AN ACT

RELATING TO INSURANCE; AMENDING, REPEALING AND ENACTING SECTIONS OF THE NEW MEXICO INSURANCE CODE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new Section 59A-1-8.2 NMSA 1978 is enacted to read:

"59A-1-8.2. DELIVER OR DELIVERY--DEFINITION.--"Deliver" or "delivery" means send to by:

A. email and retain an email delivery confirmation;

B. electronic transmission through a dedicated two-way communication portal and retain delivery confirmation;

C. fax and retain a fax delivery confirmation;

D. regular mail; or

E. personal delivery."

SECTION 2. Section 59A-2-8 NMSA 1978 (being Laws 1984, Chapter 127, Section 26, as amended) is amended to read:

"59A-2-8. GENERAL POWERS AND DUTIES OF SUPERINTENDENT.--

A. The superintendent shall:

(1) organize and manage the office of superintendent of insurance and direct and supervise all its activities;

(2) execute the duties imposed upon the superintendent by the Insurance Code;

(3) enforce those provisions of the Insurance Code that are administered by the superintendent;

(4) have the powers and authority expressly conferred by or reasonably implied from the provisions of the Insurance Code;

(5) conduct such examinations and investigations of insurance matters, in addition to those expressly authorized, as the superintendent may deem proper upon reasonable and probable cause to determine whether a person has violated a provision of the Insurance Code or to secure information useful in the lawful enforcement or administration of the provision;

(6) have the power to sue or be sued;

(7) have the power to make, enter into and enforce all contracts, agreements and other instruments necessary, convenient or desirable in the exercise of the superintendent's powers and functions and for the purposes of the Insurance Code;

(8) prepare an annual budget for the office of superintendent of insurance;

(9) have the right to require performance bonds of employees as the superintendent deems necessary pursuant to the Surety Bond Act. The office of

superintendent of insurance shall pay the cost of required bonds;

(10) comply with the provisions of the Administrative Procedures Act;

(11) upon an order based upon the invocation of a state of emergency under the All Hazard Emergency Management Act or the Public Health Emergency Response Act by the governor, take those actions necessary to ensure access to insurance and the stability of insurance markets during the emergency. Such actions may include issuing emergency rules or orders to address any or all of the following matters related to insurance policies issued in New Mexico:

(a) grace periods for payment of insurance premiums and performance of other duties by insureds;

(b) refund of premiums;

(c) waiver of cost sharing or deductibles;

(d) temporary postponement of cancellations and nonrenewals;

(e) reporting requirements for claims; and

(f) suspension of compliance with a statute, rule or contract, if strict compliance would prevent, hinder or delay necessary action in response to the

emergency; and

(12) have such additional powers and duties as may be provided by other laws of this state.

B. If a state of emergency under the All Hazard Emergency Management Act or the Public Health Emergency Response Act is invoked by the governor, and the superintendent issues emergency rules or orders to address matters related to insurance policies issued in New Mexico, each emergency rule or order:

(1) shall specify, by line of insurance:

(a) the geographic area in which the order applies; and

(b) the dates on which the order becomes effective and terminates; and

(2) shall not:

(a) apply retroactively;

(b) apply outside the geographic area designated in the governor's order; or

(c) extend beyond the end date of the governor's order."

SECTION 3. Section 59A-4-15 NMSA 1978 (being Laws 1984, Chapter 127, Section 59, as amended by Laws 2011, Chapter 127, Section 3 and by Laws 2011, Chapter 144, Section 1) is amended to read:

"59A-4-15. HEARINGS--IN GENERAL.--

A. The superintendent may hold a hearing, without request by others, for any purpose within the scope of the Insurance Code.

B. The superintendent shall hold a hearing:

(1) if required by any other provision of the Insurance Code; or

(2) upon written request for a hearing by a person aggrieved by any act, threatened act or failure of the superintendent to act or by any report, rule or order of the superintendent, other than an order for the holding of a hearing or order on hearing or pursuant to such an order on a hearing of which the person had notice.

C. The request for a hearing shall briefly state the respects in which the applicant is so aggrieved, the relief to be sought and the grounds to be relied upon as basis for relief. The request shall be received by the superintendent no later than thirty days from the date of the act, threatened act or failure of the superintendent to act or the date of the superintendent's report, rule or order.

D. If the superintendent finds that the request is made in good faith, that the applicant would be so aggrieved if the stated grounds are established and that such grounds otherwise justify the hearing, the superintendent shall commence the hearing within thirty days after filing of the request, unless postponed by mutual consent. No postponement

shall be later than ninety days after the filing of the request.

E. Pending the hearing and decision, the superintendent may suspend or postpone the effective date of the action as to which the hearing is requested. If upon request the superintendent refuses to grant the suspension or postponement, the person requesting the hearing may apply no later than twenty days from the superintendent's refusal to the district court of Santa Fe county for a stay of the superintendent's action or proposed action pending the hearing and the superintendent's order.

F. Except as otherwise expressly provided, this section does not apply to hearings relative to matters arising under Chapter 59A, Article 17 NMSA 1978.

G. The superintendent may appoint a hearing officer to preside over hearings. The hearing officer shall provide the superintendent with a recommended decision on the matter assigned to the hearing officer, including findings of fact and conclusions of law."

SECTION 4. Section 59A-5-23 NMSA 1978 (being Laws 1984, Chapter 127, Section 90) is amended to read:

"59A-5-23. CONTINUANCE, EXPIRATION, REINSTATEMENT OF CERTIFICATE OF AUTHORITY.--

A. A certificate of authority shall continue in force as long as the insurer is entitled thereto under the

Insurance Code, and until suspended or revoked by the superintendent or terminated at the insurer's request, subject, however, to continuance of the certificate by the insurer each year by:

(1) payment on or before March 1 of the continuation fee referred to in Section 59A-6-1 NMSA 1978;

(2) due filing by the insurer of its annual statement for the next preceding calendar year as required by Section 59A-5-29 NMSA 1978; and

(3) payment by the insurer when due of premium taxes with respect to the preceding calendar year.

B. If not so continued by the insurer its certificate of authority shall expire at midnight on the date of failure of the insurer to continue it in force, unless earlier revoked as provided in Sections 59A-5-24 through 59A-5-26 NMSA 1978.

C. Upon the insurer's request made within three months after expiration, the superintendent may reinstate a certificate of authority that the insurer inadvertently permitted to expire, after the insurer has fully cured all its failures that resulted in the expiration, and upon payment by the insurer of the fee for reinstatement specified in Section 59A-6-1 NMSA 1978. Otherwise the superintendent shall grant the insurer another certificate of authority only after filing an application therefor and meeting all other

requirements as for an original certificate of authority in this state.

