SENATE BILL 364

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

INTRODUCED BY

John M. Sapien

AN ACT

RELATING TO INSURANCE; AMENDING AND ENACTING SECTIONS OF THE NEW MEXICO INSURANCE CODE TO CHANGE PROVISIONS RELATED TO HEARINGS, FEES, LAPSE OF AUTHORITY OR LICENSURE, DEFINITIONS, EXAMINATION, INTEREST ON CERTAIN LATE PAYMENTS AND MEDICAL STANDARDS; PROVIDING PENALTIES.

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

SECTION 1. 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.--The superintendent shall:

A. organize and manage the office of superintendent of insurance and direct and supervise all its activities;

B. execute the duties imposed upon the superintendent by the Insurance Code;

C. enforce those provisions of the Insurance Code that are administered by the superintendent;

D. have the powers and authority expressly conferred by or reasonably implied from the provisions of the Insurance Code;

E. 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;

F. have the power to sue or be sued;

G. 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;

H. prepare an annual budget for the office of superintendent of insurance;

I. 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;

J. [~~comply with the provisions of the Administrative Procedures Act~~] conduct hearings in accordance

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with rules promulgated by the superintendent; and

K. have such additional powers and duties as may be provided by other laws of this state."

SECTION 2. 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

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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~~] Notwithstanding the provisions of Subsection D of this section, if the superintendent or the district court of Santa Fe county suspends or postpones the effective date of an action regarding

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which a hearing is requested, the superintendent shall commence the hearing within one hundred eighty days after the filing of the request. A hearing initiated by the superintendent that is not held at the request of an aggrieved person shall be commenced within one hundred eighty days of the filing of the notice of hearing.

[~~G.~~] F. The superintendent may appoint a hearing officer to preside over hearings [~~on reconsideration of rate filings~~]. 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 3. Section 59A-4-17 NMSA 1978 (being Laws 1984, Chapter 127, Section 61) is amended to read:

"59A-4-17. HEARING PROCEDURE.--[~~Administration~~] Administrative hearings shall be held in accordance with [~~the applicable provisions of Sections 12-8-10 through 12-8-13 and Section 12-8-15 NMSA 1978~~] rules promulgated by the superintendent."

SECTION 4. A new section of Chapter 59A, Article 5 NMSA 1978 is enacted to read:

"[NEW MATERIAL] LAPSE--REINSTATEMENT.--If an insurer allows a certificate of authority issued by the superintendent to lapse, the holder of the lapsed certificate shall remain subject to the provisions of the Insurance Code but is not

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authorized to transact any insurance business. If the insurer reinstates the lapsed certificate of authority, the reinstatement shall relate back to the date of the lapse; provided that this shall not excuse any violation of the Insurance Code that occurred during the intervening period."

SECTION 5. Section 59A-6-1 NMSA 1978 (being Laws 1984, Chapter 127, Section 101, as amended) is amended to read:

"59A-6-1. FEE SCHEDULE--PENALTY.--The superintendent shall collect the following fees:

A. insurer's certificate of authority:

(1) filing application for certificate of authority, and issuance of certificate of authority, including filing of all charter documents, financial statements, service of process, power of attorney, examination reports and other documents included with and part of the application $1,000.00

(2) annual continuation of certificate of authority, per kind of insurance 200.00

(3) reinstatement of certificate of authority (Section 59A-5-23 NMSA 1978) 150.00

(4) amendment to certificate of authority 200.00

B. charter documents - filing amendment to any charter document (as defined in Section 59A-5-3 NMSA 1978) 10.00

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C. annual statement of insurer, filing . . 200.00

D. service of process, acceptance by superintendent and issuance of certificate of service 10.00

E. producer licenses and appointments:

(1) filing application for original producer license and issuance of license 30.00

(2) biennial continuation of license . 60.00

(3) appointment of producer:

(a) filing appointment, per kind of insurance, each insurer 20.00

(b) annual continuation of appointment, per kind of insurance, each insurer 20.00

(4) temporary license filing application 30.00

F. agency business entity license and affiliations:

(1) filing application for original agency business entity license and issuance of license 30.00

(2) biennial continuation of license . 60.00

(3) filing of individual affiliation . 20.00

(4) annual continuation of individual affiliation 20.00

G. insurance vending machine license:

(1) filing application for original license and issuance of license, each machine 25.00

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(2) biennial continuation of license, each machine 50.00

