UNANNOTATED

CHAPTER 59A
Insurance Code

ARTICLE 1
Insurance Code

59A-1-1. Short title.

Chapter 59A NMSA 1978 [except for 59A-30A-1 to 59A-30A-18 NMSA 1978, and 59A-42A-1 to 59A-42A-9 NMSA 1978] shall be known and may be cited as the New Mexico Insurance Code and, in this chapter, may also be referred to as the "Insurance Code".

History: 1978 Comp., § 59A-1-1, enacted by Laws 1993, ch. 320, § 1.

59A-1-2. Definitions.

Unless context otherwise requires, words and terms defined in this article and elsewhere in the Insurance Code shall for the purposes of the Insurance Code have the meaning there ascribed.

History: Laws 1984, ch. 127, § 2.

59A-1-3. "Insurance Code".

"Insurance Code" means the New Mexico Insurance Code.

History: Laws 1984, ch. 127, § 3.

59A-1-4. Repealed.

History: Laws 1984, ch. 127, § 4; 1998, ch. 108, § 31; repealed by Laws 2013, ch. 74, § 40.

59A-1-5. "Insurance".

"Insurance" is a contract whereby one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils, or to pay or grant a specified amount or determinable benefit in connection with ascertainable risk contingencies, or to act as surety.

History: Laws 1984, ch. 127, § 5.

59A-1-6. Repealed.

59A-1-7. Insurance department.

"Insurance department", "insurance division" or "division" means the office of superintendent of insurance.

History: Laws 1984, ch. 127, § 7; 1998, ch. 108, § 32; 2013, ch. 74, § 8.

59A-1-8. "Insurer"; "authorized insurer".

A. "Insurer" includes every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance.

B. An "authorized insurer" is a [an] insurer holding a valid and subsisting certificate of authority, issued by the superintendent, to transact insurance in this state.

History: Laws 1984, ch. 127, § 8.

59A-1-8.1. Multiple employer welfare arrangement.

"Multiple employer welfare arrangement" means a plan for providing welfare benefits for employees of more than one employer as defined by 29 U.S.C. Section 1002.

History: Laws 1991, ch. 125, § 2.

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."

History: 1978 Comp., § 59A-1-8.2, enacted by Laws 2021, ch. 108, § 1.

59A-1-9. "New Mexico".

"New Mexico" means the state of New Mexico.

History: Laws 1984, ch. 127, § 9.

59A-1-10. "Person"; "individual".

A. "Person" includes an individual, association, organization, reciprocal or Lloyds plan insurer, partnership, firm, syndicate, trust, corporation and every legal entity.

B. An "individual" is a natural person, a human being.

History: Laws 1984, ch. 127, § 10.

59A-1-11. "State".

When used in context indicating a jurisdiction other than New Mexico, "state" means any state, district, commonwealth, territory or possession of the United States of America.

History: Laws 1984, ch. 127, § 11.

59A-1-12. Superintendent.

"Superintendent" means the superintendent of insurance or the superintendent's duly authorized representative acting in official capacity.

History: Laws 1984, ch. 127, § 12; 1998, ch. 108, § 33.

59A-1-13. "Transacting insurance".

In addition to other aspects of insurance operations to which the Insurance Code by its terms applies, "transacting insurance" with respect to an insurance contract or a business of insurance includes any of the following, by mail or otherwise or whether or not for profit:

A. solicitation or inducement;

B. negotiation;

C. effectuation of an insurance contract;

D. transaction of matters subsequent to effectuation and arising out of such a contract;

E. maintenance in this state of an office or personnel performing any function in furtherance of an insurer's business of insurance; or

F. maintenance by an insurer of assets in trust in this state for the benefit, security or protection of its policyholders or its policyholders and creditors.

History: Laws 1984, ch. 127, § 13; 1991, ch. 125, § 1.

59A-1-14. Compliance required.

No person shall transact a business of insurance in New Mexico, or relative to a subject of insurance resident, located or to be performed in New Mexico or elsewhere, without complying with the applicable provisions of the Insurance Code.

History: Laws 1984, ch. 127, § 14.

59A-1-15. Application of the code as to particular types of insurers, organization or subjects.

No provision of the Insurance Code shall apply to:

A. fraternal benefit societies, as identified in Chapter 59A, Article 44 NMSA 1978, except as stated in that article;

B. nonprofit health care plans, as identified in Chapter 59A, Article 47 NMSA 1978, except as stated in that article;

C. health maintenance organizations, as identified in Chapter 59A, Article 46 NMSA 1978, except as stated in that article;

D. prepaid dental plans, as identified in Chapter 59A, Article 48 NMSA 1978, except as stated in that article;

E. motor clubs, as identified in Chapter 59A, Article 50 NMSA 1978, except as stated in that article;

F. bail bondsmen, as identified in Chapter 59A, Article 51 NMSA 1978, except as stated in that article;

G. insurance premium finance companies, as identified in Chapter 59A, Article 45 NMSA 1978, except as stated in that article; and

H. title insurers and title insurance agents, as identified in Chapter 59A, Article 30 NMSA 1978, except as stated in that article.

History: Laws 1984, ch. 127, § 15; 1985, ch. 28, § 15.

59A-1-16. Exempted from code.

In addition to organizations and businesses otherwise exempt, the Insurance Code shall not apply to:

A. a labor organization that, incidental only to operations as a labor organization, issues benefit certificates to members or maintains funds to assist members and their families in times of illness, injury or need, and is not for profit;

B. the credit union share insurance corporation, as identified in Chapter 58, Article 12 NMSA 1978, and similar corporations and funds for protection of depositors, shareholders or creditors of financial institutions and businesses other than insurers; or

C. the risk management division of the general services department, the public school insurance authority, the retiree health care authority and any public school district or to insurance of public property or public risks by any agency of government not otherwise engaged in the business of insurance, except the provisions of the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978] and Sections 59A-2-9.2 and 59A-23E-18 NMSA 1978 shall apply to any entity required or authorized to purchase health care benefits pursuant to the Health Care Purchasing Act [Chapter 13, Article 7 NMSA 1978].

History: Laws 1984, ch. 127, § 16; 1998, ch. 107, § 12; 2001, ch. 351, § 4.

59A-1-16.1. Charitable gift annuities; exempt from regulation as insurance company.

A. As used in this section:

(1) "charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes;

(2) "charitable organization" means an entity described in:

(a) Section 501(c)(3) of the Internal Revenue Code of 1986; or

(b) Section 170(c) of that act; and

(3) "qualified charitable gift annuity means a charitable gift annuity described in Section 501(m)(5) and Section 514(c)(5) of that act that is issued by a charitable organization that on the date of the annuity agreement:

(a) has either an unrestricted fund balance consisting of assets in excess of liabilities of not less than three hundred thousand dollars ($300,000) or unencumbered assets in its gift annuity fund of not less than three hundred thousand dollars ($300,000); and

(b) has been in continuous operation for at least three years or is a successor or affiliate of a charitable organization that has been in continuous operation for at least three years.

B. The issuance of a qualified charitable gift annuity does not constitute engaging in the business of insurance in this state.

C. A charitable gift annuity issued prior to July 1, 1999 is a qualified charitable gift annuity for purposes of this section, and the issuance of that charitable gift annuity does not constitute engaging in the business of insurance in this state.

D. When entering into an agreement for a qualified charitable gift annuity, the charitable organization shall disclose to the donor in writing in the annuity agreement that a qualified charitable gift annuity is not insurance under the laws of this state and is not subject to regulation by the insurance division or protected by a guaranty association affiliated with the division. The disclosure shall be in a separate paragraph in a print size no smaller than that employed generally in the annuity agreement.

E. A charitable organization that issues qualified charitable gift annuities shall notify the insurance division in writing by the later of October 1, 1999 or the date on which it enters into the organization's first qualified charitable gift annuity agreement. The notice shall:

(1) be signed by an officer or director of the charitable organization;

(2) identify the charitable organization; and

(3) certify that the organization is a charitable organization and the annuities issued by the organization are qualified charitable gift annuities. The charitable organization shall not be required to provide additional information to the division except as provided in Subsection F of this section.

F. The failure of a charitable organization to comply with the notice requirements provided in Subsections D and E of this section does not prevent a charitable gift annuity that otherwise meets the requirements of this section from constituting a qualified charitable gift annuity; provided, however, that the superintendent may enforce performance of those requirements by sending a letter by certified mail, return receipt requested, demanding that the charitable organization comply with the notice requirements provided in Subsections D and E of this section.

G. The issuance of a qualified charitable gift annuity does not constitute a violation of the Unfair Practices Act [Chapter 57, Article 12 NMSA 1978].

History: Laws 1999, ch. 34, § 1.

59A-1-17. Particular provisions prevail.

Provisions of the Insurance Code relative to a particular kind of insurance or type of insurer or particular matter shall prevail over provisions relating to insurance in general or insurers in general or to such matter in general.

History: Laws 1984, ch. 127, § 17.

59A-1-18. General penalty.

A. Unless the same is defined as a felony under any other law of this state or punishment therefor classifies it otherwise, every violation of the Insurance Code is a petty misdemeanor punishable by a fine not to exceed five hundred dollars ($500).

B. Where other monetary penalty is not expressly provided for, an administrative penalty may be assessed for violations of the Insurance Code. The administrative penalty shall be not over five thousand dollars ($5,000) for each violation, except that if the violation is to be found willful and intentional, the penalty may be up to ten thousand dollars ($10,000) for each violation. Every administrative penalty shall be imposed by written order of the superintendent made after hearing held as provided in Chapter 59A, Article 4 NMSA 1978.

C. A monetary penalty imposed may be additional to any applicable suspension, revocation or denial of a license or certificate of authority.

D. In addition to the authority of the insurance department to bring an action to recover statutory fines and assessments, the insurance department may bring civil actions for penalties in sums not to exceed the criminal fine for each violation of the Insurance Code, in lieu of criminal prosecution.

E. The penalties contained in Subsections A through D of this section shall be in addition to any other penalty provided by law.

History: Laws 1984, ch. 127, § 18; 1987, ch. 259, § 1; 1989, ch. 145, § 1.

ARTICLE 2
Office of Superintendent of Insurance

59A-2-1. Office of superintendent of insurance.

A. The office of superintendent of insurance, created as of July 1, 2013 by Article 11, Section 20 of the constitution of New Mexico, is an adjunct agency pursuant to Section 9-1-6 NMSA 1978.

B. All powers relating to state supervision of insurance, insurance rates and rate practices, together with collection of insurance licenses, taxes or fees, and all records pertaining to such supervision are under control of the office of superintendent of insurance.

History: Laws 1984, ch. 127, § 19; 1998, ch. 108, § 34; 2013, ch. 74, § 9.

59A-2-2. Superintendent; appointment; term; compensation; removal.

A. The position of superintendent of insurance shall be the chief officer of the office of superintendent of insurance.

B. The superintendent shall be appointed by the insurance nominating committee.

C. The superintendent shall serve for a term of four years, except that the initial term beginning July 1, 2013 shall end on December 31, 2015. An incumbent superintendent may apply to the insurance nominating committee for appointment to additional terms.

D. The superintendent's annual compensation shall be subject to legislative appropriation and established by the insurance nominating committee at the start of each term and annually thereafter. The superintendent's annual compensation shall be no lower than that of the lowest-compensated cabinet secretary and no higher than that of the highest-compensated cabinet secretary.

E. The superintendent shall not be removed except for incompetence, willful neglect of duty or malfeasance in office. The insurance nominating committee may remove the superintendent after providing the superintendent with notice and a hearing.

History: Laws 1984, ch. 127, § 20; 1998, ch. 108, § 35; 2013, ch. 74, § 10; 2015, ch. 11, § 3; 2020, ch. 63, § 1.

59A-2-2.1. Insurance nominating committee; duties; administrative attachment.

A. The "insurance nominating committee" is created and consists of nine members, including:

(1) four members who are selected by the New Mexico legislative council as follows:

(a) two members who shall represent the interests of the insurance industry;

(b) two members who shall represent the interests of insurance consumers and who have experience advocating on behalf of consumers or the public interest on insurance issues. These consumer members shall not be employed by or on behalf of or have a contract with an employer that is regulated by the office of superintendent of insurance; and

(c) no more than two of the four members shall be from the same political party;

(2) four members who are selected by the governor as follows:

(a) two members who shall represent the interests of the insurance industry;

(b) two members who shall represent the interests of insurance consumers and who have experience advocating on behalf of consumers or the public interest on insurance issues. These consumer members shall not be employed by or on behalf of or have a contract with an employer that is regulated by the office of superintendent of insurance; and

(c) no more than two of the four members shall be from the same political party; and

(3) a ninth member who shall be chair of the committee and who shall be selected by a majority of the other eight members; provided that the member shall:

(a) not be a candidate for the position of superintendent of insurance; and

(b) be either a former New Mexico superintendent of insurance or another person with extensive knowledge of insurance regulation in New Mexico, but does not have, nor have a spouse or child who has, any direct financial interest in an insurer, insurance agency or insurance transaction except as a policyholder or a claimant under a policy or as an owner of less than one percent of the shares of an insurer that is a publicly traded corporation.

B. A vacancy on the committee shall be filled by the original appointing authority for the remainder of the term.

C. A committee member shall:

(1) be a resident of New Mexico;

(2) serve a four-year term; except that a member of the first committee appointed shall serve for a term that ends on June 30, 2015; and

(3) serve without compensation, but shall be eligible to receive per diem and mileage pursuant to the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978].

D. The committee is subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978] and the Open Meetings Act [Chapter 10, Article 15 NMSA 1978]. Individual members of the committee are subject to the Governmental Conduct Act [Chapter 10, Article 16 NMSA 1978] and the Financial Disclosure Act [Chapter 10, Article 16A NMSA 1978].

E. The committee shall convene within ninety days in anticipation of the occurrence of a vacancy in the superintendent position or the expiration of a superintendent's term of office.

F. Upon the occurrence of a vacancy in the superintendent position, or after the conclusion of the superintendent's term, the chair of the committee may appoint an interim superintendent who shall serve until a successor is duly qualified.

G. The committee shall actively solicit, accept and evaluate applications from qualified individuals for the position of superintendent and may require an applicant to submit any information it deems relevant to the consideration of the individual's application.

H. The committee shall appoint the superintendent by a vote of a majority of all members of the committee.

I. The committee shall meet no less often than annually.

J. The committee is administratively attached to the office of superintendent of insurance. The office of superintendent of insurance shall provide staff for the committee.

K. An employee of the office of superintendent of insurance who serves as staff for the committee shall not reveal to any person, except another committee staff person, any requests or statements disclosed in confidence by a committee member, except that this restriction shall not apply to any disclosure that is:

(1) protected under the Whistleblower Protection Act [10-16C-1 to 10-16C-4 NMSA 1978]; or

(2) required by law.

History: Laws 2013, ch. 74, § 15; 2015, ch. 11, § 4; 2020, ch. 63, § 2.

59A-2-3. Superintendent; qualifications and bond.

The superintendent shall:

A. be bonded as provided in the Surety Bond Act [10-2-13 to 10-2-16 NMSA 1978];

B. not have a direct financial interest in an insurer, insurance agency or insurance transaction except as a policyholder or a claimant under a policy or as an owner of less than one percent of the shares of an insurer that is a publicly traded corporation; and

C. not have a spouse who:

(1) has a direct financial interest in an insurer or insurance agency regulated by the office of superintendent of insurance, except as an owner of less than one percent of the shares of an insurer that is a publicly traded corporation; or

(2) is licensed as an individual by the office of superintendent of insurance.

History: Laws 1984, ch. 127, § 21; 2013, ch. 74, § 11; 2015, ch. 11, § 5; 2020, ch. 63, § 3.

59A-2-4. Staff.

The superintendent:

A. may hire employees and prescribe their duties and qualifications and fix their compensation pursuant to the Personnel Act [Chapter 10, Article 9 NMSA 1978]; and

B. shall designate an employee of the office of superintendent of insurance as chief deputy superintendent, who shall be acting superintendent when the superintendent position is vacant or the superintendent is unable to perform the duties of that office because of mental or physical disability.

History: Laws 1984, ch. 127, § 22; 1993, ch. 320, § 2; 1998, ch. 108, § 36; 2013, ch. 74, § 12.

59A-2-5, 59A-2-6. Repealed.

59A-2-7. Delegation of powers.

A. The superintendent may delegate to his deputy, assistant or examiner the exercise or discharge in the superintendent's name of any power, duty or function, whether ministerial, discretionary or of whatever character, vested in or imposed upon or to be performed by the superintendent.

B. The official act of any such individual acting in the superintendent's name and by his authority shall be deemed an official act of the superintendent.

History: Laws 1984, ch. 127, § 25.

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 [Chapter 59A NMSA 1978];

(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 [10-2-13 to 10-2-16 NMSA 1978]. The office of superintendent of insurance shall pay the cost of required bonds;

(10) comply with the provisions of the Administrative Procedures Act [12-8-1 to 12-8-25 NMSA 1978];

(11) upon an order based upon the invocation of a state of emergency under the All Hazard Emergency Management Act [12-10-1 to 12-10-10 NMSA 1978] or the Public Health Emergency Response Act [Chapter 12, Article 10A NMSA 1978] 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.

History: Laws 1984, ch. 127, § 26; 2013, ch. 74, § 13; 2021, ch. 108, § 2.

59A-2-8.1. Producer licensing; national producer registry; fees collected.

The division may contract with a nongovernmental entity, including the national association of insurance commissioners or its affiliates or subsidiaries, to perform ministerial functions related to licensure of producers. Fees collected shall be remitted to the division on a schedule approved by the superintendent. The division may adopt

by rule any uniform standards and procedures necessary to participate in a national producer registry.

History: Laws 2001, ch. 297, § 9.

59A-2-9. Rules and regulations; promulgation; violation.

A. The superintendent, after a hearing thereon, may make reasonable rules and regulations necessary for or as an aid to administration or effectuation of any provision of the Insurance Code administered by the superintendent, and from time to time withdraw, modify or amend any such rule or regulation.

B. No such rule or regulation shall extend, modify or conflict with any such provision or other laws of New Mexico.

C. The superintendent shall file all new rules, amendments of rules or repeals of rules in accordance with the State Rules Act [Chapter 14, Article 4 NMSA 1978] not later than the submittal deadline for publication in the New Mexico register on or before the effective date of any such rule, amendment or repeal.

D. Willful violation of any such rule or regulation shall subject the violator to such penalty as may be applicable under the Insurance Code for violation of the provision to which the rule or regulation relates; but no penalty shall apply to any act done or omitted in good faith in conformity with any such rule or regulation, notwithstanding that the rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

History: Laws 1984, ch. 127, § 27; 1997, ch. 121, § 1.

59A-2-9.1. Regulations; leased employees.

The superintendent shall adopt and promulgate regulations:

A. for defining temporary and leased employees;

B. for rating temporary and leased employees;

C. to ensure that employers utilize accurate employee classifications;

D. to prevent employers from reducing their experience modifiers through various employee-leasing schemes;

E. to establish and enforce penalties for any violations of these regulations; and

F. which shall be reported to the first session of the fortieth legislature.

History: Laws 1990 (2nd S.S.), ch. 2, § 108.

59A-2-9.2. Recompiled.

59A-2-9.3. Superintendent authorized and directed to promulgate privacy rules.

The superintendent is authorized to and shall promulgate rules to reasonably protect the privacy of insurance consumers' nonpublic personal information, including personal health and financial information. Rules promulgated pursuant to this section shall meet any applicable federal requirements for protecting nonpublic personal information of insured persons from improper access or disclosure.

History: Laws 2001, ch. 202, § 1.

59A-2-9.4. Superintendent of insurance; additional powers.

The superintendent of insurance shall promulgate rules to define minimum coverage for smoking cessation treatment.

History: Laws 2003, ch. 337, § 6.

59A-2-9.5. Repealed.

History: Laws 2003, ch. 235, § 3; 1978 Comp. § 8-8-9.2, recompiled by Laws 2007, ch. 282, § 14; repealed by Laws 2015, ch. 111, § 7.

59A-2-9.6. Health insurance cooperative; rulemaking.

The superintendent shall adopt rules to govern the registration of health insurance cooperatives, including the registration of cooperative employees, pursuant to Chapter 59A, Article 23 NMSA 1978.

History: Laws 2011, ch. 34, § 3.

59A-2-9.7. Annual report required.

No later than December 1 of each year, the superintendent shall report to the legislature, to the insurance nominating committee and to the governor on the activities of the office of superintendent of insurance during the previous fiscal year.

History: Laws 2013, ch. 74, § 14.

59A-2-9.8. Prior authorization request form; development.

A. On or before January 1, 2014, the division shall jointly develop with the board of pharmacy a uniform prior authorization form that, notwithstanding any other provision of law, a prescribing practitioner in the state shall use to request prior authorization for coverage of prescription drugs. The uniform prior authorization form shall:

(1) not exceed two pages;

(2) be made electronically available on the web site of the division and on the web site of each health insurer, health care plan or health maintenance organization that uses the form;

(3) be developed with input received from interested parties pursuant to at least one public meeting; and

(4) take into consideration the following:

(a) any existing prior authorization forms that the federal centers for medicare and medicaid services or the human services department [health care authority department] has developed; and

(b) any national standards pertaining to electronic prior authorization for prescription drugs.

B. As used in this section, "prescribing practitioner" means a person that is licensed or certified to prescribe and administer drugs that are subject to the New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978].

History: Laws 2013, ch. 170, § 2.

59A-2-9.9. State innovation waiver application.

The superintendent, in consultation with and pursuant to approval by the governor, is authorized to submit a state innovation waiver application pursuant to Section 1332 of the federal Patient Protection and Affordable Care Act to establish a program relating to access and affordability of health insurance coverage. In applying for a waiver pursuant to Section 1332 of the federal Patient Protection and Affordable Care Act, the superintendent shall seek any federal funding available to implement the waiver.

History: Laws 2019, ch. 259, § 20.

59A-2-9.10. Reporting.

The office of superintendent of insurance shall report annually to the legislative health and human services committee and the legislative finance committee regarding the implementation, regulation, compliance and enforcement of the provisions of this 2023 act.

History: Laws 2023, ch. 114, § 45.

59A-2-10. Orders, notices in general.

A. Orders and notices of the superintendent shall be effective only when in writing signed by him or by his authority.

B. Every order of the superintendent shall state its effective date and shall concisely state:

(1) what is ordered;

(2) the grounds on which the order is based; and

(3) the provisions of the Insurance Code pursuant to which action is taken or proposed to be taken; but failure to so designate a particular provision shall not deprive the superintendent of the right to rely thereon.

C. Except as provided as to particular procedures, an order or notice may be given by delivery to the person to be ordered or notified, or by mailing it, postage prepaid, addressed to such person at [his] principal place of business or residence last of record with the insurance department. If so mailed, the order or notice shall be deemed given when deposited in a mail depository of the United States post office; and as to which the affidavit of the individual who so mailed it shall be prima facie evidence that the order or notice was given.

History: Laws 1984, ch. 127, § 28.

59A-2-11. Enforcement.

A. The superintendent may invoke the aid of any court of competent jurisdiction through injunction, mandamus or other appropriate process to enjoin any existing or threatened violation of any provision of the Insurance Code or to enforce any order made or action taken by him in pursuance of law.

B. If the superintendent has reason to believe that any person has violated any provision of the Insurance Code or other law applicable to insurance operations, for which criminal prosecution in his opinion would be in order, he shall give the information relative thereto to the attorney general or other appropriate public law enforcement officials. The attorney general or such other law enforcement official shall promptly institute or cause to be instituted such action or proceedings against such person as in his opinion the information may require or justify.

