the elimination period in days (30, 60, 180) instead of months is reasonable and adds clarity and should be accepted. This change to the proposed rule meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible.

58. ACLI and Aflac both recommend in their comments that a new subsection be added to the proposed 13.10.34.10 to define the benefit structures allowed in an accident-only plan. ACLI asserts that this is needed to clarify that an accident-only plan may contain not only injuries caused by an accident but also "ancillary fixed indemnity benefits that are directly related to covered accidental injuries. ACLI suggests its proposed new subsection appear after 13.10.34.10(C) as follows:

> D. Benefits Structure. An accident-only plan may be offered as a stand-alone policy or certificate of insurance, or as a rider to an excepted benefit plan. An accident-only plan shall contain benefits for losses resulting from a covered accident and may contain ancillary fixed indemnity benefit [sic] directly related to treatment of or services for a covered accident. Ancillary fixed indemnity benefits may be included for [the] covered person being hospitalized, hospital treatment, ambulatory surgical

center services, outpatient services, physician visits, imaging, anesthesia, surgery, emergency care, travel to or from services or treatment of a covered accident.

Aflac would add an additional three sentences to ACLI's language that prohibit accident-only plans from having "the tendency to be ambiguous, deceptive or misleading to a prospective insured" based on the number and type of fixed-benefits contained in the plan and the structure of the plan. OSI Staff responds by reiterating its commitment to a larger policy of encouraging consumers to enroll in comprehensive major medical insurance and discouraging them from relying on varying combinations of excepted benefits coverage instead. Staff argues that the proposed rules already allow for a number of other fixed indemnity benefits that can be selected with other plans or as a stand-alone policy. Staff asserts that the proposed subsection would unnecessarily expand opportunities for consumers to enroll in more excepted benefits products in the belief that the combined plans would provide the coverage of major medical coverage at a lower cost. In his response Mr. Seaton expresses opposition to the proposed new subsection. The Hearing Officer finds that there is not a sufficient basis for the proposed additional subsection and recommends that it not be added.

59. The proposed 13.10.34.10(C) provides: "An accident-only plan shall only compensate for losses on a fixed-indemnity basis." Chubb urges in its late-filed comments that this subsection be amended to allow blanket accident-only plans to provide the payment of accident benefits on a reimbursement basis, or accident medical expense coverage, "when coverage is paid for entirely by the group sponsor and the group is recognized pursuant to [NMSA 1978, Section] 59A-23-2." As an illustration to its argument, Chubb give the example of a blanket accident-only policy issued to a school district that provides accident medical expense coverage for accidental injuries suffered

by students during school activities. Chubb asserts that such coverage protects the injured student's parents from out-of-pocket expenses without undermining the public policy interest in encouraging the purchase of major medical coverage. Mr. Seaton's response opposes any such exemption, arguing that accident-contingent insurance that paid medical expenses would be duplicative of existing comprehensive medical coverage and thus contrary to public policy. OSI Staff's response points out that the benefit trigger under the proposed rule is a covered accident, not the receipt of treatment or care. Staff also notes that medical or other treatment expenses necessitated by a covered accident can be covered through other fixed indemnity benefits as long as those benefits are offered in compliance with the proposed 13.10.34.12. The Hearing Officers finds that there is not a sufficient basis for the amendments sought by Chubb and recommends no change to this subsection.

60. American Fidelity expresses concern that the occupational accident plan notice required in the proposed 13.10.34.10(E)(4) would not fit on the first page of a policy given other text that must also be located there. American Fidelity recommends the prefatory language in Subsection 10(E)(4) be modified to add the words "on a cover page or" after "displayed". OSI Staff agrees with the proposed change and recommends it be added. Mr. Seaton's response opposes the modification. American Fidelity's suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended proposed rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed amendment may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that proposed 13.10.34.10(E)(4) be

changed to state: "(4) shall include this notice, displayed on a cover page or on the first page of the plan in bold 14 point type".

61. ACLI requests that the proposed 13.10.34.10(F) be modified to allow for a sickness benefit in travel policies of less than 365 days. ACLI notes that such policies are popular and are specifically allowed under 45 CFR 160.103. Mr. Seaton opposes such a change. OSI Staff's response also opposes any change, noting that travel policies are not in the list of excepted benefits in Section 59A-23G-2 of the Act, and this rule applies only to excepted benefits listed in that statute. The Hearing Officer agrees with the position of OSI Staff and recommends against any change to this subsection.

62. Securian and HBI complain that the minimum benefit of $2500 for an initial hospital confinement set by the proposed 13.10.34.11(A) is too high and would result in significant premium increases that could make this coverage unaffordable. OSI Staff response appears to recognize this as a legitimate concern, while noting that the commentators do not suggest an alternative minimum amount. OSI Staff recommends changing the minimum benefit for initial hospital confinement to $1500, which it contends strikes a balance between a benefit that is too high and one that is too low. The Hearing Officer finds that this proposed change reasonably addresses the commentators' concern. OSI Staff's suggested change meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible and because is based on comments received during the comment period. The Hearing Officer finds that OSI Staff's recommended change to this subsection should be adopted and recommends that it be adopted.

63. In accordance with its comments on the proposed 13.10.34.10, ACLI recommends that new language be added to the proposed 13.10.34.11(D) to define the benefit structures allowed in hospital indemnity plans. ACLI asserts that this is needed to clarify that a hospital indemnity plan "may contain benefits covering services and treatment directly related to hospital confinement but not provided in a confinement setting." ACLI suggests the following proposed language appear at the end of 13.10.34.11(D):

> Benefits may be offered in a hospital indemnity plan which are other than for hospitalization or confinement. Ancillary fixed indemnity benefits shall be directly related to hospitalization or confinement, and may include benefits for ambulatory surgical center services, ambulance services, outpatient services, physician visits, imaging, anesthesia, surgery, emergency care, travel to or from services, or treatment of a covered period of hospital confinement.

Aflac also proposes adding a paragraph to this proposed subsection. While Aflac's suggested language differs from ACLI's, its intent appears to be generally the same. Aflac states that its language "clarifies that a hospital indemnity product may contain benefits covering services and treatment directly related to hospitalization or confinement." OSI Staff responds, as it did to ACLI's recommendations for amending the proposed 13.10.34.10, that the language in Subsection 11(D) provides sufficient information to allow carriers to design hospital indemnity products without undercutting OSI's policy of encouraging consumers to enroll in comprehensive major medical insurance. The Hearing Officer notes that, subject to the limitations of the proposed 13.10.34.12(B), the proposed 13.10.34.12(C) already expressly allows for a carrier to offer other fixed indemnity benefits related to "hospitalization, outpatient services, ambulance and other transportation services, behavioral services, laboratory and imaging services, in-home care, durable medical equipment, home, work or vehicle modifications to accommodate disability,

therapy services, treatment-related lost wages, health care related lodging, pet care and daycare service, or cosmetic services relating to a covered accident or illness." The proposed Subsection 12(C) also specifies that other fixed indemnity benefits can be offered as stand-alone policies or certificates of insurance or as a rider to an excepted benefits plan. Accordingly, the Hearing Officer finds that the additional language requested for the proposed 13.10.34.11(D) is unnecessary and could create confusion and recommends that it not be adopted.

64. ACLI also recommends modifying the definition of "confinement" in the proposed 13.10.34.11(E) by adding the following sentence at the end of the subsection: "Confinement includes [a] stay in an ambulatory surgical facility for less than a 24-hour period." ACLI notes that this change is needed to reflect that hospital-based services such as surgery are increasingly delivered on an out-patient basis. ACLI further suggests striking the final clause of this subsection that would count as a day of confinement any period of less than 24 hours on the day of discharge from a period of confinement. ACLI states this change is warranted because hospitals rarely charge for the day of discharge. OSI Staff opposes the inclusion of ambulatory surgical facility stays in the definition of confinement on the grounds that it expands the scope of hospital indemnity plans beyond hospital confinement. OSI Staff notes that a carrier can choose to offer coverage for outpatient surgical services as an other fixed indemnity benefit, whether added to the hospital indemnity plan or as part of a stand-alone policy. OSI Staff does not directly address ACLI's suggestion that the day of discharge not be counted as a day of confinement but urges that no changes be made to this subsection.

65. The Hearing Officer recognizes the common practice of admitting surgical patients, including those undergoing major orthopedic surgeries, and discharging them the same day

without the provision of overnight care. However, the Hearing Officer concludes that ACLI's proposed amendment would result in an unwarranted extension of coverage under hospital indemnity plans. The Hearing Officer agrees with OSI Staff that carriers can offer coverages for such outpatient surgical or other hospital-based procedures or treatments not requiring an overnight stay as an other excepted benefit either added to the hospital indemnity plan or as part of a stand-alone policy. The Hearing Officer also finds that there is an insufficient basis for adopting ACLI's recommendation to strike language that includes the discharge day as part of the period of confinement. Accordingly, the Hearing Officer recommends no changes be made to the proposed rule in response to this comment.

66. The introductory sentence of the proposed 13.10.34.12 makes clear that this subsection imposes additional regulations on other fixed indemnity *benefits* as opposed to other fixed indemnity *plans*. This is in contrast to adjacent sections of the rule that would impose additional regulatory requirements on certain types of excepted benefit plans, e.g. the regulation of disability income plans (proposed 13.10.34.9), accident-only plans (proposed 13.10.34.10), hospital indemnity plans (proposed 13.10.34.11), specified disease plans (proposed 13.10.34.13), hospice care plans (proposed 13.10.34.14), supplemental plan (proposed 13.10.34.15), and non-subject worker plans (proposed 13.10.34.16). In comments on the proposed 13.10.34.12 and consistent with their comments regarding the definition of "other fixed indemnity benefits" in Subsection 7(H) of the proposed rule, ACLI and Aflac restate their objections to the proposed rule's regulation of other fixed indemnity *benefits* as opposed to other fixed indemnity *plans.* Both ACLI and Aflac call for other fixed indemnity plans to be defined and regulated as a separate product category. In furtherance of this position Aflac suggests adding the word "PLAN" after the words "OTHER

FIXED INDEMNITY" in the opening sentence of the proposed 13.10.34.12. RIA, on behalf of Aflac, appears to believe that the proposed rule would not allow or would place unreasonable restrictions on the provision of other fixed indemnity benefits within or ancillary to hospital indemnity, accident only, or specified disease products.

67. OSI Staff's response rejects this contention and maintains that the proposed rule does in fact allow other excepted benefits to be offered in such plans, while also allowing for the sale of other fixed indemnity benefits in a stand-alone policy, as a certificate of insurance or as a rider to a subject excepted benefits plan. OSI Staff asserts that regulating other fixed indemnity benefits as opposed to fixed indemnity products is a more effective way to limit the number of other fixed indemnity benefits offered for sale to consumers to make it less likely that consumers would purchase a range of health-related excepted benefit products as a substitute for major medical insurance. The Hearing Officer agrees with OSI Staff's analysis and finds that the regulation of other fixed indemnity benefits in the proposed 13.10.34.12 reasonably balances the interests of consumers and industry. The Hearing Officer finds that Section 12 of the proposed rule would not place unreasonable restrictions on the provision of other fixed indemnity benefits within or ancillary to hospital indemnity, accident only, or specified disease products. Accordingly, the Hearing Officer recommends against any change to the first sentence of Section 12.