H. examination for license, application for examination conducted directly by the superintendent, each grouping of kinds of insurance to be covered by the examination as provided by the superintendent's rules, and payable as to each instance of examination, not to exceed 75.00

I. surplus lines insurer - filing application for qualification as eligible surplus lines insurer . . . 1,000.00

J. surplus lines broker license:

(1) filing application for original license and issuance of license 100.00

(2) biennial continuation of license 200.00

K. surplus lines brokerage business entity license and affiliations:

(1) filing application for original surplus lines brokerage business entity license and issuance of license 100.00

(2) filing of individual affiliation . 20.00

(3) annual continuation of individual affiliation 20.00

(4) biennial continuation of license 100.00

L. adjuster license:

(1) filing application for original license

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and issuance of license 30.00

(2) biennial continuation of license 60.00

M. insurance consultant license:

(1) filing application for original license and issuance of license 50.00

(2) application examination 75.00

(3) biennial continuation of license 100.00

N. viatical settlements license:

(1) providers:

(a) filing application for original license and issuance of license 1,000.00

(b) biennial continuation of license 400.00

(2) brokers:

(a) filing application for original license and issuance of license 100.00

(b) biennial continuation of license 200.00

(3) brokerages:

(a) filing application for original business entity license and issuance of license 100.00

(b) biennial continuation of license 200.00

(c) filing of individual

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affiliation 20.00

(d) annual continuation of individual affiliation 20.00

O. advisory organization license:

(1) filing application for license and issuance of license 100.00

(2) annual continuation of license 100.00

P. nonprofit health care plans:

(1) filing application for preliminary permit and issuance of permit 100.00

(2) certificate of authority, application, issuance, continuation, reinstatement, charter documents--same as for insurers

(3) annual statement, filing 200.00

Q. prepaid dental plans:

(1) certificate of authority, application, issuance, continuation, reinstatement, charter documents--same as for insurers

(2) annual report, filing 200.00

R. prearranged funeral insurance--application for certificate of authority, issuance, continuation, reinstatement, charter documents, filing annual statement, licensing of sales representatives--same as for insurers

S. premium finance companies:

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(1) filing application for original license and issuance of license 100.00

(2) annual renewal of license 100.00

T. motor clubs:

(1) certificate of authority:

(a) filing application for original certificate of authority and issuance of certificate of authority 200.00

(b) annual continuation of certificate of authority 100.00

(2) sales representatives:

(a) filing application for registration or license and issuance of registration or license, each representative 30.00

(b) biennial continuation of registration or license, each representative 60.00

U. bail bondsmen:

(1) filing application for original license as bail bondsman or solicitor, and issuance of license 30.00

(2) examination for license, each instance of examination 50.00

(3) biennial continuation of license 60.00

V. required filing of forms or rates - by all lines

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of business other than property or casualty:

(1) rates 50.00

(2) major form - each new policy and each package submission, which can include multiple policy forms, application forms, rider forms, endorsement forms or amendment forms 30.00

(3) incidental forms and rates--forms filed for informational purposes; riders, applications, endorsements and amendments filed individually; rate service organization reference filings; rates filed for informational purposes 15.00

W. health maintenance organizations:

(1) filing an application for a certificate of authority 1,000.00

(2) annual continuation of certificate of authority 200.00

(3) filing each annual report 200.00

(4) filing an amendment to organizational documents requiring approval 200.00

(5) filing informational amendments . . 50.00

X. purchasing groups and foreign risk retention groups:

(1) original registration 500.00

(2) annual continuation of registration 200.00

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(3) producer fees - same as for authorized insurers

Y. third party administrators:

(1) filing application for original business entity insurance administrator license 100.00

(2) biennial continuation or renewal of license 200.00

[~~(3) examination for license, each examination . . . . . 75.00~~

~~(4)~~] (3) filing of [~~annual~~] biennial report . . . . . [~~50.00~~] 100.00

Z. miscellaneous fees:

(1) duplicate license 30.00

(2) [~~name change~~] license amendment . . 30.00

(3) for each signature and seal of superintendent affixed to any instrument 10.00

AA. pharmacy benefits managers:

(1) filing an application for a license 1,000.00

(2) annual continuation of license, each year continued 500.00

(3) filing each annual report 200.00

(4) filing an amendment to organizational documents requiring approval 200.00

(5) filing informational amendments . 100.00

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BB. independent review organizations:

(1) filing an application for a license 250.00

(2) biennial continuation of license 100.00

CC. continuing education providers:

(1) filing an application for a course of instruction 80.00

(2) biennial continuation of course of instruction . . . . . 40.00.