C. The superintendent may enforce civil penalties provided under the Insurance Code, and for the purpose use services of attorneys of the insurance department.

History: Laws 1984, ch. 127, § 29.

59A-2-12. Records; inspection; destruction.

A. The superintendent shall preserve in the office of superintendent of insurance and in permanent form copies of all notices and orders given or made and of all other papers and records relating to the business and transactions of the office and shall hand the same over to the superintendent's successor in office.

B. Except as otherwise provided by the Insurance Code or by order of court, the papers and records shall be open to public inspection. The superintendent may classify as confidential certain records and information obtained from another governmental agency or other source upon the express condition that they remain confidential or are deemed confidential by the superintendent, and such records and information shall not be subject to public inspection while confidentiality exists; except that no filing required to be made with the superintendent under the Insurance Code shall be deemed confidential unless expressly so provided by law.

C. The superintendent may destroy unneeded or obsolete records and filings in the office of superintendent of insurance pursuant to the Public Records Act [Chapter 14, Article 3 NMSA 1978].

History: Laws 1984, ch. 127, § 30; 2013, ch. 74, § 16.

59A-2-13. Seal as evidence.

The superintendent shall have an official seal. Every instrument executed by the superintendent in pursuance with law and sealed with such seal shall be received as evidence. Copies of books, records and papers kept or filed in the office of superintendent of insurance pursuant to law, certified by the superintendent and authenticated by the seal, shall be received in evidence in like manner as the originals.

History: Laws 1984, ch. 127, § 31; 2013, ch. 74, § 17.

59A-2-14. Publications; preparation and sale.

A. The superintendent may authorize preparation and sale of bound pamphlet copies of the insurance laws of this state, of rules and regulations adopted pursuant to such laws, and of any other publication which the superintendent, in administration of the insurance laws, deems to be of interest sufficiently widespread to so warrant.

B. The superintendent shall offer, or cause to be offered, the publications for sale at a price adequate to cover costs of printing and handling.

C. The superintendent shall promptly deposit in the state treasury all revenues derived from any such sale. The state treasurer shall credit the deposits to the insurance department suspense fund.

History: Laws 1984, ch. 127, § 33.

59A-2-15. Interstate, federal and international cooperation.

A. On request of the insurance supervisory official of any other state, province or country; of the national association of insurance commissioners or similar association of insurance regulatory officials; or of a federal agency, the superintendent shall communicate to the official, association or agency information that it is the superintendent's duty by law to ascertain respecting an insurer or other person transacting insurance in this state or otherwise subject to the superintendent's supervision.

B. The superintendent may be a member of the national association of insurance commissioners or any successor organization and may participate in and support cooperative activities of public agencies having supervision of the insurance business.

History: Laws 1984, ch. 127, § 34; 1991, ch. 125, § 3; 2014, ch. 59, § 1.

59A-2-15.1. Office of superintendent of insurance; cooperation with New Mexico health insurance exchange.

The office of superintendent of insurance shall cooperate with the New Mexico health insurance exchange to share information and assist in the implementation of the functions of the exchange.

History: Laws 2013, ch. 54, § 10.

59A-2-16. Nonpreemption.

Nothing contained in the Interstate Insurance Product Regulation Compact [11-19-1 NMSA 1978], nor any decision or action by the interstate insurance product regulation commission, shall preempt, alter or modify any claims or remedies against insurance companies, agents or other persons or entities regulated under the Insurance Code that are or may become available under the common law, the Insurance Code or other statutes of this state.

History: Laws 2009, ch. 188, § 1.

59A-2-17. Reporting.

Until January 1, 2027:

A. the office of superintendent of insurance shall report by November 1 of each year to the governor, the legislative finance committee and the interim legislative health and human services committee data regarding the elimination of cost sharing pursuant to the provisions of this 2021 act, including the effects on providers and patients with regard to costs for behavioral health services and the effects on health and social outcomes for patients, by using a set of performance measurement tools related to health care quality assurance, developed by a nationally recognized organization; and

B. the legislative finance committee shall report by November 1 of each year to the governor and the interim legislative health and human services committee data regarding the elimination of cost sharing pursuant to the provisions of this 2021 act, including the effects on providers and patients with regard to costs for behavioral health services and the effects on health and social outcomes for patients, by using a set of performance measurement tools related to health care quality assurance, developed by a nationally recognized organization.

History: Laws 2021, ch. 136, § 10.

ARTICLE 3
State Insurance Board (Repealed.)

59A-3-1 to 59A-3-9. Repealed.

ARTICLE 4
Examinations, Hearings and Appeals

59A-4-1. Scope of article.

Except as otherwise expressly provided as to particular matters in the Insurance Code, the provisions of Chapter 59A, Article 4 NMSA 1978 as to investigations and hearings by the superintendent shall apply as to all persons and operations subject to licensing or supervision under the Insurance Code.

History: Laws 1984, ch. 127, § 45; 1998, ch. 108, § 37.

59A-4-2. Investigations; confidentiality of information pending completion.

A. Evidence relative to the subject of an investigation being conducted by the superintendent shall not be open to public inspection for so long as the superintendent deems reasonably necessary to complete the investigation, to protect the person investigated from unwarranted injury, or to be in the public interest.

B. Evidence relative to the subject of such an investigation shall not be subject to subpoena until opened for public inspection by the superintendent, unless the superintendent consents to such subpoena or until, after notice to the superintendent and hearing, the court determines that conduct of the superintendent's investigation or the subject thereof would not be unreasonably injured by the subpoena.

C. Except as otherwise expressly provided, the superintendent or insurance department investigators shall not be subject to subpoena in civil actions by any court of this state to testify concerning any information secured by them during their uncompleted investigation or examination.

History: Laws 1984, ch. 127, § 46.

59A-4-3. Inquiries by superintendent.

The superintendent may direct an inquiry to any person subject to supervision under the Insurance Code with respect to any transaction or matter within the scope of such supervision. Upon receipt of the request, the person shall promptly furnish to the superintendent requested information in possession or control of such person. If so specified by the superintendent, the requested information shall be furnished under oath.

History: Laws 1984, ch. 127, § 47.

59A-4-4. Power of examination; in general.

A. In addition to examinations otherwise expressly authorized for purpose of ascertaining financial condition where applicable, compliance with law, relationships and transactions between any such persons and others and treatment accorded its contract holders, subscribers and others served by it, the superintendent as often as he deems advisable may examine the accounts, records, documents, transactions and affairs of the following persons subject to the superintendent's supervision under the Insurance Code or other laws and within the lawful scope of such supervision:

(1) any person engaged or purporting or proposing to engage in this state in the business of provision of services on a prepaid basis for health care, dental care, funerals or burial or in premium financing, together with the managers, parent organization and affiliates of any such person;

(2) any person having a contract under which he enjoys in fact the exclusive or dominant right to manage or control an insurer or to produce substantially all of its business;

(3) any insurance holding company and its affiliates and any person holding the shares of voting stock or the policyholder proxies of a domestic insurer for the purpose of controlling management thereof as voting trustee or otherwise;

(4) any subsidiary of an insurer;

(5) any person engaged or proposing or purporting to be engaged in this state in, or in this state assisting in, promotion, formation or financing of an insurer or insurance holding corporation, or corporation or other group to finance an insurer or its business;

(6) any self-insureds;

(7) any insurer that insures or administers a multiple employer welfare arrangement covering risks in this state; and

(8) any person transacting insurance in this state.

B. In lieu of making the examination of a foreign or alien person authorized to do business in this state or applying for such authority and subject to examination under the above provisions, the superintendent may accept a full report of a recent examination of such person by the appropriate examining official of another state, certified by such official.

History: Laws 1984, ch. 127, § 48; 1987, ch. 119, § 1; 1991, ch. 125, § 4.

59A-4-5. Examination of insurers.

A. For the purpose of determining financial condition, fulfillment of contractual obligations, methods of doing business, treatment accorded policyholders and compliance with law, the superintendent shall, as often as the superintendent deems advisable, examine or investigate the affairs, transactions, accounts, records and assets of each authorized insurer and of any other person as to any matter that the superintendent in the superintendent's sole discretion has determined to be relevant to the financial affairs of the insurer or to the examination. Except as expressly otherwise provided, the superintendent shall so examine each domestic insurer not less frequently than every five years. In scheduling and determining the nature, scope and frequency of the examinations, the superintendent may consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, evidence of market practices, policyholder complaints and other criteria as set forth in the handbooks for financial or market conduct examiners adopted by the national association of insurance commissioners in effect when the superintendent exercises discretion under this section.

B. For like purposes, the superintendent shall examine each insurer, or proposed insurer, applying for an initial certificate of authority to transact insurance in this state. The initial examination shall be completed prior to issuance of a certificate of authority.

C. Whenever the superintendent examines the affairs of a domestic insurer, the superintendent may invite the representative of the insurance supervisory agency of at least one other state, if any, in which the insurer is an authorized insurer, to participate in the examination.

D. Until January 1, 1994, in lieu of making the superintendent's own examination of a foreign or alien insurer, the superintendent may accept a full report of an examination of the insurer made by competent examiners as of a date not more than one year prior and participated in by at least two states in which the insurer was authorized to transact insurance. The report shall be certified by the insurance supervisory official of the state under whose jurisdiction the examination was conducted. The superintendent may, at the superintendent's discretion, so accept the report of examination as of a date more than one year but not more than three years prior; and with respect to an alien insurer, the superintendent may at the superintendent's discretion so accept a report of recent examination made by the insurance supervisory official of the port of entry state of the insurer into the United States without participation therein of another state.

E. After January 1, 1994, examination reports prepared by examiners employed by other state insurance departments may be accepted only if:

(1) made as of a date not more than five years prior to acceptance and the examiner in charge was employed by and under the direction of the insurance commissioners of the insurer's state of domicile or port of entry, which insurance department was at the time of the examination accredited under the financial regulation standards and accreditation program of the national association of insurance commissioners; or

(2) made as of a date not more than three years prior to acceptance and the examination was performed under the supervision of an accredited insurance department or with the participation of one or more examiners who were employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

F. As far as practical the superintendent shall conduct examination of a foreign or alien insurer in cooperation with the insurance supervisory officials of other states in which the insurer is authorized to transact business.

History: Laws 1984, ch. 127, § 49; 1993, ch. 320, § 3; 2011, ch. 127, § 1.

59A-4-6. Examiners and specialists.

A. The superintendent may appoint one or more competent individuals, sufficiently knowledgeable in applicable accounting and operations, as examiners to represent the

superintendent in an examination and shall fix the reasonable compensation of the examiners.

B. The superintendent may also employ and fix reasonable compensation of independently contracting accountants knowledgeable of insurance accounting principles and practices, actuaries, attorneys, appraisers and other specialists not otherwise part of the insurance department staff, as the superintendent deems necessary for the examination, the cost of which shall be borne by the company which is the subject of the examination. All specialists shall be under the direction and control of the superintendent.

History: Laws 1984, ch. 127, § 50; 1993, ch. 320, § 4; 2011, ch. 127, § 2.

59A-4-7. Conduct of examination; access to information; correction of records; penalties.

A. Upon determining that an examination should be conducted, the superintendent or the superintendent's designee shall issue an order appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the national association of insurance commissioners. The superintendent may also employ such other guidelines or procedures as the superintendent may deem appropriate.

B. Every company or person from whom information is sought, its officers, directors and agents must provide to the examiners appointed under Subsection A of this section timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the company to engage in an insurance or other business subject to the superintendent's jurisdiction.

C. The superintendent or any of his examiners shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the superintendent may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

D. If the superintendent or examiner finds any accounts or records to be inadequate or inadequately or improperly kept or posted, the superintendent may employ experts to reconstruct, rewrite, post or balance them at the expense of the person being examined if such person has failed to maintain, complete or correct such records or accounting after the superintendent or examiner has given written notice and reasonable opportunity to do so.

E. Any individual giving false testimony or information as to any matter material to the examination with knowledge of such falsity, shall upon conviction thereof be guilty of a fourth degree felony and shall be punished by a fine not to exceed twenty thousand dollars ($20,000). Any individual who willfully refuses or fails to attend at the examination, or to produce books, records, accounts or files requested, or to give the superintendent or the examiner full and truthful information in writing in response to any written inquiry of the superintendent or examiner in regard to matters under examination, or to appear and testify under oath before the superintendent or examiner when so requested and given reasonable opportunity to do so, or who willfully obstructs or interferes with the superintendent or examiner in the conduct of the examination, shall upon conviction thereof be guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000) for each such offense.

F. Nothing contained in Chapter 59A, Article 4 NMSA 1978 shall be construed to limit the superintendent's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

G. Nothing contained in Chapter 59A, Article 4 NMSA 1978 shall be construed to limit the superintendent's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the superintendent may, in his sole discretion, deem appropriate.

History: 1978 Comp., § 59A-4-7, enacted by Laws 1993, ch. 320, § 5.

59A-4-8. Appraisal of assets.

A. If the superintendent deems it necessary to value any asset involved in an examination, he shall request in writing the person being examined to appoint one or more impartial appraisers who through education, experience or training are competent to appraise the asset. The appraiser so selected shall be subject to the superintendent's approval; and if an appraiser is not so selected within ten (10) days after the superintendent's request was delivered to the examinee, the superintendent may appoint the appraiser or appraisers.

B. The appraisal shall be expeditiously made, and a copy thereof furnished to the superintendent and to the examinee.

C. The reasonable expense of the appraisal shall be borne by the examinee.

History: Laws 1984, ch. 127, § 52.

59A-4-9. Examination report; contents.

No later than sixty days following completion of an examination, the examiner in charge shall file with the office of superintendent of insurance a verified, written examination report. The examination report shall comprise only facts appearing upon the books, records or other documents of the person examined, or from information provided to the examiner during the course of the examination by the examinee's officers or agents and other individuals examined concerning its affairs, together with the conclusions and recommendations of the examiners as may reasonably be warranted from the facts. The examination report shall be verified by the oath of the examiner in charge of the examination.

History: Laws 1984, ch. 127, § 53; 1991, ch. 125, § 5; 2017, ch. 130, § 1.

59A-4-10. Examination report; conference; adoption orders; investigatory hearings.

A. Upon completion of the examination and receipt of the examination report, the superintendent shall transmit the report to the person examined and shall allow the person a reasonable period, but not to exceed twenty days, within which to review the report and to file with the superintendent in writing requested corrections or modifications, with the reasons therefor. For good reason shown, the superintendent may grant reasonable extension of the review period.

B. Within twenty days after the superintendent's receipt of the request, the person examined shall confer with the superintendent and examiner relative to requested corrections and modification.

C. Within thirty days of the end of the period allowed for the receipt of written submissions or rebuttals, the superintendent shall fully consider and review the examination report, together with any written submission or rebuttal, any conference and any relevant portion of the examiner's work papers and shall enter an order. An order entered pursuant to this subsection shall be accompanied by findings of fact and conclusions of law resulting from the superintendent's consideration and review of the examination report, any written submission or rebuttal, any conferences and any relevant portion of the examiner's work papers. An order shall be considered a final administrative decision that may be appealed pursuant to Section 59A-4-20 NMSA 1978. An order shall be served on all parties by certified mail, together with a copy of the adopted examination report. An order issued pursuant to this subsection shall:

(1) adopt the examination report as filed or with modification or corrections. If the examination report reveals that the person is operating in violation of statute, rule or prior order of the superintendent, the superintendent may order the person to take any action that the superintendent considers necessary and appropriate to cure the violation;

(2) reject the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information and refiling pursuant to Section 59A-4-9 NMSA 1978; or

(3) call for an investigatory hearing with no less than twenty days' notice to the person for purposes of obtaining additional documentation, data, information or testimony.

D. An investigatory hearing held pursuant to Paragraph (3) of Subsection C of this section:

(1) may be conducted by the superintendent or the superintendent may authorize a representative to conduct the hearing; provided that the superintendent shall not authorize an examiner to conduct the hearing;

(2) shall be conducted for the resolution of any inconsistency, discrepancy or disputed issue apparent upon the face of the examination report or raised by or as a result of the superintendent's review of work papers and conferences or by the written submission or rebuttal of the person;

(3) shall proceed expeditiously with discovery by the person limited to those work papers of the examiner that tend to substantiate any assertions set forth in any written submission or rebuttal; and

(4) shall be confidential, unless confidentiality is waived by the person being examined.

E. Relating to an investigatory hearing held pursuant to Paragraph (3) of Subsection C of this section, the superintendent or the superintendent's representative may issue a subpoena to compel the attendance of any witness or the production of any document that the superintendent or the superintendent's representative deems relevant to the investigation, whether the document is under the control of the office of superintendent of insurance, the person being examined or any other person. Documents produced shall be included in the record and testimony taken by the superintendent or the superintendent's representative and shall be made under oath and preserved for the record. The person being examined and the office of superintendent of insurance shall be permitted to make closing statements and may be represented by counsel. Nothing in this section shall be construed to require the office of superintendent of insurance to disclose any information or record that would indicate or demonstrate the existence or content of any investigation or activity of a criminal justice agency.

F. Within twenty days of the conclusion of an investigatory hearing pursuant to Paragraph (3) of Subsection C of this section, the superintendent shall enter an order in accordance with Paragraph (1) of Subsection C of this section.

History: Laws 1984, ch. 127, § 54; 1991, ch. 125, § 6; 1993, ch. 320, § 6; 2017, ch. 130, § 2.

59A-4-11. Examination report; filing for public inspection; confidentiality.

A. When the superintendent has adopted a report of examination he shall so notify the examinee in writing and file the report for public inspection in the insurance department. If deemed advisable the superintendent may, after adoption of the report, cause the results of the examination to be published in one or more newspapers of general circulation in the state. The superintendent shall expedite review and adoption of the report and cause it to be filed for public inspection as soon as reasonably possible.

B. Except as expressly otherwise provided, pending, during or after examination of any insurer or other person, the superintendent shall not make public, or permit to be made public, any financial statement, report or finding affecting the status, standing or rights of the insurer or person until after the report of examination has been adopted by the superintendent, and all working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the superintendent or any other person in the course of an examination shall remain confidential, are not subject to subpoena and may not be made public by the superintendent or any other person, except to the extent permitted by Sections 59A-4-7 and 59A-4-13 NMSA 1978. The superintendent may grant access to the national association of insurance commissioners on condition that it agree in writing prior to receiving the information to accord it the same confidential treatment as required by this section, unless the prior written consent of the insurer or person to which it pertains has been obtained.

History: Laws 1984, ch. 127, § 55; 1993, ch. 320, § 7.

59A-4-12. Examination report; information to management of domestic entities.

If the examination is of a domestic insurer or other person domiciled in New Mexico, when the examination report has been filed for public inspection, the chief executive officer of the insurer or person shall cause to be delivered to each member of the examinee's board of directors, or other similar governing body, a copy of the report, or summary thereof, and of its recommendations approved by the superintendent. Within ninety days of the issuance of the adopted report or within fifteen days after the first board meeting after the issuance of the adopted report, whichever occurs first, the insurer shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

History: Laws 1984, ch. 127, § 56; 2017, ch. 130, § 3.

59A-4-13. Examination report as evidence; proceedings during examination.

A. In any proceeding by or against the examinee or any officer or agent thereof the examination report as adopted by the superintendent shall be admissible as evidence of the facts stated therein, and shall constitute prima facie evidence of such facts.

B. Nothing contained in the Insurance Code shall prevent or be construed as prohibiting the superintendent from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with Chapter 59A, Article 4 NMSA 1978.

C. In the event the superintendent determines that regulatory action is appropriate as a result of any examination, whether completed, adopted or not, he may initiate any proceedings or actions as provided by law, and the superintendent or examiners may testify and give evidence, including any evidence received by them during the course of the examination.

History: Laws 1984, ch. 127, § 57; 1993, ch. 320, § 8.

59A-4-14. Examination expense; payment.

A. The person examined shall pay all reasonable costs and expenses of the examination upon presentation by the superintendent, upon completion of the examination, of a detailed statement of accrued costs and expenses. Remuneration and expenses of salaried personnel of the insurance department serving in the examination shall be paid to the superintendent, and upon receipt thereof, the superintendent shall deposit the payment with the state treasurer to the credit of the "insurance examination fund" which is hereby created in the state treasury. Money in the fund is appropriated to the superintendent to be used by the superintendent exclusively for expenses for examinations. All money in excess of twenty thousand dollars ($20,000) remaining in the fund and unencumbered at the end of any fiscal year shall revert to the general fund. The examinee, upon the superintendent's written request and approval of the amount thereof, shall pay direct to the examiners or specialists remuneration and expenses of independently contracting examiners and specialists used by the superintendent in the examination, which remuneration shall be based on but not limited to the suggested compensation amounts of a national association of insurance commissioners.

B. If another state in examination of a person domiciled in this state charges per diem and other allowances in excess of those generally charged by this state in a

similar examination, the superintendent in examination of a person domiciled in that state shall charge per diem and allowances at the same rate charged by the other state.

History: Laws 1984, ch. 127, § 58; 1985, ch. 3, § 1; 1987, ch. 119, § 2.

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 [Chapter 59A NMSA 1978].

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.

History: Laws 1984, ch. 127, § 59; 1991, ch. 125, § 7; 2011, ch. 127, § 3; 2011, ch. 144, § 1; 2021, ch. 108, § 3.

59A-4-16. Notice of hearing.

A. Except where a different period is expressly provided, the superintendent shall give written notice of the hearing not less than twenty days in advance. The notice shall state the date, time and place of the hearing and specify the matters to be considered thereat.

B. If any person is entitled to a hearing by any provision of the Insurance Code before any proposed action is taken, or if the superintendent otherwise deems advisable, notice of the hearing may be in the form of a notice to show cause, stating that proposed action may be taken unless such person shows cause at a hearing to be held as specified in the notice why the action should not be taken, and stating the basis of the proposed action.

C. If a hearing is to be held for consideration of rules of the superintendent, the superintendent may give notice of the hearing by publication thereof in a newspaper of general circulation in this state, and once in the New Mexico register; and the superintendent shall mail the notice to all persons who had requested the same in writing in advance and shall have paid to the superintendent the reasonable costs of such mailing as fixed by the superintendent.

D. If the hearing is for a purpose other than the consideration of rules of the superintendent, and if the persons to be given notice are not specified in the provision pursuant to which the hearing is held, the superintendent shall give the notice to all persons whose pecuniary interests, to the superintendent's knowledge or belief, are to be directly and immediately affected by the hearing.

E. All such notices, except published notice, shall be given as provided for in 59A-2-10 NMSA 1978.

F. The superintendent shall specify in the notice of hearing whether the hearing is to be an administrative hearing pursuant to Section 59A-4-17 NMSA 1978 or an informal hearing pursuant to Section 59A-4-18 NMSA 1978.

History: Laws 1984, ch. 127, § 60; 1997, ch. 121, § 2.

59A-4-17. Hearing procedure.

Administration 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.

History: Laws 1984, ch. 127, § 61.

59A-4-18. Informal hearings.

Informal hearings shall be held in accordance with the rules and regulations for such hearings promulgated by the superintendent in accordance with Section 27 [59A-2-9 NMSA 1978] of the Insurance Code.

History: Laws 1984, ch. 127, § 62.

59A-4-19. Testimony compelled; immunity.