68. Aflac comments that the $5000 maximum limit imposed by the proposed 13.10.34.12(A) on the aggregate amount of other fixed indemnity benefits offered is unrealistically low, and recommends it be stricken or raised to at least $10,000. OSI Staff's response agrees that an increase in the maximum aggregate benefit for other fixed indemnity benefits is reasonable and recommends that it be increased to $10,000. The Hearing Officer finds that this proposed increase

is reasonable and is in the best interest of consumers. The Hearing Officer also finds that the subject matter of the suggested amendment is that same as that in the published proposed rule. Accordingly, the proposed amendment may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that "$5000" be stricken at the end of the proposed 13.10.34.12(A) and "$10,000" be substituted in its place.

69. Both ACLI and Aflac request clarifications to the proposed 13.10.34.12(B) reflecting their preference that the proposed rule not regulate other fixed indemnity benefits as benefits but as products or plans. OSI Staff opposes these changes as noted above, and the Hearing Officer agrees and recommends that these changes not be adopted.

70. ACLI and Aflac also express concern about the limits imposed on the number of other fixed indemnity benefits that may be included in a single excepted benefit plan or in a combination of such plans under the proposed 13.10.34.12(B). The proposed Subsection 12(B) imposes a limit of 10 other fixed indemnity benefits in a single plan or combination of plans either sold by a specific carrier or when combined with other fixed indemnity benefits purchased by the same consumer from another carrier. Aflac states that it supports "limit[ing] the number of benefits that can be provided in an Other Fixed Indemnity Plan to ten", but elsewhere appears to oppose limits on the number or aggregate amount of such benefits when they are "ancillary" to hospital indemnity, accident only or specified disease excepted benefit products. OSI Staff opposes any change to the proposed 13.10.34.12(B). The Hearing Officer finds that proposed Subsection 12(B)'s limit of ten other fixed indemnity benefits under one or more plans is reasonable and consistent with the policy of encouraging consumers to purchase comprehensive medical

coverage. The Hearing Officer further finds that there is not a sufficient basis for amending the proposed 13.10.34.12(B).

71. RIA urges that specified disease plan carriers be allowed under the proposed 13.10.34.13 to require that insureds obtain health care services or treatment for a covered specified disease in order to receive benefits. In its response OSI Staff notes that the proposed 13.10.34.8(Z) provides: "Except as expressly authorized in this rule, no accident only or specified disease plan shall condition a benefit on a covered person's receipt of health care or offer a fee for service benefit." OSI Staff then points out that accident only and specified disease plans may offer other fixed indemnity benefits that provide added medical benefits related to treatment necessitated by covered accidents or diseases, and that the proposed 13.10.34.12(D) provides that these added medical benefits can be conditioned on the receipt of medical care. The Hearing Officer agrees with the analysis of OSI Staff, and recommends no changes be made to the proposed rule in response to this comment.

72. ACLI, Aflac and HBI all expressed concerns about the aggregate benefit minimum for a triggering diagnosis in the proposed 13.10.34.13(B). Citing to Subsection 13(B)(3), ACLI asserts the $5000 minimum "would prohibit a specified disease plan from having lower benefit amounts for subtypes of diseases that normally create much less financial hardship for the insured, and therefore will unnecessarily increase premiums significantly." Aflac urges that the minimum be decreased or removed completely and points in support of its position to the difference in the financial impact on an insured consumer who has non-metastatic skin cancer and one diagnosed with metastatic brain cancer. OSI Staff's response suggests that the issue raised by ACLI is already addressed in the proposed rule at 13(B)(1), which provides: "The OSI may approve product filings

that allow a lower aggregate amount for a variant of a covered specified disease that requires minimally invasive treatment or are non-life-threatening." OSI Staff suggests that this language provides sufficient flexibility to allow specified disease plans covering diseases such as cancer that encompass a wide range of severity and treatment costs depending upon the type.

73. The Hearing Officer finds the concerns asserted by ALCI, Aflac and HBI are well taken but also agrees with OSI Staff that the referenced sentence in Subsection 13(B)(1) provides an adequate procedure for addressing this concern. However, the Hearing Officer also recognizes the need to clarify that this procedure for the approval of lower minimum benefit applies to Subsection 13(B)(3) as well. Accordingly, the Hearing Officer recommends two amendments to Subsection 13(B). First, the Hearing Officer notes that 13(B)(1) refers to a "variant" of a disease while 13(B)(3) refers to the "subtype" of a disease. Read in the context this subsection, the Hearing Officer concludes that the terms were intended to have the same meaning. In order to clarify the rule and avoid ambiguity the Hearing Officer recommends that the phrase "variant or subtype" be substituted for the word "variant" in 13(B)(1) and "subtype" in 13(B)(3). For the same reason the Hearing Officer also recommends adding the following clause at the end of Subsection 13(B)(3) after "disease": ", unless lower aggregate amounts have otherwise been approved under Subparagraph (1) of this subsection." The Hearing Officer's recommended amendments to the proposed Subsection 13(B) meet the "logical outgrowth" test because interested parties should have anticipated that the change was possible.

74. Mr. Seaton expresses opposition to the proposed 13.10.34.13(D) based upon what he perceives to be the impracticality of limiting the number of specified diseases under specified disease plans. He recommends either striking the subsection entirely, or re-writing it to prohibit

any carrier from offering or selling a specified disease plan that applies to more than one disease or from carrying more than one specified disease plan covering a given person at a given time. ACLI responds that limiting specified disease plans to one covered disease would greatly devalue such products and likely render the market for them unsustainable. OSI Staff did not directly respond to Mr. Seaton's comment, but their response to other comments on this subsection indicate that they continue to believe it to be in consumers' best interest to have available specified disease coverage for up to eight diseases. The Hearing Officer finds that it is in the best interest of consumers not to adopt Mr. Seaton's proposed changes to the proposed 13.10.34.13(D) and recommends they be rejected.

75. ACLI also opposes the requirement in the proposed Subsection 13(D) that a carrier not sell or offer to sell a specified disease plan if it would result in a customer having coverage for more than eight specified diseases either solely under the plan offered by that carrier or under a combination of plans issued by different carriers. ACLI complains that it is unrealistic to expect a carrier to know what specified disease coverage a consumer has obtained from a different carrier and that it would be difficult for consumers to specify on an application for coverage what other specified disease coverage they may already have. Aflac and AHIP express similar concerns. ACLI recommends striking the second sentence of Subsection 13(D) and modifying the third sentence. Such amendments would effectively remove any prohibition on a carrier selling specified disease coverage that in combination with coverage obtained by a consumer from a different carrier would result in that consumer having specified disease coverage for more than eight specified diseases. OSI Staff responds that these amendments are not needed because carriers can use the required application questions to make a reasonable and good faith effort to determine the number of

specified diseases for which a prospective customer already has coverage. OSI Staff also responds that this would likely benefit consumers to take stock of the coverage they currently have. OSI Staff recommends against adopting ACLI's proposed amendments. The Hearing Officer finds that it is in the best interest of consumers to reject these changes and recommends that they not be adopted.

76. Mutual of Omaha's late-filed comments suggest adding the qualifying clause "Except for group specified disease plans offered by an employer," at the beginning of the second sentence of the proposed Subsection 13(D). OSI Staff's response concludes that this modification is reasonable and improves the clarity of this subsection. The second sentence of the subsection prohibits selling "a specified disease plan if doing so would result in the customer having coverage for more than eight specified diseases under plans issued by different carriers." The third sentence imposes a duty to inquire in specified disease plan applications about other specified disease coverage the applicant may have. But this sentence begins by exempting group specified disease plans offered by employers, using the same language Mutual of Omaha proposes to add to the second sentence. The Hearing Officer finds that the proposed change adds clarity and consistency to this subsection and recommends its adoption. The proposed change meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible. Accordingly, the proposed amendment may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that the second sentence of the proposed 13.10.34.13(D) be amended to read: "Except for group specified disease plans offered by an employer, no carrier or producer shall sell a specified disease plan if that would result in the

customer having coverage for more than eight specified diseases under plans issued by different carriers."

77. Both ACLI and Aflac request the addition of new language at the end of the proposed 13.10.34.13(D) expressly allowing specified disease plans to include "ancillary" fixed indemnity benefits covering services and treatments directly related to the treatment of a covered specified disease. ACLI again requests clarification that "the other fixed indemnity product category is separate and distinct from the specified disease category and that other fixed indemnity benefit limits do not apply the specified disease product type." OSI Staff's response restates their opposition to regulating other fixed indemnity benefits as separate product and points out again that other fixed indemnity benefits may be included in specified disease plans and other excepted benefit plans or sold as stand-alone policies. OSI Staff argues against adopting the additional language proposed by ACLI and Aflac. Pointing to what they describe as "obvious confusion and misunderstanding about the relationship of the other fixed indemnity rules in 13.10.34.12 to accident-only and specified disease products, OSI Staff proposes adding new language in the sections addressing accident-only plans and specific disease plans. OSI Staff recommends adding a new subsection after the proposed 13.10.34.10(F) that reads: "**Other Fixed Indemnity Benefits:** An accident-only plan may offer other fixed indemnity benefits in compliance with Section 13.10.34.12." The addition of this subsection would also require the re-numbering of the proposed Subsections 10(G) through 10(L). OSI Staff also recommends the addition of a new paragraph to be numbered 13.10.34.13(A)(8) that reads: "A specified disease plan may offer other fixed indemnity benefits in compliance with 13.10.34.12." The Hearing Officer finds that these proposed additions reasonably address concerns expressed by commentators and add clarity and

consistency to the proposed rule. OSI Staff's recommended amendments to the proposed 13.10.34.10 and 13.10.34.13(A) meet the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the Hearing Officer recommends they be adopted.

78. Mr. Seaton's comments suggest changing the introductory text of the proposed 13.10.34.14 from "HOSPICE CARE PLANS" to "HOSPICE CARE BENEFITS". Mr. Seaton notes that hospice benefits are not offered as a separate plan but rather are provided as benefits under hospital indemnity plans or other fixed indemnity plans. OSI Staff does not support this change, asserting that it does not clarify or otherwise correct a problem in the proposed language. The Hearing Officer notes that outside of the introductory text, this section refers only to hospice care benefits and not to hospice care plans. The Hearing Officer disagrees with OSI Staff and finds that Mr. Seaton's suggested change makes the language of this section more consistent with the language and structure of Sections 9 through 16 of the proposed rule. Accordingly, the Hearing Officer recommends that the word "PLANS" be replaced with the word "BENEFITS" in the introductory text on the first line of the proposed 13.10.34.14. This change was suggested by Mr. Seaton during the comment period and the ten day response period was provided. The Hearing Officer finds that the subject matter of this suggested amendment is that same as that in the published proposed rule. Accordingly, the proposed amendment may be adopted, and the Hearing Officer recommends that it be adopted.

79. In his comments Mr. Seaton recommends that the phrase "primary major medical plan" be deleted from the proposed 13.10.34.15(A). Mr. Seaton argues that despite falling within the definition of "excepted benefits", supplements to major medical coverage are not excepted from

the requirements of NMSA 1978, 59A-23, 59A-23(E) and other provision of the Insurance Code, and therefore must be regulated separately from supplements to TRICARE and CHAMPUS plans. OSI Staff responds that Mr. Seaton's reasoning is incorrect and that there is no need to exempt supplemental plans from Insurance Code section he cites because the Insurance Code describes major medical coverage and not supplement coverage. Staff also rejects Mr. Seaton's contention that community rating provision of the Insurance Code are applicable to supplemental coverage and recommends there be no changes to Subsection 15(A). No other parties submitted comments or responses on this subsection. The Hearing Officer agrees with the analysis of OSI Staff and recommends no changes be made to this subsection.