D. If an insurer allows a certificate of authority issued by the superintendent to expire, the holder of the expired certificate shall remain subject to the provisions of the Insurance Code but is not authorized to transact any insurance business. If the insurer reinstates the expired certificate of authority within three months after expiration, the reinstatement shall relate back to the date of the expiration; provided that this shall not excuse any violation of the Insurance Code that occurred during the intervening period."

SECTION 5. Section 59A-5-32 NMSA 1978 (being Laws 1984, Chapter 127, Section 99) is amended to read:

"59A-5-32. SERVING PROCESS--TIME TO PLEAD.--

A. Service of process against an insurer for whom the superintendent is attorney shall be made by delivering by email to the superintendent, or the superintendent's designee, an electronic copy of the process together with the fee specified in Section 59A-6-1 NMSA 1978, taxable as costs in the action.

B. Upon such service the superintendent shall deliver such process showing the date and time of service on the superintendent, to the email or electronic portal address of the person currently designated by the insurer to receive

such process as provided in Section 59A-5-31 NMSA 1978. Service of process on the insurer shall be complete upon such electronic delivery of the process.

C. Process served as provided in this section shall for all purposes constitute valid and binding personal service within this state upon the insurer. If summons is served under this section, the time within which the insurer is required to appear shall be extended an additional ten days beyond that otherwise allowed by New Mexico rules of civil procedure.

D. The superintendent shall keep record of the day and time of service of legal process under this section.

E. If the electronic delivery requirements of this section create a hardship for any person serving an insurer pursuant to this subsection, that person shall deliver to the superintendent or the superintendent's designee two copies of the process together with the fee specified in Section 59A-6-1 NMSA 1978, taxable as costs in the action. Upon such service, the superintendent shall deliver the process to the insurer as provided in Subsection B of this section."

SECTION 6. Section 59A-12-2 NMSA 1978 (being Laws 2016, Chapter 89, Section 26) is amended to read:

"59A-12-2. DEFINITIONS.--As used in Chapter 59A, Article 12 NMSA 1978:

A. "affiliate" means a person that controls, is

controlled by or is under common control with the insurance producer;

B. "business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity;

C. "home state" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains the insurance producer's principal place of residence or principal place of business and is licensed to act as an insurance producer;

D. "insurance" means any of the lines of authority in Chapter 59A, Article 7 NMSA 1978;

E. "insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance;

F. "insurer" means every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance;

G. "license" means a document issued by the superintendent authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier;

H. "limited line credit insurance" includes credit

life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation;

I. "limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy;

J. "limited lines insurance" means those lines of insurance referred to in Section 59A-12-18 NMSA 1978 or any other line of insurance that the superintendent deems necessary to recognize for the purposes of complying with Subsection E of Section 59A-11-24 NMSA 1978;

K. "limited lines producer" means a person authorized by the superintendent to sell, solicit or negotiate limited lines insurance;

L. "negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract; provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers;

M. "personal lines insurance producer" means a general lines producer who is limited to transacting business related to property and casualty insurance sold to individuals and families for noncommercial purposes;

N. "reinstatement" means reestablishment of a licensee's authority to transact insurance after a lapse of that authority that restores the licensee's authority to the same scope and condition that pertained to that authority before the lapse;

O. "sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer;

P. "solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular insurer;

Q. "terminate" means to cancel the relationship between an insurance producer and the insurer or to terminate an insurance producer's authority to transact insurance;

R. "uniform application" means the current version of the national association of insurance commissioners uniform application for resident and nonresident insurance producer licensing; and

S. "uniform business entity application" means the current version of the national association of insurance commissioners uniform business entity application for

resident and nonresident business entities."

SECTION 7. Section 59A-12-3 NMSA 1978 (being Laws 1984, Chapter 127, Section 203, as amended) is amended to read:

"59A-12-3. "BROKER" DEFINED.--For the purpose of the Insurance Code, a "broker" is a type of insurance producer who, not being an agent of the insurer, as an independent contractor and on behalf of the insured solicits, negotiates or procures insurance or annuity contracts or renewal or continuation thereof for insureds or prospective insureds other than the broker. "Broker" does not include a surplus line broker, as defined in Chapter 59A, Article 14 NMSA 1978."

SECTION 8. Section 59A-12-16 NMSA 1978 (being Laws 1984, Chapter 127, Section 217, as amended) is amended to read:

"59A-12-16. EXAMINATION FOR LICENSE.--

A. A resident individual applying for an insurance producer license shall, prior to issuance of license, personally take and pass a written examination. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and rules of this state. Examinations required by this section shall be developed and conducted under rules prescribed by the superintendent.

B. The superintendent may contract with an outside testing service for administering examinations and collecting the nonrefundable fee set forth in Section 59A-6-1 NMSA 1978.

C. Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the superintendent as set forth in Section 59A-6-1 NMSA 1978.

D. An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

E. No examination shall be required:

(1) for renewal or continuance of an existing license, except as provided in Subsection D of Section 59A-11-10 NMSA 1978;

(2) of an applicant for limited license as provided in Section 59A-12-18 NMSA 1978;

(3) of applicants with respect to life and annuities or accident and health insurances who hold the chartered life underwriter designation by the American college of financial services;

(4) of applicants with respect to property and casualty insurance who hold the designation of chartered property and casualty underwriter designation by the American institute for chartered property casualty underwriters;

(5) of applicants for temporary license as

provided for in Section 59A-12-19 NMSA 1978;

(6) of an applicant for a license covering the same kind or kinds of insurance as to which licensed in this state under a similar license within one year preceding date of application for the new license, unless the previous license was suspended, revoked or continuation thereof refused by the superintendent;

(7) of an applicant for insurance producer license, if the applicant took and passed a similar examination in a state in which already licensed, subject to Section 59A-5-33 NMSA 1978; or

(8) of an applicant for self-service storage insurance producer license.

F. An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to take an examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's insurance producer database records, maintained by the national association of insurance commissioners, its affiliates or subsidiaries, indicate that

the insurance producer is or was licensed in good standing for the line of authority requested.

G. A person licensed as an insurance producer in another state who moves to this state shall apply within ninety days of establishing legal residence to become a resident insurance producer. No examination shall be required of that person to obtain any line of authority previously held in the prior state except where the superintendent determines otherwise by rule."