An insurance producer who allows the insurance producer's license to lapse may, within twelve months from the due date of the license renewal fee, reinstate the same license without the requirement of passing a written examination; provided that the office of superintendent of insurance shall assess a penalty in the amount of double the unpaid renewal fee for any renewal application received after the due date. An insurer shall be subject to additional fees or charges, termed retaliatory or reciprocal requirements, whenever form or rate-filing fees in excess of those imposed by state law are charged to insurers in New Mexico doing business in another state or whenever a condition precedent to the right to issue policies in another state is imposed by the laws of that state over and above the conditions imposed upon insurers by the laws of New Mexico; in those cases, the same form or rate-filing fees may be imposed upon an insurer from another state transacting or applying to

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transact business in New Mexico so long as the higher fees remain in force in the other state. If an insurer does not comply with the additional retaliatory or reciprocal requirement charges imposed under this subsection, the superintendent may refuse to grant or may withdraw approval of the tendered form or rate filing.

All fees are earned when paid and are not refundable."

SECTION 6. Section 59A-6-1.2 NMSA 1978 (being Laws 2001, Chapter 302, Section 2) is amended to read:

"59A-6-1.2. PROPERTY AND CASUALTY ANNUAL RATES AND FORMS FILING FEES.--[~~The annual filing fee for rates and forms due in advance on July 1 for each company in the following groupings shall be equal to the product produced by multiplying three thousandths by the company's previous calendar year's direct written premium as shown on its annual financial statement, but not to exceed an amount of one thousand five hundred dollars ($1,500) and not to be less than an amount of one hundred dollars ($100):~~

~~A. private passenger automobile - liability and physical damage;~~

~~B. homeowner's and farm owners';~~

~~C. workers' compensation;~~

~~D. other casualty, including surety and fidelity;~~ ~~and~~

~~E. other property~~] By July 1, 2019 and each July 1

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thereafter, an entity that transacts, or that is authorized to transact, property or casualty insurance, excluding title insurance, shall pay a filing fee. The fee shall be computed by multiplying by .003 the insurer's previous calendar year's direct written premium for risks located in the state in each such line or type of insurance. The maximum annual fee for each entity that pays a fee pursuant to this section is five thousand dollars ($5,000) and the minimum fee is five hundred dollars ($500)."

SECTION 7. A new section of Chapter 59A, Article 6 NMSA 1978 is enacted to read:

"[NEW MATERIAL] FORM OF PAYMENT--TAXES--SURTAXES--FINES--PENALTIES.--The superintendent may require any person that is obligated to pay to the superintendent a fee, tax, surtax, fine or penalty to make the payment through an electronic funds transfer. Any charge imposed by the payor's financial institution or by the payment processor to make the payment is the responsibility of the payor and shall not reduce, or be deducted from, the amount due to the superintendent."

SECTION 8. Section 59A-11-10 NMSA 1978 (being Laws 1984, Chapter 127, Section 189, as amended) is amended to read:

"59A-11-10. CONTINUATION, EXPIRATION OF LICENSE.--

A. The term of the license shall be perpetual, contingent upon payment of fees and completion of any continuing education requirements.

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B. Individual licenses shall renew and continue on a biennial basis on the last day of the licensee's month of birth. Business entity licenses shall renew and continue on a biennial basis on March 1 of the biennial year; except for those types of business entity licenses that, pursuant to Section 59A-6-1 NMSA 1978, renew and continue on an annual basis, in which case those licenses shall renew and continue on March 1 of every year. Business entity affiliations shall renew and continue on an annual basis on March 1 of every year.

C. Any license referred to in this section that is not so continued shall be deemed to have terminated as of midnight on the last day of the licensee's month of birth if an individual license and as of midnight of March 1 if a business entity license; except that the superintendent may effectuate a request for continuation received within thirty days thereafter if accompanied by a continuation fee equal to one hundred fifty percent of the continuation fee otherwise required.

D. If the superintendent has reason to believe that the competence of any licensee, or individual designated to exercise license powers, is questionable, the superintendent may require as condition of continuation of the license or license powers that the licensee or individual take and pass a written examination as required under the Insurance Code of new individual applicants for the same license.