80. American Fidelity expresses concern with the requirement in proposed 13.10.34.15(F) that a supplemental plan "not contain an exclusion that does not appear in the covered person's group major medical plan." American Fidelity asserts that it would have no way of knowing what exclusions a potential customer's major medical plan contained. OSI Staff responds to this concern by recommending the proposed subsection be amended to read: "**Exclusions**. A supplemental plan shall include a provision that guarantees the plan will not impose an exclusion that does not appear in the covered person's group major medical plan." The Hearing Officer finds that alternative language suggested by OSI Staff fairly and adequately addresses the legitimate concern expressed by American Fidelity without lessening the consumer protections contained in the proposed 13.10.34.15(F). OSI Staff's recommended amendment to the proposed 13.10.34.15(F) meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the Hearing Officer recommends it be adopted.

81. ACLI requests clarification of the term "credible data" as used in the last sentence of the proposed 13.10.34.17(B). OSI Staff responds that "it is common practice to rely on other, similar data sources when developing rates for a new product", and rejects the contention that clarification is needed. OSI Staff's response notes that OSI will review the sources utilized by a carrier and "make a determination on the data's credibility on a case-by-case basis." Mr. Seaton's response appears to agree with OSI Staff that no clarification is needed. The Hearing Officer finds that there is no need for clarification of the term "credible data" in the proposed 13.10.34.17(B). However, the Hearing Officer does find that there is an apparent typographical error in the second sentence of this subsection, where the word "resident" should be changed to the plural "residents". The Hearing Officer's recommended correction of a typographical error in the proposed 13.10.34.17(B) meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible.

82. The Hearing Officer notes that there appear to be typographical errors related to formatting in the statement of the formula for the adjustment of loss ratios in the proposed 13.10.34.17(D)(2). Under the formula for "RN", a semi-colon should be added at the end of the line stating "R is the table ratio; a semi-colon should be added after "ratio" in the next line and "I is" should be moved to the beginning of the next line, where a semi-colon should be added after the word "factor", followed by the addition of the word "and" at the end of that line. In the next formula describing the factor "I", "CPI-" should be moved from the end of the first line of the formula to the beginning of the second line. With these corrections, the formula would read as follows:

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

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

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

The Hearing Officer's recommended corrections of typographical errors in the proposed 13.10.34.17(E)(2) meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the corrections should be adopted.

83. The Hearing Officer also notes that there appear to be typographical errors related to formatting in the statement of the formula for the adjustment of loss ratios in the proposed 13.10.34.17(E)(2), identical to those identified above in the proposed 13.10.34.17(D)(2). Under the formula for "RN", a semi-colon should be added at the end of the line stating "R is the table ratio", a semi-colon should be added in the next line after "ratio", and "I is" should be moved to the beginning of the next line, where a semi-colon should be added after the word "factor", followed by the addition of the word "and" at the end of that line. In the next formula describing the factor "I", "CPI-" should be moved from the end of the first line of the formula to the beginning of the second line. With these corrections, the formula would read as follows:

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

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

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

The Hearing Officer's recommended corrections of typographical errors in the proposed 13.10.34.17(D)(2) meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the corrections should be adopted.

84. The Hearing Officer notes that there also appear to be typographical errors related to formatting in the statement of the formula for the adjustment of loss ratios in the proposed 13.10.34.17(D)(2). Under the formula for "RN", a semi-colon should be added at the end of the line stating "R is the table ratio, a semi-colon should be added after "ratio" in the next line, and "I is" should be moved to the beginning of the next line, where a semi-colon should be added after the word "factor", followed by the addition of the word "and" at the end of that line. In the next formula describing the factor "I", "CPI-" should be moved from the end of the first line of the formula to the beginning of the second line. With these corrections, the formula would read as follows:

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

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

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

The Hearing Officer's recommended corrections of typographical errors in the proposed 13.10.34.17(E)(2) meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the corrections should be adopted.

85. Both Principal and Mutual of Omaha submitted late-filed comments on the proposed 13.10.34.17(G), which addresses annual rate certification filing procedures. Mutual of Omaha suggests that the proposed Subsection 17(G)(2) would severely restrict what plan designs could be offered while necessitating a massive amount of work to offer even template plan designs. Mutual of Omaha also requests removing "on a nationwide basis" in the proposed Subsection 17(G)(7). Principal's late-filed comment complain that the requirements for the return of excess premiums in the proposed Subsections 17(G)(9) and (10) are impractical to administer. OSI Staff responds that the proposed Subsection 17(G)(7) allows for brand new products, or products for which there is no New Mexico experience, to be offered. While it does not specifically address the comments regarding Subsection 17(G)(9) and (10), OSI Staff's response notes generally that the language in the proposed Subsection 17(G) is unchanged from the current rule and that staff has observed that carriers have been able to meet the requirements. Staff also assert that these requirements further the policy goals underlying the design of the rule, such as reducing the occurrence of consumers substituting excepted benefit plans for major medical insurance, the overinsurance of excepted benefits, and the phenomenon of consumers who purchase lower levels of benefits and coverage subsidizing consumers who select higher levels of benefits and coverage. The Hearing Officer finds that it is in the best interest of consumers to make no changes to the proposed 13.10.34.17(G).

86. Principal's late-filed comments also contend that there is no practical way to comply with requirements of the proposed 13.10.34.17(I), which specifies that "a carrier shall not offer a plan

subject to these rules to any person unless each possible plan design selectable by that person meets the MLR [minimum loss ratio] requirements as reflected in an approved rate filing." Subsection 17(I) further provides: "The carrier must base MLR calculations on the average premium for each possible combination of benefits and levels offered by demographics used for underwriting." The Hearing Officer finds it significant that no other comments were received expressing this particular concern. While OSI Staff's response does not address this question directly, the Hearing Officer finds Staff's above referenced response to comments regarding the proposed Subsection 17(G), stating that these requirements further the policy goals underlying the design of the rule, persuasive here as well. The Hearing Officer finds that it is in the best interest of consumers to make no changes to the proposed 13.10.34.17(I).

87. ACLI recommends that the proposed 13.10.34.17(J) be deleted because it would not allow premium increases to account for age changes or addition of covered persons under most plans for three years. OSI Staff responds that this subsection is indeed intended to prevent carriers from increasing premiums during the first three years of coverage for persons covered under subject plans other than disability income plans, even if the covered person or persons age into another age grouping. However, OSI Staff agrees that it is reasonable to allow premium increases where additional covered lives are added to an existing policy within the first three years of coverage. Accordingly, OSI Staff recommends the addition of new language after the word "force" so that the proposed 13.10.34.17(J) now read:

> **J. Premium Increases.** A carrier shall not increase a covered person's premium under any plan, other than a disability income plan, during the first three years that the covered person's coverage is in force except in cases where an additional covered person(s) is added to the policy during this three year period. The new

premium resulting from the addition of a covered person(s) shall not change for the first three years the policy with the added lives is in force.

The Hearing Officer finds that OSI Staff's recommended amendment reasonably addresses the commentator's concerns about the impact of the addition of a covered person or persons under a plan but concludes it does not adequately address concerns expressed about increased age and other factors that can impact rates. The Hearing Officer recommends shortening the period during which premiums, other than for disability income plans, cannot be increased from three years to two years. Accordingly, the Hearing Officer recommends that the proposed 13.10.34.17(J) be amended to read:

> **J. Premium Increases.** A carrier shall not increase a covered person's premium under any plan, other than a disability income plan, during the first two years that the covered person's coverage is in force except in cases where one or more persons are added to the policy as covered persons during this two year period. The new premium resulting from the addition of a covered person(s) shall not change for the first two years the policy with the added lives is in force.

The recommended amendments to the proposed 13.10.34.17(J) meet the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the corrections should be adopted.

88. ACLI requests that the last sentence of the proposed 13.10.34.18(K) be deleted on the ground that it is unfair. This sentence would hold the carrier responsible for the failure of a master group policyholder to deliver plan documents to the prospective insured. OSI Staff responds that a carrier should not be held responsible for the failure of a master group policyholder to deliver health plan documents as required in this subsection, but suggests a better approach is to amend

the subsection to require the group master policyholder to attest to the carrier that the plan documents were delivered. Accordingly, OSI Staff recommends adding the following language at the end of Subsection 18(K):

> In the case where the group master policyholder delivers the plan documents to the prospective policyholders, the carrier shall require the group master policyholder to attest to the compliance with the requirements of this section and to provide documents that clearly support the attestation. The carrier shall not bind coverage until it has received the master policyholder's attestation.

The Hearing Officer finds that the addition of OSI Staff's recommended language would adequately and reasonably address ACLI's concern without undermining the clear intent of the rule that prospective insureds receive and have a reasonable opportunity to review plan documents. OSI Staff's recommended amendments to the proposed 13.10.34.18(K) meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible, and the Hearing Officer recommends they be adopted.

89. Mr. Seaton notes in his comments that the second reference to "Subsection C" in the proposed 13.10.34.19(B) should be to "Subsection D". In its response, OSI Staff agrees. The Hearing Officer also agrees and recommends that this apparent typographical error be corrected by replacing "C" with "D" in the second sentence of Subsection 19(B) following the word "Subsection". This change was suggested by Mr. Seaton during the comment period and the ten day response period was provided. The Hearing Officer finds that the subject matter of this suggested amendment is that same as that in the published proposed rule. Accordingly, the proposed amendment may be adopted, and the Hearing Officer recommends that it be adopted.

90. ACLI expresses serious concern about the proposed 13.10.34.20(B), which it interprets as requiring a carrier to provide notice to prospective insureds that they are not permitted to purchase more than one supplemental benefits product from each carrier. HBI and Securian express similar concerns with this subsection. Mr. Seaton appears to take the position that this subsection should clearly state a carrier cannot sell more than one excepted benefit plan of the same type to consumer. ACLI, HBI and Securian all assert that these products offer valuable financial protections that consumers should be able to purchase without the limitation imposed by Subsection 20(B). OSI Staff responds that that it was not the intent of this subsection to limit the number of different excepted benefit product types a carrier can sell to a consumer. OSI Staff asserts that the intent is to avoid misleading consumers by limiting the number of product types that can be sold to a consumer "on a single application". In order to clarify this intent, OSI Staff recommends adding the words "using the same application" at the end of the second sentence, to be followed immediately by the new sentence: "This provision does not preclude the same carrier from selling more than one product type to a single purchaser as long as each policy is available at its own stated premium rate, independent of the other product types."

91. The Hearing Officer finds that in its present form the proposed subsection is potentially confusing. The Hearing Officer also finds that that the amendments proposed by OSI Staff clarifies the intent of the subsection and in so doing address the concerns of the commentators. These amendments meet the "logical outgrowth" test because interested parties should have anticipated that the chance was possible. The Hearing Officer finds that OSI Staff's proposed amendments can be adopted and recommends that they be adopted, with the proposed 13.10.34.20(B) to now read:

B. No bundling. No carrier, directly or through an affiliated producer, shall market or sell a bundled combination of accident-only, specified disease, hospital indemnity and non-subject worker plans. An application that is used in connection with more than one type of plan subject to this rule shall include a conspicuous notice that the applicant cannot purchase more than one type of plan from the carrier using the same application. This provision does not preclude the same carrier from selling more than one product type to a single purchaser as long as each policy is available at its own stated premium rate, independent of the other product types. A carrier shall not offer or provide memberships or discounts relating to health care services or products. The provisions of this subsection shall not apply to a plan sold through a group identified in Paragraphs (1) or (3) of Subsection A of 59A-23-3 NMSA 1978, or to a bona fide association.