SECTION 9. Section 59A-16-15 NMSA 1978 (being Laws 1984, Chapter 127, Section 281) is amended to read:

"59A-16-15. DISCRIMINATION--REBATES AND CERTAIN INDUCEMENTS PROHIBITED--LIFE, HEALTH AND ANNUITY CONTRACTS.--Except as otherwise expressly provided by law, no person shall directly or indirectly, as an inducement to any contract of life, annuity or health insurance:

A. offer, pay or accept any special favor or advantage, any rebate of premiums or any valuable consideration or promise whatsoever; or

B. promise any returns or profits, interest or dividends not specified in the contract."

SECTION 10. Section 59A-16-16 NMSA 1978 (being Laws 1984, Chapter 127, Section 282) is amended to read:

"59A-16-16. EXCEPTIONS TO DISCRIMINATION, REBATE AND INDUCEMENT PROHIBITION--LIFE, HEALTH AND ANNUITY CONTRACTS.--

A. Nothing in Section 59A-16-11 or 59A-16-15 NMSA 1978 shall be construed as including within the definition of discrimination or rebates any of the following practices:

(1) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the insurer and its policyholders;

(2) in the case of life insurance policies issued on the industrial or debit plan, making allowance, in an amount which fairly represents the saving in collection expense, to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer;

(3) readjusting the rate of premiums for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(4) reducing the premium rate for policies of large amounts, but not exceeding savings in issuance and administration expenses reasonably attributable to such policies as compared with policies of similar plan issued in

smaller amounts;

(5) reducing the premium rates for life or health insurance policies or annuity contracts on salary savings, payroll deduction, preauthorized check, bank draft or similar plans in amounts reasonably commensurate with the savings made by the use of such plans;

(6) extending credit for the payment of any premium, and for which credit a reasonable rate of interest is charged and collected; or

(7) offering or providing any value-added product or service in conformance with Subsection G of Section 59A-16-17 NMSA 1978.

B. Nothing in Chapter 59A, Article 16 NMSA 1978 shall be construed as including within the definition of securities as inducements to purchase insurance the selling or offering for sale, contemporaneously with life insurance, of mutual fund shares or face amount certificates of regulated investment companies under offerings registered with the securities and exchange commission where such shares or such face amount certificates or such insurance may be purchased independently of and not contingent upon purchase of the other, at the same price and upon similar terms and conditions as where purchased independently."

SECTION 11. Section 59A-16-17 NMSA 1978 (being Laws 1984, Chapter 127, Section 283, as amended) is amended to

read:

"59A-16-17. DISCRIMINATION, REBATES AND CERTAIN INDUCEMENTS PROHIBITED--OTHER COVERAGES.--

A. No person subject to the superintendent's jurisdiction shall induce or attempt to induce another person to enter into or continue a contract of insurance by directly or indirectly offering to pay or accept any special favor or advantage, any rebate of premiums or any valuable consideration or promise whatsoever not specified in the insurance contract, except to the extent provided for in an applicable filing with the superintendent as provided by law or as allowed by this section.

B. No title insurer or title insurance producer shall:

(1) pay, directly or indirectly, to the insured or any person acting as agent, representative, attorney or employee of the owner, lessee, mortgagee, existing or prospective, of the real property, or interest therein, that is the subject matter of title insurance or as to which a service is to be performed any commission or part of its fee or charges or other consideration as inducement or compensation for the placing of any order for a title insurance policy or for performance of any escrow or other service by the insurer with respect thereto;

(2) issue any policy or perform any service in

connection with which it or any insurance producer or other person has paid or contemplates paying any commission, rebate or inducement in violation of this section;

(3) give or receive, directly or indirectly, any consideration or thing of value for the referral of title insurance business or escrow or other service provided by a title insurer or title insurance producer unless otherwise permitted by regulation of the superintendent; or

(4) enter into a reinsurance agreement with an affiliate of a real estate developer, real estate agency, mortgage lender or referrer of title business without the prior written approval of the superintendent.

C. No insured named in a policy or any employee of such insured shall knowingly receive or accept, directly or indirectly, any rebate, discount, abatement, credit or reduction of premium, or any special favor or advantage or valuable consideration or inducement, except as allowed by this section.

D. No insurer or organization shall make or permit any unfair discrimination between insureds or property having like insuring or risk characteristics, in the premium or rates charged for insurance or coverage, or in the dividends or other benefits payable thereon or in any other of the terms and conditions of the insurance or coverage.

E. Nothing in this section shall be construed as

prohibiting the payment of commissions or other compensation to licensed insurance producers or other representatives; or as prohibiting the extension of credit to an insured for the payment of any premium and for which credit a reasonable rate of interest is charged and collected; or as prohibiting any insurer or insurance producer from allowing or returning to its participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits. As to title insurance, nothing in this section shall prohibit bulk rates or special rates for customers of prescribed classes if such bulk or special rates are provided for in the currently effective schedule of fees and charges of the title insurer as filed with the superintendent.

F. The provisions of this section shall not prohibit a property or casualty insurer, or any employee or representative thereof, or a property or casualty insurance producer or other representative thereof from providing to customers or prospective customers prizes and gifts, including goods, gift cards, gift certificates, charitable donations, raffle entries, meals, event tickets and other items not exceeding one hundred dollars ($100) in the aggregate in value per customer or prospective customer in any one calendar year.

G. A person subject to the superintendent's jurisdiction may offer or provide value-added products or

services at no or reduced cost, even when such products or services are not specified in the insurance contract, if the product or service:

(1) relates to the insurance coverage;

(2) is offered at a cost that is reasonable in comparison to the insured's or prospective insured's premiums;

(3) has its availability based on documented objective evidence and offered in a manner that is not unfairly discriminatory; and

(4) is primarily designed to:

(a) provide loss mitigation or loss control;

(b) reduce claim costs or claim settlement costs;

(c) monitor or assess risk, identify sources of risk or develop strategies for eliminating or reducing risk;

(d) enhance health;

(e) enhance financial wellness through items such as education or financial planning services;

(f) provide post-loss services;

(g) incentivize behavioral changes to improve the health or reduce the risk of death or disability of an insured or prospective insured;

(h) assist in the administration of employee or retiree benefit insurance coverage; or

(i) provide education about liability risks or risk of loss to persons or property.

H. Prior to offering or providing a value-added product or service, a person shall notify the superintendent of the person's intent to offer or provide a value-added product or service."

SECTION 12. Section 59A-16-21 NMSA 1978 (being Laws 1984, Chapter 127, Section 287, as amended by Laws 2017, Chapter 15, Section 1 and by Laws 2017, Chapter 130, Section 12) is amended to read:

"59A-16-21. PAYMENT OF CLAIM BY CHECK, DRAFT OR ELECTRONIC TRANSFER--FAILURE TO PAY--INTEREST.--

A. An insurer shall pay promptly claims arising under its policies with checks or drafts, or, if a claimant requests, may pay by electronic transfer of funds. Without amending other statutes dealing with checks, drafts or electronic transfer of funds, a resident of New Mexico is granted a cause of action for ten percent of the amount of any check, draft or electronic transfer of funds that is not paid or lawfully rejected within ten days of forwarding by a New Mexico financial institution, but in no case to be less than five hundred dollars ($500) plus costs of suit and attorney fees. The insurer shall not be required to pay such

civil damages for delay if it proves that the delay in processing and payment was caused by a financial institution or postal or delivery service and the check, draft or electronic transfer of funds was paid or lawfully rejected within forty-eight hours of actual receipt of the draft, check or electronic transfer of funds by the person on whom drawn.