E. [~~This section shall not apply as to temporary~~

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~~licenses, which shall be for such duration and subject to extension as provided in the respective sections of the Insurance Code by which such licenses are authorized~~] An insurance producer who allows the insurance producer's license to lapse may, within twelve months from the due date of the license renewal fee, reinstate the license without being required to pass a written examination; provided that the office of superintendent of insurance shall assess a penalty in the amount of double the unpaid renewal fee for any renewal fee received after its due date.

F. All licenses and appointments of an insurer or other principal that ceases to be authorized to transact business in this state shall automatically terminate without notice as of date of such cessation.

G. A license shall terminate upon death of the licensee, if an individual, or dissolution, if a corporation, or change in partners, if a partnership; provided that, in the case of a partnership, the license may be continued for a reasonable period while application for new license is being made or pending, as provided by rule."

SECTION 9. 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

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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

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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 [~~23 of this 2016 act~~] 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;

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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;

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

[~~N.~~] 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;

[~~O.~~] 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;

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

[~~Q.~~] S. "uniform business entity application" means the current version of the national association of insurance

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commissioners uniform business entity application for resident and nonresident business entities."

SECTION 10. Section 59A-12-3 NMSA 1978 (being Laws 1984, Chapter 127, Section 203, as amended) is amended to read:

"59A-12-3. "BROKER" [~~AND "SERVICE REPRESENTATIVE"~~] DEFINED.--For the purpose of the Insurance Code, [~~A.~~] 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 [~~and~~

~~B. "service representative" means an individual, regularly employed on salary by an insurer, group of insurers or managing general agent, who assists insurance producers in soliciting, negotiating and effectuating insurance for such insurer, group or managing general agent and, in conduct of their business, receives no part of the commission on insurance written. A service representative is not required to be licensed, nor shall the service representative independently solicit or negotiate insurance or annuity contracts~~]."

SECTION 11. 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.--

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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;

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(3) of applicants with respect to life and annuities or accident and health insurances who hold the chartered life underwriter (C.L.U.) designation by the American college of life underwriters;

(4) of applicants with respect to property and casualty insurance who hold the designation of chartered property and casualty underwriter (C.P.C.U.) designation by the American institute of property and 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 [~~five years~~] one year preceding date of application for the new license, unless the previous license was suspended, revoked or continuation thereof refused by the superintendent; or

(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.

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

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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 12. Section 59A-13-8 NMSA 1978 (being Laws 1984, Chapter 127, Section 236, as amended) is amended to read:

"59A-13-8. POWERS CONFERRED BY ADJUSTER LICENSE.--An independent adjuster shall have the powers granted by its principal to investigate, report upon, adjust and settle claims on behalf of an insurer or self insurer and have additional powers as to claims and losses as may be conferred by the principal. A staff adjuster shall have only such powers with respect to claims and losses as granted by the adjuster's

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employer or affiliates of the adjuster's employer. [~~A temporary adjuster shall, as to claims and losses, have the powers of the employer, subject to extension or limitation by contract.~~]"

SECTION 13. 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

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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 [~~as determined by the superintendent~~] for New Mexico banks per year during the period the claim is unpaid. Interest shall accrue, and the interest rate shall be determined, as of the date the proof of loss was furnished.

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

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 [~~an agent~~] 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

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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 [~~(90)~~] 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 [~~(90)~~] 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-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 [~~to females nine to fourteen years of age~~] in accordance with the current standards promulgated by 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

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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 16. 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

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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 [~~mental retardation~~] intellectual 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

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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 17. 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~~] that the health care insurer is obligated to pay for or to provide under a health benefit plan;

C. "emergency care" means [~~covered~~] services delivered to a covered person after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that [~~are severe~~

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~~enough that~~] a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

[~~(1) the lack of immediate medical attention could result in:~~

~~(a)~~] (1) placing the person's health in serious jeopardy;

[~~(b)~~] (2) serious impairment of bodily functions; or

[~~(c)~~] (3) serious dysfunction of any bodily organ or part; [~~or~~

~~(2) a reasonable person believes that immediate medical attention is required;~~]

D. "health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer [~~which~~] 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

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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 [~~which~~] that complies with all the requirements of the Preferred Provider Arrangements Law."

SECTION 18. 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;

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(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

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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 [~~mental retardation~~] intellectual disability or physical [~~handicap~~] 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

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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;

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(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

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to the qualified higher deductibles."