92. To the extent that the Administrative Law Division may require formatting of the final rules different from originally proposed, the Hearing Officer recommends following those formatting requirements.

CONCLUSIONS:

A. The Superintendent has jurisdiction over the subject matter and the parties.

B. OSI caused the NOPR to be published on November 30, 2021 in the New Mexico Register and in a newspaper of general circulation in compliance with NMSA 1978, Section 14-4-5.2.

C. The NOPR provided interested persons and the public appropriate notice of the hearing and the opportunity to offer oral and written comments.

D. The Hearing Officer has considered all oral and written comments.

E. The current 13.10.34 NMAC should be repealed.

F. The proposed replacement rule, with changes set forth above, should be adopted.

WHEREFORE, in light of the findings and conclusions above, the Hearing Officer **RECOMMENDS** that the Superintendent should sign an Order repealing the current 13.10.34 NMAC and adopting as its replacement the proposed new 13.10.34 attached hereto as Exhibit A.

The Hearing Officer also **RECOMMENDS** that a copy of this Hearing Officer's Findings, Conclusions, and Recommendation, with its attachment, be sent to all interested persons.

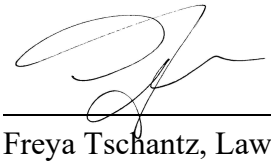
ISSUED at Santa Fe, New Mexico this 7th day of July, 2022.

OFFICE OF SUPERINTENDENT OF INSURANCE

Richard B. Word, Hearing Officer

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 7th day of July 2022, I filed the foregoing *Hearing Officer's Findings, Conclusions, and Recommended Decision* through the OSI eDocket filing system, which caused the parties to be served by electronic means, as more fully reflected on the eService recipients list for this case.



Freya Tschantz, Law Clerk
Office of Legal Counsel
Office of Superintendent of insurance

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 34 STANDARDS FOR ACCIDENT-ONLY, SPECIFIED DISEASE, HOSPITAL INDEMNITY, DISABILITY INCOME, SUPPLEMENTAL, AND NON-SUBJECT WORKER EXCEPTED BENEFITS

13.10.34.1 ISSUING AGENCY: New Mexico Office of Superintendent of Insurance ("OSI").
[13.10.34.1 NMAC - Rp, 13.10.34.1 NMAC, 03/01/2022]

13.10.34.2 SCOPE: This section identifies the excepted benefits and excepted benefits products that are subject to thisese rules, and applicablecility exceptions.

A. Subject products. Thisese rules applies to these excepted benefits products:

(1) accident only;

(2) specified disease or illness;

(3) hospital indemnity;

(4) other fixed indemnity;

(5) disability income;

(6) supplemental; and

(7) insurance similar to workers' compensation (non-subject worker).

B. Extraterritorial plans. Thisese rules applies to every subject individual, group and blanket contract of insurance, including any certificate, delivered in this state, and to any subject contract issued to a group located outside of this state, if any covered person resides in this state, except:

(1) a group plan, and certificates of insurance relating to that plan, issued to an out-of-state employer that employs 100 orwith fewer than 201 New Mexico residents at any time during the calendar yearenrolled in the plan; or

(2) a group or blanket plan issued to an out-of-state entity that resides in a state whose laws offer protections that, in the discretion of the superintendent, are equivalent to or more protective than New Mexico law.

C. Grandfathered plans. Thisese rules does not apply to:

(1) An individual or blanket plan issued prior to the effective date of these rules if:

(a) the plan is guaranteed renewable, non-cancellable, or guaranteed renewable through a specified age, or conditionally renewable in the case of disability income plans;

(b) the plan is continually in force without any lapse; and

(c) there are no material changes in the substantive provisions of the plan after the effective date of thisese rules. An annual rate change that does not exceed ten percent is not considered a material change in the substantive provisions of a grandfathered plan unless the plan was issued with a guaranteed rate.

(2) An employer group, labor union, credit union, or bona fide association, as defined at NMSA 1978, §59A-23G-2(A), if:

(a) the carrier began offering the plan through the employer, labor union, credit union, or association prior to the effective date of thisese rules;

(b) the plan is continually in force without any lapse;

(c) eligibility for the plan is limited to employees, labor union, credit union, or association members and their dependents;

(d) there are no material changes in the substantive provisions of the plan after the effective date of thisese rules. An annual rate change that does not exceed ten percent is not considered a material change in the substantive provisions of a grandfathered plan unless the plan was issued with a guaranteed rate. Incremental changes in fixed dollar coverage amounts or benefit limitations consistent with inflation, and changes in plan enrollment of employees and their dependents (whether newly hired or newly enrolled) are also not considered a material change.

D. Self-funded plans. Thisese rules does not apply to a self-funded employer plan.
[13.10.34.2 NMAC - Rp, 13.10.34.2 NMAC, 03/01/2022]

13.10.34.3 STATUTORY AUTHORITY: Sections 59A-18, 59A-16 and 59A-23G-3 NMSA 1978.
[13.10.34.3 NMAC - Rp, 13.10.34.3 NMAC, 03/01/2022]

13.10.34.4 DURATION: Permanent.

[13.10.34.4 NMAC – Rp, 13.10.34.4 NMAC, 03/01/2022]

13.10.34.5 EFFECTIVE DATE: AprilJanuary 1, 2023, unless a later date is cited at the end of a section.
[13.10.34.5 NMAC - Rp, 13.10.34.5 NMAC, 03/01/2022]

13.10.34.6 OBJECTIVE: The purpose of thisese rules is to establish regulatory requirements for the subject excepted benefit plans. The rules will standardize and simplify the terms and coverages; facilitate public understanding and comparison of coverage; eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims and require disclosures in the marketing and sale of subject excepted benefit plans.
[13.10.34.6 NMAC - Rp, 13.10.34.6 NMAC, 03/01/2022]

13.10.34.7 DEFINITIONS: For definitions of terms contained in thisese rules, refer to 13.10.29 NMAC, unless otherwise noted below.

A. "Accident only plan" means an insurance agreement that conditions a fixed indemnity benefit on the occurrence of an injurious accident.

B. "Certificate" means a document that extends coverage under a group plan to a group member.

C. "Direct response insurer" means a carrier who does not sell its insurance products through producers.

D. "Disability income plan" means an insurance agreement that provides income protection benefits during a period of disability resulting from either sickness, pregnancy, injury or a combination of these.

E. "Domestic co-insured" means a spouse or domestic partner insured under the same plan or certificate.

F. "Hospital indemnity plan" means an insurance agreement that conditions a fixed indemnity benefit on the hospitalization, hospital-based treatment or hospice care of a covered person.

G. "Occupational accident plan" means an accident-only plan that pays a fixed indemnity benefit for injury that results from an occupational accident involving a covered subject worker.

H. "Other fixed indemnity" means a fixed cash benefit payable to a covered person on the occurrence of an event, circumstance or condition, other than or in addition to accident, injury, illness or disability.

I. "Plan" means any individual, group or blanket insurance subject to thisese rules provided through a standalone policy, certificate, contract or rider.

J. "Non-contributory" means that a covered person pays no premium, membership fee or dues to qualify for coverage or benefits under the plan.

KJ. "Non-subject worker plan" means an insurance agreement that provides benefits similar to workers' compensation benefits to a self-employed non-subject worker.

LK. "Specified disease plan" means an insurance agreement that conditions a fixed indemnity benefit on the occurrence or diagnosis of a specific disease or illness that is either life-threatening or likely to cause a covered person to incur significant financial obligations.

ML. "Supplemental plan" means an insurance agreement that provides benefits that supplement coverage under a group major medical, TRICARE or Champus plan.
[13.10.34.7 NMAC - Rp, 13.10.34.7 NMAC, 03/01/2022]

13.10.34.8 GENERALLY APPLICABLE PROVISIONS: A plan subject to thisese rules shall comply with these provisions:

A. Probationary periods. A plan shall not include a probationary or waiting period during which no coverage is provided for a covered benefit after the coverage effective date. A probationary period does not include an eligibility-waiting period during which no premium is paid, or an elimination period for a disability income plan.

B. Riders and other supplements. A rider, amendment, endorsement or other supplement shall explicitly state which benefits the carrier has amended or supplemented from the original plan.

C. Preexisting conditions. An individual plan, or plan sold through an association or group described in Paragraph (2) or (4) of Subsection A of Section 59A-23-3 NMSA 1978, shall not exclude coverage for a loss due to a preexisting condition unless the application or enrollment form includes a conspicuous notice about the scope and applicability of any such exclusion that will apply in the coverage, and that notice also appears in the plan document issued to the covered person at the start of the free look period.

D. Return of premium. A plan may include a return of premium or cash value benefit if authorized by the superintendent following an evaluation of the potential impact on the carrier's reserves and ability to service

policy obligations. Nothing in thisese rules requires a carrier to seek authorization from the superintendent to return premiums unearned through termination or suspension of coverage, retroactive waiver of premium paid during a medical condition, payment of dividends on participating policies, or experience rating refunds.

E. Exclusions. A plan shall not exclude any type, circumstance or cause of loss that would not otherwise be covered, and the plan exclusions shall not, individually or collectively, unreasonably or deceptively alter the scope of coverage. Subject to the foregoing, a plan may exclude coverage for the following conditions, circumstances and causes of loss:

(1) preexisting conditions;

(2) loss resulting from or contributed to by:

(a) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary to it;

(b) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury within two years of the effective date of coverage;

(c) aviation, other than travel as a fare paying passenger on a commercial carrier; or

(d) incarceration or detention due to illegal activity.

(3) loss for which benefits are provided under Medicare or other governmental program (except Medicaid), a state or federal workers' compensation program, employers liability or occupational disease law, or motor vehicle no-fault law;

(4) participation in an illegal activity;

(5) voluntary intoxication by any legal or illegal drug, including alcohol;

(6) specifically named high-risk physical activities;

(7) international territorial limitations;

(8) occupational injury or disease;

(9) normal pregnancy or childbirth;

(10) foreign travel or residency; or

(11) any other type, circumstance or cause of loss if the carrier satisfies the superintendent that the exclusion promotes a legitimate underwriting or public policy objective or is required to comply with any state or federal law.

F. Contracted providers. A plan shall not condition a benefit or offer an enhanced benefit based on receipt of health care from any specific provider, provider network or facility, or based on the care methodology. A carrier shall not refer to a network or provider arrangement in any plan document or advertisement.

G. Marketing of blanket or group coverages. A carrier shall not sell any blanket coverage ~~to a group~~ that is not described in Section 59A-23-2 NMSA 1978 or group coverage that is not identified or described in Section 59A-23-3 NMSA 1978.

H. Arbitration provisions. A plan shall not require a covered person or master policyholder to submit a dispute arising out of or relating to the plan to mediation or arbitration. A covered person or master policyholder may agree to participate in voluntary mediation or arbitration after the submission of a claim for benefits, or after a dispute arises.

I. Legal compliance. A covered person's rights under any plan shall be governed by the terms of the plan approved by the superintendent, and by applicable state and federal law. Thisese rules does not limit the superintendent's authority to approve or disapprove a plan or plan provision as authorized by any other state or federal law.

J. Telemedicine services. A plan that provides a benefit conditioned on a covered person's receipt of a health care service shall provide that benefit if the service is delivered in-person or virtually. No plan may offer a telemedicine only benefit.

K. Discrimination. No carrier or plan shall discriminate in eligibility for coverage or benefits on the basis of sex, sexual orientation, gender, gender identity, race, religion, or national origin. A plan may differentiate on the basis of age in rating and age limits on coverage.