B. Notwithstanding any provision of the Insurance Code, any insurer issuing any policy, certificate or contract of insurance, surety, guaranty or indemnity of any kind or nature that fails for a period of forty-five days, after required proof of loss has been furnished, to pay to the person entitled the amount justly due shall be liable for the amount due and unpaid with interest on that amount at the rate of one and one-half times the prime lending rate for New Mexico banks during the period the claim is unpaid. Interest shall accrue, and the interest rate shall be determined, as of the forty-sixth day after the proof of loss was furnished.

C. Subsection B of this section shall not apply to any claims in arbitration or litigation."

SECTION 13. Section 59A-18-1 NMSA 1978 (being Laws 1984, Chapter 127, Section 331, as amended) is amended to read:

"59A-18-1. SCOPE OF ARTICLE.--Chapter 59A, Article 18 NMSA 1978 applies as to all insurance policies and annuity contracts of authorized insurers covering individuals

resident, or risks located, or insurance protection to be rendered in this state, other than:

A. reinsurance;

B. policies or contracts not issued for delivery in this state nor delivered in this state, except for contracts for or endorsements of workers' compensation insurance when the workers' compensation risk insured arises from the employment of a worker performing work for an employer in New Mexico and that employer is not domiciled in New Mexico;

C. wet marine and transportation insurance; or

D. surplus lines insurance contracts, unless such contracts are specifically included by rule."

SECTION 14. Section 59A-18-22 NMSA 1978 (being Laws 1984, Chapter 127, Section 351) is amended to read:

"59A-18-22. BINDERS.--

A. While acting within the scope of authority granted by the insurer, binders or other contracts for temporary insurance may be made by a producer orally or in writing, and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

B. No binder shall be valid beyond the issuance of the policy as to which given, or beyond ninety days for

written binders, fifteen days for oral, from its effective date, whichever period is the shorter.

C. If the policy has not been issued, a binder may be extended or renewed beyond such ninety or fifteen days with the written approval of the insurer.

D. This section shall not apply as to life or health insurances; and binders under the standard fire policy are governed by Section 492 of the Insurance Code and not by this section."

SECTION 15. Section 59A-18-29 NMSA 1978 (being Laws 1984, Chapter 127, Section 358) is amended to read:

"59A-18-29. CANCELLATION OF CERTAIN POLICIES.--

A. An insurer or agent may at any time cancel a policy for nonpayment of premium when due, whether the premium is payable directly to the insurer or agent or indirectly under any premium financing plan or extension of credit. The insurer or agent shall give the named insured written notice of the cancellation not less than ten days prior to the effective date of the cancellation.

B. An insurer may cancel its policy without cause at any time within sixty days following original issuance and effective date of the policy. The insurer shall give the named insured written notice of the cancellation not less than ten days prior to the effective date of the cancellation, which effective date shall fall within the

sixty-day period.

C. Subject to Subsection A of this section, after expiration of the sixty-day period referred to in Subsection B of this section, an insurer or agent shall not cancel except for reasonable cause such policies and for such causes, and with advance notice of cancellation for such period of time, as may from time to time be provided by rules and regulations of the superintendent. Such rules and regulations may also require that statement of the reasons for cancellation be contained in the notice of cancellation given to specified persons.

D. Notice of cancellation shall be given using any communication method authorized by the named insured, or by personal delivery to the named insured or by mailing the notice postage-paid addressed to the named insured at the address last of record with the insurer. Notice so mailed shall be deemed given when deposited in a mail depository of the United States post office.

E. There shall be no liability on the part of and no cause of action shall arise against an insurer or other person for furnishing information as to reasons for cancellation or for a statement made or information given pursuant to this section.

F. This section shall not apply as to life insurance or annuity contracts, health insurance contracts,

title insurance, inland marine insurance contracts, or to an insurance policy that by its terms is not cancellable during the term of the policy at the option of the insurer."

SECTION 16. Section 59A-22-2 NMSA 1978 (being Laws 1984, Chapter 127, Section 423) is amended to read:

"59A-22-2. FORM AND CONTENT OF POLICY.--No policy of individual health insurance shall be delivered or issued for delivery in this state unless:

A. the entire money and other considerations therefor are expressed therein;

B. the time at which insurance takes effect and terminates is expressed therein;

C. it purports to insure only one person, except as provided in Chapter 59A, Article 23 NMSA 1978, and except that a policy or contract may be issued upon application of the head of a family, who shall be deemed the policyholder, covering members of any one family, including husband, wife, dependent children or any children under the age of twenty-six and other dependents living with the family;

D. every printed portion of the text matter and of any endorsements or attached papers shall be printed in uniform type of which the face shall be not less than ten point (the "text" shall include all printed matter except the name and address of the insurer, name and title of the policy, captions, subcaptions and form numbers), but

notwithstanding any provision of this law, the superintendent shall not disapprove any such policy on the ground that every printed portion of its text matter or of any endorsement or attached paper is not printed in uniform type if it shall be shown that the type used is required to conform to the laws of another state in which the insurer is authorized;

E. the exceptions and reductions of indemnity are adequately captioned and clearly set forth in the policy or contract;

F. each separate form, including riders and endorsements, shall be identified by a form number and consecutive page numbers in the lower left-hand corner of each page; and

G. if any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of insurance laws of such other state shall have advised the superintendent that any such policy is not subject to approval or disapproval by such official, the superintendent may by ruling require that such policy meet the standards set forth in Sections 59A-22-3 through 59A-22-25 NMSA 1978."

SECTION 17. Section 59A-22-30.1 NMSA 1978 (being Laws 2005, Chapter 41, Section 1) is amended to read:

"59A-22-30.1. MAXIMUM AGE OF DEPENDENT.--An individual

or group health policy or certificate of insurance delivered, issued for delivery or renewed in New Mexico that provides coverage for an insured's dependent shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-sixth birthday, regardless of whether the dependent is enrolled in an educational institution."