A. If any individual refuses to attend or testify or to produce any books, papers, records, contracts, correspondence or other documents in connection with any examination, hearing or investigation on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to penalty or forfeiture, and is nonetheless, upon written application by a prosecuting attorney, directed by a court of competent jurisdiction in a written order finding that the testimony, or the record, document or other object may be necessary to the public interest and that the person has refused or is likely to refuse to testify or to produce the record, document or other subject on the basis of his privilege against self-incrimination, to give such testimony or produce such evidence, he must comply with such direction; but no testimony so given or evidence produced shall be used against him upon any criminal action, investigation or proceedings. However, no such individual so testifying or producing evidence shall be exempt from:

(1) prosecution or punishment for any perjury committed by him in such testimony, and the testimony or evidence so given or produced shall be admissible against him upon any criminal action, investigation or proceeding concerning such perjury; or

(2) refusal, suspension or revocation of any license, permission or authority conferred pursuant to the Insurance Code.

B. Any such individual may execute, acknowledge and file in the offices of the superintendent and attorney general a statement expressly waiving such immunity or privilege in respect to any transaction, matter or thing specified in such statement, and thereupon the testimony of such individual or such evidence in relation to such transaction, matter or thing may be received or produced before any judge or court, tribunal, grand jury or otherwise; and if such testimony or evidence is so received or produced the individual shall not be entitled to any immunity or privileges on account of the testimony or evidence given or produced.

History: Laws 1984, ch. 127, § 63; 1993, ch. 320, § 9.

59A-4-20. Appeal to court.

A. Except in matters arising from Sections 6 [59A-18-13.3 NMSA 1978] and 7 [repealed] of this 2011 act, a party may appeal from an order of the superintendent made after an informal hearing or an administrative hearing. The appeal shall be taken to the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

B. This section shall not apply as to matters arising pursuant to Chapter 59A, Article 17 NMSA 1978.

History: Laws 1984, ch. 127, § 67; 1987, ch. 259, § 3; 1998, ch. 55, § 61; 1999, ch. 265, § 65; 2011, ch. 144, § 13.

59A-4-21. Immunity from civil liability.

A. No cause of action shall arise nor shall any liability be imposed against the superintendent, the superintendent's authorized representatives or any examiner appointed by the superintendent for any statements made or conduct performed in good faith while carrying out the provisions of Chapter 59A, Article 4 NMSA 1978.

B. No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the superintendent or the superintendent's authorized representative or examiner pursuant to an examination made under Chapter 59A, Article 4 NMSA 1978, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

C. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in Subsection A of this section.

D. A person identified in Subsection A of this section shall be entitled to an award of attorneys' fees and costs if he is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of Chapter 59A, Article 4 NMSA 1978 and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

History: 1978 Comp., § 59A-4-21, enacted by Laws 1993, ch. 320, § 10.

ARTICLE 5
Authorization of Insurers and General Requirements

59A-5-1. Definitions, in general.

In the Insurance Code words defined in Sections 69 through 76 [59A-5-2 to 59A-5-9 NMSA 1978], inclusive, of this article have the meaning ascribed in the respective such sections.

History: Laws 1984, ch. 127, § 68.

59A-5-2. "Alien" insurer defined.

An "alien" insurer is one formed under the laws of a country other than the United States.

History: Laws 1984, ch. 127, § 69.

59A-5-3. "Charter" defined.

"Charter" means certificate of incorporation, articles of incorporation, articles of agreement, articles of association, charter granted by legislative act, or other basic constituent document of a corporation, or the subscribers' agreement and power of attorney of the attorney-in-fact of a reciprocal insurer or constituent documents of a Lloyds insurer.

History: Laws 1984, ch. 127, § 70.

59A-5-4. "Domestic" insurer defined.

A "domestic" insurer is one formed under the laws of New Mexico.

History: Laws 1984, ch. 127, § 71.

59A-5-5. "Foreign" insurer defined.

A "foreign" insurer is generally one organized under the laws of a state other than New Mexico. Except where distinguished by context, "foreign" insurer includes also an "alien" insurer.

History: Laws 1984 ch. 127, § 72.

59A-5-6. "Lloyds" insurer defined.

A "Lloyds" insurer is an unincorporated but formally associated group of separate persons ("underwriters" or "underwriting syndicates") by whom an insurance risk is assumed in whole or part by one or more of such persons.

History: Laws 1984, ch. 127, § 73.

59A-5-7. "Mutual" insurer defined.

A "mutual" insurer is an incorporated insurer without capital stock, the governing body of which is elected by its policyholders. This definition shall not be deemed to exclude as "mutual" insurers certain foreign insurers found by the superintendent to be organized on the mutual plan under the laws of the state of domicile, but having temporary share capital or providing for election of the governing body on other reasonable basis.

History: Laws 1984, ch. 127, § 74.

59A-5-8. "Reciprocal" insurer defined.

A "reciprocal" insurer is an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact common to all such persons to provide insurance on basis of reciprocity among themselves.

History: Laws 1984, ch. 127, § 75.

59A-5-9. "Stock" insurer defined.

A "stock" insurer is an incorporated insurer with capital divided into shares, and owned by its shareholders.

History: Laws 1984, ch. 127, § 76.

59A-5-10. Certificate of authority required; penalty.

A. No person shall act as an insurer, and no insurer shall transact insurance in this state by direct solicitation or solicitation through the mails or otherwise, unless so authorized by a subsisting certificate of authority issued by the superintendent, except as to such transactions as are expressly otherwise provided for in the Insurance Code.

B. No insurer from offices or by personnel or facilities located in this state shall solicit insurance applications or otherwise transact insurance in another state or country unless it holds a subsisting certificate of authority granted by the superintendent authorizing it to transact the same kind or kinds of insurance in this state. As to domestic insurers, this provision is further subject to Section 579 [59A-34-33 NMSA 1978] (unauthorized business in other states) of the Insurance Code.

C. Any officer, director, agent, representative or employee of any insurer who wilfully authorizes, negotiates, makes or issues any insurance contract in violation of this section commits a misdemeanor, subject on conviction to a fine of not over one thousand dollars ($1,000).

History: Laws 1984, ch. 127, § 77.

59A-5-11. Exemptions from authority requirement.

A certificate of authority shall not be required of an insurer with respect to any of the following:

A. investigation, settlement or litigation of claims under its policies lawfully written in this state, or liquidation of assets and liabilities of the insurer (other than collection of new premiums), all as resulting from its former authorized operations in this state;

B. collection of premiums on and servicing policies remaining in force by an insurer which has withdrawn from this state, and lawfully written in this state while the insurer held a certificate of authority issued by the superintendent, is transacting insurance in New Mexico for purpose of premium tax requirements only;

C. transactions thereunder subsequent to issuance of a policy covering only subjects of insurance not resident, located or expressly to be performed in this state at time of issuance, and lawfully solicited, written and delivered outside this state;

D. prosecution or defense of suits at law; but no insurer unlawfully transacting insurance in this state without certificate of authority shall be permitted to institute or maintain (other than defend) any action at law or in equity in any court of this state, either directly or through an assignee or successor in interest, to enforce any right, claim or demand arising out of such an insurance transaction until such insurer or assignee or successor has obtained a certificate of authority in this state. This provision does not apply to any suit or action by the duly constituted receiver, rehabilitator or liquidator of the insurer, assignee or successor under laws similar to those contained in Article 41 [Chapter 59A, Article 41 NMSA 1978] (conservation, rehabilitation, liquidation) of the Insurance Code;

E. transactions pursuant to surplus line coverages lawfully written under Article 14 [Chapter 59A, Article 14 NMSA 1978] (surplus line) of the Insurance Code;

F. suit, action or proceeding by the insurer for enforcement or defense of its rights relative to an investment in this state;

G. reinsurance, except as to a domestic reinsurer; or

H. transactions in this state involving group life insurance, group health or blanket health insurance, or group annuities, where the master policy or contract of such group was lawfully solicited, issued and delivered pursuant to the laws of a state in which the insurer was authorized to transact such insurance, to a group organized for purposes other than procurement of insurance, and where the policyholder is domiciled or otherwise has a bona fide business situs. Except, that such an insurer is subject to Section 261 [59A-15-6 NMSA 1978] (superintendent is attorney of unauthorized insurer

for service of process) and related sections of the Insurance Code with respect to contracts and certificates of insurance under any such master policy or contract, issued for delivery and delivered in this state to residents thereof.

History: Laws 1984, ch. 127, § 78.

59A-5-11.1. Exemption from authority requirement; provider service networks.

A certificate of authority shall not be required of a provider service network, except as provided in the Provider Service Network Act [59A-42A-1 to 59A-42A-9 NMSA 1978].

History: 1978 Comp., § 59A-5-11.1, enacted by Laws 1997, ch. 107, § 10.

59A-5-12. General eligibility for certificate of authority.

To qualify for and hold authority to transact insurance in this state, an insurer must have accepted in writing all of the laws of New Mexico, be otherwise in compliance with the Insurance Code and with its charter powers, and must be an incorporated stock or mutual insurer, or a reciprocal insurer, or Lloyds insurer; except that:

A. no foreign insurer shall be authorized in this state which does not maintain reserves as required by Sections 121 through 129 [59A-8-4 to 59A-8-12 NMSA 1978], inclusive, of Article 8 [Chapter 59A, Article 8 NMSA 1978] (assets and liabilities) of the Insurance Code, as applicable to the insurance transacted by the insurer in the United States, or which transacts business anywhere in the United States on the assessment plan, or stipulated premium plan, or any similar plan;

B. no insurer shall be authorized to transact a kind of insurance in this state unless duly authorized or qualified to transact such insurance in the state or country of its domicile;

C. no insurer shall be authorized to transact in this state any kind of insurance not within the definitions set forth in Article 7 [Chapter 59A, Article 7 NMSA 1978] (kinds of insurance) of the Insurance Code; and

D. no such authority shall be granted or continued to any insurer while in arrears to this state for fees, licenses, taxes, assessments, fines or penalties accrued on business previously transacted.

History: Laws 1984, ch. 127, § 79.

59A-5-13. General eligibility for authority; ownership and management.

A. No foreign insurer which is owned or controlled in whole or substantial part by any government or governmental agency shall be authorized to transact insurance in New Mexico. Membership in a mutual insurer or subscribership in a reciprocal insurer, or ownership of stock in an insurer by the alien property custodian or similar officer of the United States or ownership of stock or other security without voting rights as to the insurer management, or supervision of an insurer by public authority, shall not be deemed to be an ownership or control of the insurer under this subsection.

B. The superintendent shall not grant or continue authority to transact insurance to any insurer or proposed insurer:

(1) of which any director, officer or other individual materially part of its management is found by him after investigation or upon reliable information to be incompetent, or dishonest, or untrustworthy, or of unfavorable business repute; or

(2) of which the managers are so lacking in insurer managerial experience in operations as existing or proposed in this state as to make such operations currently or prospectively hazardous to or contrary to the best interests of the insurance-buying or investing public of this state; or

(3) which he has reason to believe is affiliated directly or indirectly through ownership, control, management, reinsurance or other business relations with any person or persons of unfavorable business repute; or

(4) the business operations of whose director, officer, manager or controlling owner are or have been marked, to the injury of insurers, stockholders, policyholders, creditors or the public, by illegality, or by manipulation of assets, or of accounts, or of reinsurance, or by bad faith; or

(5) as to which the superintendent is not satisfied that its business policies and methods would be in the best interests of the people of New Mexico.

History: Laws 1984, ch. 127, § 80.

59A-5-14. Name of insurer.

A. No insurer shall be formed or authorized to transact insurance in this state which has or uses a name:

(1) the same as or deceptively similar to that of another insurer already so authorized; or

(2) deceptively similar to that of another insurer, other than a predecessor in interest, authorized to transact insurance in this state within the preceding ten (10) years if policies originally issued by such other insurer are still outstanding in this state; or

(3) the same as or deceptively similar to that of any insurer, or proposed insurer, not so authorized if such insurer has within the next preceding twelve (12) months signified its intention to secure an incorporation in this state under such name, or to do business as a foreign insurer in this state under such name, by filing notice of such intention with the superintendent, unless written consent to use of such name or deceptively similar name has been given by such insurer.

B. No insurer shall be so authorized which has or uses a name tending to mislead as to its type of organization.

C. In case of conflict of names between two insurers, or a conflict otherwise prohibited under this section, the superintendent may permit (or shall require as condition to issuance of an original certificate of authority to an applicant insurer) the insurer to use in this state such supplementation or modification of its name or such business name as may reasonably be necessary to avoid the conflict.

D. Except as provided in Subsection C, above, an insurer shall conduct its business in its own corporate or proper name.

E. Subsections A and C of this section shall not apply as to a corporation or insurer formed under [a] plan approved by the superintendent and court for rehabilitation of a domestic insurer pursuant to Article 41 [Chapter 59A, Article 41 NMSA 1978] (conservation, rehabilitation and liquidation) of the Insurance Code, or as to a corporation or insurer resulting from consolidation or merger, or acquisition of substantially all the assets and assumption of liabilities of another insurer through bulk reinsurance or otherwise, so long as the name used is [the] same as or similar to that of the predecessor corporation or insurer and is not in conflict with or deceptively similar to that of any other insurer then authorized or proposed (as provided in Subsection A(3) above) to transact insurance in this state. Subsections A and C shall not apply as to an insurer which is [a] subsidiary or affiliate of an authorized insurer and using name factors similar to those of the parent or insurer with which affiliated.

History: Laws 1984, ch. 127, § 81.

59A-5-15. Insuring power combinations.

An insurer which otherwise qualifies therefor shall be authorized to transact any one kind or combination of kinds of insurance as defined in Sections 107 through 115 [59A-7-1 to 59A-7-9 NMSA 1978] (kinds of insurance) of the Insurance Code, except:

A. a life insurer may grant annuities and may be authorized to transact in addition only health insurance;

B. a reciprocal insurer or Lloyds insurer shall not transact life insurance; and

C. a title insurer shall be a stock or mutual corporation, and shall not transact any additional kind of insurance.

History: Laws 1984, ch. 127, § 82.

59A-5-16. Capital funds, deposits, required for certificate of authority.

A. To qualify for certificate of authority to transact any one kind or combination of kinds of insurance in this state, an insurer shall possess:

(1) if a stock insurer, paid-in capital stock and, when first so authorized, surplus all as shown in Schedule I of this section; or

(2) if a mutual, reciprocal or Lloyds insurer, basic capital surplus, including guaranty funds, if any, and additional unassigned surplus when first so authorized, as required under Schedule I of this section.

B. Except that an insurer that on January 1, 1985, having applied for a certificate on or before February 15, 1984, held a valid and subsisting certificate of authority to transact insurance in this state may, if a domestic insurer, continue to be so authorized until December 31, 1995, so long as otherwise qualified therefor and possessing paid-in capital stock, if a stock insurer, or basic capital surplus, if a mutual, reciprocal or Lloyds insurer, not less than that required of the insurer by the laws of this state in force on January 1, 1986; and if a foreign insurer, may so continue to be so authorized, if otherwise qualified therefor, while possessing such capital funds (paid-in capital stock and surplus if a stock insurer, and surplus if a mutual or reciprocal insurer) until December 31, 1990. At the expiration of such period, as applicable, the insurer shall meet the basic capital requirements of this section as set forth in Schedule I of this section in order to maintain its certificate of authority. Upon a change in the control of either a domestic insurer or foreign insurer, the insurer shall, within one year from effective date of such change of control, meet the capital funds requirements of Schedule I of this section as though a newly authorized insurer, but this sentence shall not act to extend the otherwise applicable time period. For the purposes of this subsection, "control" shall have the meaning ascribed in Section 59A-37-2 NMSA 1978.

C. The capital funds required for authority to transact insurance in this state shall be based upon all the kinds of insurance the insurer transacts, wherever transacted or to be transacted.

D. This section shall not apply as to domestic Lloyds plan insurers as identified in Chapter 59A, Article 38 NMSA 1978 except as stated in that article.

E. The capital requirements of this section are set forth in the following schedule:

Schedule I
NEW MEXICO
Minimum Capital, Surplus and Deposit Requirements

Property/Casualty Insurer

Premium Volume:		Under $5 Million	$5 to $10 Million	$10 to $25 Million	Over $25 Million
	Number of Kinds of Insurance				
	1	2			
Basic Capital	500,000	600,000	800,000	900,000	1,000,000
Additional Surplus	500,000	600,000	same as Under $5 Million	same as Under $5 Million	same as Under $5 Million
General Deposit	200,000	300,000	500,000	500,000	500,000
Special Deposit	200,000	300,000	same as Under $5 Million	same as Under $5 Million	same as Under $5 Million

Life/Health Insurer

Premium Volume:	Under $5 Million	$5 to $10 Million	$10 to $25 Million	Over $25 Million
Basic Capital	600,000	700,000	800,000	900,000
Additional Surplus	400,000	400,000	400,000	400,000
General Deposit	200,000	200,000	200,000	200,000
Special Deposit	200,000	200,000	200,000	200,000

Premium Volume means the insurer's worldwide direct premiums earned (if Property/Casualty) or received (if Life/Health) during the previous calendar year.

Notes:

Kinds of insurance pertains to the general kinds of insurance that property/casualty insurers are authorized to transact.

The following groups or single kinds of insurance shall be counted as one kind of insurance when calculating the amount of required Basic Capital, Additional Surplus, General Deposit and Special Deposit:

Casualty;
Property; and
Title.

When determining Basic Capital and Additional Surplus amounts, the kinds of Insurance shall be based on the insurer's actual or

requested transaction authority Worldwide.

When determining General Deposit and Special Deposit amounts, the kinds of Insurance shall be based on the insurer's actual or requested transaction authority in New Mexico.

"Basic Capital" means paid-in capital stock (if a stock insurer) or basic capital surplus (if a mutual, reciprocal or Lloyds insurer). General Deposit or Special Deposit funds are included within, and are not additional to, required Basic Capital and Additional Surplus. General Deposit amounts shown above are not applicable to alien insurers.

History: Laws 1984, ch. 127, § 83; 1987, ch. 259, § 4; 1987, ch. 262, § 1; repealed and reenacted by Laws 2007, ch. 282, § 1; 2016, ch. 89, § 1.

59A-5-17. Insuring powers without added basic capital.

An insurer while authorized to transact property insurance may include in "homeowners" and similar package policies insuring property against loss, reasonable amounts of supplemental liability and medical benefits coverage without being authorized to transact casualty or health insurances; and such supplemental coverages shall not be deemed otherwise to be subject to provisions of the Insurance Code relating to casualty or health insurance contracts.

History: Laws 1984, ch. 127, § 84.

59A-5-18. General deposit.

A. For certificate of authority to transact insurance in this state the insurer shall make and thereafter maintain while so authorized a general deposit in trust for the benefit of all its policyholders and creditors. The deposit shall consist of assets eligible therefor under Section 59A-10-3 NMSA 1978, and shall be deposited with or through the superintendent or in a commercial depository located in the state of New Mexico approved by the superintendent subject to rules and regulations issued by the superintendent. As to foreign insurers, in lieu of such deposit or part thereof in this state, the superintendent shall accept the certificate in proper form of the public official having

supervision over insurers in another state to the effect that a like deposit or part thereof by such insurer is being maintained in public custody therein in trust for the purpose (among other reasonable purposes of protection of policyholders and/or creditors) of the protection of all its policyholders and creditors in New Mexico.

B. Whenever because of volume of business being transacted by the insurer, or methods of doing business, or for other good cause the superintendent deems advisable for protection of policyholders and creditors, the superintendent may require an insurer to make and maintain a general deposit in reasonable amount greater than required under Schedule I of Section 59A-5-16 NMSA 1978.

C. All such deposits made in this state shall be subject to the applicable provisions of Chapter 59A, Article 10 NMSA 1978.

D. This section does not apply as to a domestic Lloyds plan motor vehicle insurer, as identified in Chapter 59A, Article 38 NMSA 1978.

History: Laws 1984, ch. 127, § 85; 1987, ch. 262, § 2.

59A-5-19. Special deposit or bond.

A. To qualify for and continue to hold a certificate of authority to transact insurance in this state, the insurer shall also make a special deposit in trust for the benefit only of all its policyholders and creditors in this state in applicable amount as shown in Schedule I of Section 59A-5-16 NMSA 1978. The deposit shall consist of assets eligible therefor under Section 59A-10-3 NMSA 1978 and shall be deposited with or through the superintendent or in a commercial depository located in the state of New Mexico approved by the superintendent subject to rules and regulations issued by the superintendent.

B. In lieu of such deposit, the insurer may file with the state treasurer of New Mexico through the superintendent a surety bond issued by a surety insurer authorized to transact such insurance in this state, in penal sum not less than the aggregate special deposits required by this section. The bond shall be in such form as may be prescribed by the attorney general of New Mexico. The bond shall not be subject to cancellation except upon not less than sixty days advance written notice to the superintendent by the insurer or surety; and the insurer shall promptly replace, not later than fifteen days prior to expiration of the bond, with another like bond, any bond so canceled or otherwise terminated. The bond shall expressly provide that failure of the insurance company to replace a canceled or terminated bond as provided in this section shall constitute a breach of the condition upon which the bond is given, upon which occurrence the superintendent may immediately recover from the surety the penal sum of the bond to be held as a special deposit in the manner described in Subsection A of this section.

C. The special deposit, or bond in lieu thereof, shall remain on deposit or on file and in force for so long as there may arise in this state any claim under any policy issued by

the insurer covering a subject located or a service to be performed in this state or a claim arising out of the insurer's operations in this state.

D. Whenever because of volume of business being transacted by the insurer, methods of doing business, regulatory practices of the domiciliary state or for other good cause the superintendent deems advisable for protection of policyholders and creditors, the superintendent may require an insurer to make and maintain a special deposit in reasonable amount greater than required under Schedule I of Section 59A-5-16 NMSA 1978, but no greater than one hundred fifteen percent of its direct unpaid losses in New Mexico.

E. The special deposit shall be subject to the applicable provisions of Chapter 59A, Article 10 NMSA 1978.

F. This section shall not apply to domestic Lloyds plan automobile insurers as identified in Chapter 59A, Article 38 NMSA 1978.

G. For purposes of this section, "creditors" shall not include:

(1) shareholders or other owners of the insurer regarding claims arising out of their capacity as shareholders or other owners; or

(2) holders of bonds, surplus notes, capital notes, contribution notes or similar obligations of the insurer regarding claims arising out of their capacity as holders of bonds, surplus notes, capital notes, contribution notes or similar obligations of the insurer.

History: Laws 1984, ch. 127, § 86; 1987, ch. 262, § 3; 2003, ch. 202, § 2; 2012, ch. 9, § 1.

59A-5-20. General deposit of alien insurer.

A. The superintendent shall not issue or permit to exist a certificate of authority to transact insurance in this state as to an alien insurer unless and while the insurer has made and maintains out of its surplus over its United States' liabilities a general deposit of assets acceptable to the superintendent with or through the insurance supervisory officer of a state in which the insurer is authorized to transact insurance, in trust for the benefit of all the insurer's policyholders and creditors in the United States.

B. The deposit shall at all times have a value of not less than the capital and surplus required under Schedule I of Section 59A-5-16 NMSA 1978, of a foreign insurer transacting like kinds of insurance in this state. The amount of the deposit shall to like amount offset the amount of general deposit otherwise required of the insurer under Schedule I of Section 59A-5-16 NMSA 1978.

History: Laws 1984, ch. 127, § 87; 1991, ch. 125, § 8.

59A-5-21. Application for certificate of authority.