L. Insurance cards. A carrier shall not issue an insurance card or similar proof of coverage to a covered person.

M. Direct reimbursement. A carrier shall pay fixed indemnity benefits directly to a covered person unless the covered person assigns benefits after a covered loss occurs. A coercive assignment is unenforceable.

N. Inducements. Except as authorized by Section 59A-16-17 NMSA 1978, and these rules, a carrier shall not offer or provide monetary or other valuable consideration, engage in misleading or deceptive practices or make untrue, misleading, or deceptive representations in any plan document, advertising or sales presentation to induce enrollment.

O. Military service exclusion or suspension. If a plan contains a military service exclusion or a provision that suspends coverage during military service, the plan shall refund unearned premiums upon receipt of a written request for refund, or upon learning that a covered person has entered military service.

P. Individual noncancellable and guaranteed renewable policies. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual plan shall not provide for termination of coverage of the domestic co-insured solely because of the occurrence of an event specified for termination of coverage of the covered person, other than nonpayment of premium. In addition, the plan shall provide that in the event of the covered person's death, the domestic co-insured of the covered person, if covered under the plan, shall become the policyholder.

(1) The terms "noncancellable" or "noncancellable and guaranteed renewable" may only be used in an individual excepted benefit plan if the covered person has the right to continue the coverage by timely paying premiums, until the age of 65 or until eligibility for Medicare, during which time the carrier has no unilateral right to change any provision of the plan.

(2) The term "guaranteed renewable" may only be used in a plan where the covered person has the right to continue in force, by timely paying premiums, until the age of 65 or until eligibility for Medicare, during which period the carrier has no unilateral right to change any provision of the plan, other than changes in premium rates by classes.

(3) In an individual plan covering domestic co-insureds, the age of the younger of the two shall be used as the basis for meeting the age and durational requirements of the definitions of "non-cancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older of the two upon attainment of the stated age, so long as the plan may be continued in force as to the younger of the two to the age or for the durational period as specified in the plan.

Q. Dependent child. An individual excepted benefit plan's coverage for a child who is incapable of self-sustaining employment on the date the child would otherwise age out of coverage shall continue if the child depends on the covered person for support and maintenance. The plan may require that within 31 days of the date the company receives proof of the child's incapacity, the covered person may elect to continue the plan in force with respect to the child or insure the child under an approved conversion plan.

R. Continuous loss. A carrier shall not terminate a plan, except for non-payment of premium, during a period of continuous loss that commences during the period of coverage unless expressly limited by the duration of the benefit period, if any, or any maximum benefit limit.

S. Waivers. Where a waiver is required as a condition of plan issuance, renewal or reinstatement, a signed acceptance by the covered person is required. A waiver shall be limited to a specifically named or described disease, physical condition or activity.

T. Termination of coverage. A carrier may terminate a plan only for a reason specified in the agreement delivered to the covered person. A plan may authorize termination for:

(1) failure of the covered person or subscriber to pay the premiums and other applicable charges for coverage;

(2) material breach of a contractual obligation, or a prejudicial failure to satisfy a post-loss condition;

(3) fraud or misrepresentation affecting underwriting;

(4) expiration of term; or

(5) any reason that the superintendent determines is not substantively or procedurally unconscionable.

U. Notice required upon termination of coverage for individual plans. A carrier shall not terminate a plan unless it provides written notice to a covered person 30 days prior to the intended termination date. Notice of termination shall:

(1) be in writing and dated;

(2) state the reason for termination, with specific references to the clauses of the plan that justify the termination;

(3) state that a covered person's plan cannot be terminated because of health status, need for services, race, religion, national origin, gender, gender identity, age (except where allowed by law or rule), or sexual orientation of covered persons under the contract;

(4) state that a covered person who alleges that an enrollment has been terminated or not renewed because of the covered person's health status, need for health care services, race, religion, national origin, gender, gender identity, age or sexual orientation may file a complaint with the superintendent of insurance at www.osi.state.nm.us or 1-855-427-5674; and

(5) state that in the event of termination by either the covered person or the carrier, except in the case of fraud or deception, the carrier shall, within 30 calendar days, return to the covered person or subscriber the portion of the money paid to the carrier that corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any.

V. Notice required upon termination of coverage for group plans. A group plan shall specify that either the carrier or the group master policyholder shall provide notice to the party responsible for providing notice to each group certificate holder of any plan expiration, lapse or termination at least 30 days in advance. Except where the group policyholder or the~~an~~ employer is replacing a group plan with another carrier's plan, a carrier shall not terminate a group plan unless it provides written notice to the party responsible for providing notice to each certificate holder 30 days prior to the certificate holder's intended termination date. The party responsible for providing notice to each certificate holder shall attest that notice was provided 30 days prior to the intended termination date. Notice of termination shall:

(1) be in writing and dated;

(2) state the reason(s) for termination, with specific references to the clauses of the plan that justify the termination; and

(3) state that in the event of termination by either the group policyholder or the carrier, except in the case of fraud or deception, the carrier shall, within 30 calendar days, return to the group policyholder the money paid to the carrier that corresponds to any unexpired period for which payment had been received.

W. Claim form. If a carrier requires submission of a claim form as a condition of payment, the carrier, upon receipt of notice of a claim, shall deliver the form to the covered person. If a carrier does not deliver a claim form within 15 days after notice of a claim, the claimant shall be deemed to have complied with any proof of loss requirement if a written notice of claim contains sufficient detail to determine that a covered loss occurred.

X. Grace periods. A carrier shall grant a premium payment grace period of at least 10 days for a monthly premium plan and at least 31 days for a plan billed less frequently.

Y. Variability. A carrier who offers an individual plan with variable benefit types and levels shall submit for approval the~~an~~ outline of coverage and benefits that illustrates the~~final~~ plan design that would be available to a prospective covered person. A carrier who offers coverage to eligible covered persons under a group plan shall submit for approval an outline of coverage or certificate that corresponds with the plan design ultimately offered to those covered persons. A carrier shall comply with the variability guidance posted on the OSI website, including mapping requirements. Each distinct outline of coverage, or certificate shall be subject to a filing fee as specified in statute.

Z. Treatment trigger. Except as expressly authorized in this~~ese~~ rule~~s~~, no accident only or specified disease plan shall condition a benefit on a covered person's receipt of health care or offer a fee for service benefit.

AA. Portability. A portability or continuation provision in an employer group plan shall not allow a person whose group eligibility ends to continue group coverage for more than nine months. A portability or continuation provision in any other type of group plan shall not allow a covered person to continue coverage for more than three months. In the event of the death of a covered group member, coverage for a domestic co-insured of the decedent insured may continue for two years, until one-year after any minor dependent insured obtains the age of majority, and for one-year after circumstances creating dependency end for any other dependent insured.

BB. Subrogation. A carrier who offers or pays a fixed indemnity benefit shall not claim, assert or pursue subrogation.

CC. Benefit minimums. The superintendent may, after conducting a public hearing, issue an order mandating, or reducing mandated, benefit minimums for any type of subject plan. A non-contributory plan is not subject to any benefit minimum mandated by this~~ese~~ rule~~s~~. Benefit minimums are not applicable to the non-contributory portion of a plan that has both contributory and non-contributory portions.

DD. Value added product or service. A carrier shall not provide or offer a value added product or service in connection with a subject plan if any part of the cost of providing the product or service is included in the plan rates. A carrier who proposes to offer a value added product or service must provide actuarial certification of compliance with this rule.

[13.10.34.8 NMAC - Rp, 13.10.34.8 NMAC, 03/01/2022]

13.10.34.9 ADDITIONAL REQUIREMENTS~~ULES~~ FOR DISABILITY INCOME PLANS: A disability income plan is subject to these additional requirements~~ules~~:

A. Benefit reduction. A disability income plan may provide that benefits shall decrease by up to fifty percent if the covered person is or attains the age of 62 during the period of disability.

B. Disability limitation. A disability income plan shall only provide benefits for disability resulting from injury, sickness, pregnancy or combination of these causes.

C. Partial disability. A disability income plan shall consider an individual to be partially disabled if the individual:

(1) is unable to perform one or more but not all of the substantial and material ~~"major," "important," or "essential"~~ duties or words of similar import, of the individual's employment or existing occupation or work a specified percentage of time, or a specified number of hours, or earn a specified amount of compensation; and

(2) remains engaged in work for wage or profit.

D. Residual disability. A disability income plan shall consider "residual disability" in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation or to the inability to perform all usual business duties for as long as is usually required. A disability income plan that provides for residual disability benefits may require a qualification period, during which the covered person must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," a disability income plan may use "proportionate disability" or other term of similar import that, in the opinion of the superintendent, adequately and fairly describes the benefit.

E. Total disability. A disability income plan shall not define "total disability" more restrictively than a definition requiring that an individual who is totally disabled not be able to perform the duties of any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience; and is not, in fact, engaged in any employment or occupation for wage or profit.

(1) Total disability may be defined in relation to the inability of the insured to perform duties, and may include a reduction in earnings requirement, but may not be based solely on an insured's inability to:

(a) Perform any occupation whatsoever, any occupational duty, or any and every duty of his or her occupation; or

(b) Engage in a training or rehabilitation program.

(2) A disability income plan may require the covered person to have complete inability to perform all of the substantial and material duties of his or her regular occupation, or words of similar import.

(3) If the covered person is not employed at the onset of disability, a disability income plan shall not define total disability more restrictively than the inability to perform three or more activities of daily living, as certified by a physician.

(4) A carrier may require proof of disability or care to be provided by a physician other than the insured of a member of the insured's immediate family.

F. Independent examination. A carrier may require a covered person to undergo an independent examination to evaluate disability as often as reasonably necessary.

G. Elimination period. A disability income plan shall not include an elimination period greater than 30 days in the case of coverage providing a benefit duration of one year or less; 60 days in the case of coverage providing a benefit duration of greater than one year and no more than two years ~~or less~~; 90 days in the case of coverage providing a benefit duration of greater than two years and no more than thre~~e~~five years ~~or less~~; 180 days in the case of coverage providing a benefit duration of greater than three years and no more than five years; or ~~or~~ 365 days in all other cases. For purposes of this provision, the benefit duration shall disregard reduced benefit durations based on age. If a plan provides both full and partial disability, only one elimination period is allowed. The requirements of this section do not apply to a short term disability plan.

H. Minimum benefit period. After the elimination period, a disability income plan shall not have a benefit duration of less than three months, or until the disability ends, whichever is less.

I. Recurrent disabilities. Unless a disability income plan provides for a benefit payable to a certain age limit, a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six months.

[13.10.34.9 NMAC - Rp, 13.10.34.9 NMAC, 03/01/2022]

13.10.34.10 ADDITIONAL REQUIREMENTS~~ULES~~ FOR ACCIDENT-ONLY PLANS: An accident-only plan is subject to these additional requirements~~ules~~.

A. Plan definitions. An accident-only plan:

(1) shall not define "accident" more narrowly than an injurious event during the coverage period that was unexpected and unintended from the standpoint of the covered person.

(2) shall not define "injury" more narrowly than physical or mental harm that results from an accident, no matter the degree of harm or when it manifests.

B. Coverage requirements. An accidental death benefit in an accident-only plan shall be no less than $5,000 for a named covered person and any domestic co-insured. Dependent coverage for accidental death shall be no less than $2,500 for each dependent. The death benefit amount may vary for each specifically identified life insured under the policy or certificate. A dismemberment benefit shall be at least $2,500 for loss of an arm or leg. The benefit amount for partial dismemberment and loss of a non-limb body part shall be no less than $250 for each covered loss.