SECTION 18. Section 59A-22-33 NMSA 1978 (being Laws 1984, Chapter 127, Section 455) is amended to read:

"59A-22-33. CHILDREN WITH DISABILITIES--COVERAGE CONTINUED.--An individual or group hospital or medical expense insurance policy delivered or issued for delivery in this state that provides that coverage of a dependent child of an insured, or of an employee or other member of the covered group, shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide, in substance, that attainment of the limiting age shall not operate to terminate the coverage of a child while the child is, and continues to be both incapable of self-sustaining employment, by reason of intellectual or developmental disability or physical disability, and chiefly dependent upon the policyholder for support and maintenance. However, proof of the incapacity and dependency of the child must be furnished to the insurer by the insured employee or member within thirty-one days of the child's attainment of

the limiting age and subsequently, as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age."

SECTION 19. Section 59A-22-40.1 NMSA 1978 (being Laws 2007, Chapter 278, Section 1) is amended to read:

"59A-22-40.1. COVERAGE FOR THE HUMAN PAPILLOMAVIRUS VACCINE.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall provide coverage for the human papillomavirus vaccine in accordance with the current standards of the federal centers for disease control and prevention.

B. Coverage for the human papillomavirus vaccine may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

C. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified disease policies.

D. For the purposes of this section, "human papillomavirus vaccine" means a vaccine approved by the federal food and drug administration used for the prevention of human papillomavirus infection and cervical precancers."

SECTION 20. Section 59A-22-41.1 NMSA 1978 (being Laws 2003, Chapter 192, Section 1) is amended to read:

"59A-22-41.1. COVERAGE FOR MEDICAL DIETS FOR GENETIC INBORN ERRORS OF METABOLISM.--

A. As of July 1, 2003, each individual and group health insurance policy, health care plan, certificate of health insurance and managed health care plan delivered, issued for delivery, renewed, extended or modified in this state shall provide coverage for the treatment of genetic inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist.

B. Coverage shall include expenses of diagnosing, monitoring and controlling disorders by nutritional and medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and special medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

C. Services required to be covered pursuant to this section are subject to the terms and conditions of the applicable individual or group policy or plan that establishes durational limits, dollar limits, deductibles and

co-payments as long as the terms are not less favorable than for physical illness generally.

D. As used in this section:

(1) "genetic inborn error of metabolism" means a rare, inherited disorder that:

(a) is present at birth;

(b) if untreated, results in intellectual or developmental disability or death; and

(c) causes the necessity for consumption of special medical foods;

(2) "special medical foods" means nutritional substances in any form that are:

(a) formulated to be consumed or administered internally under the supervision of a physician;

(b) specifically processed or formulated to be distinct in one or more nutrients present in natural food;

(c) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

(d) essential to optimize growth, health and metabolic homeostasis; and

(3) "treatment" means medical services provided

by licensed health care professionals, including physicians, dieticians and nutritionists, with specific training in managing patients diagnosed with genetic inborn errors of metabolism."

SECTION 21. Section 59A-22-50 NMSA 1978 (being Laws 2010, Chapter 94, Section 1, as amended) is amended to read:

"59A-22-50. HEALTH INSURERS--DIRECT SERVICES.--

A. A health insurer shall reimburse direct services as follows:

(1) for small groups, at no less than eighty percent of aggregate premiums for all such products; and

(2) for large groups, at no less than eighty-five percent of aggregate premiums for all such products.

B. Reimbursement for direct services shall be determined based on services provided over the preceding three calendar years, but not earlier than calendar year 2010, as determined by reports filed with the office of superintendent of insurance. Reimbursement calculations shall include short-term plans, but exclude all other excepted benefits plans governed by the provisions of Chapter 59A, Article 23G NMSA 1978.

C. For individually underwritten health care policies, plans or contracts, the superintendent shall establish, after notice and informal hearing, the level of

reimbursement for direct services, as determined by the reports filed with the office of superintendent of insurance, as a percent of premiums. Additional informal hearings may be held at the superintendent's discretion. In establishing the level of reimbursement for direct services, the superintendent shall consider the costs associated with the individual marketing and medical underwriting of these policies, plans or contracts at a level not less than seventy-five percent of premiums. A health insurer writing these policies shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which that rate is established, but not earlier than calendar year 2010. Nothing in this subsection shall be construed to preclude a purchaser of one of these policies, plans or contracts from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services.

D. An insurer that fails to comply with the reimbursement requirements pursuant to this section shall issue a dividend or credit against future premiums to all policyholders in an amount sufficient to ensure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the required

direct services reimbursement level pursuant to Subsection A of this section for group health coverage and blanket health coverage or the required direct services reimbursement level pursuant to Subsection B of this section for individually underwritten health policies, contracts or plans for the preceding three calendar years. If the insurer fails to issue the dividend or credit in accordance with the requirements of this section, the superintendent shall enforce these requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

E. After notice and hearing, the superintendent may adopt and promulgate reasonable rules necessary and proper to carry out the provisions of this section.

F. For the purposes of this section:

(1) "direct services" means services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided, however, that "direct services" does not include care coordination, utilization review or

management or any other activity designed to manage utilization or services;

(2) "health insurer" means a person duly authorized to transact the business of health insurance in the state pursuant to the Insurance Code, including a person that issues a short-term plan and a person that only issues an excepted benefit policy intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;

(3) "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any tax paid pursuant to the Insurance Premium Tax Act and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance; and

(4) "short-term plan" means a nonrenewable health benefits plan covering a resident of the state, regardless of where the plan is delivered, that:

(a) has a maximum specified duration of not more than three months after the effective date of the

plan;

(b) is issued only to individuals who have not been enrolled in a health benefits plan that provides the same or similar nonrenewable coverage from any health insurance carrier within the three months preceding enrollment in the short-term plan; and

(c) is not an excepted benefit or combination of excepted benefits."

SECTION 22. Section 59A-22A-3 NMSA 1978 (being Laws 1993, Chapter 320, Section 61) is amended to read:

"59A-22A-3. DEFINITIONS.--As used in the Preferred Provider Arrangements Law:

A. "covered person" means any person on whose behalf the health care insurer is obligated to pay for or to provide health benefit services;

B. "covered services" means health care services which the health care insurer is obligated to pay for or to provide under a health benefit plan;

C. "emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's

health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person;

D. "health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer that defines the covered services and benefit levels available;

E. "health care insurer" means any person who provides health insurance in this state. For the purposes of the Small Group Rate and Renewability Act, "carrier" or "insurer" includes a licensed insurance company, a licensed fraternal benefit society, a prepaid hospital or medical service plan, a health maintenance organization, a nonprofit health care organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation;

F. "health care provider" means providers of health care services licensed as required in this state;

G. "health care services" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

H. "preferred provider" means a health care provider or group of providers who have contracted with a

health care insurer to provide specified covered services to a covered person; and

I. "preferred provider arrangement" means a contract between or on behalf of the health care insurer and a preferred provider that complies with all the requirements of the Preferred Provider Arrangements Law."