SECTION 19. Section 59A-23E-2 NMSA 1978 (being Laws 1997, Chapter 243, Section 2, as amended) is amended to read:

"59A-23E-2. DEFINITIONS.--As used in the Health Insurance Portability Act:

A. "affiliation period" means a period that must expire before health insurance coverage offered by a health maintenance organization becomes effective;

B. "beneficiary" means that term as defined in Section 3(8) of the federal Employee Retirement Income Security Act of 1974;

C. "bona fide association" means an association that:

(1) has been actively in existence for five or more years;

(2) has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) does not condition membership in the association on any health status related factor relating to an individual, including an employee or a dependent of an employee;

(4) makes health insurance coverage offered through the association available to all members regardless of any health status related factor relating to the members or individuals eligible for coverage through a member; and

(5) does not offer health insurance coverage to

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an individual through the association except in connection with a member of the association;

D. "church plan" means that term as defined pursuant to Section 3(33) of the federal Employee Retirement Income Security Act of 1974;

E. "COBRA" means the federal Consolidated Omnibus Budget Reconciliation Act of 1985;

F. "COBRA continuation provision" means:

(1) Section 4980 of the Internal Revenue Code of 1986, except for Subsection (f)(1) of that section as it relates to pediatric vaccines;

(2) Part 6 of Subtitle B of Title 1 of the federal Employee Retirement Income Security Act of 1974 except for Section 609 of that part; or

(3) Title 22 of the federal Health Insurance Portability and Accountability Act of 1996;

G. "creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the Social Security Act;

(4) Title 19 of the Social Security Act except coverage consisting solely of benefits pursuant to Section 1928 of that title;

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(5) 10 USCA Chapter 55;

(6) a medical care program of the Indian health service or of an Indian nation, tribe or pueblo;

(7) the [~~Comprehensive Health~~] Medical Insurance Pool Act;

(8) a health plan offered pursuant to 5 USCA Chapter 89;

(9) a public health plan as defined in federal regulations; or

(10) a health benefit plan offered pursuant to Section 5(e) of the federal Peace Corps Act;

H. "employee" means that term as defined in Section 3(6) of the federal Employee Retirement Income Security Act of 1974;

I. "employer" means:

(1) a person who is an employer as that term is defined in Section 3(5) of the federal Employee Retirement Income Security Act of 1974, and who employs two or more employees; and

(2) a partnership in relation to a partner pursuant to Section 59A-23E-17 NMSA 1978;

J. "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

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K. "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment;

L. "excepted benefits" means benefits furnished pursuant to the following:

(1) coverage only accident or disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other similar insurance coverage specified in regulations under which benefits for medical care are secondary or incidental to other benefits;

(9) the following benefits if offered separately:

(a) limited scope dental, [~~or~~] vision, audiology or podiatry benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care or any

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combination of those benefits; and

(c) other similar limited benefits specified in regulations;

(10) the following benefits, offered as independent noncoordinated benefits:

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

(b) hospital indemnity or other fixed indemnity insurance; and

(11) the following benefits if offered as a separate insurance policy:

(a) medicare supplemental health insurance as defined pursuant to Section 1882(g)(1) of the Social Security Act; and

(b) coverage supplemental to the coverage provided pursuant to Chapter 55 of Title 10 USCA and similar supplemental coverage provided to coverage pursuant to a group health plan;

M. "federal governmental plan" means a governmental plan established or maintained for its employees by the United States government or an instrumentality of that government;

N. "governmental plan" means that term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal governmental plan;

O. "group health insurance coverage" means health

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insurance coverage offered in connection with a group health plan;

P. "group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

Q. "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;

R. "health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise, and items, including items and services paid for as medical care, pursuant to any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

S. "health insurance issuer" means an insurance company, insurance service or insurance organization, including a health maintenance organization, that is licensed to engage in the business of insurance in the state and that is subject to state law that regulates insurance within the meaning of

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Section 514(b)(2) of the federal Employee Retirement Income Security Act of 1974, but "health insurance issuer" does not include a group health plan;

T. "health maintenance organization" means:

(1) a federally qualified health maintenance organization;

(2) an organization recognized pursuant to state law as a health maintenance organization; or

(3) a similar organization regulated pursuant to state law for solvency in the same manner and to the same extent as a health maintenance organization defined in Paragraph (1) or (2) of this subsection;

U. "health status related factor" means any of the factors described in Section 2702(a)(1) of the federal Health Insurance Portability and Accountability Act of 1996;