C. Basis of compensation. An accident-only plan shall only compensate for losses on a fixed-indemnity basis.

D. Specified accident. Specified accident insurance coverage shall only be sold as blanket coverage pursuant to Section 59A-23-2 NMSA 1978, or as nonrenewable individual coverage with a term not to exceed 30 days. Specified accident coverage shall only be offered in a designated specified accident plan.

E. Occupational accident plan. An occupational accident plan:

(1) shall only be issued to an individual or group member who is a worker engaged in employment subject to New Mexico workers' compensation law protections.

(2) shall only pay benefits conditioned on the covered person sustaining a work-related injury.

(3) shall not coordinate with workers' compensation benefits.

(4) shall include this notice, displayed on a cover page or on the first page of the plan in bold 14-point type:

YOUR PURCHASE OF THIS PLAN DOES NOT RELEASE YOUR EMPLOYER FROM ANY LEGAL DUTY TO PROVIDE WORKERS' COMPENSATION COVERAGE. TO LEARN MORE ABOUT YOUR RIGHTS TO WORKERS' COMPENSATION COVERAGE PLEASE CONTACT:

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION
2410 CENTRE AVE SE
ALBUQUERQUE, NM 87106
505-841-6000
www.workerscomp.nm.gov

THIS PLAN ONLY PROVIDES BENEFITS IF YOU ARE INJURED WHILE ENGAGED IN EMPLOYMENT SUBJECT TO NEW MEXICO WORKERS' COMPENSATION LAWS. IF YOU ARE NOT ENGAGED IN SUCH EMPLOYMENT OR CEASE TO BE ENGAGED IN SUCH EMPLOYMENT, CONTACT US AT [INSERT NUMBER] AND WE WILL CANCEL THIS PLAN AND REFUND ANY UNEARNED PREMIUM.

(5) shall not reduce or eliminate any benefit because a covered person receives, or is entitled to receive, workers' compensation benefits.

(6) shall not exclude activities or accidents inherent to the covered person's occupation.

(7) shall not require a covered person to waive rights to workers' compensation coverage or benefits.

(8) shall be cancellable at any time.

(9) shall not be conditioned on a covered person receiving workers' compensation benefits.

(10) shall provide benefits for any injury that results during a covered person's work hours at the covered person's work location, subject to any authorized exclusion and to the going-and-coming rule. An injury to a traveling worker shall be covered if the injury results while the worker is traveling for the employer and is being compensated for the travel.

F. Sickness benefit. An accident-only plan shall not offer a benefit for any sickness or disease that is not caused by a covered accident. Sickness or disease benefits shall be limited to illness that arises within 90 days of the accident. Sickness benefits may include coverage for mental health care or nervous disorders that result from an accident.

G. Other Fixed Indemnity Benefits: An accident-only plan may offer other fixed indemnity benefits in compliance with Section 13.10.34.12.

H. Income replacement benefit. An accident-only plan may offer income replacement benefits only for disability resulting from a covered accident.

IH. Accidental cause variation. An accident only plan that provides benefits, or benefit amounts, that vary depending on the accident cause, place, time or manner shall prominently set forth in the outline of coverage the circumstances under which different benefits or amounts are payable. A plan that includes accidental cause variation may be deemed a specified accident plan subject to the specified accident provisions of thisese rules.

JI. Exclusion consistency. A carrier shall not suggest or imply that an accident only plan applies to injury that results from an excluded activity.

KJ. Death and dismemberment. An accident-only plan may offer a death and dismemberment benefit. When accidental death and dismemberment coverage is part of an individual plan, the covered person shall have the option to include all covered persons under the coverage and not just the principal covered person.

LK. Delayed loss. Accident-only benefits shall be payable if a covered loss was caused by a covered accident during the period of coverage even if the loss first manifests after the period of coverage, provided notice of loss is provided within five years of the covered accident

ML. Fractures or dislocations. A plan that provides coverage for fractures or dislocations shall provide benefits for full and partial fractures or dislocations.

[13.10.34.10 NMAC - Rp, 13.10.34.10 NMAC, 03/01/2022]

13.10.34.11 ADDITIONAL REQUIREMENTSULES FOR HOSPITAL INDEMNITY PLANS: A hospital indemnity plan is subject to these additional requirementules.

A. Benefit minimum. A hospital indemnity plan shall pay a minimum lump-sum of no less than $21,500 upon initial confinement. A plan may offer additional lump-sum or daily benefits for additional periods of confinement as defined by the plan, subject to the provisions contained in thisese rules.

B. Continuous hospital confinement. A hospital indemnity plan shall treat consecutive days of in-hospital service received as an inpatient, and successive inpatient confinement for treatment of the same condition within 30 days of prior discharge, as a single period of confinement. A carrier shall not combine confinements that result from medically distinct causes. A plan may exclude benefits for any calendar day period of confinement that does not result in billed charges by a hospital.

C. Basis of compensation. A hospital indemnity plan shall provide benefits only on a fixed indemnity basis.

D. Hospital indemnity benefit limitations. A hospital indemnity plan shall only offer benefits conditioned on a covered person being hospitalized, or receiving hospice, convalescent or extended care, hospital-treatment related ambulatory surgical center services, ambulance service to or from a covered confinement, hospital-affiliated outpatient services, anesthesia, surgery, emergency care leading to a hospital, convalescent or hospice confinement, lost wages during a period of hospital confinement, or expenses to travel to or from a hospital confinement. These benefits shall not be offered as a separate rider.

E. Confinement defined. A hospital indemnity plan shall define "confinement" as any consecutive 24-hour period during which medical observation or services are provided on a continuous basis in a licensed medical facility, each immediately successive such period, and any period of time less than 24-hours on the date of discharge from any such confinement. Confinement includes a stay in an ambulatory surgical facility for less than a 24 hour period.

F. Convalescent or extended care. A plan that provides a benefit conditioned on a covered person receiving convalescent or extended care following hospitalization shall provide such benefits if the admission to the convalescent or extended care facility is within 14-days after discharge from the hospital.

[13.10.34.11 NMAC - Rp, 13.10.34.11 NMAC, 03/01/2022]

13.10.34.12 OTHER FIXED INDEMNITY: Other fixed indemnity benefits are subject to these additional requirementsules.

A. Benefits. An other fixed indemnity benefit shall be no less than $50 per triggering event, circumstance or condition. The aggregate amount of all other fixed indemnity benefits offered shall not exceed $510,000.

B. Limitations. A carrier shall not offer or sell a person a plan, or combination of plans, that provide more than ten other fixed indemnity benefits. A carrier shall not sell a plan that includes other fixed indemnity benefits if that would result in the customer having coverage for more than ten other fixed indemnity benefits under one or more plans. An application for a plan that offers other fixed indemnity benefits shall inquire whether a prospective insured has other excepted benefits coverage, and about the number and type of other fixed indemnity

benefits covered by a prospective insured's other coverage, if any. A carrier that offers more than five other fixed indemnity benefits must do so in a manner which is not ambiguous, deceptive, or misleading, or which suggests that the package of fixed indemnity benefits is a substitute for or constitutes major medical insurance.

C. Other fixed indemnity benefit types. Unless otherwise limited by thisese rules, the other fixed indemnity benefits shall be limited to hospitalization, outpatient services, ambulance and other transportation services, behavioral health services, laboratory and imaging services, in-home care, durable medical equipment, home, work or vehicle modifications to accommodate disability, therapy services, treatment-related lost wages, health care related lodging, pet care and daycare services, or cosmetic services relating to a covered accident or illness. Other fixed indemnity benefits may be offered as a stand-alone policy or certificate of insurance or as a rider to an excepted benefit subject plan. A stand-alone other fixed indemnity plan shall include all notices required by thisese rules at an appropriate reading level which is understandable to a prospective insured.

D. Treatment trigger. Other fixed indemnity benefits may be conditioned upon a covered person receiving medical care given in a medically appropriate location. A carrier shall not condition payment for any such benefit on prior approval of treatment or on medical necessity.

[13.10.34.12 NMAC - Rp, 13.10.34.12 NMAC, 03/01/2022]

13.10.34.13 ADDITIONAL REQUIREMENTSULES FOR SPECIFIED DISEASE PLANS: A specified disease plan is subject to these additional requiremntsules.

A. General requirementsules.

(1) A plan covering a single specified disease or combination of specified diseases shall not be sold or offered for sale other than as a specified disease plan.

(2) A specified disease plan that conditions payment upon a pathological diagnosis shall also provide that if the pathological diagnosis is not medically feasible, a clinical diagnosis will be accepted.

(3) A specified disease plan shall pay a lump-sum upon medical diagnosis of the specified disease, or for any form or variation of a specified disease that is covered by the plan.

(4) An individual specified disease plan shall be guaranteed renewable.

(5) A specified disease plan shall not be sold to a person covered by any Title XIX program (Medicaid, Centennial Care or any similar name). An individual specified disease plan shall contain a statement above the signature line of an individual applicant or covered person attesting that the person seeking to be covered for a specified disease is not covered by Medicaid. The statement may not be combined with any other statement for which the carrier may require the applicant or covered person's signature. For group plans, the carrier shall provide a notice in any enrollment materials of the above prohibition of sale of a specified disease plan to persons covered by Title XIX programs.

(6) Any benefit that is conditioned on repeated care for a specified disease shall begin with the first day of care even if the diagnosis is made at some later date.

(7) A specified disease plan shall provide benefits only on a fixed indemnity basis.

(8) A specified disease plan may offer other fixed indemnity benefits in compliance with 13.10.34.12.

B. Minimum benefits. The following minimum benefits standards apply to all specified disease coverages:

(1) No less than an aggregate amount of $5,000 per triggering diagnosis. The OSI may approve product filings that allow a lower aggregate amount for a variant or subtype of a covered specified disease that requires minimally invasive treatment or are non-life-threatening. OSI may also approve plan designs for more extensive coverage for dependents.

(2) Dollar benefit limits shall be offered for sale only in even increments of $1,000 unless for dependent extended coverage riders, in which case this extended coverage may be offered for sale only in even increments of $500.

(3) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular variant or subtype of the disease, unless lower aggregate amounts have otherwise been approved under Paragraph (1) of this subsection.

C. Reductions in benefits. A specified disease plan shall not eliminate or reduce benefits based on the occurrence of specified events or attaining a certain age.

D. Overinsurance. No carrier or producer shall offer or sell a specified disease plan, or combination of such plans, that apply to more than eight specified diseases. Except for group specified disease plans offered by an employer, nNo carrier or producer shall sell a specified disease plan if that would result in the customer having coverage for more than eight specified diseases under plans issued by different carriers. Except for group specified

disease plans offered by an employer, a specified disease plan application shall inquire whether a prospective insured has other specified disease coverage, and about the number and type of diseases covered by a prospective insured's other coverage, if any. A specified disease plan may provide benefits for all medically diagnosed and commonly recognized forms or variations of each specified disease or illness without having each variation count against the eight disease limit. A carrier shall not sell to an individual a specified disease plan if such coverage would result in the individual being covered by more than one specified disease plan for the same specified disease.
[13.10.34.13 NMAC - Rp, 13.10.34.13 NMAC, 03/01/2022]

13.10.34.14 ADDITIONAL REQUIREMENTS~~ULES~~ FOR HOSPICE CARE BENEFITS~~PLANS~~: A hospital indemnity plan that provides hospice coverage, separately or in conjunction with other hospital indemnity coverage, is subject to these additional requirements~~ules~~.