A. To apply for an original certificate of authority in this state the insurer shall file with the superintendent its written application therefor on forms as prescribed and furnished by the superintendent, accompanied by the applicable fees as specified or referred to in Section 59A-6-1 NMSA 1978, stating under the oath of the president or vice president or other chief officer and the secretary of the insurer, or of the attorney-in-fact (if a reciprocal insurer or Lloyds insurer), the insurer's name, location of its home office, or principal office, in the United States (if an alien insurer), the kinds of insurance to be transacted, date of organization or incorporation, form of organization, state or country of domicile, and such additional or other information as the superintendent may reasonably require, together with the following documents:

(1) if a corporation, a copy of its charter or certificate or articles of incorporation, together with all amendments thereto, or as restated and amended under the laws of its state or country of domicile, currently certified by the public officer with whom the originals are on file in such state or country;

(2) if a domestic incorporated insurer of a mutual insurer, a copy of its bylaws, certified by its corporate secretary;

(3) if a reciprocal insurer or Lloyds insurer, a copy of the power of attorney of its attorney-in-fact, certified by the attorney-in-fact; and if a domestic reciprocal insurer or a Lloyds insurer, additional documentation showing that it has been properly formed and is lawfully existing under applicable laws;

(4) a complete copy of its financial statement as of not earlier than the December 31 next preceding, in form as customarily used in the United States by like insurers, sworn to by at least two executive officers of the insurer or certified by the public insurance supervisory officer of the insurer's state of domicile, or of entry into the United States if an alien insurer;

(5) a copy of the report of last examination made of the insurer certified by the public insurance supervisory officer of its state of domicile, or of entry into the United States if an alien insurer;

(6) appointment of the superintendent pursuant to Section 59A-5-31 NMSA 1978 as its attorney to receive service of legal process;

(7) if a foreign or alien insurer, a certificate of the public insurance supervisory officer of its state or country of domicile showing that it is authorized or qualified for authority to transact in such state or country the kinds of insurance proposed to be transacted in this state;

(8) if a foreign insurer, a certificate as to a deposit elsewhere if to be tendered pursuant to Section 59A-5-18 or 59A-5-20 NMSA 1978;

(9) if an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records; and

(10) designation by the insurer of its officer or representative authorized to appoint and remove its agents in this state.

B. If the superintendent so requests, the applicant insurer shall supplement the documents and information above required with true biographical information concerning the members of the insurer's board of directors or other governing body and its principal operating officers, together with proof of identity of each such individual.

History: Laws 1984, ch. 127, § 88; 1999, ch. 289, § 1.

59A-5-22. Issuance, refusal of authority; ownership of certificate.

A. Upon completion of application of an insurer or proposed insurer for certificate of authority to transact insurance in this state, the superintendent, upon such examination or investigation of the applicant as deemed advisable, shall promptly determine whether the applicant meets financial and other applicable requirements and qualifications for the authority as set forth in Sections 79 through 87 [59A-5-12 to 59A-5-20 NMSA 1978] of this article. If found to be qualified and in compliance, the superintendent shall promptly issue a certificate of authority to the applicant covering the kind or kinds of insurance so applied and qualified for; otherwise, the superintendent shall issue order to the applicant refusing the certificate of authority and stating therein the reasons for refusal.

B. The certificate, if issued, shall state the insurer's name, home office address, state or country of domicile, and the kind or kinds of insurance it is authorized to transact in this state. At the insurer's request the superintendent may issue a certificate limited to particular types of insurance or coverages within a kind of insurance as defined in Article 7 [Chapter 59A, Article 7 NMSA 1978] (kinds of insurance) of the Insurance Code.

C. Although issued and delivered to the applicant, the certificate of authority at all times shall be the property of the state of New Mexico. Upon any expiration, suspension or termination thereof the insurer shall promptly deliver the certificate to the superintendent.

History: Laws 1984, ch. 127, § 89.

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 [Chapter 59A NMSA 1978], 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.

History: Laws 1984, ch. 127, § 90; 2021, ch. 108, § 4.

59A-5-24. Suspension or revocation of certificate of authority; mandatory grounds.

A. The superintendent shall suspend or revoke an insurer's certificate of authority:

(1) if such action is required by any provision of the Insurance Code; or

(2) if a foreign insurer and it no longer meets the qualifications and requirements for a certificate of authority, on account of deficiency of capital or surplus or otherwise, subject to Section 92 [59A-5-25 NMSA 1978] of this article relative to impairment; or

(3) if a domestic insurer and it has failed to cure an impairment of capital or surplus within the time allowed therefor by the superintendent under the Insurance Code or is otherwise no longer qualified for the certificate of authority; or

(4) if the insurer's certificate of authority to transact insurance therein is suspended or revoked by its state of domicile, or state of entry into the United States if an alien insurer.

B. Except in case of insolvency or impairment of required capital or surplus, or suspension or revocation by another state as referred to in Paragraph (4) of Subsection A, the superintendent shall give the insurer at least twenty (20) days written notice in advance of suspension or revocation under this section, and the reasons therefor.

History: Laws 1984, ch. 127, § 91.

59A-5-25. Impairment as grounds for suspension or revocation of certificate of authority.

A. For the purposes of Section 91 [59A-5-24 NMSA 1978] (suspension or revocation of certificate of authority - mandatory grounds) of this article, an insurer shall be deemed impaired when the superintendent at any time finds that the excess of the insurer's admitted assets over its liabilities is less than the minimum basic capital required to be maintained by the insurer under this article, and the insurer has failed to make good the deficiency within the period provided for below.

B. The superintendent shall give the insurer written notice of the deficiency stating the amount thereof, and require the insurer to eliminate the deficiency within sixty (60) days after notice was so given. If the insurer fails to cure the deficiency within the sixty-day period the superintendent shall immediately suspend or revoke its certificate of authority. This provision shall not be deemed to prevent the superintendent, within such sixty-day period or at any other time, from taking other action as to the insurer as authorized under any provision of Article 41 [Chapter 59A, Article 41 NMSA 1978] (conservation, rehabilitation, liquidation) of the Insurance Code.

History: Laws 1984, ch. 127, § 92.

59A-5-26. Suspension, limitation or revocation of authority; discretionary and special grounds.

A. The superintendent may, at his discretion, suspend, limit or revoke an insurer's certificate of authority if he finds after a hearing thereon, or upon waiver of hearing by the insurer, that the insurer has:

(1) violated or failed to comply with any lawful order of the superintendent;

(2) willfully violated or willfully failed to comply with any lawful regulation of the superintendent;

(3) violated any provision of the Insurance Code other than those for violation of which suspension or revocation is mandatory; or

(4) reinsured all or substantially all of its risks, or all or substantially all of its risks in a particular kind of insurance, in another insurer.

B. In lieu of suspension or revocation of certificate of authority as provided in Subsection A of this section, the superintendent may, at his discretion, levy upon the insurer and the insurer shall forthwith pay to the superintendent, an administrative fine of not more than five thousand dollars ($5,000). The superintendent shall promptly deposit with the state treasurer to the credit of the general fund all money received under this subsection.

C. The superintendent shall suspend or revoke an insurer's certificate of authority on any of the following grounds, if found after a hearing thereon that the insurer:

(1) is in unsound condition, or being fraudulently conducted, or in such condition or using such methods and practices in conduct of its business as to render its further transaction of insurance in this state currently or prospectively hazardous or injurious to policyholders or the public;

(2) with such frequency as to indicate its general business practice in this state:

(a) has without just cause failed to pay, or delayed payment of, claims arising under its policies, whether the claim is in favor of an insured or in favor of a third person with respect to the liability of an insured to such third person; or

(b) without just cause compels insureds or claimants to accept less than amount due them or to employ attorney or to bring suit against the insurer or such an insured to secure full payment or settlement of a claim;

(3) refuses to be examined, or if its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce books, papers, records, contracts, correspondence or other documents for examination by the superintendent when required, or refuses or fails to pay expenses of the examination or to perform any other legal obligation relative to the examination; or

(4) has failed to pay any final judgment rendered against it in this state upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within thirty days after the judgment becomes final.

D. The superintendent may, at his discretion and without advance notice or hearing thereon, immediately suspend the certificate of authority of an insurer as to which proceedings for receivership, conservation, rehabilitation or other delinquency proceedings have been commenced in any state by the public insurance supervisory officer of that state.

History: Laws 1984, ch. 127, § 93; 1997, ch. 121, § 3.

59A-5-27. Duration of suspension; insurer's obligations during suspension; reinstatement.

A. Suspension of an insurer's certificate of authority shall be for a fixed period of time not to exceed two years or until the occurrence of a specific event necessary for remedying the reasons for suspension. During the suspension period the superintendent may modify or rescind the suspension by further order.

B. During the suspension period the insurer shall not solicit or write any new business in this state, but shall file its annual statement, pay fees, licenses and taxes as required under the Insurance Code, and may service its business already in force in this state, as if the certificate of authority had continued in full force. Upon failure of the insurer to continue its certificate of authority in accordance with this subsection, the insurer's certificate of authority shall be revoked.

C. If the suspension of the certificate of authority is for a fixed period of time and the certificate of authority has not been otherwise terminated, upon expiration of the suspension period, the insurer's certificate of authority shall automatically reinstate unless the superintendent finds that the insurer is not in compliance with the requirements of the Insurance Code.

D. If the suspension of the certificate of authority was until the occurrence of a specific event and the certificate of authority has not been otherwise terminated, upon the presentation of evidence satisfactory to the superintendent that the specific event has occurred, the insurer's certificate of authority shall be reinstated unless the superintendent finds that the insurer is otherwise not in compliance with the requirements of the Insurance Code. The superintendent shall promptly notify the insurer of such reinstatement, and the insurer shall not consider its certificate of authority reinstated until so notified by the superintendent. If satisfactory evidence as to the occurrence of the specific event has not been presented to the superintendent within two years of the date of the suspension, the certificate of authority shall be revoked.

E. Nothing contained in this section shall prevent the superintendent from revoking a certificate of authority at any time upon any ground specified in the Insurance Code.

History: Laws 1984, ch. 127, § 94; 1993, ch. 320, § 11.

59A-5-28. General corporation statutes inapplicable to foreign insurers.

The general corporation statutes of New Mexico shall not apply to foreign insurers holding certificate of authority to transact insurance in this state.

History: Laws 1984, ch. 127, § 95.

59A-5-29. Annual statement.

A. Each authorized insurer shall annually on or before March 1, or within any reasonable extension of time that the superintendent for good cause may have granted on or before such date, file with the superintendent and with the national association of insurance commissioners a full and true statement of its financial condition and of its transactions and affairs as of the December 31 next preceding. The statement shall be prepared in the form of the annual statement blank prescribed by the national association of insurance commissioners for use in the United States for the type of insurer and kinds of insurance to be reported upon, in accordance with the annual statement instructions and the accounting practices and procedures manual published by the national association of insurance commissioners, or such other form and instructions as the superintendent may prescribe, and supplemented by additional information reasonably required by the superintendent; the superintendent may require that the annual statement data be filed in electronically readable format or in lieu of filing, may accept a statement or supplemental information filed in electronic format with the national association of insurance commissioners that is readily available to the superintendent and that the superintendent can reproduce or otherwise make available to the public for a period of at least five years from the date that the filing is due. The statement shall be verified by the oath of the insurer's president or vice president and secretary or actuary, as applicable; or, in absence of the foregoing, by two other principal officers; or if a reciprocal insurer or Lloyds insurer, the oath of the attorney-in-fact or its like officers if a corporation.

B. The statement of an alien insurer shall be verified by its United States manager or other officer duly authorized and shall relate only to the insurer's transactions and affairs in the United States unless the superintendent requires otherwise. If the superintendent requires a statement as to the alien insurer's affairs throughout the world, the insurer shall file such statement with the superintendent as soon as reasonably possible.

C. If the insurer's statement is in any language other than English or in monetary amounts other than United States dollars, the statement shall be accompanied by an English-language translation and monetary amounts shall be shown in United States dollars with statement of the basis upon and date as of which the monetary conversion was made.

D. The superintendent may suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due.

E. At time of filing, the insurer shall pay the fee for filing its annual statement with the superintendent as prescribed by Section 59A-6-1 NMSA 1978, and pay to the national association of insurance commissioners the fee established for filing, review or processing of the information, unless such fee has been disapproved by the superintendent.

F. In the absence of actual malice, members of national association of insurance commissioners, their duly authorized committees, subcommittees and task forces, their delegates, employees and all others charged by the superintendent or the national association of insurance commissioners with the responsibility of collecting, reviewing, analyzing and disseminating the information developed from the filing of the annual statement blanks shall be acting as agents of the superintendent under the authority of the Insurance Code [Chapter 59A NMSA 1978] and shall not be subject to civil liability for libel, slander or any other cause of action by virtue of their collection, review and analysis or dissemination of the data and information collected from the filings required hereunder.

G. As to publication of nonstatutory financial statements, refer to Section 59A-16-9 NMSA 1978.

History: Laws 1984, ch. 127, § 96; 1986, ch. 78, § 1; 1993, ch. 320, § 12; 2007, ch. 282, § 2.

59A-5-29.1. Quarterly reports.

The superintendent may, in his sole discretion at any time and for any reason, including those set forth in Sections 59A-41-24 through 59A-41-26 NMSA 1978, require any authorized insurer to file quarterly financial statements with the superintendent and with the national association of insurance commissioners in accordance with the provisions of Section 59A-5-29 NMSA 1978.

History: 1978 Comp., § 59A-5-29.1, enacted by Laws 1993, ch. 320, § 13.

59A-5-30. Penalties for late, false annual statements.

A. Any insurer failing, without just cause reasonably beyond control of the insurer, to file its annual statement as required in Section 59A-5-29 NMSA 1978 shall be required to pay a penalty of one hundred dollars ($100) for each day's delay, but not to exceed five thousand dollars ($5,000) in aggregate amount. This penalty may be in addition to any refusal to continue, or suspension or revocation of, the insurer's certificate of authority for such failure.

B. Any director, officer, agent or employee of any insurer who subscribes to, makes or concurs in making or publishing any annual or other statement of the insurer required by law, knowing the same to contain any material statement that is false, shall upon conviction thereof be guilty of a misdemeanor and upon conviction shall be sentenced to a fine of not more than one thousand dollars ($1,000), unless by its extent and nature the offense is punishable under other statutes as a felony.

History: Laws 1984, ch. 127, § 97; 2017, ch. 130, § 4.

59A-5-31. Appointment of superintendent as process agent.

A. Before the superintendent authorizes it to transact insurance in this state, each insurer shall appoint the superintendent and [his] successors in office as its attorney to receive service of legal process issued against the insurer in this state. The appointment shall be on form as designated and furnished by the superintendent, accompanied by copy of resolution of the board of directors or like governing body of the insurer, or other appropriate instrument acceptable to the superintendent, showing that those who executed the appointment were duly authorized to do so on behalf of the insurer.

B. The appointment shall be irrevocable, shall bind the insurer and any successor in interest to the assets or liabilities of the insurer, and shall remain in effect as long as there exists any contract of the insurer in this state or any obligation of the insurer arising out of its transactions in this state.

C. The insurer shall file the appointment with the superintendent as part of its application for certificate of authority, together with a designation of the person to whom the superintendent shall forward process against the insurer served upon the superintendent. The insurer may change such designation by a new filing.

History: Laws 1984, ch. 127, § 98.

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.

History: Laws 1984, ch. 127, § 99; 2021, ch. 108, § 5.

59A-5-33. Reciprocity provision.

A. When by or pursuant to the laws of any other state or foreign country or province, any licenses and other fees, in the aggregate, and any fines, penalties, deposit requirements or other material requirements, obligations, prohibitions or restrictions are or would be imposed upon New Mexico insurers doing business or that might seek to do business in such state, country or province, or upon the agents or representatives of such insurers or upon brokers or adjusters, which are in excess of such licenses and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit or other requirements, obligations, prohibitions or restrictions directly imposed upon similar insurers, or upon the agents or representatives of such insurers, or upon brokers, or upon adjusters, of such other state, country, or province under the statutes of this state, so long as such laws of such other state, country or province continue in force or are so applied, the same licenses and other fees, in the aggregate, or fines, penalties or deposit requirements or other material requirements, obligations, prohibitions or restrictions of whatever kind may be imposed by the superintendent upon the insurers, or upon the agents or representatives of such insurers, or upon brokers of such other state, country or province, doing business or seeking to do business in New Mexico. Any license or other fee or obligation imposed by any city, county or other political subdivision or agency of such other state, country or province on New Mexico insurers or their agents, representatives, brokers or adjusters shall be deemed to be imposed by such state, country or province within the meaning of this section.

B. This section does not apply to special purpose obligations or assessments, or assessments under insurance guaranty fund laws, imposed by another state in connection with particular kinds of insurance, except that assessment of insurers for financing of public safety, health, and protection purposes is not exempt under this subsection.

C. For purposes of this section, domicile of an alien insurer, other than Canadian insurer, shall be the state designated by the insurer in writing and filed with the superintendent at the time of authorization in this state or within six months after the effective date of the Insurance Code, whichever date is the later, and may be any one of the following states:

(1) that in which the insurer was first authorized to transact insurance;

(2) that in which is located the insurer's principal place of business in the United States; or

(3) that in which is held the largest deposit of trusteed assets of the insurer for protection of its policyholders in the United States.

D. If the insurer makes no designation pursuant to Subsection C of this section, the insurer's domicile shall be deemed to be that state in which is located its principal place of business in the United States.

E. The domicile of a Canadian insurer shall be Canada and the province of Canada in which its head office is located.

History: Laws 1984, ch. 127, § 100; 2018, ch. 57, § 13.

ARTICLE 5A
Risk-Based Capital

59A-5A-1. Short title.

Chapter 59A, Article 5A NMSA 1978 may be cited as the "Risk-Based Capital Act".

History: 1978 Comp., § 59A-5A-1, enacted by Laws 1995, ch. 149, § 1.

59A-5A-2. Definitions.

As used in the Risk-Based Capital Act:

A. "adjusted risk-based capital report" means a risk-based capital report adjusted in accordance with Subsection E of Section 59A-5A-3 NMSA 1978;

B. "authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions bearing the same designation;

C. "company action level risk-based capital" means an amount equal to two hundred percent of an insurer's or health organization's authorized control level risk-based capital;

D. "corrective order" means an order issued by the superintendent specifying required corrective actions;

E. "domestic insurer or health organization" means an insurer, fraternal benefit society or health organization domiciled in New Mexico;

F. "foreign insurer or health organization" means an insurer, fraternal benefit society or health organization that is authorized to do business in New Mexico but is not domiciled in New Mexico;

G. "fraternal benefit society" means an incorporated society, order or supreme lodge, without capital stock, including one exempted pursuant to the provisions of Paragraph (2) of Subsection A of Section 59A-44-40 NMSA 1978, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government and that provides benefits in accordance with Chapter 59A, Article 44 NMSA 1978;

H. "health organization" means a health maintenance organization; nonprofit health care plan; limited health service organization; dental or vision plan; hospital, medical and dental indemnity or service corporation; or other managed care organization, but does not mean an organization that is licensed as either a life or health insurer or as a property and casualty insurer and that is otherwise subject to either the life or property and casualty risk-based capital requirements;

I. "life or health insurer" means any authorized life insurer, health insurer or property and casualty insurer writing only health insurance;

J. "mandatory control level risk-based capital" means an amount equal to seventy percent of an insurer's or health organization's authorized control level risk-based capital;

K. "property and casualty insurer" means any insurer authorized to write property, marine and transportation, casualty, vehicle or surety insurance, but does not include any insurer writing only one of the following:

(1) mortgage guaranty insurance;

(2) financial guaranty insurance;

(3) title insurance; or

(4) health insurance;

L. "negative trend" means, with respect to a life or health insurer or a fraternal benefit society, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the life or fraternal risk-based capital instructions;

M. "regulatory action level risk-based capital" means an amount equal to one hundred fifty percent of an insurer's or health organization's authorized control level risk-based capital;

N. "revised risk-based capital plan" means a risk-based capital plan that has been rejected by the superintendent and revised by the insurer or health organization, with or without the superintendent's recommendation;

O. "risk-based capital instructions" means the risk-based capital report, including risk-based capital instructions, adopted by the national association of insurance commissioners, as they may be amended by the national association of insurance commissioners from time to time, and not disapproved by the superintendent;

P. "risk-based capital level" means an insurer's or health organization's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital or mandatory control level risk-based capital;

Q. "risk-based capital plan" means a comprehensive financial plan as specified in Subsection B of Section 59A-5A-4 NMSA 1978;

R. "risk-based capital report" means the report specified in Section 59A-5A-3 NMSA 1978; and

S. "total adjusted capital" means the sum of:

(1) an insurer's or health organization's capital and surplus as determined in accordance with statutory accounting principles applicable to annual financial statements required to be filed under Section 59A-5-29 NMSA 1978; and

(2) such other items, if any, as the risk-based capital instructions may provide.

History: 1978 Comp., § 59A-5A-2, enacted by Laws 1995, ch. 149, § 2; 2014, ch. 59, § 2.

59A-5A-3. Risk-based capital reports.

A. On or before March 1 each year, every domestic insurer and health organization shall prepare and submit to the superintendent a report of its risk-based capital levels as of December 31 of the immediately preceding calendar year, in a form and containing

such information as is required by the risk-based capital instructions. In addition, every domestic insurer and health organization shall file its risk-based capital report with:

(1) the national association of insurance commissioners in accordance with the risk-based capital instructions; and

(2) the insurance commissioner of each state in which the insurer or health organization is authorized to do business, if the insurance commissioner for that state has notified the insurer or health organization of the request in writing. The insurer or health organization shall file a copy of its risk-based capital report with each commissioner not later than March 1 each year or fifteen days from receipt of the notice, whichever is later.

B. A life or health insurer's or a fraternal benefit society's risk-based capital shall be determined in accordance with the formula in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance among the following factors:

(1) asset risk;

(2) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) the interest rate risk with respect to the insurer's business; and

(4) all other business risks and other relevant risks set forth in the risk-based capital instructions.

C. A health organization's or property and casualty insurer's risk-based capital shall be determined in accordance with the appropriate formula in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance among the following factors:

(1) asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and other relevant risks set forth in the risk-based capital instructions.

D. Capital in excess of the amount produced by the risk-based capital requirements contained in the Risk-Based Capital Act and formulas, schedules and instructions referenced in the Risk-Based Capital Act is desirable in the business of insurance. Additional capital is used and useful in the insurance business and helps to secure an

insurer or health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in the Risk-Based Capital Act. Accordingly, insurers and health organizations should seek to maintain capital above the risk-based capital levels required by that act.

E. If a domestic insurer or health organization files a risk-based capital report that in the superintendent's judgment is inaccurate, then the superintendent shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer or health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment.

History: 1978 Comp., § 59A-5A-3, enacted by Laws 1995, ch. 149, § 3; 2014, ch. 59, § 3.

59A-5A-4. Company action level event.

A. As used in the Risk-Based Capital Act, a "company action level event" means any of the following events:

(1) the filing of a risk-based capital report by an insurer or health organization that indicates:

(a) that the insurer or health organization has total adjusted capital greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital;

(b) in the case of a life or health insurer or fraternal benefit society, that the insurer has total adjusted capital greater than or equal to its company action level risk-based capital but less than three hundred percent of its authorized control level risk-based capital and has a negative trend;

(c) in the case of a property and casualty insurer, that the insurer has total adjusted capital greater than or equal to its company action level risk-based capital but less than three hundred percent of its authorized control level risk-based capital and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty risk-based capital instructions; or

(d) in the case of a health organization, that the health organization has total adjusted capital greater than or equal to its company action level risk-based capital but less than three hundred percent of its authorized control level risk-based capital and triggers the trend test determined in accordance with the trend test calculation included in the health risk-based capital instructions;

(2) the superintendent's notification to an insurer or health organization that its adjusted risk-based capital report indicates the existence of an event described in

Paragraph (1) of this subsection, unless the insurer or health organization challenges the adjusted report pursuant to Section 59A-5A-8 NMSA 1978; or

(3) if an insurer or health organization challenges the adjusted risk-based capital report, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge.