V. "individual health insurance coverage" means health insurance coverage offered to an individual in the individual market, but "individual health insurance coverage" does not include short-term limited duration insurance;

W. "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

X. "large employer" means, in connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one

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employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

Y. "large group market" means the health insurance market under which individuals obtain health insurance coverage on behalf of themselves and their dependents through a group health plan maintained by a large employer;

Z. "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period pursuant to Sections 59A-23E-8 and 59A-23E-9 NMSA 1978;

AA. "medical care" means:

(1) services consisting of the diagnosis, cure, mitigation, treatment or prevention of human disease or provided for the purpose of affecting any structure or function of the human body; and

(2) transportation services primarily for and essential to provision of the services described in Paragraph (1) of this subsection;

BB. "network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care are provided through a defined set of

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providers under contract with the issuer;

CC. "nonfederal governmental plan" means a governmental plan that is not a federal governmental plan;

DD. "participant" means:

(1) that term as defined in Section 3(7) of the federal Employee Retirement Income Security Act of 1974;

(2) a partner in relationship to a partnership in connection with a group health plan maintained by the partnership; and

(3) a self-employed individual in connection with a group health plan maintained by the self-employed individual;

EE. "placed for adoption" means a child has been placed with a person who assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child;

FF. "plan sponsor" means that term as defined in Section 3(16)(B) of the federal Employee Retirement Income Security Act of 1974;

GG. "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of the coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended before that date, but genetic information is not included as a

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preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information;

HH. "small employer" means, in connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

II. "small group market" means the health insurance market under which individuals obtain health insurance coverage through a group health plan maintained by a small employer;

JJ. "state law" means laws, decisions, rules, regulations or state action having the effect of law; and

KK. "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan."

SECTION 20. Section 59A-42-3 NMSA 1978 (being Laws 2012, Chapter 9, Section 6, as amended) is amended to read:

"59A-42-3. DEFINITIONS.--As used in the Life and Health Insurance Guaranty Association Act:

A. "account" means either of the two accounts maintained pursuant to Section 59A-42-5 NMSA 1978;

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B. "association" means the life and health insurance guaranty association created pursuant to Section 59A-42-5 NMSA 1978;

C. "authorized assessment", or the term "authorized" when used in the context of assessments, means that a resolution by the board has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;

D. "benefit plan" means a specific employee, a union or an association of natural persons benefit plan;

E. "board" means the board of directors organized pursuant to Section 59A-42-6 NMSA 1978;

F. "called assessment", or the term "called" when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;

G. "contractual obligation" means an obligation under a policy or contract or a certificate under a group policy or contract, or portion thereof, for which coverage is provided pursuant to Section 59A-42-4 NMSA 1978;

H. "covered policy" means a policy or contract or

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portion of a policy or contract for which coverage is provided pursuant to Section 59A-42-4 NMSA 1978;

I. "domiciliary state" means the state in which an insurer is incorporated or organized or, as to an alien insurer, the state in which at commencement of delinquency proceedings the larger amount of the insurer's assets are held in trust or on deposit for the benefit of its policyholders and creditors in the United States;

J. "extra-contractual claims" includes claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney fees and costs;

K. "impaired insurer" means a member insurer that, after the effective date of the Life and Health Insurance Guaranty Association Act, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

L. "insolvent insurer" means a member insurer that, after the effective date of the Life and Health Insurance Guaranty Association Act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

M. "member insurer" means an insurer that is licensed or that holds a certificate of authority to transact in this state insurance for which coverage is provided pursuant to Section 59A-42-4 NMSA 1978 and includes an insurer whose

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license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

[~~(1) a health care plan, whether profit or nonprofit;~~

~~(2) a health maintenance organization;~~

~~(3)~~] (1) a prepaid dental plan;

[~~(4)~~] (2) a fraternal benefit society;

[~~(5)~~] (3) a mandatory state pooling plan;

[~~(6)~~] (4) a mutual assessment company or other person that operates on an assessment basis;

[~~(7)~~] (5) an insurance exchange;

[~~(8)~~] (6) a charitable organization that is in good standing with the superintendent pursuant to Section 59A-1-16.1 NMSA 1978;

[~~(9)~~] (7) any insurer that was insolvent or unable to fulfill its contractual obligations as of April 9, 1975; or

[~~(10)~~] (8) an entity similar to any of the above;