A. Scope. The hospice benefit shall apply to care received in a facility or through an in-home program, licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(1) for terminally ill patients whose life expectancy is less than six months;

(2) provided on an inpatient or outpatient basis; and

(3) directed by a physician.

B. Benefits trigger. Hospice benefits shall be payable when the attending physician of the covered person provides a written statement that the covered person has a life expectancy of six months or less, and the person is receiving hospice care as described in this~~ese~~ rule~~s~~.

C. Hospice benefit. A hospice care benefit shall be no less than a lump-sum of $2,500.
[13.10.34.14 NMAC - Rp, 13.10.34.14 NMAC, 03/01/2022]

13.10.34.15 SUPPLEMENTAL PLAN: A supplemental plan is subject to these additional requirements~~ules~~.

A. Group coverage limitation. A carrier shall only offer or issue a supplemental plan to a person who is covered under a primary group major medical, TRICARE or Champus plan.

B. Plan design. A supplemental plan must be specifically designed to fill gaps in the primary coverage. This requirement is satisfied if the coverage is designed to fill gaps in cost-sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits as defined under section 1302(b) of the Patient Protection and Affordable Care Act in the New Mexico benchmark plan, or the coverage is designed to both fill such gaps in cost-sharing under, and cover such benefits not covered by, the primary coverage.

C. No coordination. A supplemental plan shall not include a coordination-of-benefits provision but may condition payment of benefits on the covered person becoming obligated to pay a cost-sharing obligation under the primary coverage.

D. Indemnity. A supplemental plan shall not offer fixed indemnity benefits.

E. Filing requirement. For each supplemental plan filed with the superintendent, the carrier shall also file a separate document specifically identifying any offered benefits that are not covered by group major medical coverage and are not essential health benefits.

F. Exclusions. A supplemental plan shall include a provision that guarantees the plan will not impose ~~contain~~ an exclusion that does not appear in the covered person's group major medical plan.
[13.10.34.15 NMAC – N, 03/01/2022]

13.10.34.16 NON-SUBJECT WORKER PLAN: A non-subject worker plan is subject to these additional requirements~~ules~~.

A. Eligibility. A non-subject worker plan shall only be offered or sold to a person who is self-employed and not subject to New Mexico workers' compensation law protections. A carrier shall investigate and evaluate the self-employment status of each applicant for an individual non-subject worker plan, and of each person who applies to enroll in a group non-subject worker plan. An attestation of self-employment by an applicant shall not relieve a carrier from these duties. 1099 income, standing alone, is insufficient proof of self-employment.

B. Notice. An application for individual coverage, and an enrollment form for group coverage, shall include this notice, printed in 14-point type:

THE INSURANCE YOU ARE APPLYING FOR IS NOT A MAJOR MEDICAL INSURANCE PLAN. THE INSURANCE YOU ARE APPLYING FOR DOES NOT OFFER ANY BENEFIT FOR MEDICAL CARE YOU REQUIRE FOR AN OFF-WORK INJURY OR ILLNESS.

TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT WWW.BEWELLNM.COM. OR CALL 1-833-862-3935. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, MEDICAID OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

C. Benefit requirements. The benefits provided under a non-subject worker plan are limited to medical expense reimbursement, wage loss replacement and lump-sum payment for permanent or temporary disability (full or partial) sustained by a covered person as a result of an on-the-job injury or occupational disease. A subject plan may provide any combination of such benefits, subject to the benefit levels rule.

D. Benefit levels. The benefits offered under a non-subject worker plan shall be no less than what a covered person would be entitled to receive if that person's self-employment was subject to New Mexico workers' compensation laws. A subject plan may provide lower benefit levels, and omit some such benefits, provided the carrier offers an applicant a plan that would provide workers' compensation equivalent benefits, and the covered person rejects that offer in writing. The rejection document shall include the following attestation printed in 14-point type:

[CARRIER] OFFERED APPLICANT AN INSURANCE PLAN THAT INCLUDED BENEFITS EQUIVALENT TO WHAT APPLICANT WOULD BE ENTITLED TO IF THE APPLICANT'S SELF-EMPLOYMENT WAS SUBJECT TO NEW MEXICO WORKERS' COMPENSATION LAWS. THE MONTHLY PREMIUM FOR THAT COVERAGE WOULD BE [$XX]. APPLICANT ELECTED TO PURCHASE THIS PLAN WHICH PROVIDES LESS COVERAGE THAN WOULD BE AVAILABLE TO A SUBJECT WORKER UNDER THE NEW MEXICO WORKERS COMPENSATION LAWS. THE MONTHLY PREMIUM FOR THIS PLAN IS [$XX]. [CARRIER] OFFERED APPLICANT A CHART SHOWING THE DIFFERENCES BETWEEN THIS PLAN AND THE FULL COVERAGE PLAN AND OFFERED TO EXPLAIN THOSE DIFFERENCES.

I ATTEST THAT THE STATEMENT ABOVE IS TRUE AND CORRECT:

_____ _____

[APPLICANT NAME] DATE

E. Notice to Workers' Compensation Administration. Upon the sale of any non-subject worker plan, the carrier shall file a disclosure notice with the New Mexico Workers' Compensation Administration Employer Compliance Bureau. The notice shall contain the following information:

(1) name of covered person;

(2) covered person's occupation;

(3) name, address, and telephone number of any group sponsor of the plan; and

(4) effective dates of the plan.

[13.10.34.16 NMAC - Rp, 13.10.34.16 NMAC, 03/01/2022]

13.10.34.17 FORM AND RATE FILING AND APPROVAL REQUIRED:

A. Prior approval of forms required. A carrier shall not issue, deliver or use a form associated with a plan, unless and until such form has been filed with and approved by the superintendent.

B. Prior approval of rates required. A carrier shall not use rates or modified rates for an individual or group plan unless and until such rates are filed with and approved by the superintendent, except for rates for a plan issued to eligible members of an out-of-state group policyholder defined by 59A-23-3(A)(1). A carrier shall not offer a group coverage plan to New Mexico residents that are members of a group not defined in 59A-23-3(A)(1) under a plan issued to an out-of-state group policyholder unless the plan complies with Subsections D and G of this Section. Projected loss ratios for new plans or products shall be filed prior to sales and be based on credible data.

C. Rate filing requirements. The superintendent shall post on its website requirements for filing actuarial memorandums and rates for rate filing requests.

D. **Minimum loss ratios for group plans.** A group product subject to thisese rules shall be subject to the following actual minimum loss ratios, adjusted for low or high average premium forms:

(1) Definitions of renewal clause. The following definitions shall be applied to the table:

Type of Coverage:	OR	CR	GR	NC
Medical Expense	65%	60%	60%	55%

Loss of Income and Other	65%	60%	55%	50%

(a) **OR- Optionally Renewable:** renewal is at the option of the insurance company;

(b) **CR- Conditionally Renewable:** renewal can be declined by class; by geographic area or for stated reasons other than deterioration of health;

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

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

(2) **Low average premium forms.** For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is low (as defined below), the appropriate ratio from the table above should be adjusted downward by the following formula:

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

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

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

~~CPI-~~

where:

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

(b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of labor, bureau of labor statistics based on the 1982=100 basis;

(c) the CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 97.9;

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

(e) Low average annual premium is defined as average annual premium less than or equal to I x 250.

(f) High average annual premium is defined as average annual premium more than or equal to I x 1500.

(3) **High average premium forms**. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is high (as defined above), the appropriate ratio from the table above should be adjusted upward by the following formula:

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

where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor (as defined in Paragraph (2) above)
X is the average annual premium, not less than I x 1500.

In no event, however, shall RN exceed the lesser of:
(a) R + 5 percentage points, or
(b) 68%.

(4) **Determination of average premium.** A carrier shall determine the average annual premium per form based on the distribution of business by all significant criteria having a price difference, such as

age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all certificates (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

E. Individual plan minimum loss ratio. An individual plan subject to thisese rules shall be subject to the following actual minimum loss ratios, adjusted for low or high average premium forms:

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

(1) Definitions of renewal clause. The following definitions shall be applied to the table:

(a) OR- Optionally Renewable: renewal is at the option of the insurance company;

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

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

(d) NC- Non-cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

(2) Low average premium forms. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is low (as defined below), the appropriate ratio for the table above should be adjusted downward by the following formula:

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

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

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

where:

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

(b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of labor, bureau of labor statistics, based on the 1982=100 basis;

(c) the CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 97.9;

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

(3) High average premium forms. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is high (as defined above), the appropriate ratio from the table above should be adjusted upward by the following formula:

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

where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor (as defined in Paragraph (2) above)
X is the average annual premium, not less than I x 1500.

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

(a) R + 5 percentage points, or
(b) 63%.

(4) Determination of average premium. A carrier shall determine the annual premium per form based on an anticipated distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all certificates (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation). The value of X should be determined on the basis of rates being filed. Thus, where this adjustment is applicable to a rate revision under Paragraph G, rather than to a new form, X should be determined on the basis of anticipated average size premium immediately after the revised rates have fully taken effect.

F. Rate revisions. The following requirements shall apply to rate revision requests:

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

(2) Carriers are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid non-compliance with thisese rules.

G. Annual rate certification filing procedures. Carriers not filing new or updated premium rates in any given plan year shall file an actuarial memorandum demonstrating that minimum loss ratios have been met for all products.

(1) General requirement. Carriers shall meet the minimum loss ratio ("MLR") established, and in the manner calculated, under this section of the rules.

(2) Aggregation. Loss ratios shall be calculated on a consolidated level across policies with the same product type and benefit design.

(3) Measurement period. Compliance with the minimum loss ratio shall be measured over all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years). A filing for a new pool shall be based on credible data from generally recognized industry sources. Separate filings shall be made for separate rating pools.

(4) Frequency. Actual loss ratios shall be calculated annually by carriers that issue excepted benefits products specified in thisese rules, beginning in 2023.

(5) Timeline. The evidence of compliance with the minimum loss ratio requirements shall be filed with the superintendent on the anniversary date when the product or the product's most recent rate filing was approved.

(6) Methodology. Actual loss ratios shall be calculated using company claim data including an estimate for claims incurred but not reported. The claims will be reported for all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years after the third year of experience is available). The actual accumulated loss ratio over the measurement period (A) will be compared to original pricing accumulated loss ratios over the measurement period (E) as a method of justifying the minimum loss ratio is being met or showing the need for remedial action if (A)/(E) is below the threshold specified in Paragraph (8) of this subsection.

(7) Waiver. For noncredible blocks of business on a nationwide basis, the company may request a waiver of the requirement. The request shall be made annually and must be accompanied by a letter indicating the nature of the filing, the type of product, and the reason for the request.

(8) Compliance with minimum loss ratios. Each carrier shall submit to the superintendent an exhibit showing the calculation of the applicable loss ratios and:

(a) a statement signed by a qualified actuary that the minimum loss ratio requirements have been met; or

(b) a rate filing to justify the rates, revise rates, modify benefits through a benefit endorsement or to return excess premium, if the actual accumulated loss ratio divided by the expected accumulated loss ratio (A/E) over the measurement period is below eighty-five percent.

(9) The superintendent may require a plan to return excess premiums or increase benefits proportionately if the ratio of the actual accumulated experience to the expected accumulated experience (A/E) is below eighty percent.

(10) A carrier shall not return excess premiums per the above guidelines, until the carrier files

a refund plan and calculation with and obtains approval of the plan by the superintendent.