B. In the event of a company action level event, the insurer or health organization shall prepare and submit to the superintendent a risk-based capital plan, which shall:

(1) identify the conditions that contribute to the company action level event;

(2) contain proposals of corrective actions that the insurer or health organization intends to take to eliminate the company action level event;

(3) provide projections of the insurer's or health organization's expected financial results in the current year and at least the four succeeding years, both in the absence of and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. Projections for new and renewal business may, if appropriate, include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(4) identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(5) identify the quality of, and problems associated with, the insurer's or health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The risk-based capital plan shall be submitted on or before the later of the following dates:

(1) forty-five days after the company action level event; or

(2) if the insurer or health organization challenges the adjusted risk-based capital report pursuant to Section 59A-5A-8 NMSA 1978, forty-five days after the date of the notification to the insurer or health organization that the superintendent has, after hearing, rejected the insurer's or health organization's challenge.

D. Within sixty days after the submission of an insurer's or health organization's risk-based capital plan, the superintendent shall notify the insurer or health organization whether the plan shall be implemented or is, in the superintendent's judgment, unsatisfactory. If the superintendent determines that the risk-based capital plan is unsatisfactory, the notification to the insurer or health organization shall set forth the

reasons for the determination and may set forth proposed revisions that will render the plan satisfactory. Upon notification, the insurer or health organization shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the superintendent, and shall submit the revised plan to the superintendent. The revised plan shall be submitted on or before the last of the following dates:

(1) forty-five days after the date of the superintendent's notification; or

(2) if the insurer or health organization challenges the notification pursuant to Section 59A-5A-8 NMSA 1978, forty-five days after the date of the notification to the insurer or health organization that the superintendent has, after hearing, rejected the insurer's or health organization's challenge.

E. A notification that the insurer's or health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory may include a statement that the notification constitutes a regulatory action level event, subject to the insurer's or health organization's right to a hearing pursuant to Section 59A-5A-8 NMSA 1978.

F. Every domestic insurer or health organization that files a risk-based capital plan or revised risk-based capital plan with the superintendent shall file a copy of the risk-based capital plan and any revised risk-based capital plan with the insurance commissioner of each state in which the insurer or health organization is authorized to do business if:

(1) the state has confidentiality provisions substantially similar to those in Subsection A of Section 59A-5A-9 NMSA 1978; and

(2) the insurance commissioner for that state has notified the insurer or health organization of the request in writing. The insurer or health organization shall file a copy of the risk-based capital plan or revised risk-based capital plan with each commissioner on or before the later of the following dates:

(a) fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or

(b) the date that the risk-based capital plan or revised risk-based capital plan is filed under Subsections C and D of this section.

History: 1978 Comp., § 59A-5A-4, enacted by Laws 1995, ch. 149, § 4; 2014, ch. 59, § 4.

59A-5A-5. Regulatory action level event.

A. For purposes of the Risk-Based Capital Act, "regulatory action level event" means any of the following events:

(1) the filing of a risk-based capital report by an insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital;

(2) the superintendent's notification to an insurer or health organization that its adjusted risk-based capital report indicates the existence of an event described in Paragraph (1) of this subsection, unless the insurer or health organization challenges the adjusted report pursuant to Section 59A-5A-8 NMSA 1978;

(3) if an insurer or health organization challenges the adjusted risk-based capital report, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge;

(4) an insurer's or health organization's failure to file a risk-based capital report by the filing date, unless the insurer or health organization has provided an explanation satisfactory to the superintendent and has cured the failure within ten days after the filing date;

(5) an insurer's or health organization's failure to submit a risk-based capital plan to the superintendent by the date specified in Subsection C of Section 59A-5A-4 NMSA 1978;

(6) the superintendent's notification to an insurer or health organization that:

(a) the risk-based capital plan or revised risk-based capital plan submitted by the insurer or health organization is, in the superintendent's judgment, unsatisfactory; and

(b) the notification constitutes a regulatory action level event with respect to the insurer or health organization, unless the insurer or health organization has challenged the determination pursuant to Section 59A-5A-8 NMSA 1978;

(7) if an insurer or health organization challenges the superintendent's determination made pursuant to Paragraph (6) of this subsection, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge;

(8) the superintendent's notification to an insurer or health organization that the insurer or health organization has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has had or will have a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event, unless the insurer or health organization has challenged the determination pursuant to Section 59A-5A-8 NMSA 1978; or

(9) if an insurer or health organization challenges the superintendent's determination made pursuant to Paragraph (8) of this subsection, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge.

B. In the event of a regulatory action level event, the superintendent shall:

(1) require the insurer or health organization to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan;

(2) perform such examination or analysis as the superintendent deems necessary of the assets, liabilities and operations of the insurer or health organization, including a review of its risk-based capital plan or revised risk-based capital plan; and

(3) subsequent to the examination or analysis, issue an order specifying such corrective actions as the superintendent determines are required.

C. In determining corrective actions, the superintendent may take into account such factors as are deemed relevant based upon the superintendent's examination or analysis of the assets, liabilities and operations of the insurer or health organization, including the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan shall be submitted on or before the later of the following dates:

(1) forty-five days after the occurrence of the regulatory action level event; or

(2) if the insurer or health organization challenges an adjusted or revised risk-based capital report or plan pursuant to Section 59A-5A-8 NMSA 1978 and the challenge is not frivolous in the superintendent's judgment, forty-five days after notification to the insurer or health organization that the superintendent has, after hearing, rejected the insurer's or health organization's challenge.

D. The superintendent may retain actuaries and investment experts and other consultants as the superintendent deems necessary to review the insurer's or health organization's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities and operations of the insurer or health organization and formulate the corrective order with respect to the insurer or health organization. The fees, costs and expenses incurred by consultants shall be paid by the affected insurer or health organization or such other party as the superintendent directs.

History: 1978 Comp., § 59A-5A-5, enacted by Laws 1995, ch. 149, § 5; 2014, ch. 59, § 5.

59A-5A-6. Authorized control level event.

A. As used in the Risk-Based Capital Act, "authorized control level event" means any of the following events:

(1) the filing of a risk-based capital report by an insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized control level risk-based capital;

(2) the superintendent's notification to an insurer or health organization that its adjusted risk-based capital report indicates the existence of an event described in Paragraph (1) of this subsection, unless the insurer or health organization challenges the adjusted report pursuant to Section 59A-5A-8 NMSA 1978;

(3) if an insurer or health organization challenges the adjusted risk-based capital report, notification to the insurer or health organization that the superintendent has, after hearing, rejected the challenge;

(4) an insurer's or health organization's failure to respond, in a manner satisfactory to the superintendent, to a corrective order unless the insurer or health organization has challenged the order pursuant to Section 59A-5A-8 NMSA 1978; or

(5) if an insurer or health organization has challenged a corrective order and the superintendent has, after hearing, rejected the challenge or modified the corrective order, the failure of the insurer or health organization to respond, in a manner satisfactory to the superintendent, to the corrective order subsequent to rejection or modification.

B. In the event of an authorized control level event with respect to an insurer or health organization, the superintendent shall:

(1) take such actions as are required pursuant to Section 59A-5A-5 NMSA 1978 regarding an insurer or health organization with respect to which a regulatory action level event has occurred; or

(2) if the superintendent deems it to be in the best interests of the insurer's or health organization's policyholders and creditors and of the public, take such actions as are necessary to cause the insurer or health organization to be placed under regulatory control pursuant to Chapter 59A, Article 41 NMSA 1978. The authorized control level event constitutes sufficient grounds for the superintendent to take action pursuant to Chapter 59A, Article 41 NMSA 1978, and the superintendent has the rights, powers and duties with respect to the insurer or health organization set forth in Chapter 59A, Article 41 NMSA 1978.

History: 1978 Comp., § 59A-5A-6, enacted by Laws 1995, ch. 149, § 6; 2014, ch. 59, § 6.

59A-5A-7. Mandatory control level event.

A. As used in the Risk-Based Capital Act, "mandatory control level event" means any of the following events:

(1) the filing of a risk-based capital report that indicates that an insurer's or health organization's total adjusted capital is less than its mandatory control level risk-based capital;

(2) the superintendent's notification to an insurer or health organization that its adjusted risk-based capital report indicates the existence of an event described in Paragraph (1) of this subsection, unless the insurer or health organization challenges the adjusted report pursuant to Section 59A-5A-8 NMSA 1978; or

(3) if the insurer or health organization challenges the adjusted risk-based capital report, notification to the insurer or health organization that the superintendent has, after hearing, rejected the insurer's or health organization's challenge.

B. In the event of a mandatory control level event, the superintendent shall:

(1) with respect to a life or health insurer, fraternal benefit society or health organization, take such actions as are necessary to place the life or health insurer, fraternal benefit society or health organization under regulatory control pursuant to Chapter 59A, Article 41 NMSA 1978. In that event, the mandatory control level event constitutes sufficient grounds for the superintendent to take action pursuant to Chapter 59A, Article 41 NMSA 1978, and the superintendent has the rights, powers and duties with respect to the insurer set forth in Chapter 59A, Article 41 NMSA 1978. Notwithstanding the foregoing provisions of this paragraph, the superintendent may forgo action for up to ninety days after the mandatory control level event if the superintendent finds that there is a reasonable expectation that the mandatory control level event can be eliminated within the ninety-day period; or

(2) with respect to a property and casualty insurer, take such actions as are necessary to place the insurer under regulatory control pursuant to Chapter 59A, Article 41 NMSA 1978, or, in the case of an insurer that is writing no business and that is running off its existing business, may allow the insurer to continue its run off under the superintendent's supervision. In either event, the mandatory control level event constitutes sufficient grounds for the superintendent to take action pursuant to Chapter 59A, Article 41 NMSA 1978, and the superintendent has the rights, powers and duties with respect to the insurer as are set forth in Chapter 59A, Article 41 NMSA 1978. Notwithstanding the foregoing provisions of this paragraph, the superintendent may forgo action for up to ninety days after the mandatory control level event if the superintendent finds that there is a reasonable expectation that the mandatory control level event can be eliminated within the ninety-day period.

History: 1978 Comp., § 59A-5A-7, enacted by Laws 1995, ch. 149, § 7; 2014, ch. 59, § 7.

59A-5A-8. Challenge hearings.

Any insurer or health organization has the right to a confidential administrative hearing of record in accordance with Chapter 59A, Article 4 NMSA 1978 at which the insurer or health organization may challenge any determination or action by the superintendent pursuant to the Risk-Based Capital Act.

A. The insurer or health organization shall file and serve on the superintendent its request for hearing within five days after any of the following events:

(1) the superintendent's notification to the insurer or health organization of an adjusted risk-based capital report;

(2) the superintendent's notification to the insurer or health organization that:

(a) the insurer's or health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory; and

(b) such notification constitutes a regulatory action level event with respect to the insurer or health organization;

(3) the superintendent's notification to the insurer or health organization that the insurer or health organization has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that such failure has had or will have a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event; or

(4) the superintendent's notification to an insurer or health organization of a corrective order with respect to the insurer or health organization.

B. Upon receipt of the insurer's or health organization's request for hearing, the superintendent shall set a hearing date, which shall be not less than ten nor more than thirty days after the date of the insurer's or health organization's request.

History: 1978 Comp., § 59A-5A-8, enacted by Laws 1995, ch. 149, § 8; 2014, ch. 59, § 8.

59A-5A-9. Confidentiality; prohibition on announcements; prohibition on use in ratemaking.

A. To the extent not set forth in any other form accessible to the public, all information in risk-based capital reports, risk-based capital plans, results or reports of any examination or analysis of an insurer or health organization performed exclusively

for the purposes required by the Risk-Based Capital Act and all corrective orders issued by the superintendent pursuant to such examination or analysis are and shall be kept confidential by the superintendent and are not subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. Nothing in this section shall be construed as a grant of privilege or confidentiality or a bar to production of that information by an insurer in a civil suit, whether or not the office of superintendent of insurance is a party.

B. To assist in the performance of the superintendent's duties, the superintendent may:

(1) share documents, materials or other information, including the confidential and privileged documents, materials or information identified in Subsection A of this section, with other state, federal and international regulatory agencies, with the national association of insurance commissioners, its affiliates or its subsidiaries and with state, federal and international law enforcement authorities if the recipient agrees in writing to maintain the confidentiality and privilege of the documents, materials or other information;

(2) receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners, its affiliates or its subsidiaries and from regulatory and law enforcement officials of foreign or domestic jurisdictions, except that the superintendent shall maintain as confidential or privileged documents, materials or other information received with notice or the understanding that the content is confidential or privileged pursuant to the laws of the jurisdiction from which the information originates; and

(3) enter into agreements governing the sharing and use of information that are consistent with this subsection.

C. The comparison of an insurer's or health organization's total adjusted capital to any of its risk-based capital levels is a regulatory tool that may indicate the need for possible corrective action by the superintendent with respect to the insurer or health organization and is not intended as a means to rank insurers or health organizations generally or to compare insurers or health organizations for marketing purposes. Use of such comparisons for such purposes is inherently misleading and deceptive. Except as otherwise required under the provisions of the Risk-Based Capital Act or applicable law, no insurer, health organization, agent, broker or other person engaged in any manner in the business of insurance shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the risk-based capital levels of any insurer or health organization, or of any component derived in their calculation; provided, however,

that if any materially false statement with respect to the comparison regarding an insurer's or health organization's total adjusted capital to its risk-based capital levels or an inappropriate comparison of any other amount to the insurer's or health organization's risk-based capital levels is published in any written publication and the insurer or health organization is able to demonstrate to the superintendent's satisfaction the falsity or inappropriateness of the statement, then the insurer or health organization may publish an announcement approved in advance by the superintendent in a written publication whose sole purpose is to rebut the materially false statement.

D. The risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans and revised risk-based capital plans are intended solely for use by the superintendent in monitoring the solvency of insurers and health organizations and the need for possible corrective action with respect to insurers and health organizations. They shall not be used by the superintendent for ratemaking, considered or introduced as evidence in any rate proceeding or used to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer, health organization or any affiliate is authorized to write.

History: 1978 Comp., § 59A-5A-9, enacted by Laws 1995, ch. 149, § 9; 2014, ch. 59, § 9.

59A-5A-10. Supplemental provisions; rules; exemption.

A. The provisions of the Risk-Based Capital Act are supplemental to any other provisions of law, and shall not supersede, preclude the exercise of or limit any other powers or duties of the superintendent under such laws, including but not limited to Chapter 59A, Article 41 NMSA 1978.

B. The superintendent may adopt reasonable rules and regulations for the implementation of the Risk-Based Capital Act.

C. The superintendent may exempt from the application of the Risk-Based Capital Act any domestic insurer which:

(1) writes direct business only in this state;

(2) writes direct annual premiums of two million dollars ($2,000,000) or less; and

(3) assumes no reinsurance in excess of five percent of direct premium written.

History: 1978 Comp., § 59A-5A-10, enacted by Laws 1995, ch. 149, § 10.

59A-5A-11. Foreign insurers.

A. Any foreign insurer or health organization shall, upon the superintendent's written request, submit to the superintendent a risk-based capital report, as of the end of the most recent calendar year, on the same date risk-based capital reports are required to be filed by domestic insurers and health organizations under the Risk-Based Capital Act or fifteen days after the request is received by the foreign insurer or health organization, whichever is later. Any foreign insurer or health organization shall, upon the superintendent's written request, promptly submit to the superintendent a copy of any risk-based capital plan filed with the insurance commissioner of any other state.

B. In the event of a company action level event, regulatory action level event or authorized control level event with respect to any foreign insurer or health organization as determined pursuant to the risk-based capital statute applicable in an insurer's or health organization's state of domicile, or, if no risk-based capital requirements are in force in that state, under the provisions of the Risk-Based Capital Act, the superintendent may require the foreign insurer or health organization to file a risk-based capital plan with the superintendent unless the insurance commissioner of the insurer's or health organization's state of domicile has previously so required. The failure of the foreign insurer or health organization to timely file a risk-based capital plan with the superintendent shall be grounds to order the insurer or health organization to cease and desist from writing new insurance business in this state or to suspend or revoke its certificate of authority.

C. In the event of a mandatory control level event with respect to any foreign insurer or health organization, the superintendent may proceed in accordance with Subsection B of Section 59A-5A-7 NMSA 1978.

History: 1978 Comp., § 59A-5A-11, enacted by Laws 1995, ch. 149, § 11; 2014, ch. 59, § 10.

59A-5A-12. Immunity.

There shall be no civil liability on the part of, and no civil cause of action shall arise against the superintendent, the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under the Risk-Based Capital Act.

History: 1978 Comp., § 59A-5A-12, enacted by Laws 1995, ch. 149, § 12.

59A-5A-13. Notices.

The superintendent's notices to an insurer or health organization pursuant to the Risk-Based Capital Act shall be effective upon mailing by certified mail or, in the case of any other mode of transmission, shall be effective upon the insurer's or health organization's receipt.

History: 1978 Comp., § 59A-5A-13, enacted by Laws 1995, ch. 149, § 13; 2014, ch. 59, § 11.

ARTICLE 6
Fees and Taxes

59A-6-1. Fee schedule.

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

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

(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 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

L. adjuster license -

(1) filing application for original license 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 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 -

(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 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

(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) filing of annual report 50.00

Z. miscellaneous fees -

(1) duplicate license 30.00

(2) name change 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

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 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 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.

History: Laws 1984, ch. 127, § 101; 1990, ch. 34, § 1; 1991, ch. 124, § 1; 1993, ch. 320, § 14; 1999, ch. 272, § 2; 1999, ch. 289, § 2; 2001, ch. 302, § 1; 2003, ch. 306, § 1; 2011, ch. 127, § 4; 2014, ch. 14, § 7; 2016, ch. 89, § 2.

59A-6-1.1. Surcharge imposed; appropriation.

A three-dollar ($3.00) surcharge shall be assessed for the period beginning March 1, 1996 and ending June 30, 2009 on the annual continuation of appointment fees imposed in Subsections E, F, N, S, W and X of Section 59A-6-1 NMSA 1978. The surcharge collected shall be distributed monthly to the New Mexico finance authority to be pledged irrevocably for the payment of principal, interest and any other expenses or obligations related to the bonds issued by the authority to finance information and communication equipment, including computer hardware and software, for the insurance division.

History: 1978 Comp., § 59A-6-1.1, enacted by Laws 1996, ch. 6, § 1; 2005, ch. 278, § 1.

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.

History: Laws 2001, ch. 302, § 2.

59A-6-1.3. Dishonored checks and other forms of payment; penalty.

When a check or an electronic payment transaction for payment of fees is dishonored or reversed by the payer's financial institution, the payer shall pay to the insurance division a civil penalty in the amount of twenty-five dollars ($25.00). Neither the division nor the fiscal agent of New Mexico is obligated to resubmit the transaction or check for payment. The superintendent shall treat the transaction as though payment has not been made and cancel, suspend, rescind or revoke the transaction for failure to make payment. Any other penalty, reinstatement fee or other cost associated with failure to make the payment shall be in addition to the penalty set forth in this section. In this section, "electronic payment transaction" means credit card payments, electronic fund transfers, automated clearinghouse transactions and other similar forms of payment.

History: Laws 2007, ch. 282, § 5.

59A-6-2. Repealed.

History: Laws 1984, ch. 127, § 102; 1987, ch. 259, § 5; 1988, ch. 74, § 2; 1988, ch. 75, § 1; 1991, ch. 9, § 40; 1993, ch. 320, § 15; 2003, ch. 14, § 18; 2003, ch. 58, § 1; 2004, ch. 122, § 2; 2005, ch. 132, § 1; 2007, ch. 282, § 3; 2014, ch. 59, § 13; repealed by Laws 2018, ch. 57, § 31.

59A-6-2.1. Repealed.

59A-6-3. Insurer must pay tax on withdrawal from state.

Any insurer holding certificate of authority to transact insurance in New Mexico that ceases to do business in the state shall thereupon file with the secretary of taxation and revenue a report of its premiums collected to date of such cessation of business that are subject to the premium tax or the health insurance premium surtax and not theretofore reported, and forthwith pay to the secretary the tax thereon and surrender its certificate of authority to the superintendent. Upon receipt, the secretary shall submit a copy of the report to the superintendent and shall certify that all tax obligations have been satisfied by the withdrawing insurer.

History: Laws 1984, ch. 127, § 103; 2018, ch. 57, § 14.

59A-6-4. Penalty for failure to pay fees.

Every insurer, nonprofit health care plan, health maintenance organization, prepaid dental plan or prearranged funeral plan transacting business in New Mexico that fails to pay when due any fees as required in Chapter 59A, Article 6 NMSA 1978 may be liable to the state for the amount thereof and for penalty of up to one thousand dollars ($1,000) for each month or part thereof it has failed to pay the fees when due. Services of process in any action against a person to recover the fee or penalty may be made

upon the superintendent as attorney for service of process as provided in Section 59A-5-32 NMSA 1978.

History: Laws 1984, ch. 127, § 104; 1987, ch. 259, § 6; 1988, ch. 76, § 2; 1993, ch. 320, § 16; 2018, ch. 57, § 15.

59A-6-5. Distribution of office collections.

A. All money received by the office of superintendent of insurance for fees, licenses and penalties shall be paid daily by the superintendent to the state treasurer and credited to the "insurance department suspense fund" except as provided by the Law Enforcement Protection Fund Act [Chapter 29, Article 13 NMSA 1978].

B. The superintendent may authorize the refund of money erroneously paid as fees, licenses or penalties from the insurance department suspense fund upon request for refund, if the request is made within one year after the erroneous payment.

C. The "insurance operations fund" is created in the state treasury. The fund shall consist of the distributions made to it pursuant to Subsection D of this section. The legislature shall annually appropriate from the fund to the division those amounts necessary for the division to carry out its responsibilities pursuant to the Insurance Code and other laws. Any balance in the fund at the end of a fiscal year shall revert to the general fund.

D. At the end of every month, after applicable refunds are made pursuant to Subsection B of this section, the state treasurer shall make the following transfers from the balance remaining in the insurance department suspense fund:

(1) to the "fire protection fund", that part of the balance derived from property and vehicle insurance business;

(2) to the insurance operations fund, that part of the balance derived from the fees imposed pursuant to Subsections A and E of Section 59A-6-1 NMSA 1978 other than fees derived from property and vehicle insurance business; and

(3) to the general fund, the balance remaining in the insurance department suspense fund derived from all other kinds of insurance business.

History: Laws 1984, ch. 127, § 105; 1985, ch. 29, § 3; 1996, ch. 6, § 2; 1999, ch. 289, § 3; 2003, ch. 14, § 19; 2004, ch. 5, § 1; 2007, ch. 282, § 4; 2011, ch. 156, § 3; 2014, ch. 2, § 2; 2017, ch. 1, § 4; 2018, ch. 57, § 16.

59A-6-6. Preemption and in lieu provision.

The state government of New Mexico preempts the field of taxation of insurers, nonprofit health care plans, health maintenance organizations, prepaid dental plans,

prearranged funeral plans and insurance producers as such. The payment of the taxes, licenses and fees provided for in the Insurance Premium Tax Act [7-40-1 to 7-40-10 NMSA 1978] and the Insurance Code shall be in lieu of all other taxes, licenses and fees of every kind now or hereafter imposed by this state or any political subdivision thereof on any of the foregoing specified entities, excepting the regular state, county and city taxes on property located in New Mexico and excepting the income tax on insurance producers. The provisions of this section shall not apply to revenues or receipts that are not directly attributable to persons, entities and activities subject to the provisions of the Insurance Code.