N. "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, incorporated, or its successor;

O. "owner" of a policy or contract, "policy owner" and "contract owner" means the person who is identified as the

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legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms "owner", "policy owner" and "contract owner" do not include persons with a mere beneficial interest in a policy or contract;

P. "plan sponsor" means:

(1) the employer in the case of a benefit plan established or maintained by a single employer;

(2) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(3) the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations;

Q. "premiums" means amounts or considerations, by whatever name used, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include:

(1) amounts or considerations received for policies or contracts or for the portions of policies or

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contracts for which coverage is not provided pursuant to Subsection E of Section 59A-42-4 NMSA 1978, except that assessable premiums shall not be reduced on account of Paragraph (3) of Subsection E of Section 59A-42-4 NMSA 1978, relating to interest limitations, or Paragraph (2) of Subsection F of Section 59A-42-4 NMSA 1978, relating to limitations, with respect to one individual, one participant or one contract owner;

(2) premiums in excess of five million dollars ($5,000,000) on an unallocated annuity contract not issued under a governmental retirement benefit plan, or its trustee, established pursuant to Section 401, 403(b) or 457 of the federal Internal Revenue Code of 1986; or

(3) with respect to multiple non-group policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

R. "principal place of business" means:

(1) in the case of a plan sponsor or a person other than a natural person, the single state in which the natural person who establishes a policy for the direction,

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control and coordination of the operations of the entity as a whole primarily exercises that function, as determined by the association in its reasonable judgment by considering the following factors:

(a) the state in which the primary executive and administrative headquarters of the entity is located;

(b) the state in which the principal office of the chief executive officer of the entity is located;

(c) the state in which the board, or similar governing person or persons, of the entity conducts the majority of its meetings;

(d) the state in which the executive or management committee of the board, or similar governing person or persons, of the entity conducts the majority of its meetings;

(e) the state from which the management of the overall operations of the entity is directed; and

(f) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors in this subsection; but

(g) in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be

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the principal place of business of the plan sponsor; and

(2) in the case of a plan sponsor of a benefit plan described in Paragraph (3) of Subsection P of this section, the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

S. "receivership court" means the court in the insolvent or impaired insurer's domiciliary state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer;

T. "resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business. Citizens of the United States that are either residents of foreign countries or residents of United States possessions, territories or protectorates that do not have an association

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similar to the association created by the Life and Health Insurance Guaranty Association Act shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;

U. "structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

V. "supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract; and

W. "unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by an insurer under the contract or certificate."

SECTION 21. 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 [~~to females nine to fourteen years of age~~] in accordance with the current standards promulgated by

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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 22. Section 59A-57-3 NMSA 1978 (being Laws 1998, Chapter 107, Section 3, as amended) is amended to read:

"59A-57-3. DEFINITIONS.--As used in the Patient Protection Act:

A. "continuous quality improvement" means an ongoing and systematic effort to measure, evaluate and improve a managed health care plan's process in order to improve continually the quality of health care services provided to enrollees;

B. "covered person", "enrollee", "patient" or "consumer" means an individual who is entitled to receive health care benefits provided by a managed health care plan;

C. "department" means the office of superintendent of

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insurance;

D. "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~~] services delivered to a covered person after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

(1) the placing of the health of the individual, or for a pregnant woman, the health of the woman or her unborn fetus, in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part;

E. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment

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center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting;

F. "health care insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan;

G. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;

H. "health care provider" or "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals and health care facilities;

I. "health care services" includes, to the extent offered by the plan, physical health or community-based mental health or developmental disability services, including services for developmental delay;

J. "managed health care plan" or "plan" means a health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a

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covered person to use, health care providers managed, owned, under contract with or employed by the health care insurer or provider service network. "Managed health care plan" or "plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit or specified disease policies;

K. "person" means an individual or other legal entity;

L. "point-of-service plan" or "open plan" means a managed health care plan that allows enrollees to use health care providers other than providers under direct contract with or employed by the plan, even if the plan provides incentives, including financial incentives, for covered persons to use the plan's designated participating providers;

M. "provider service network" means two or more health care providers affiliated for the purpose of providing health care services to covered persons on a capitated or similar prepaid flat-rate basis that hold a certificate of authority pursuant to the Provider Service Network Act;

N. "superintendent" means the superintendent of insurance; and

O. "utilization review" means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of

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patients."