H. Disapproval of forms and rates. The superintendent shall disapprove a form:

(1) if the benefit provided therein is unreasonable in relation to the premium charged; or

(2) that misrepresents the benefits, advantages, conditions or terms of any plan or that unfairly characterizes the plan as more favorable to the covered person than the actual terms of the plan, such as naming coverage for specific diseases whose primary forms of treatment are then listed as exclusions;

(3) that uses any false or misleading statements;

(4) that uses any name or title of any plan or class of plans misrepresenting the true nature thereof, including misrepresenting the plan as major medical coverage; or

(5) that is contrary to law, discriminatory, deceptive, unfair, impractical, unnecessary or unreasonable.

I. Variable MLR. A carrier shall not offer a plan subject to thisese rules to any person unless each possible plan design selectable by that person meets the MLR requirements as reflected in an approved rate filing. For variable forms, a carrier cannot satisfy MLR requirements with average premiums for the form as a whole. The carrier must base MLR calculations on the average premium for each possible combination of benefits and levels offered by demographics used for underwriting. The superintendent reserves the right to reject a plan that has no meaningful difference from another plan offered by the same carrier. The requirements of this rule do not apply to a non-contributory plan.

J. Premium increases. A carrier shall not increase a covered person's premium under any plan, other than a disability income plan, during the first twothree years that the covered person's coverage is in force except in cases where one or more persons are added to the policy as covered persons during this two year period. The new premium resulting from the addition of a covered person(s) shall not change for the first twothree years the policy with the added lives is in force. .

[13.10.34.17 NMAC - Rp, 13.10.34.15 NMAC, 03/01/2022]

13.10.34.18 REQUIRED DISCLOSURES AND NOTICES:

A. General notice requirement. An application for an individual plan or plan sold through an association or group described in Paragraphs (2) or (4) of Subsection A of 59A-23-3 NMSA 1978, other than a disability income plan, shall contain in bold, 14-point type, directly above the applicant signature line the following notice:

NOTICE TO BUYER: PLEASE REVIEW THIS PLAN CAREFULLY. IT ONLY PROVIDES LIMITED BENEFITS, AND IT DOES NOT ON ITS OWN OR IN COMBINATION WITH OTHER LIMITED BENEFITS POLICIES CONSTITUTE MAJOR MEDICAL INSURANCE. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT [WWW.BEWELLNM.COM] OR CALL [1-833-862-3935]. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

B. Renewal provision. A plan shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of plan to be issued. The provision shall be appropriately captioned, shall appear on the first page of the plan, and shall clearly state the duration of coverage and renewal terms.

C. Riders. A rider, endorsement, or supplement added to a plan after its effective date that reduces or eliminates benefits or coverage shall not be effective unless signed by the covered person. Signature may include electronic signature or voice signature, however, this signature must be recorded by the carrier and time-stamped. This signature requirement does not apply to certificates issued to covered persons in a group plan. A signature shall not be required if the rider, endorsement or supplement reflects a change to the plan that is required by law.

D. Additional premium for riders, endorsements or supplement. If an additional premium is charged for benefits specified in a rider, endorsement or supplement, the plan or certificate shall specify the premium.

E. Preexisting conditions. If a plan includes any preexisting condition exclusion or limitation, the plan or certificate shall include a separate section labeled "Preexisting Conditions, Exclusions and Limitations."

F. Right of return/Free look. A plan shall include a prominent notice, printed on or attached to the

first page of the plan, stating that the covered person has the right to return the plan, and cancel any associated voluntary group membership enrolled in contemporaneous with the plan enrollment, within 30 days of its delivery, and to have the premium and membership fees refunded in full if the covered person is not satisfied for any reason.

G. Age factors. If age is a factor that reduces aggregate benefits, that factor shall be prominently set forth in the outline of coverage.

H. Conversion privilege. If a plan includes a conversion privilege, the provision shall be captioned, "Conversion Privilege." The provision shall specify who is eligible for conversion and the circumstances that govern conversion, or may state that the conversion coverage will be as provided in an approved plan form used by the carrier for that purpose.

I. Medicare supplement notice.

(1) The outline of coverage delivered with an accident-only, specified disease, hospital indemnity, supplemental or non-subject plan shall contain the following notice in bold 14-point type:

THIS IS NOT A MEDICARE SUPPLEMENT PLAN. IF YOU ARE ELIGIBLE FOR MEDICARE, ASK FOR INFORMATION ABOUT MEDICARE SUPPLEMENT POLICIES.

(2) A carrier shall deliver to persons eligible for Medicare any notice required under 13.10.25 NMAC.

J. Outline of coverage requirements. Each subject plan and certificate shall include the outline of coverage that provides a basic overview of the plan's purpose, benefits, coverage minimums and maximums.

(1) The outline of coverage shall include the following notice, printed in bold 14-point type:

READ YOUR PLAN CAREFULLY – THIS OUTLINE OF COVERAGE PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR COVERAGE. THIS IS NOT THE INSURANCE CONTRACT AND ONLY THE ACTUAL PLAN PROVISIONS WILL DETERMINE THE TERMS OF COVERAGE. THE PLAN ITSELF SETS FORTH IN DETAIL THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND YOUR INSURANCE COMPANY. IT IS, THEREFORE, IMPORTANT THAT YOU READ YOUR PLAN CAREFULLY!

(2) The outline of coverage shall provide contact information for the OSI consumer assistance bureau.

K. Delivery of plan documents. A carrier shall not bind coverage for any subject plan without delivering all plan documents to a prospective insured and allowing the prospective insured 30 calendar days to review those materials. Nothing in this subsection precludes a carrier from making coverage retroactive to the date that the plan documents were delivered to the prospective insured. The carrier shall maintain proof of compliance with this requirement for each sale for five years from the coverage effective date. For a group plan, either the carrier or the group master policyholder may satisfy the delivery requirement, but the carrier shall remain responsible for any failure to do so by the master policyholder. In the case where the group master policyholder delivers the plan documents to the prospective policyholders, the carrier shall require the group master policyholder to attest to the compliance with the requirements of this section and to provide documents that clearly support the attestation. The carrier shall not bind coverage until it has received the master policyholder's attestation.

[13.10.34.18 NMAC - Rp, 13.10.34.16 NMAC, 03/01/2022]

13.10.34.19 REQUIREMENTS FOR REPLACEMENT OF INDIVIDUAL PLAN COVERAGE:

A. Required questions. An application for an individual plan or a plan sold through an association or group described in Paragraphs (2) or (4) of Subsection A of 59A-23-3 NMSA 1978 shall ask whether the insurance requested will replace any other plan subject to thisese rules.

B. Notice requirement. Upon determining that a sale will involve replacement of a plan, a carrier, other than a direct response carrier, or its agent, shall furnish the applicant, prior to issuance or delivery of the plan, the notice described in Subsection C below. A direct response carrier shall deliver to the applicant, upon issuance of

the plan, the notice described in Subsection DC below. No notice is required for the solicitation of accident-only or single premium nonrenewal policies. The carrier shall retain proof of notice for five years from the coverage effective date.

C. Non-direct response carrier notice:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LIMITED BENEFIT HEALTH INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing insurance and replace it with a plan to be issued by [insert company name] Insurance company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new plan.

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

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present plan. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

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

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

D. Direct response carrier notice:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LIMITED BENEFIT HEALTH INSURANCE

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

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

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present plan. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) [To be included only if the application is attached to the plan]. If, after due consideration, you still wish to terminate your present plan and replace it with new coverage, read the copy of the application attached to your new plan and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

[13.10.34.19 NMAC - Rp, 13.10.34.17 NMAC, 03/01/2022]

13.10.34.20 COORDINATION OF BENEFITS, BUNDLING AND VARIABILITY:

A. Noncoordination of benefits. Benefits under a plan shall:

(1) be provided under a separate plan, certificate, or contract of insurance;

(2) have no coordination with the benefits offered under a health plan; and

(3) pay benefits regardless of any benefits provided under a health plan.

B. No bundling. No carrier, directly or through an affiliated producer, shall market or sell a bundled combination of accident-only, specified disease, hospital indemnity and non-subject worker plans. An application that is used in connection with more than one type of plan subject to thisese rules shall include a conspicuous notice that the applicant cannot purchase more than one type of plan from the carrier using the same application. This provision does not preclude the same carrier from selling more than one product type to a single purchaser as long as each policy is available at its own stated premium rate, independent of the other product types.
A carrier shall not offer or provide memberships or discounts relating to health care services or products. The provisions of this subsection shall not apply to a plan sold through a group identified in Paragraphs (1) or (3) of Subsection A of 59A-23-3 NMSA 1978, or to a bona fide association.

C. Major medical coverage requirement. Accident-only, specified disease, hospital indemnity and non-subject worker plans, excluding blanket coverage compliant with Section 59A-23-2 NMSA 1978 and group plans described in Paragraph (1) of Subsection A of 59A-23-3 NMSA 1978, shall only be issued to persons who acknowledge that the plan is not major medical or comprehensive health insurance. For purposes of this requirement, short-term, limited-duration insurance shall not be considered major medical coverage.

(1) An application or enrollment form for a plan subject to this subsection shall include an attestation by the applicant affirming that the applicant understands that the individual is not purchasing major medical insurance at the time of application. An application for a hospital indemnity plan, or plan offering other fixed indemnity benefits, shall also include any disclosure required by federal law. The attestation shall be in writing and signed by the applicant before coverage becomes effective. The carrier may retroactively apply coverage to the date of application.

(2) A sale of a plan subject to this subsection is unauthorized if an applicant fails to sign or deliver the attestation described in thisese rules.

(3) A carrier shall retain a copy of the attestation for at least five years.

(4) If a carrier of a plan subject to this subsection learns, directly or through an agent, that a covered person's major medical coverage has lapsed or was canceled, the carrier shall send the person the following notice:

YOUR MAJOR MEDICAL COVERAGE MAY HAVE RECENTLY LAPSED. YOUR POLICY WITH [IDENTIFY COMPANY] IS NOT MAJOR MEDICAL HEALTH INSURANCE. THE BENEFITS PROVIDED BY [IDENTIFY COMPANY] DO NOT COVER ALL MEDICAL EXPENSES.

TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT WWW.BEWELLNM.COM. OR CALL 1-833-862-3935. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, MEDICAID OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

D. Matrix forms. The coverages governed by thisese rules are subject to prohibitions on matrix forms as otherwise specified in New Mexico law.

[13.10.34.20 NMAC - Rp, 13.10.34.18 NMAC, 03/01/2022]

13.10.34.21 PENALTIES: The sale of any plan that does not comply with thisese rules is unlawful. In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the New Mexico Insurance Code, a penalty for any material violation of thisese rules may be imposed against a health care insurance carrier or insurance producer by the superintendent. The actions of any producer or third-party administrator relating to the sale of a plan subject to thisese rules, or a claim under any such plan, shall be deemed the actions of the plan issuer.

[13.10.34.21 NMAC - Rp, 13.10.34.19 NMAC, 03/01/2022]

13.10.34.22 SEVERABILITY: If any section of thisese rules, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.
[13.10.34.22 NMAC - Rp, 13.10.34.20 NMAC, 03/01/2022]

History of 13.10.34 NMAC:
13.10.34 NMAC - Standards For Accident Only, Specified Disease Or Illness, Hospital Indemnity, And Related Excepted Benefits, filed 10/01/2020 was repealed and replaced by 13.10.34 NMAC - Standards For Accident-Only, Specified Disease, Hospital Indemnity, Disability Income, Supplemental, And Non-Subject Worker Excepted Benefits, effective 03/01/2022.