History: Laws 1984, ch. 127, § 106; 1987, ch. 259, § 7; 1988, ch. 76, § 3; 2016, ch. 89, § 3; 2018, ch. 57, § 17.

59A-6-7. Repealed.

59A-6-8. Superintendent shall provide information to the taxation and revenue department necessary to administer the Insurance Premium Tax Act.

The superintendent shall provide to the taxation and revenue department information regarding an insurer or plan subject to the Insurance Premium Tax Act [7-40-1 to 7-40-10 NMSA 1978] that is necessary to that department to administer the provisions of the Insurance Premium Tax Act.

History: Laws 2019, ch. 47, § 3.

ARTICLE 7
Kinds of Insurance; Limits of Risk; Reinsurance

59A-7-1. Definitions not mutually exclusive; insuring powers; classification of insurers.

A. It is intended that certain insurance coverages may come within more than one "kind" of insurance as defined in Chapter 59A, Article 7 NMSA 1978, and inclusion of such coverage within one definition shall not exclude it as to any other kind of insurance within the definition of which the coverage is likewise reasonably includable.

B. No insurer shall be authorized to transact any kind or kinds of insurance other than those defined in Chapter 59A, Article 7 NMSA 1978. Insurers shall be classified as to insuring powers according to kind or kinds of insurance for which so authorized.

C. An insurer may apply to engage in insurance activities in one or more of the following lines of insurance:

(1) life and annuities;

(2) accident and health;

(3) property;

(4) casualty; and

(5) variable life and annuity.

History: Laws 1984, ch. 127, § 107; 2016, ch. 89, § 4.

59A-7-2. Life and annuity.

Life and annuity includes:

A. fixed annuity;

B. immediate annuity;

C. deferred annuity;

D. equity-indexed annuity;

E. endowment;

F. term life;

G. universal life;

H. whole life;

I. credit life; and

J. similar products relating to life and annuity matters.

History: Laws 1984, ch. 127, § 108; 1995, ch. 149, § 14; 1978 Comp., § 59A-7-2, repealed and reenacted by Laws 2016, ch. 89, § 5.

59A-7-3. Accident and health insurance.

A. Accident and health includes:

(1) accident;

(2) accidental death and dismemberment;

(3) blanket accident and sickness;

(4) credit disability;

(5) critical illness;

(6) dental;

(7) disability income;

(8) home health care;

(9) hospital indemnity;

(10) long-term care;

(11) major medical;

(12) medical expense;

(13) medicare supplement;

(14) prescription drug;

(15) sickness;

(16) specified disease;

(17) vision; and

(18) similar products relating to accident and health matters.

B. An insurer or a health maintenance organization authorized to transact accident and health insurance may write stop-loss liability insurance as listed in Paragraph (51) of Subsection A of Section 59A-7-6 NMSA 1978.

History: Laws 1984, ch. 127, § 109; Laws 2000, ch. 61, § 1; 1978 Comp., § 59A-7-3, repealed and reenacted by Laws 2016, ch. 89, § 6; 2017, ch. 58, § 1; 2017, ch. 130, § 5.

59A-7-4. Property.

Property includes:

A. aircraft cargo;

B. aircraft hull;

C. auto commercial physical damage;

D. baggage;

E. builders risk;

F. business owners;

G. cargo;

H. commercial inland marine;

I. commercial multi-peril;

J. commercial property;

K. crop;

L. crop hail;

M. difference in conditions;

N. dwelling;

O. earthquake;

P. event cancellation;

Q. extended coverages;

R. farm and ranch property;

S. fire and allied lines;

T. flood;

U. garage;

V. marine cargo;

W. marine hull;

X. ocean marine;

Y. personal inland marine;

Z. personal property;

AA. pet insurance;

BB. travel coverage; and

CC. similar products relating to property matters.

History: Laws 1984, ch. 127, § 110; 1978 Comp., § 59A-7-4, repealed and reenacted by Laws 2016, ch. 89, § 7.

59A-7-5. Repealed.

History: Laws 1984, ch. 127, § 111; repealed by Laws 2016, ch. 89, § 70.

59A-7-6. Casualty.

A. Casualty includes:

(1) aircraft liability;

(2) auto commercial liability;

(3) auto private passenger liability;

(4) auto warranty contract;

(5) boiler and machinery;

(6) burglary and theft;

(7) collateral protection;

(8) commercial excess/umbrella liability;

(9) commercial general liability;

(10) congenital defects;

(11) contractual liability;

(12) credit;

(13) credit property;

(14) creditor-placed dual/single interest;

(15) crime;

(16) directors and officers liability;

(17) employers liability;

(18) elevator;

(19) entertainment;

(20) errors and omissions;

(21) failure to file instrument;

(22) farm and ranch liability;

(23) fidelity bonds;

(24) fidelity insurance;

(25) financial guaranty;

(26) gap;

(27) garage liability;

(28) glass;

(29) involuntary unemployment;

(30) kidnap and ransom;

(31) leakage and fire-extinguishing equipment;

(32) legal liability;

(33) liquor liability;

(34) livestock;

(35) mechanical breakdown;

(36) medical malpractice;

(37) mobile homes under transport;

(38) money and securities;

(39) motor club service contracts;

(40) mortgage guaranty;

(41) personal excess/umbrella liability;

(42) personal effects;

(43) personal liability;

(44) personal property floater;

(45) pollution liability;

(46) premises and operations;

(47) product liability;

(48) products and completed operations;

(49) professional liability;

(50) owners and contractors;

(51) stop loss liability;

(52) surety;

(53) title;

(54) vandalism and malicious mischief;

(55) workers' compensation; and

(56) similar products relating to casualty matters.

B. An insurer authorized to transact casualty insurance may write accident and health insurance as those terms are defined in Section 59A-7-3 NMSA 1978.

History: Laws 1984, ch. 127, § 112; 1978 Comp., § 59A-7-6, repealed and reenacted by Laws 2016, ch. 89, § 8; 2017, ch. 130, § 6.

59A-7-7. Variable life and annuity.

Variable life and annuity includes:

A. variable deferred annuity;

B. variable immediate annuity;

C. variable life; and

D. similar products relating to variable life and annuity matters.

History: Laws 1984, ch. 127, § 113; 1978 Comp., § 59A-7-7, repealed and reenacted by Laws 2016, ch. 89, § 9.

59A-7-8. Repealed.

History: Laws 1984, ch. 127, § 114; repealed by Laws 2016, ch. 89, § 70.

59A-7-9. Repealed.

History: Laws 1984, ch. 127, § 115; repealed by Laws 2016, ch. 89, § 70.

59A-7-10. Limit of risk.

A. No insurer shall, other than as stated in this section, retain any risk on any one subject of insurance, whether located or to be performed in this state or elsewhere, in an amount exceeding ten percent of its surplus to policyholders.

B. No domestic Lloyds plan insurer shall retain any risk on any one subject of insurance in an amount in excess of ten percent of the sum of its surplus as to policyholders plus additional liability assumed by individual underwriters in the articles of agreement and policies or contracts of insurance.

C. No insurer shall retain as to title insurance risk on any one subject of insurance in an amount exceeding fifty percent of its surplus as to policyholders. If the insurer also transacts other kinds of insurance, its "surplus as to policyholders" for the purposes of this subsection shall be such reasonable proportion of the insurer's general surplus as to policyholders as may be allocated to title insurance in relation to premium income or other reasonable basis approved by the superintendent.

D. A "subject of insurance" for the purposes of this section means the following:

(1) as to insurance covering damage or loss of real or personal property, all real or personal property insured by an insurer which could reasonably be subject to loss or damage from the same occurrence of an insured hazard; and

(2) as to all other types of insurance, all policies issued by the same insurer applicable to a single insured exposure or occurrence.

E. Reinsurance ceded as authorized by Section 59A-7-11 NMSA 1978 [repealed] shall be deducted in determining risk retained; but as to surety risks reinsurance shall be allowed as a deduction only if such reinsurance is with an insurer authorized to transact such insurance in this state, and is in such form as to enable the obligee or beneficiary to maintain an action thereon against the reinsured jointly with the reinsurer, and upon recovering judgment against the reinsured to have recovery against the reinsurer for payment to the extent in which it may be liable under such reinsurance and in discharge thereof. As to surety risks, deduction shall also be made of the amount assumed by any authorized cosurety and the value of any security deposited, pledged or held subject to the surety's consent and for the surety's protection.

F. As to alien insurers, this section relates only to risks and surplus to policyholders of the insurer's United States branch.

G. "Surplus as to policyholders" for the purposes of this section, in addition to the insurer's paid-in capital stock, if any, and surplus, includes also any voluntary reserves which are not required by law, and shall be determined from the last sworn financial statement of the insurer on file with the insurance department, or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

H. This section does not apply to life or health insurance, annuities, insurance of wet marine and transportation risks, workers' compensation insurance, or employers' liability coverages.

History: Laws 1984, ch. 127, § 116; 1993, ch. 320, § 17.

59A-7-11. Repealed.

History: Laws 1984, ch. 127, § 117; 1993, ch. 320, § 18; 1994, ch. 13, § 1; 2014, ch. 59, § 14; repealed by Laws 2022, ch. 35, § 19.

ARTICLE 8
Assets and Liabilities

59A-8-1. "Assets" defined.

In determination of the financial condition of any insurer or fraternal benefit society or United States branch of an alien insurer there shall be allowed as assets only such assets as are owned by the insurer or society and which consist of:

A. cash, including legal tender or equivalent thereof, in the principal or any branch office of the insurer or society or in transit under its control, and including the true balance of any deposit in a solvent bank or trust company;

B. investments, securities, properties and loans acquired or held in accordance with the Insurance Code, and in connection therewith the following items:

(1) interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest;

(2) declared and unpaid dividends on stock and shares, unless such amount has otherwise been allowed as an asset;

(3) interest due or accrued upon a collateral loan in an amount not to exceed one year's interest thereon;

(4) interest due or accrued on deposits in solvent banks and trust companies, and interest due or accrued on other assets, if such interest is, in the superintendent's judgment, a collectible asset;

(5) interest due or accrued on a mortgage or deed of trust loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of eighteen months be allowed as an asset;

(6) rent due or accrued on real property if such rent is not in arrears for more than three months, and rent more than three months in arrears if the payment of such rent is adequately secured by property held in the name of the tenant and conveyed to the insurer or society as collateral; and

(7) the unaccrued portion of taxes paid prior to the due date on real property;

C. premium notes, policy loans and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon, in amount not exceeding the legal reserve and other policy liabilities carried on each individual policy or contract;

D. the net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer or fraternal benefit society which carries the full mean tabular reserve liability; and in case of a fraternal benefit society which does not carry the full mean tabular reserve liability, premiums or assessments actually collected by subordinate branches of the society and not yet received by its home office;

E. premiums in course of collection, other than for life insurance, not more than ninety days past due, less commissions payable thereon. This limitation as to ninety days shall not apply as to premiums payable directly or indirectly by the United States government or by any of its instrumentalities; nor shall it apply to reinsurance premiums receivable by an assuming insurer to the extent offset by amounts carried by the assuming insurer as liabilities for amounts due to the ceding insurer for unpaid losses or other mutual debts, but in no event shall reinsurance premiums more than ninety days past due be allowed in excess of ten percent of the assuming insurer's admitted assets as shown by its most recent annual statement on file with the superintendent;

F. installment premiums other than life insurance or annuity premiums, to the extent of the unearned premium reserves carried on the policy or contract to which the premium applies;

G. notes and like written obligations not past due, taken for premiums other than life insurance or annuity premiums, on policies and contracts permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon, except as otherwise prescribed by regulations of the superintendent;

H. reinsurance recoverable by a ceding insurer to the extent credit is allowed under Section 59A-7-11 [repealed] of the Insurance Code;

I. amounts receivable by an assuming insurer for funds withheld by a solvent ceding insurer under a reinsurance treaty, but not exceeding the amounts carried by the assuming insurer as liabilities for unpaid losses and reserves under such contracts;

J. deposits or equities recoverable from underwriting associations, syndicates and reinsurance funds, or from suspended banking and other financial institutions, to the extent deemed by the superintendent available for payment of losses and claims and at values determined by the superintendent;

K. all such assets, whether or not consistent with the other provisions of this section, as may be allowed pursuant to the annual statement form approved by the superintendent for the kinds of insurance to be reported upon therein;

L. electronic and mechanical machines and related programs and equipment constituting a data processing, record keeping, accounting, word processing (excluding typewriters) or other electronic computer system in actual use, the cost of which shall be amortized in full over a period of not more than ten years. The aggregate amount invested in all such systems shall not exceed five percent of the insurer's or society's assets;

M. as to title insurance, the title plant and equipment necessary for conduct of the abstract and title insurance business, at not to exceed the original cost thereof. The superintendent may also allow as assets as to title insurance, premiums and fees for

title examination and title insurance not more than twelve months past due, less commissions payable thereon; and

N. other assets, not inconsistent with the other provisions of this section, deemed by the superintendent to be available for payment of losses and claims, at values to be determined by the superintendent.

History: Laws 1984, ch. 127, § 118; 1993, ch. 320, § 19.

59A-8-2. Assets not allowed.

A. In addition to assets impliedly excluded by provisions of Section 118 [59A-8-1 NMSA 1978] of this article, the following expressly shall not be allowed as assets in any determination of the financial condition of any insurer or fraternal benefit society:

(1) goodwill, trade names and other like intangible assets;

(2) advances to directors, officers, employees and agents (other than policy loans) whether secured or not, and advances to other persons on personal security only;

(3) stock of such insurer, owned by it, or any equity therein or loans secured thereby, or any proportionate interest in such stock acquired or held through ownership by the insurer of an interest in another corporation or business unit;

(4) furniture, fixtures, furnishings, safes, vehicles, libraries, stationery, literature and supplies (other than data processing, recordkeeping, accounting, word processing and electronic computer systems authorized under Subsection L of Section 118 [59A-8-1 NMSA 1978] of this article) except:

(a) in the case of title insurers such materials and plants as the insurer is expressly authorized to carry as an asset under Subsection M of Section 118 [59A-8-1 NMSA 1978] of this article; and

(b) in the case of any insurer or fraternal benefit society, such personal property as it is permitted to hold pursuant to Article 9 (investments) [Chapter 59A, Article 9 NMSA 1978] of the Insurance Code, or which is reasonably necessary for the maintenance or operation of real property lawfully acquired and held, other than real property used for home office, branch office and similar purposes;

(5) the amount, if any, by which the aggregate book value of investments as carried in ledger assets exceeds the aggregate value thereof as determined under the Insurance Code.

B. All nonadmitted assets and all other assets of doubtful value or character included as ledger or nonledger assets in any statement by an insurer or fraternal

benefit society to the superintendent, or in any examiner's report to the superintendent, shall be reported, to the extent of the value disallowed, as deductions from gross assets except where the superintendent permits a reserve to be carried among liabilities in lieu of any such deductions.

History: Laws 1984, ch. 127, § 119.

59A-8-3. Disallowance of "wash" transactions.

A. The superintendent shall disallow as an asset or as a credit against liabilities of an insurer, any sale or transfer of property or accounts or any reinsurance found by him after a hearing thereon to have been arranged for the purpose principally of an apparent but temporary betterment as to the transferor, vendor or ceding insurer's financial condition as of the date of any financial statement of the insurer. Without limiting the general purport of the foregoing provision, transfer, sale or reinsurance contracted for in fact within six (6) months prior to the date of any such financial statement and reversed or cancelled in fact within six (6) months after the date of such statement, or reinsurance under which the reinsurer bears no substantial insurance risk or chance of net loss to itself, shall prime [prima] facie be deemed to have been arranged principally for the purpose of such apparent betterment.

B. The superintendent shall disallow as an asset any deposit, funds or other property of the insurer found by him after a hearing thereon:

(1) not to be in good faith the property of the insurer; and

(2) if other than a deposit required to be made and held under or pursuant to statute, not freely subject to withdrawal or liquidation by the insurer at any time for payment or discharge of claims or other obligations arising under its policies; and

(3) to be resulting from arrangements made principally for the purpose of such apparent betterment as to the insurer's financial condition as at the date of any financial statement of the insurer.

C. The superintendent may suspend or revoke the certificate of authority of any insurer which has knowingly been party to any such transaction or attempt thereat.

History: Laws 1984, ch. 127, § 120.

59A-8-4. Liabilities, in general.

In any determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include:

A. the amount of its capital stock outstanding, if any;

B. the amount, estimated to be consistent with the provisions of the Insurance Code, necessary to pay all of its unpaid losses and claims incurred on or prior to date of the statement whether reported or unreported, together with the expense of adjustment or settlement thereof;

C. as to life insurance policies and annuity contracts, and disability and accidental death benefits in or supplemental thereto:

(1) the amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest and methods adopted pursuant to the Insurance Code which are applicable thereto;

(2) reserves for disability benefits, for both active and disabled lives;

(3) reserves for accidental death benefits; and

(4) any additional reserves which may be required by the superintendent consistent with applicable customary and general practice in insurance accounting;

D. as to health insurance policies, the reserves required under Section 59A-8-7 NMSA 1978;

E. as to insurance other than referred to in Subsections C and D of this section, and other than title insurance, the amount of unearned premium reserves computed in accordance with Sections 59A-8-9 and 59A-8-10 NMSA 1978;

F. taxes, expenses and other obligations due or accrued at date of the statement; and

G. liability to agents for commissions contingent on collection of premium shall not be construed as a liability.

History: Laws 1984, ch. 127, § 121; 1987, ch. 259, § 8.

59A-8-5. Standard valuation law, life insurance and annuities.

A. This subsection shall apply to only those policies and contracts issued prior to the operative date of Section 59A-20-31 NMSA 1978.

The legal minimum standard for valuation of life insurance contracts issued before the first day of January, 1926, shall be the method and basis of valuation heretofore applied by the insurer in the valuation of such contracts, and for life insurance contracts issued on or after this date shall be the American experience table of mortality, with interest at the rate of three and one-half percent a year; or any other basis not producing a lower net value; provided, however, that the insurer may provide for not more than one-year preliminary term insurance by incorporating in the contracts a

clause plainly showing that the first year's insurance under such policies is term insurance.

Except as otherwise provided in Paragraphs (2), (3), (4) and (5) of Subsection B of this section and in Subsections C, D, and E of this section for group annuity and pure endowment contracts, the legal minimum standard for the valuation of annuities shall be the American experience table of mortality, with interest at the rate of five percent a year for group annuity and pure endowment contracts and four percent a year for other annuities.

B. Subsections B, C, D and E of this section shall apply to only those policies and contracts issued on and after the operative date of Section 59A-20-31 NMSA 1978, except as otherwise provided in Paragraphs (2), (3), (4) and (5) of this subsection and in Subsections C, D and E of this section for group annuity and pure endowment contracts issued prior to such operative date.

(1) Except as otherwise provided in Paragraphs (2), (3), (4) and (5) of this subsection and Subsections C, D, and E of this section, the minimum standard for the valuation of all such policies and contracts shall be the commissioners reserve valuation methods defined in Paragraphs (1) and (2) of Subsection E of this section, five percent interest for group annuity and pure endowment contracts and three and one-half percent interest for all other such policies and contracts, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, four percent interest for such policies issued prior to July 1, 1977, five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other such policies issued on or after July 1, 1977, and the following tables:

(a) for all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies - the commissioners 1941 standard ordinary mortality table for such policies issued prior to the operative date of Paragraph (1) of Subsection D of Section 59A-20-31 NMSA 1978 and the commissioners 1958 standard ordinary mortality table for such policies issued on or after the operative date of Paragraph (1) of Subsection D of Section 59A-20-31 NMSA 1978 and prior to the operative date of Subsection F of Section 59A-20-31 NMSA 1978, provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in Subsections B, C, D and E of this section may be calculated according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the operative date of Subsection F of Section 59A-20-31 NMSA 1978: 1) the commissioners 1980 standard ordinary mortality table; or 2) at the election of the insurer for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; or 3) any ordinary mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies;

(b) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies - the 1941 standard industrial mortality table for such policies issued prior to the operative date of Subsection E of Section 59A-20-31 NMSA 1978, and for such policies issued on or after such operative date, the commissioners 1961 standard industrial mortality table or any industrial mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies - the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the superintendent;

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies - the group annuity mortality table for 1951, any modification of such table approved by the superintendent, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(e) for total and permanent disability benefits in or supplementary to ordinary policies or contracts: 1) for policies or contracts issued on or after January 1, 1966 the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies; 2) for policies or contracts issued on or after January 1, 1961 and prior to January 1, 1966 either such tables or, at the option of the insurer, the class (3) disability table (1926); and 3) for policies issued prior to January 1, 1961 the class (3) disability table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(f) for accidental death benefits in or supplementary to policies: 1) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies; 2) for policies issued on or after January 1, 1961 and prior to January 1, 1966, either such table or, at the option of the insurer, the intercompany double indemnity mortality table; and 3) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table. 4) Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and

(g) for group life insurance, life insurance issued on the substandard basis and other special benefits - such tables as may be approved by the superintendent.

(2) Except as provided in Paragraphs (3), (4) and (5) of this subsection and in Subsections C, D and E of this section, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph, as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation methods defined in Paragraphs (1) and (2) of Subsection E of this section and the following tables and interest rates:

(a) for individual annuity and pure endowment contracts issued prior to July 1, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any modification of this table approved by the superintendent, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts;

(b) for individual single premium immediate annuity contracts issued on or after July 1, 1977, excluding any disability and accidental death benefits in such contracts - the 1971 individual annuity mortality table, or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the superintendent, and seven and one-half percent interest;

(c) for individual annuity and pure endowment contracts issued on or after July 1, 1977, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts - the 1971 individual annuity mortality table, or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the superintendent, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts;

(d) for all annuities and pure endowments purchased prior to July 1, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts - the 1971 group annuity mortality table, or any modification of this table approved by the superintendent, and six percent interest; and

(e) for all annuities and pure endowments purchased on or after July 1, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts - the 1971 group annuity mortality table, or any group annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such

annuities and pure endowments, or any modification of this table approved by the superintendent, and seven and one-half percent interest.

(f) After July 1, 1973, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such insurer, provided that an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1979.

(3) The interest rates used in determining the minimum standard for the valuation of:

(a) all life insurance policies issued in a particular calendar year, on or after the operative date of Subsection F of Section 59A-20-31 NMSA 1978;

(b) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

(c) all annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982 under group annuity and pure endowment contracts; and

(d) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in Paragraph (4) of this subsection.

(4) The calendar year statutory valuation interest rates shall be determined as follows and the results rounded to the nearest one-quarter of one percent:

(a) for life insurance,

$$I = .03 + W (R1 - .03) + W/2 (R2 - .09);$$

(b) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and for guaranteed interest contracts with cash settlement options,

$$I = .03 + W (R - .03)$$

where R1 is the lesser of R and .09, R2 is the greater of R and .09, R is the reference interest rate defined in Subsection D of this section, and W is the weighting factor defined in Subsection C of this section;

(c) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in Subparagraph (b) of this paragraph, the formula for life insurance stated in Subparagraph (a) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in Subparagraph (b) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less;

(d) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in Subparagraph (b) of this paragraph shall apply; and

(e) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in Subparagraph (b) of this paragraph shall apply.

(5) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when Subsection F of Section 59A-20-31 NMSA 1978 becomes operative.