SECTION 23. Section 59A-23-4 NMSA 1978 (being Laws 1984, Chapter 127, Section 463, as amended) is amended to read:

"59A-23-4. OTHER PROVISIONS APPLICABLE.--

A. A blanket or group health insurance policy or contract shall not contain a provision relative to notice or proof of loss or the time for paying benefits or the time within which suit may be brought upon the policy that in the superintendent's opinion is less favorable to the insured than would be permitted in the required or optional provisions for individual health insurance policies as set forth in Chapter 59A, Article 22 NMSA 1978.

B. The following provisions of Chapter 59A, Article 22 NMSA 1978 shall also apply as to Chapter 59A, Article 23 NMSA 1978 and blanket and group health insurance contracts:

(1) Section 59A-22-1 NMSA 1978, except Subsection C of that section; and

(2) Section 59A-22-32 NMSA 1978.

C. The following provisions of Chapter 59A, Article 22 NMSA 1978 shall also apply as to group health insurance

contracts:

(1) Section 59A-22-2 NMSA 1978;

(2) Section 59A-22-3 NMSA 1978;

(3) Section 59A-22-4 NMSA 1978;

(4) Section 59A-22-5 NMSA 1978;

(5) Section 59A-22-6 NMSA 1978;

(6) Section 59A-22-7 NMSA 1978;

(7) Section 59A-22-8 NMSA 1978;

(8) Section 59A-22-9 NMSA 1978;

(9) Section 59A-22-10 NMSA 1978;

(10) Section 59A-22-11 NMSA 1978;

(11) Section 59A-22-12 NMSA 1978;

(12) Section 59A-22-13 NMSA 1978;

(13) Section 59A-22-14 NMSA 1978;

(14) Section 59A-22-25 NMSA 1978;

(15) Section 59A-22-28 NMSA 1978;

(16) Section 59A-22-29 NMSA 1978;

(17) Section 59A-22-32 NMSA 1978;

(18) Section 59A-22-32.1 NMSA 1978;

(19) Section 59A-22-33 NMSA 1978;

(20) Section 59A-22-34 NMSA 1978;

(21) Section 59A-22-34.1 NMSA 1978;

(22) Section 59A-22-34.3 NMSA 1978;

(23) Section 59A-22-35 NMSA 1978;

(24) Section 59A-22-36 NMSA 1978;

(25) Section 59A-22-39 NMSA 1978;

(26) Section 59A-22-39.1 NMSA 1978;

(27) Section 59A-22-40 NMSA 1978;

(28) Section 59A-22-40.1 NMSA 1978;

(29) Section 59A-22-41 NMSA 1978;

(30) Section 59A-22-42 NMSA 1978;

(31) Section 59A-22-43 NMSA 1978;

(32) Section 59A-22-44 NMSA 1978; and

(33) Section 59A-22-50 NMSA 1978."

SECTION 24. Section 59A-23-7.3 NMSA 1978 (being Laws 2003, Chapter 391, Section 3) is amended to read:

"59A-23-7.3. MAXIMUM AGE OF DEPENDENT.--Each blanket or group health policy or certificate of insurance delivered, issued for delivery or renewed in New Mexico on or after July 1, 2003 that provides coverage for an insured's dependent shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-sixth birthday, regardless of whether the dependent is enrolled in an educational institution."

SECTION 25. Section 59A-23D-2 NMSA 1978 (being Laws 1995, Chapter 93, Section 2, as amended) is amended to read:

"59A-23D-2. DEFINITIONS.--As used in the Medical Care Savings Account Act:

A. "account administrator" means any of the following that administers medical care savings accounts:

(1) a national or state-chartered bank, savings and loan association, savings bank or credit union;

(2) a trust company authorized to act as a fiduciary in this state;

(3) an insurance company or health maintenance organization authorized to do business in this state pursuant to the Insurance Code; or

(4) a person approved by the federal secretary of health and human services;

B. "deductible" means the total covered medical expense an employee or the employee's dependents must pay prior to any payment by a qualified higher deductible health plan for a calendar year;

C. "department" means the office of superintendent of insurance;

D. "dependent" means:

(1) a spouse;

(2) an unmarried or unemancipated child of the employee who is a minor and who is:

(a) a natural child;

(b) a legally adopted child;

(c) a stepchild living in the same household who is primarily dependent on the employee for maintenance and support;

(d) a child for whom the employee is the

legal guardian and who is primarily dependent on the employee for maintenance and support, as long as evidence of the guardianship is evidenced in a court order or decree; or

(e) a foster child living in the same household, if the child is not otherwise provided with health care or health insurance coverage;

(3) an unmarried child described in Subparagraphs (a) through (e) of Paragraph (2) of this subsection who is between the ages of eighteen and twenty-five; or

(4) a child over the age of eighteen who is incapable of self-sustaining employment by reason of intellectual or developmental disability or physical disability and who is chiefly dependent on the employee for support and maintenance;

E. "eligible individual" means an individual who with respect to any month:

(1) is covered under a qualified higher deductible health plan as of the first day of that month;

(2) is not, while covered under a qualified higher deductible health plan, covered under a health plan that:

(a) is not a qualified higher deductible health plan; and

(b) provides coverage for a benefit that

is covered under the qualified higher deductible health plan; and

(3) is covered by a qualified higher deductible health plan that is established and maintained by the employer of the individual or of the spouse of the individual;

F. "eligible medical expense" means an expense paid by the employee for medical care described in Section 213(d) of the Internal Revenue Code of 1986 that is deductible for federal income tax purposes to the extent that those amounts are not compensated for by insurance or otherwise;

G. "employee" includes a self-employed individual;

H. "employer" includes a self-employed individual;

I. "medical care savings account" or "savings account" means an account established by an employer in the United States exclusively for the purpose of paying the eligible medical expenses of the employee or dependent, but only if the written governing instrument creating the trust meets the following requirements:

(1) except in the case of a rollover contribution, no contribution will be accepted:

(a) unless it is in cash; or

(b) to the extent the contribution, when added to previous contributions to the trust for the calendar year, exceeds seventy-five percent of the highest annual

limit deductible permitted pursuant to the Medical Care Savings Account Act;

(2) no part of the trust assets will be invested in life insurance contracts;

(3) the assets of the trust will not be commingled with other property except in a common trust fund or common investment fund; and

(4) the interest of an individual in the balance in the individual's account is nonforfeitable;

J. "program" means the medical care savings account program established by an employer for employees; and

K. "qualified higher deductible health plan" means a health coverage policy, certificate or contract that provides for payments for covered health care benefits that exceed the policy, certificate or contract deductible, that is purchased by an employer for the benefit of an employee and that has the following deductible provisions:

(1) self-only coverage with an annual deductible of not less than one thousand five hundred dollars ($1,500) or more than two thousand two hundred fifty dollars ($2,250) and a maximum annual out-of-pocket expense requirement of three thousand dollars ($3,000), not including premiums;

(2) family coverage with an annual deductible of not less than three thousand dollars ($3,000) or more than

four thousand five hundred dollars ($4,500) and a maximum annual out-of-pocket expense requirement of five thousand five hundred dollars ($5,500), not including premiums; and

(3) preventive care coverage may be provided within the policies without the preventive care being subjected to the qualified higher deductibles."