C. The weighting factors referred to in the formulas stated above are given in the following tables:

(1) Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to

convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(2) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

(3) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in Paragraph (2) of this subsection, shall be as specified in the tables set forth in Subparagraphs (a), (b) and (c) of this paragraph, according to the rules and definitions set forth in Subparagraphs (d), (e) and (f) of this paragraph:

(a) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(b) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in the table set forth in Subparagraph (a) of this paragraph increased by:

Plan Type		
A	B	C
.15	.25	.05

(c) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in the table set forth in Subparagraph (a) of this paragraph or derived as required in the table set forth in Subparagraph (b) of this paragraph increased by:

Plan Type		
A	B	C
.05	.05	.05

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(e) Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only: with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or without such adjustment but in installments over five years or more; or as an immediate life annuity; or no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only: with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or without such adjustment but in installments over five years or more; or no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either: without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(f) An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in Subsections B, C and D of this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

D. The reference interest rate referred to in Paragraph (4) of Subsection B of this section shall be defined as follows:

(1) for all life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year next preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(2) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(3) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Paragraph (2) of this subsection, with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(4) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Paragraph (2) of this subsection, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(5) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(6) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Paragraph (2) of this subsection, the average over a period of twelve months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated; and

(7) in the event that the national association of insurance commissioners determines that the monthly average of the composite yield on seasoned corporate

bonds, as published by Moody's investors service, incorporated is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the national association of insurance commissioners and approved by regulation promulgated by the superintendent may be substituted.

E. The reserve valuation method shall be defined as follows:

(1) Except as otherwise provided in this paragraph and Paragraph (2) of this subsection, reserves according to the national association of insurance commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of Subparagraph (a) over Subparagraph (b) of this paragraph, as follows:

(a) a net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age of one year higher than the age at issue of such policy; and

(b) a net one-year term premium for such benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after January 1, 1985 for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Subparagraph (e) of this paragraph, be the greater of the reserve as of such policy anniversary calculated as described previously in this paragraph and the reserve as of such policy anniversary calculated as previously described in this paragraph, but with: the value defined in Subparagraph (a) of this paragraph being reduced by fifteen percent of the amount of such excess first year premium; all present values of benefits and premiums

being determined without reference to premiums or benefits provided for by the policy after the assumed ending date; the policy being assumed to mature on such date as an endowment; and the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in Paragraphs (1), (3), (4) and (5) of Subsection B of this section and in Subsections C and D of this section shall be used.

Reserves according to the commissioners reserve valuation method for: 1) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; 2) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; 3) disability and accidental death benefits in all policies and contracts; and 4) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this paragraph, except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums;

(c) in no event shall an insurer's aggregate reserves for all life insurance policies excluding disability and accidental death benefits, be less than the aggregate reserves calculated in accordance with the methods set forth in this paragraph and Paragraph (2) of this subsection and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies;

(d) reserves for any category of policies, contracts or benefits as established by the superintendent, may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for therein.

Any such insurer which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the superintendent, adopt any lower standard of valuation, but not lower than the minimum herein provided; but, for the purpose of this section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by Section 59A-8-7 NMSA 1978 shall not be deemed to be the adoption of a higher standard of valuation;

(e) if in any contract year the gross premium charged by any insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum

valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this paragraph are those standards stated in Paragraphs (1), (3), (4) and (5) of Subsection B of this section.

Provided that for any life insurance policy issued on or after January 1, 1985 for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of Subparagraph (e) of this paragraph shall be applied as if the method actually used in calculating the reserve for such policy were the method previously described in this paragraph ignoring the unnumbered paragraph immediately following Subparagraph (b) of this paragraph. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with the method previously described in this paragraph, including the unnumbered paragraph immediately following Subparagraph (b), and the minimum reserve calculated in accordance with Subparagraph (e), of this paragraph; and

(f) in the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in Paragraphs (1) and (2) of this subsection, the reserves which are held under any such plan must: 1) be appropriate in relation to the benefits and the pattern of premiums for that plan; and 2) be computed by a method which is consistent with the principles of this standard valuation law, as determined by regulations promulgated by the superintendent.

(2) This paragraph shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including

guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

History: Laws 1984, ch. 127, § 122; 1993, ch. 320, § 20.

59A-8-6. Recompiled.

History: Laws 1984, ch. 127, § 123; 1993, ch. 320, § 21; recompiled and amended as 59A-8A-3 by Laws 2014, ch. 59, § 17.

59A-8-7. Recompiled.

History: 1978 Comp., § 59A-8-7, enacted by Laws 1993, ch. 320, § 22; recompiled and amended as 59A-8A-4 by Laws 2014, ch. 59, § 18.

59A-8-7.1. Continued liability after assumption reinsurance transactions.

A ceding insurer shall remain jointly and severally liable with an unauthorized assuming insurer on ceded contracts or policies for which assumption certificates have been issued covering risks resident in this state until such time as:

A. the assuming insurer obtains a certificate of authority to transact the applicable kind of insurance in this state; or

B. the assuming insurer deposits with the superintendent a special deposit in an amount equal to the greater of:

(1) one hundred thousand dollars ($100,000); or

(2) twenty thousand dollars ($20,000) plus the statutory reserves required of an authorized insurer for the contracts assumed.

History: 1978 Comp., § 59A-8-7.1, enacted by Laws 1993, ch. 320, § 23.

59A-8-8. Loss reserves.

A. Each authorized insurer shall maintain reserves in such amount as is requisite to cover losses and claims incurred and unpaid, together with related adjustment and settlement expense, whether reported or unreported as at financial statement date. In computing or approving such reserves the superintendent may estimate any portion which it is not practicable to compute accurately for [due to] failure to receive notice or otherwise.

B. Whenever the loss and loss expense experience of an insurer shows that its loss reserves, however calculated, are inadequate, the superintendent may require the insurer to maintain additional reserves.

History: Laws 1984, ch. 127, § 125.

59A-8-9. Unearned premium reserve, casualty, vehicle, property, marine and surety insurances.

As to property, casualty, vehicle and surety insurance, and marine and transportation insurance other than as provided in Section 59A-8-10 NMSA 1978, the insurer shall maintain as a liability an unearned premium reserve on policies in force computed as follows: fifty percent of the gross premium in force on policies having one year or less to run and pro rata on those for longer periods, or pro rata for all premiums in force.

History: Laws 1984, ch. 127, § 126; 1997, ch. 121, § 4.

59A-8-10. Unearned premium reserve, marine and transportation insurance.

As to marine and transportation insurance, the entire amount of premiums on trip risks not terminated shall be deemed unearned; and the superintendent may require the insurer to carry a reserve equal to one hundred percent of premiums on trip risks written during the month ended as of the date of statement.

History: Laws 1984, ch. 127, § 127.

59A-8-11. Title insurance reserves.

A. As to title insurance the insurer shall set up and maintain unearned premium reserves as follows:

(1) as to guaranties and policies on property in this state issued prior to January 1, 1957, the insurer shall reserve initially a sum equal to ten percent of gross premiums therefor. The sum so accumulated may be reduced by five percent thereof at the end of each calendar year thereafter;

(2) as to guaranties and policies on property in this state issued on and after January 1, 1957, the insurer shall reserve initially a sum equal to ten percent of the gross risk premium therefor. At end of each calendar year following the year in which the guaranty or policy was issued the insurer may reduce the sum so reserved by five percent thereof.

B. The sums so reserved initially, or maintained thereafter, in accordance with the above provisions shall be considered unearned portions of the gross risk premiums on such guaranties or policies and shall be shown as a liability of the insurer in determining its financial condition.

C. If a title insurer on withdrawing from the title insurance business in this state desires to reinsure with another title insurer all its title guaranties or policies in this state, the superintendent may require the reinsurer to increase its unearned premium reserve by an amount not greater than the unearned premium reserve required of the withdrawing insurer as to the guaranties and policies so reinsured.

D. The term "gross risk premium" as used in this action [section] shall not include charges for abstracting, record searching, escrow and closing services and other related services which may be provided by the insurer, or costs and expenses of examinations of title, or premiums paid for reinsurance.

History: Laws 1984, ch. 127, § 128.

59A-8-12. Mortgage guaranty contingency reserve.

A. Casualty or surety insurers insuring real property mortgage or deed of trust lenders against loss by nonpayment of the indebtedness shall maintain a contingency reserve for protection of policyholders against the effects of adverse economic cycles.

B. The insurer shall contribute to such contingency reserve fifty percent of net premiums (gross premiums less premiums returned to policyholders) written on such insurance remaining after establishment of the unearned premium reserve.

C. Subject to the superintendent's approval, the contingency reserve shall be available for payment of losses only when the insurer's incurred losses in any one (1) calendar year exceed the rate formula expected losses by ten percent of the related earned premiums.

History: Laws 1984, ch. 127, § 129.

59A-8-13. Valuation of bonds.

A. Subject to the provisions of Subsections B, C and D of this section, all bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

(1) if purchased at par, at the par value; and

(2) if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made.

B. The purchase price shall in no event be taken at a higher figure than actual market value at time of purchase, plus incidental costs of acquisition of the securities.

C. No such security shall be carried at above the call price for the entire issue during any period within which the security may be so called, and premiums paid at purchase shall be amortized by the scientific method to the first call date at which the entire issue may be redeemed.

D. Obligations subject to amortization under the published findings of the national association of insurance commissioners shall be carried at their amortized values. Obligations which do not qualify for amortization shall be reported at their market value or book value based upon an amortized computation, whichever is lower.

History: Laws 1984, ch. 127, § 130; 1987, ch. 259, § 9; 1993, ch. 320, § 24.

59A-8-14. Valuation of other securities.

A. Common stocks shall be valued at their market value, as determined by customary method, or, at the option of the company, they may be carried at cost if cost is less than market value. If no publicly traded market quotation is available, the value of the stocks shall be based on the pro rata share of the issuing company's net worth as shown by its audited financial statements or, in the case of an insurance company, the pro rata share of its statutory net worth.

B. Preferred stocks shall be valued in accordance with procedures promulgated periodically by the securities valuation office of the national association of insurance commissioners.

C. Stock of an insurer's subsidiary shall be valued only on the basis of value of the assets of the subsidiary that would constitute lawful investments of the insurer if acquired or held directly by the insurer.

History: 1978 Comp., § 59A-8-14, enacted by Laws 1993, ch. 320, § 25.

59A-8-15. Valuation of property.

A. Real property held by a company may be valued at not more than: its cost plus the cost of capitalized additions and permanent improvements, less depreciation, or its fair market value as determined by appraisal within the most recent three years, whichever is less. Depreciation shall be computed under the straight line method or, at

the option of the company, under any other method resulting in larger accumulated depreciation at any given time. Depreciation of any buildings shall be based upon an estimated useful life of not more than fifty years.

B. Property acquired in satisfaction of a debt shall be valued at its fair market value or the amount of the debt, including capitalized taxes and expenses, whichever amount is less.

History: 1978 Comp., § 59A-8-15, enacted by Laws 1993, ch. 320, § 26.

59A-8-16. Valuation of purchase money mortgages.

Purchase money mortgages or deeds of trust on real property referred to in Subsection A of Section 132 [59A-8-15 NMSA 1978] of this article shall be valued in an amount not exceeding acquisition cost of the real property covered thereby or ninety percent of the fair value of the real property, whichever is less.

History: Laws 1984, ch. 127, § 133.

ARTICLE 8A
Standard Valuation

59A-8A-1. Short title.

Chapter 59A, Article 8A NMSA 1978 may be cited as the "Standard Valuation Law".

History: 1978 Comp., § 59A-8A-1, enacted by Laws 2014, ch. 59, § 15.

59A-8A-2. Definitions.

As used in the Standard Valuation Law:

A. "accident and health insurance" means a policy that reflects morbidity risk and provides protection against economic loss resulting from an accident, a sickness or a medical condition and includes policies identified by the valuation manual as accident and health insurance;

B. "appointed actuary" means a qualified actuary who is appointed pursuant to the valuation manual to prepare the actuarial opinion required by Section 59A-8A-5 NMSA 1978;

C. "company" means an entity that has written, issued or reinsured life insurance contracts, accident and health insurance contracts or deposit-type contracts in New Mexico and has at least one contract for a life insurance, accident and health insurance or deposit-type policy in force or on claim or an entity that has written, issued or

reinsured life insurance contracts, accident and health insurance contracts or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance or deposit-type contracts in New Mexico;

D. "deposit-type contract" means a contract that does not reflect mortality or morbidity risks and includes contracts identified by the valuation manual as deposit-type contracts;

E. "life insurance" means a policy that reflects mortality risk and includes annuity policies, pure endowment policies and policies identified by the valuation manual as life insurance;

F. "operative date of the valuation manual" means the January 1 of the first calendar year following the first July 1 after which the following have occurred:

(1) the valuation manual has been adopted by the national association of insurance commissioners by an affirmative vote of at least forty-two members or three-fourths of the members voting, whichever is greater;

(2) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by states that collectively represent more than seventy-five percent of written direct premiums, as reported in the life, accident and health annual statements, the health annual statements and the fraternal annual statements submitted for 2008; and

(3) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions:

(a) the fifty states of the United States;

(b) American Samoa;

(c) the Virgin Islands of the United States;

(d) the District of Columbia;

(e) Guam; and

(f) Puerto Rico;

G. "policyholder behavior" means an action that a policyholder, a contract holder or a person who has the right to elect options, such as a certificate holder, may take pursuant to a policy or contract that is subject to the Standard Valuation Law and, if

allowed pursuant to the policy or contract, includes lapses, withdrawals, transfers, deposits, premium payments, loans and annuitization and benefit elections, but excludes events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract;

H. "principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and that is required to comply with Section 59A-8A-9 NMSA 1978;

I. "qualified actuary" means, on or after the operative date of the valuation manual, an individual who, according to the applicable qualification standards of the American academy of actuaries, is qualified to sign the applicable statement of actuarial opinion and who meets the applicable requirements indicated by the valuation manual;

J. "tail risk" means a risk that occurs either when the frequency of low-probability events is higher than expected under a normal probability distribution or when events of very significant magnitude are observed; and

K. "valuation manual" means the most recent version of the manual of valuation instructions adopted by the national association of insurance commissioners.

History: 1978 Comp., § 59A-8A-2, enacted by Laws 2014, ch. 59, § 16.

59A-8A-3. Reserve valuation.

A. For policies and contracts issued prior to the operative date of the valuation manual:

(1) the superintendent shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer authorized to do business in New Mexico and that are issued on or after the operative date of Section 59A-20-31 NMSA 1978, except that, for an alien insurer, the value is limited to the alien insurer's United States business. In calculating such reserves the superintendent may use group methods and approximate averages for fractions of a year or otherwise. In lieu of valuation of reserves herein required of a foreign or alien insurer, the superintendent may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard provided by the Standard Valuation Law;

(2) the provisions of Sections 59A-8A-6 and 59A-8A-7 NMSA 1978 apply, as appropriate, to a policy or contract that is subject to the provisions of the Standard Valuation Law and that is issued on or after the operative date of Section 59A-20-31 NMSA 1978 but prior to the operative date of the valuation manual. The provisions of Sections 59A-8A-8 and 59A-8A-9 NMSA 1978 do not apply to a policy or contract that is subject to the provisions of the Standard Valuation Law and that is issued on or after the

operative date of Section 59A-20-31 NMSA 1978 but prior to the operative date of the valuation manual; and

(3) the minimum standard for the valuation of a policy or contract that is issued prior to the operative date of Section 59A-20-31 NMSA 1978 is the minimum standard provided in the laws in effect immediately prior to that date.

B. For a policy or contract that is issued on or after the operative date of the valuation manual:

(1) the superintendent shall annually value, or cause to be valued, the reserve liabilities, hereinafter called reserves, of all outstanding life insurance, annuity and pure endowment, accident and health and deposit-type contracts of a life insurer authorized to do business in New Mexico that are issued on or after the operative date of the valuation manual. In the case of a foreign or alien insurer, the superintendent may, in the alternative, accept a valuation made, or caused to be made, by the insurance supervisory official of a state or other jurisdiction if that valuation complies with the minimum standard provided in the Standard Valuation Law; and

(2) the provisions of Sections 59A-8A-8 and 59A-8A-9 NMSA 1978 apply to all policies and contracts issued on or after the operative date of the valuation manual.

C. In no event shall the aggregate reserves for all policies, contracts and benefits issued prior to the operative date of the valuation manual be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by Section 59A-8A-4 NMSA 1978.

History: Laws 1984, ch. 127, § 123; 1993, ch. 320, § 21; § 59A-8-6 recompiled and amended as § 59A-8A-3 by Laws 2014, ch. 59, § 17.

59A-8A-4. Actuarial opinion prior to operative date of valuation manual.

A. This section applies to actuarial opinions issued prior to the operative date of the valuation manual.

B. Every life insurer doing business in New Mexico shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the superintendent by regulation are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of New Mexico. The superintendent by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

C. Every life insurer, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by Subsection B of this section, an opinion of

the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the superintendent by regulation, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. The superintendent may provide by regulation for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this section.

D. Every opinion required by Subsection C of this section shall be governed by the following provisions:

(1) a memorandum, in form and substance acceptable to the superintendent as specified by regulation, shall be prepared to support each actuarial opinion; and

(2) if the insurer fails to provide a supporting memorandum at the request of the superintendent within a period specified by rule or if the superintendent determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the superintendent, the superintendent may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the superintendent.

E. Every opinion required by this section shall be governed by the following provisions:

(1) the opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994;

(2) the opinion shall apply to all business in force, including individual and group health insurance plans in form and substance acceptable to the superintendent as specified by regulation;

(3) the opinion shall be based on standards adopted from time to time by the actuarial standards board and on such additional standards as the superintendent may by regulation prescribe;

(4) in the case of an opinion required to be submitted by a foreign or alien insurer, the superintendent may accept the opinion filed by that insurer with the insurance supervisory official of another state if the superintendent determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in New Mexico;

(5) for the purposes of this section, "qualified actuary" means a member in good standing of the American academy of actuaries who meets the requirements set forth in such regulations;

(6) except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurer and the superintendent, for any act, error, omission, decision or conduct with respect to the actuary's opinion;

(7) disciplinary action by the superintendent against the insurer or the qualified actuary shall be defined in regulations by the superintendent;

(8) except as provided in Paragraph (12) of this subsection, the documents, materials and other information that constitute a memorandum in support of the opinion and that are in the possession or control of the office of superintendent of insurance, and other materials provided by the company to the superintendent in connection with the memorandum, are confidential and are not subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. Nothing in this section shall be construed as a grant of privilege or confidentiality or a bar to production of that information by an insurer in a civil suit, whether or not the office of superintendent of insurance is a party; provided that the superintendent may use the documents, materials or other information in the furtherance of a regulatory or legal action brought in the course of the superintendent's official duties;

(9) neither the superintendent nor any person who receives documents, materials or other information while acting pursuant to the authority of the superintendent shall be permitted or required in a private civil action to testify on the confidential documents, materials or information subject to Paragraph (8) of this subsection;

(10) to assist in the performance of the superintendent's duties, the superintendent may:

(a) if the recipient agrees to maintain the confidentiality and privilege of the document, material or other information, share documents, materials or other information, including the confidential and privileged documents, with a state, federal or international regulatory agency, with the national association of insurance commissioners, its affiliates or its subsidiaries and with state, federal and international law enforcement authorities;

(b) receive documents, materials or information, including that which is otherwise confidential and privileged, from the national association of insurance commissioners, its affiliates or its subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions if the superintendent maintains as confidential or privileged a document, material or other information received with notice or the understanding that the content is confidential or privileged pursuant to the laws of the jurisdiction from which the information originates; and

(c) consistent with Paragraphs (8) through (10) of this subsection, enter into agreements governing sharing and the use of information;

(11) a disclosure to or a sharing by the superintendent pursuant to this section does not constitute a waiver of an applicable privilege or claim of confidentiality in the documents, materials or information; and

(12) a memorandum in support of the opinion and any other material provided by the insurer to the superintendent in connection therewith may be subject to subpoena for the purpose of defending an action seeking damages from the actuary who submitted the memorandum by reason of any action required by this section or by regulations promulgated hereunder; provided, however, that the memorandum or other material may otherwise be released by the superintendent, with the written consent of the insurer, or to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the superintendent for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the insurer in its marketing or is cited before any governmental agency other than a state insurance department or is released by the insurer to the news media, all portions of the confidential memorandum shall be no longer confidential.

History: 1978 Comp., § 59A-8-7, enacted by Laws 1993, ch. 320, § 22; recompiled and amended as § 59A-8A-4 by Laws 2014, ch. 59, § 18.

59A-8A-5. Actuarial opinion after operative date of valuation manual.

A. This section applies to actuarial opinions issued after the operative date of the valuation manual.

B. A company with outstanding life insurance, accident and health insurance or deposit-type contracts in New Mexico and that is subject to regulation by the superintendent shall annually submit the opinion of the appointed actuary on whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, based on assumptions that satisfy contractual provisions, consistent with prior reported amounts and comply with the laws of New Mexico. The opinion shall comport with related provisions of the valuation manual.

C. Except as excluded by the provisions of the valuation manual, a company with outstanding life insurance, accident and health insurance or deposit-type contracts in New Mexico and that is subject to regulation by the superintendent shall include in the opinion required by Subsection B of this section an assessment of whether, when considering the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the anticipated considerations to be received and retained pursuant to the policies and contracts, the

reserves and related actuarial items that are held in support of the policies and contracts that are specified in the valuation manual make adequate provision for the company's obligations pursuant to the policies and contracts, including the benefits pursuant to and expenses associated with the policies and contracts.

D. An opinion required by Subsection B of this section shall be accompanied by a memorandum of support, whose form and substance comply with the provisions of the valuation manual and are acceptable to the superintendent. If, within a period of time specified by the provisions of the valuation manual and upon the request of the superintendent, an insurance company fails to provide a memorandum of support, the superintendent may engage, at the insurance company's expense, a qualified actuary to review the opinion and the basis for it and prepare a memorandum of support. If the superintendent determines that an insurance company's memorandum of support fails to meet the standards provided in the valuation manual or is otherwise unacceptable, the superintendent may engage the services of a qualified actuary to review the opinion and the basis for it and prepare a memorandum of support.

E. An opinion required by this section shall:

(1) conform in form and substance to the provisions of the valuation manual and be acceptable to the superintendent;

(2) accompany an annual statement that indicates the valuation of reserve liabilities for each year ending on or after the operative date of the valuation manual;

(3) apply to all policies and contracts subject to Subsection B of this section and other actuarial liabilities specified by the provisions of the valuation manual; and

(4) meet the standards adopted by the actuarial standards board or its successor and the relevant standards provided in the valuation manual.

F. In the case of a foreign or alien company, the superintendent may accept, instead of an opinion filed pursuant to Subsection B of this section, an opinion filed by the company with the insurance supervisory official of another state if the superintendent determines that the opinion reasonably meets the requirements applicable to a company domiciled in New Mexico.

G. Except in cases of fraud or willful misconduct, an appointed actuary is not liable for damages to a person, except the insurance company that appointed the actuary or the superintendent, resulting from an act, error, omission, decision or conduct related to the appointed actuary's opinion.

H. Disciplinary action by the superintendent against a company or its appointed actuary shall be defined by rules promulgated by the superintendent.

History: 1978 Comp., § 59A-8A-5, enacted by Laws 2014, ch. 59, § 19.

59A-8A-6. Rule-based reserve valuation methods.

A. This subsection shall apply to only those policies and contracts issued prior to the operative date of Section 59A-20-31 NMSA 1978.