SECTION 26. Section 59A-46-30 NMSA 1978 (being Laws 1993, Chapter 266, Section 29, as amended) is amended to read:

"59A-46-30. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS.--

A. The provisions of the Insurance Code other than Chapter 59A, Article 46 NMSA 1978 shall not apply to health maintenance organizations except as expressly provided in the Insurance Code and that article. To the extent reasonable and not inconsistent with the provisions of that article, the following articles and provisions of the Insurance Code shall also apply to health maintenance organizations and their promoters, sponsors, directors, officers, employees, agents, solicitors and other representatives. For the purposes of such applicability, a health maintenance organization may therein be referred to as an "insurer":

(1) Chapter 59A, Article 1 NMSA 1978;

(2) Chapter 59A, Article 2 NMSA 1978;

(3) Chapter 59A, Article 4 NMSA 1978;

(4) Subsection C of Section 59A-5-22 NMSA 1978;

(5) Sections 59A-6-2 through 59A-6-4 and 59A-6-6 NMSA 1978;

(6) Chapter 59A, Article 8 NMSA 1978;

(7) Chapter 59A, Article 10 NMSA 1978;

(8) Chapter 59A, Article 16 NMSA 1978;

(9) the Domestic Abuse Insurance Protection Act;

(10) the Insurance Fraud Act;

(11) Chapter 59A, Article 18 NMSA 1978;

(12) the Policy Language Simplification Law;

(13) Section 59A-22-14 NMSA 1978;

(14) the Health Insurance Portability Act;

(15) Sections 59A-34-2, 59A-34-7 through 59A-34-13, 59A-34-17, 59A-34-23, 59A-34-33, 59A-34-36, 59A-34-37, 59A-34-40 through 59A-34-42 and 59A-34-44 through 59A-34-46 NMSA 1978;

(16) the Insurance Holding Company Law;

(17) the Patient Protection Act; and

(18) the Surprise Billing Protection Act.

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed as violating any provision of law relating to solicitation or advertising by health professionals, but health professionals shall be

individually subject to the laws, rules and ethical provisions governing their individual professions.

C. Any health maintenance organization authorized under the provisions of the Health Maintenance Organization Law shall not be deemed to be practicing medicine and shall be exempt from the provisions of laws relating to the practice of medicine."

SECTION 27. Section 59A-46-38.3 NMSA 1978 (being Laws 2003, Chapter 391, Section 5, as amended) is amended to read:

"59A-46-38.3. MAXIMUM AGE OF DEPENDENT.--Each individual or group health maintenance organization contract delivered or issued for delivery or renewed in New Mexico that provides coverage for an enrollee's dependents shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-sixth birthday, regardless of whether the dependent is enrolled in an educational institution; provided that this requirement does not apply to the medicaid managed care system."

SECTION 28. Section 59A-46-42.1 NMSA 1978 (being Laws 2007, Chapter 278, Section 3) is amended to read:

"59A-46-42.1. COVERAGE FOR THE HUMAN PAPILLOMAVIRUS VACCINE.--

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state shall provide coverage for the human

papillomavirus vaccine in accordance with the current standards of the federal centers for disease control and prevention.

B. Coverage for the human papillomavirus vaccine may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

C. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified disease policies.

D. For the purposes of this section, "human papillomavirus vaccine" means a vaccine approved by the federal food and drug administration used for the prevention of human papillomavirus infection and cervical precancers."

SECTION 29. Section 59A-47-33 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.32, as amended) is amended to read:

"59A-47-33. OTHER PROVISIONS APPLICABLE.--The provisions of the Insurance Code other than Chapter 59A, Article 47 NMSA 1978 shall not apply to health care plans except as expressly provided in the Insurance Code and that article. To the extent reasonable and not inconsistent with the provisions of that article, the following articles and provisions of the Insurance Code shall also apply to health care plans, their promoters, sponsors, directors, officers, employees, agents,

solicitors and other representatives; and, for the purposes of such applicability, a health care plan may therein be referred to as an "insurer":

A. Chapter 59A, Article 1 NMSA 1978;

B. Chapter 59A, Article 2 NMSA 1978;

C. Chapter 59A, Article 4 NMSA 1978;

D. Subsection C of Section 59A-5-22 NMSA 1978;

E. Sections 59A-6-2 through 59A-6-4 and 59A-6-6 NMSA 1978;

F. Section 59A-7-11 NMSA 1978;

G. Chapter 59A, Article 8 NMSA 1978;

H. Chapter 59A, Article 10 NMSA 1978;

I. Section 59A-12-22 NMSA 1978;

J. Chapter 59A, Article 16 NMSA 1978;

K. Chapter 59A, Article 18 NMSA 1978;

L. Chapter 59A, Article 19 NMSA 1978;

M. Subsections B through E of Section 59A-22-5 NMSA 1978;

N. Section 59A-22-14 NMSA 1978;

O. Section 59A-22-34.1 NMSA 1978;

P. Section 59A-22-39 NMSA 1978;

Q. Section 59A-22-40 NMSA 1978;

R. Section 59A-22-40.1 NMSA 1978;

S. Section 59A-22-41 NMSA 1978;

T. Section 59A-22-42 NMSA 1978;

U. Section 59A-22-43 NMSA 1978;

V. Section 59A-22-44 NMSA 1978;

W. Section 59A-22-50 NMSA 1978;

X. Sections 59A-34-7 through 59A-34-13, 59A-34-17, 59A-34-23, 59A-34-33, 59A-34-40 through 59A-34-42 and 59A-34-44 through 59A-34-46 NMSA 1978;

Y. the Insurance Holding Company Law, except Section 59A-37-7 NMSA 1978;

Z. Section 59A-46-15 NMSA 1978;

AA. the Patient Protection Act; and

BB. the Surprise Billing Protection Act."

SECTION 30. Section 59A-47-40 NMSA 1978 (being Laws 2003, Chapter 391, Section 7, as amended) is amended to read:

"59A-47-40. MAXIMUM AGE OF DEPENDENT.--An individual or group health care coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act that offers coverage of an insured's dependent shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-sixth birthday, regardless of whether the dependent is enrolled in an educational institution."

SECTION 31. Section 59A-54-6 NMSA 1978 (being Laws 1987, Chapter 154, Section 6, as amended) is amended to read:

"59A-54-6. NOTICE OF POOL.--

A. Every insurer shall provide a notice and an

application for coverage by the pool to any person who receives:

(1) a rejection of coverage for health insurance or health care services;

(2) a notice that the rate for health insurance or coverage for health care services provided will exceed the rates of a pool policy;

(3) a notice of reduction or limitation of coverage, including a restrictive rider, from an insurer if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan; or

(4) a termination of coverage for health insurance or health care services by either the carrier or the covered individual.

B. The notice required by Subsection A of this section shall state that the person is eligible to apply for health insurance provided by the pool. Application for the health insurance shall be on forms prescribed by the board and made available to all insurers."

SECTION 32. Section 59A-54-8 NMSA 1978 (being Laws 1987, Chapter 154, Section 8) is amended to read:

"59A-54-8. EXAMINATION.--The pool shall be subject to and responsible for examination by the superintendent. Not

later than June 1 of each year, the board shall submit to the superintendent an audited financial report for the preceding calendar year in a form approved by the superintendent."

SECTION 33. Section 59A-54-11 NMSA 1978 (being Laws 1987, Chapter 154, Section 11, as amended) is amended to read:

"59A-54-11. POOL ADMINISTRATOR--SELECTION--DUTIES.--

A. The board shall select a pool administrator through a competitive bidding process. The board shall evaluate bids based on criteria established by the board, which shall include:

(1) proven ability to handle accident and health insurance;

(2) efficiency of claim paying procedures;

(3) an estimate of total charges for administering the plan; and

(4) ability to administer the pool in a cost-efficient manner.

B. The pool administrator shall serve for a period not to exceed that provided in Subsection B of Section 13-1-150 NMSA 1978, subject to removal for cause. At least one year prior to the expiration of the pool administrator's contract, the board shall invite all interested parties, including the current administrator, to submit bids to serve as the pool administrator for the succeeding contract period.

Selection of the administrator for a succeeding period shall be made at least six months prior to the expiration of the pool administrator's current contract.

C. The pool administrator shall:

(1) perform all eligibility and administrative claim payment functions relating to the pool;

(2) establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis, not less than monthly, as determined by the board;

(3) perform all necessary functions to assure timely payment of benefits to persons covered under the pool, including:

(a) making information available relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made; and

(b) evaluating the eligibility of each claim for payment by the pool;

(4) submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board; and

(5) following the close of each fiscal year, determine net written and earned premiums, the expense of

administration and the paid and incurred losses for the year and report this information to the board and the superintendent on a form prescribed by the superintendent.

D. The administrator shall be paid as provided in the contract negotiated pursuant to the process for selection of the administrator established by the board."

SECTION 34. Section 59A-54-14 NMSA 1978 (being Laws 1987, Chapter 154, Section 14, as amended) is amended to read:

"59A-54-14. DEDUCTIBLES--COINSURANCE--MAXIMUM OUT-OF-POCKET PAYMENTS.--

A. Subject to the limitation provided in Subsection C of this section, a pool policy offered in accordance with the Medical Insurance Pool Act shall impose a deductible on a per-person calendar-year basis. Deductible plans of five hundred dollars ($500) and one thousand dollars ($1,000) shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars ($500) or one thousand dollars ($1,000) of eligible expenses incurred by the covered person.

B. Subject to the limitations provided in Subsection C of this section, a mandatory coinsurance requirement shall be imposed at the rate determined by the board.

C. The maximum aggregate out-of-pocket payments for eligible expenses by the insured shall be determined by the board."

SECTION 35. Section 59A-54-19 NMSA 1978 (being Laws 1987, Chapter 154, Section 19, as amended) is amended to read:

"59A-54-19. RATES--STANDARD RISK RATE.--

A. The pool shall determine a standard risk rate by actuarially calculating the individual rate that an insurer would charge for an individual policy with the pool benefits issued to a person who was a standard risk. Separate schedules of standard risk rates based on age and other appropriate demographic characteristics may be used. In determining the standard risk rate, the pool shall consider the benefits provided, the standard risk experience and the anticipated expenses for a standard risk for the coverage provided. The rates charged for pool coverage shall be no more than one hundred fifty percent of the standard risk rate for each class of insureds.

B. The board shall adopt a low-income premium schedule that provides coverage at lower rates for those persons with an income less than four hundred percent of the current federal poverty level guidelines applicable to New Mexico, published by the United States department of health and human services. For individuals with household incomes

of one hundred ninety-nine percent of the federal poverty level or lower, the premium reduction shall be seventy-five percent. For individuals with household incomes of two hundred percent to two hundred ninety-nine percent of the federal poverty level, the premium reduction shall be fifty percent. For individuals with household incomes of three hundred percent to three hundred ninety-nine percent of the federal poverty level, the premium reduction shall be twenty-five percent. The board shall determine income based on the preceding taxable year. No person shall be eligible for a low-income premium reduction if that person's premium is paid by a third party who is not a family member.

C. All rates and rate schedules shall be submitted to the superintendent for approval."

SECTION 36. Section 59A-58-5 NMSA 1978 (being Laws 2001, Chapter 206, Section 5, as amended) is amended to read:

"59A-58-5. REGISTRATION REQUIREMENTS.--

A. A provider who wishes to issue, sell or offer for sale service contracts in this state must submit to the superintendent:

(1) a registration application on a form prescribed by the superintendent;

(2) proof that the provider has complied with the requirements for security pursuant to Section 59A-58-6 NMSA 1978;

(3) the name, address and telephone number of each administrator with whom the provider intends to contract, if any; and

(4) provided that House Bill 248 of the first session of the fifty-fifth legislature:

(a) becomes law, the registration renewal fee provided in Section 59A-6-1 NMSA 1978; or

(b) does not become law, a fee of five hundred dollars ($500).

B. A provider's registration is valid for one year after the date the registration is filed. A provider may renew the provider's registration if, before the registration expires, the provider submits to the superintendent an application on a form prescribed by the superintendent and, provided that House Bill 248 of the first session of the fifty-fifth legislature:

(1) becomes law, the registration renewal fee provided in Section 59A-6-1 NMSA 1978; or

(2) does not become law, a fee of five hundred dollars ($500).

C. The provisions of this section shall not apply to major manufacturing companies' service contracts.

D. Service contract forms are not required to be filed with the superintendent."

SECTION 37. REPEAL.--Sections 59A-23-9, 59A-46-51 and

59A-47-46 NMSA 1978 (being Laws 1997, Chapter 243, Section 20 and Laws 2010, Chapter 94, Sections 3 and 4, as amended) are repealed.

SECTION 38. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2021.