The legal minimum standard for valuation of life insurance contracts issued before the first day of January 1926 shall be the method and basis of valuation heretofore applied by the insurer in the valuation of such contracts, and for life insurance contracts issued on or after this date shall be the American experience table of mortality, with interest at the rate of three and one-half percent a year; or any other basis not producing a lower net value; provided, however, that the insurer may provide for not more than one-year preliminary term insurance by incorporating in the contracts a clause plainly showing that the first year's insurance under such policies is term insurance.

Except as otherwise provided in Paragraphs (2), (3), (4) and (5) of Subsection B of this section and in Subsections C, D and E of this section for group annuity and pure endowment contracts, the legal minimum standard for the valuation of annuities shall be the American experience table of mortality, with interest at the rate of five percent a year for group annuity and pure endowment contracts and four percent a year for other annuities.

B. Subsections B, C, D and E of this section shall apply to only those policies and contracts issued on and after the operative date of Section 59A-20-31 NMSA 1978, except as otherwise provided in Paragraphs (2), (3), (4) and (5) of this subsection and in Subsections C, D and E of this section for group annuity and pure endowment contracts issued prior to such operative date.

(1) Except as otherwise provided in Paragraphs (2), (3), (4) and (5) of this subsection and Subsections C, D and E of this section, the minimum standard for the valuation of all such policies and contracts shall be the commissioners reserve valuation methods defined in Paragraphs (1) and (2) of Subsection E of this section, five percent interest for group annuity and pure endowment contracts and three and one-half percent interest for all other such policies and contracts, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, four percent interest for such policies issued prior to July 1, 1977, five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other such policies issued on or after July 1, 1977, and the following tables:

(a) for ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the commissioners 1941 standard ordinary mortality table for such policies issued prior to the operative date of Paragraph (1) of Subsection D of Section 59A-20-31 NMSA 1978 and the commissioners 1958 standard ordinary mortality table for such policies issued on or after the operative date of Paragraph (1) of Subsection D of Section 59A-20-31

NMSA 1978 and prior to the operative date of Subsection F of Section 59A-20-31 NMSA 1978, provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in Subsections B, C, D and E of this section may be calculated according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the operative date of Subsection F of Section 59A-20-31 NMSA 1978: 1) the commissioners 1980 standard ordinary mortality table; or 2) at the election of the insurer for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; or 3) any ordinary mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies;

(b) for industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the 1941 standard industrial mortality table for such policies issued prior to the operative date of Subsection E of Section 59A-20-31 NMSA 1978, and for such policies issued on or after such operative date, the commissioners 1961 standard industrial mortality table or any industrial mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the superintendent;

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the group annuity mortality table for 1951, any modification of such table approved by the superintendent, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(e) for total and permanent disability benefits in or supplementary to ordinary policies or contracts: 1) for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies; 2) for policies or contracts issued on or after January 1, 1961 and prior to January 1, 1966, either such tables or, at the option of the insurer, the class (3) disability table (1926); and 3) for policies issued prior to January 1, 1961, the class (3) disability table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(f) for accidental death benefits in or supplementary to policies: 1) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such policies; 2) for policies issued on or after January 1, 1961 and prior to January 1, 1966, either such table or, at the option of the insurer, the intercompany double indemnity mortality table; and 3) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table. 4) Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and

(g) for group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the superintendent.

(2) Except as provided in Paragraphs (3), (4) and (5) of this subsection and in Subsections C, D and E of this section, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this paragraph, as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation methods defined in Paragraphs (1) and (2) of Subsection E of this section and the following tables and interest rates:

(a) for individual annuity and pure endowment contracts issued prior to July 1, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any modification of this table approved by the superintendent, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts;

(b) for individual single premium immediate annuity contracts issued on or after July 1, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the superintendent, and seven and one-half percent interest;

(c) for individual annuity and pure endowment contracts issued on or after July 1, 1977, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the superintendent, and five and one-half percent interest for single premium deferred

annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts;

(d) for annuities and pure endowments purchased prior to July 1, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table, or any modification of this table approved by the superintendent, and six percent interest; and

(e) for annuities and pure endowments purchased on or after July 1, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table, or any group annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of this table approved by the superintendent, and seven and one-half percent interest.

(f) After July 1, 1973, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such insurer, provided that an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1979.

(3) The interest rates used in determining the minimum standard for the valuation of:

(a) life insurance policies issued in a particular calendar year, on or after the operative date of Subsection F of Section 59A-20-31 NMSA 1978;

(b) individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

(c) annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982 under group annuity and pure endowment contracts; and

(d) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in Paragraph (4) of this subsection.

(4) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearest one-quarter of one percent:

(a) for life insurance,

$$I = .03 + W (R1 - .03) + W/2 (R2 - .09);$$

(b) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$$I = .03 + W (R - .03)$$

where R1 is the lesser of R and .09, R2 is the greater of R and .09, R is the reference interest rate defined in Subsection D of this section, and W is the weighting factor defined in Subsection C of this section;

(c) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in Subparagraph (b) of this paragraph, the formula for life insurance stated in Subparagraph (a) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in Subparagraph (b) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less;

(d) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in Subparagraph (b) of this paragraph shall apply; and

(e) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in Subparagraph (b) of this paragraph shall apply.

(5) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when Subsection F of Section 59A-20-31 NMSA 1978 becomes operative.

C. The weighting factors referred to in the formulas stated above are given in the following tables:

(1) Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both that are guaranteed in the original policy;

(2) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

(3) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in Paragraph (2) of this subsection, shall be as specified in the tables set forth in Subparagraphs (a), (b) and (c) of this paragraph, according to the rules and definitions set forth in Subparagraphs (d), (e) and (f) of this paragraph:

(a) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(b) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in the table set forth in Subparagraph (a) of this paragraph increased by:

Plan Type		
A	B	C
.15	.25	.05

(c) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in the table set forth in Subparagraph (a) of this paragraph or derived as required in the table set forth in Subparagraph (b) of this paragraph increased by:

Plan Type		
A	B	C
.05	.05	.05

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(e) Plan type as used in the above tables is defined as follows:

Plan Type A: At any time, policyholder may withdraw funds only: with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or without such adjustment but in installments over five years or more; or as an immediate life annuity; or no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only: with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or without such adjustment but in installments over five years or more; or no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either: without adjustment to reflect changes in interest rates or asset values since receipt of the funds

by the insurer; or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(f) An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in Subsections B, C and D of this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

D. The reference interest rate referred to in Paragraph (4) of Subsection B of this section shall be defined as follows:

(1) for life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year next preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(2) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(3) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Paragraph (2) of this subsection, with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(4) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Paragraph (2) of this subsection, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June 30 of the calendar year of

issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(5) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated;

(6) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Paragraph (2) of this subsection, the average over a period of twelve months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated; and

(7) in the event that the national association of insurance commissioners determines that the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's investors service, incorporated, is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate that is adopted by the national association of insurance commissioners and approved by regulation promulgated by the superintendent may be substituted.

E. The reserve valuation method shall be defined as follows:

(1) Except as otherwise provided in this paragraph and Paragraph (2) of this subsection, reserves according to the national association of insurance commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of Subparagraph (a) over Subparagraph (b) of this paragraph, as follows:

(a) a net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age of one year higher than the age at issue of such policy; and

(b) a net one-year term premium for such benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after January 1, 1985 for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and that provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Subparagraph (f) of this paragraph, be the greater of the reserve as of such policy anniversary calculated as described previously in this paragraph and the reserve as of such policy anniversary calculated as previously described in this paragraph, but with: the value defined in Subparagraph (a) of this paragraph being reduced by fifteen percent of the amount of such excess first year premium; all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date; the policy being assumed to mature on such date as an endowment; and the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in Paragraphs (1), (3), (4) and (5) of Subsection B of this section and in Subsections C and D of this section shall be used.

Reserves according to the commissioners reserve valuation method for: 1) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; 2) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; 3) disability and accidental death benefits in all policies and contracts; and 4) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this paragraph;

(c) in no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, be less than the aggregate reserves calculated in accordance with the methods set forth in this paragraph and Paragraph (2) of this subsection and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies;

(d) at the option of the insurer, reserves for policies and contracts issued prior to the operative date of Section 59A-20-31 NMSA 1978 may be calculated according to

a standard that produces greater aggregate reserves for the policies and contracts than the minimum required by the laws in effect immediately prior to that date;

(e) reserves for any category of policies, contracts or benefits as established by the superintendent that are issued on or after the operative date of Section 59A-20-31 NMSA 1978 may be calculated, at the option of the insurer, according to any standards that produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in the policies or contracts.

Any such insurer that at any time adopts any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided by the Standard Valuation Law may, with the approval of the superintendent, adopt any lower standard of valuation, but not lower than the minimum herein provided; but, for the purpose of this section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by Section 59A-8A-4 NMSA 1978 shall not be deemed to be the adoption of a higher standard of valuation;

(f) if in any contract year the gross premium charged by any insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this paragraph are those standards stated in Paragraphs (1), (3), (4) and (5) of Subsection B of this section.

Provided that for any life insurance policy issued on or after January 1, 1985 for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and that provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of Subparagraph (f) of this paragraph shall be applied as if the method actually used in calculating the reserve for such policy were the method previously described in this paragraph ignoring the unnumbered paragraph immediately following Subparagraph (b) of this paragraph. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with the method previously described in this paragraph, including the unnumbered paragraph immediately following Subparagraph (b), and the minimum reserve calculated in accordance with Subparagraph (f) of this paragraph; and

(g) in the case of any plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in Paragraphs (1) and (2) of this subsection, the reserves that are held under any such plan must: 1) be appropriate in relation to the benefits and the pattern of premiums for that plan; and 2) be computed by a method that is consistent with the principles of this standard valuation law, as determined by regulations promulgated by the superintendent.

(2) This paragraph shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

History: Laws 1984, ch. 127, § 122; 1993, ch. 320, § 20; 1978 Comp. § 59A-8-5, recompiled and amended as § 59A-8A-6 by Laws 2014, ch. 59, § 20.

59A-8A-7. Minimum standards for accident and health insurance contracts.

For an accident and health insurance contract issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required by Subsection B of Section 59A-8A-3 NMSA 1978. For an accident and health insurance contract issued on or after the operative date of Section 59A-20-31 NMSA 1978 and prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the superintendent by rule.

History: 1978 Comp., § 59A-8A-7, enacted by Laws 2014, ch. 59, § 21.

59A-8A-8. Valuation manual for policies issued on or after operative date of valuation manual.

A. For a policy issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required by Subsection B of Section 59A-8A-3 NMSA 1978, except as provided in Subsection D or F of this section.

B. Unless an amendment to the valuation manual provides for a later effective date, an amendment to the valuation manual takes effect on the January 1 after the date that the amendment was adopted by the national association of insurance commissioners by an affirmative vote of:

(1) at least three-fourths of the members of the national association of insurance commissioners voting, but not less than a majority of the total membership; and

(2) members representing jurisdictions that collectively represent more than seventy-five percent of written direct premiums, as reported in the life, accident and health annual statements, the health annual statements and the fraternal annual statements most recently available before the time of the vote referred to in Paragraph (1) of this subsection.

C. The valuation manual shall indicate:

(1) minimum valuation standards for and definitions of the policies or contracts subject to Subsection B of Section 59A-8A-3 NMSA 1978, including:

(a) the superintendent's reserve valuation method for life insurance contracts, other than annuity contracts, subject to that subsection;

(b) the superintendent's annuity reserve valuation method for annuity contracts subject to that subsection; and

(c) minimum reserves for all other policies or contracts subject to that subsection;

(2) which policies and contracts or types of policies and contracts are subject to the requirements of a principle-based valuation in Subsection A of Section 59A-8A-9 NMSA 1978 and the minimum standards of valuation consistent with those requirements;

(3) for policies and contracts subject to a principle-based valuation pursuant to Section 59A-8A-9 NMSA 1978:

(a) requirements for the format of reports filed with the superintendent pursuant to Paragraph (4) of Subsection B of Section 59A-8A-9 NMSA 1978, which shall include information necessary to determine if the valuation is appropriate and complies with the Standard Valuation Law;

(b) prescribed assumptions for risks over which the company has no significant control or influence; and

(c) procedures for, and a process for appropriate waiver or modification of, corporate governance and oversight of the actuarial function;

(4) for policies not subject to a principle-based valuation pursuant to Section 59A-8A-9 NMSA 1978, the minimum standard of valuation shall either:

(a) be consistent with the minimum standard of valuation in effect prior to the operative date of the valuation manual; or

(b) provide for reserves that quantify the benefits and guarantees and the funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events with a reasonable probability of occurring;

(5) other requirements, including those related to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memoranda, transition rules and internal controls; and

(6) the data and form of the data required by Section 59A-8A-10 NMSA 1978, the person with whom the data must be submitted and, if appropriate, data analyses and reporting of analyses.

D. In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual does not, in the opinion of the superintendent, comply with the Standard Valuation Law, then a company shall comply with the minimum valuation standards promulgated by rule by the superintendent.

E. The superintendent may engage, at the company's expense, a qualified actuary to conduct an actuarial examination of a company and issue an opinion on the appropriateness of the company's reserve assumption or method, or to review and issue an opinion on the company's compliance with a requirement of the Standard Valuation Law. The superintendent may rely upon the opinion of a qualified actuary engaged by the insurance supervisory official of another state, district or territory of the United States if that opinion relates to the provisions of the Standard Valuation Law. As used in this subsection, "engage" includes employment and contract employment.

F. The superintendent may require a company to change an assumption or method if the superintendent believes that the change is necessary to comply with the requirements of the valuation manual or the Standard Valuation Law. The company shall adjust its reserves to comply with the superintendent's requirement.

History: 1978 Comp., § 59A-8A-8, enacted by Laws 2014, ch. 59, § 22.

59A-8A-9. Requirements of a principle-based valuation.

A. For policies and contracts that the valuation manual indicates are subject to this section, a company shall establish reserves using a principle-based valuation that:

(1) quantifies the benefits and guarantees and the funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events with a reasonable probability of occurring during the lifetime of the contracts and, for a policy or contract with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk;

(2) incorporates assumptions, risk analysis methods, financial models and management techniques that are consistent with, but not necessarily identical to, those used in the company's overall risk assessment process and that recognize potential differences in financial reporting structures and prescribed assumptions or methods;

(3) incorporates assumptions that:

(a) derive from the valuation manual; or

(b) do not derive from the valuation manual, but: 1) are established using the company's available experience and are relevant and statistically credible; or 2) if company data is not available, relevant or statistically credible, are established utilizing other relevant, statistically credible experience; and

(4) provides margins for uncertainty, including adverse deviation and estimation error, whose sizes vary in proportion to the margin and resulting reserve.

B. A company using a principle-based valuation for policies and contracts that the valuation manual indicates are subject to this section shall:

(1) establish procedures for corporate governance and oversight of the actuarial valuation function that are consistent with those provided for in the valuation manual;

(2) design its internal controls of principle-based valuation to ensure that all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation and that valuations are made in accordance with the valuation manual;

(3) each year, provide to the superintendent and to the company's board of directors a certification of effectiveness of the internal controls of the company's principle-based valuation that are in place at the end of the preceding calendar year; and

(4) develop and, upon the request of the superintendent, file a principle-based valuation report that complies with the standards prescribed in the valuation manual.

C. A principle-based valuation may include a prescribed formulaic reserve component.

History: 1978 Comp., § 59A-8A-9, enacted by Laws 2014, ch. 59, § 23.

59A-8A-10. Experience reporting for policies in force on or after operative date of valuation manual.

For policies in force on or after the operative date of the valuation manual, a company shall submit mortality, morbidity, policyholder behavior or expense experience and other data as prescribed in the valuation manual.

History: 1978 Comp., § 59A-8A-10, enacted by Laws 2014, ch. 59, § 24.

59A-8A-11. Confidentiality.

A. As used in this section, "confidential information" includes:

(1) memoranda in support of opinions submitted pursuant to Sections 59A-8A-4 and 59A-8A-5 NMSA 1978 and other documents, materials and information, including all working papers and copies of those papers, that are produced or obtained by or disclosed to the superintendent or another person in connection with those memoranda;

(2) documents, materials and other information, including all working papers and copies of those papers, that are produced or obtained by or disclosed to the superintendent or another person in the course of an examination conducted pursuant to Subsection E of Section 59A-8A-8 NMSA 1978; provided, however, that if an examination report or other material prepared in connection with an examination pursuant to Sections 59A-4-5 through 59A-4-13 NMSA 1978 is not held as private and confidential information pursuant to Sections 59A-4-5 through 59A-4-13 NMSA 1978, an examination report made under Subsection E of Section 59A-8A-8 NMSA 1978 shall not be confidential information to the same extent as if the examination report or other material had been prepared pursuant to Sections 59A-4-5 through 59A-4-13 NMSA 1978;

(3) reports, documents, materials and other information that are developed by a company in support of or in connection with an annual certification by a company

pursuant to Paragraph (3) of Subsection B of Section 59A-8A-9 NMSA 1978 and that evaluate the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials and other information, including working papers and copies of those papers that are produced by, obtained by or disclosed to the superintendent or another person in connection with those reports, documents, materials or other information;

(4) principle-based valuation reports developed pursuant to Paragraph (4) of Subsection B of Section 59A-8A-9 NMSA 1978 and other documents, materials and other information, including all working papers and copies of those papers that are produced or obtained by or disclosed to the superintendent or another person in connection with those reports; and

(5) documents, materials, data and other information that are submitted by a company pursuant to Section 59A-8A-10 NMSA 1978 and all other documents, materials, data and other information, including all working papers and copies of those papers, that are created or produced in connection with experience data that include any potentially company- or person-identifying information and that is provided to or obtained by the superintendent or another person in connection with the submissions required by Section 59A-8A-10 NMSA 1978.

B. Except as provided in this section, a company's confidential information is confidential and is not subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. Nothing in this section shall be construed as a grant of privilege or confidentiality or a bar to production of that information by an insurer in a civil suit, whether or not the office of superintendent of insurance is a party; provided that the superintendent may use the documents, materials or other information in the furtherance of a regulatory or legal action brought as a part of the superintendent's official duties. Neither the superintendent nor another person who received documents, materials or other information while acting pursuant to the authority of the superintendent shall be permitted or required in a private civil action to testify on the confidential documents, materials or information subject to this subsection.

C. In order to assist in the performance of the superintendent's duties, the superintendent may share confidential information:

(1) with another state, federal or international regulatory agency and with the national association of insurance commissioners, its affiliates or its subsidiaries; and

(2) in the case of confidential information specified in Paragraphs (1) and (4) of Subsection A of this section:

(a) with the actuarial board for counseling and discipline or its successor if the actuarial board for counseling and discipline or its successor requests the confidential information and states that it is required for a professional disciplinary proceeding; and

(b) with a state, federal or international law enforcement official if that official has the legal authority to agree and does agree to maintain the confidentiality and privilege of the documents, materials, data and other information in the same manner and to the same extent as the superintendent.

D. The superintendent may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data and other information, from the national association of insurance commissioners, its affiliates or its subsidiaries, from regulatory or law enforcement officials of foreign or domestic jurisdictions and from the actuarial board for counseling and discipline or its successor. The superintendent shall maintain as confidential or privileged a document, materials, data or other information received with notice or the understanding that the content is confidential or privileged pursuant to the laws of the jurisdiction from which the information originates.

E. The superintendent may enter into agreements governing the sharing and use of information that are consistent with Subsections B through H of this section.

F. No waiver of an applicable privilege or claim of confidentiality in confidential information results from a disclosure to the superintendent pursuant to the provisions of this section or as a result of the sharing authorized by Subsection C of this section.

G. A privilege established by the laws of a state or jurisdiction that is substantially similar to the privilege established by Subsections B through H of this section shall be available and enforced in any official proceeding in, and in any court of, New Mexico.

H. For the purposes of this section, "regulatory agency", "law enforcement agency" and "national association of insurance commissioners" include the employees, agents, consultants and contractors of the entity.

I. Notwithstanding Subsections B through H of this section, the confidential information specified in Paragraphs (1) and (4) of Subsection A of this section:

(1) may be subject to subpoena for the purpose of defending an action seeking damages from an appointed actuary who submits a related memorandum in support of an opinion pursuant to Sections 59A-8A-4 and 59A-8A-5 NMSA 1978 or who submits a principle-based valuation report developed pursuant to Paragraph (4) of Subsection B of Section 59A-8A-9 NMSA 1978 if the submission is required by the Standard Valuation Law or the rules promulgated in furtherance of that law;

(2) may, with the written consent of the company, be released by the superintendent; and

(3) ceases to be confidential once a portion of a memorandum in support of an opinion submitted pursuant to Sections 59A-8A-4 and 59A-8A-5 NMSA 1978 or a principle-based valuation report developed pursuant to Paragraph (4) of Subsection B of

Section 59A-8A-9 NMSA 1978 is cited by the company in its marketing, publicly volunteered to a governmental agency other than a state insurance department or released by the company to the news media.

History: 1978 Comp., § 59A-8A-11, enacted by Laws 2014, ch. 59, § 25.

59A-8A-12. Single state exemption.

A. The superintendent may exempt from the requirements of Section 59A-8A-8 NMSA 1978 the specific product forms or product lines of a domestic company that is licensed and doing business only in New Mexico if:

(1) the superintendent has issued a written exemption to the company and has not subsequently revoked the exemption in writing; and

(2) the company computes reserves using the assumptions and methods used prior to the operative date of the valuation manual and using any requirements established by the superintendent and promulgated by rule.

B. For a company granted an exemption pursuant to this section, Sections 59A-8A-4, 59A-8A-6 and 59A-8A-7 NMSA 1978 apply. For a company that applies this exemption, a reference to Section 59A-8A-8 NMSA 1978 that is found in Sections 59A-8A-4, 59A-8A-6 and 59A-8A-7 NMSA 1978 does not apply.

History: 1978 Comp., § 59A-8A-12, enacted by Laws 2014, ch. 59, § 26.

ARTICLE 9
Investments

59A-9-1. Scope.

This article [Chapter 59A, Article 9 NMSA 1978], with exception of Section 160 [59A-9-27 NMSA 1978], applies only to domestic insurers.

History: Laws 1984, ch. 127, § 134.

59A-9-2. Eligible investments.

A. Insurers shall invest in or lend their funds on security of, and shall hold as invested assets, only eligible investments as prescribed in this article.

B. Any particular investment held by an insurer on effective date of the Insurance Code, which was a legal investment at time made and which the insurer was legally entitled to possess immediately prior to such effective date, shall be deemed an eligible investment.

C. Eligibility of an investment shall otherwise be determined as of date of making or acquisition.

D. Any investment limitation based upon the amount of the insurer's assets or particular funds shall relate to such assets or funds as shown by the insurer's annual statement as of December 31 next preceding date of acquisition of the investment, or as shown by a more recent financial statement resulting from merger of another insurer, bulk reinsurance or change of capitalization.

E. No insurer shall pay any commission or brokerage for purchase or sale of property in excess of that usual and customary at the time and in the locality where the purchase or sale is made.

History: Laws 1984, ch. 127, § 135.

59A-9-3. General qualifications.

A. No security or investment (other than real and personal property acquired under Section 59A-9-21 NMSA 1978) shall be eligible for acquisition by an insurer unless it is interest bearing or interest accruing or by its character entitled to dividends when declared and paid, or has other income-earning entitlement, is not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing thereon.

B. No security or investment shall be eligible for purchase at a price above its fair market value.

C. No provision of Chapter 59A, Article 9 NMSA 1978 shall prohibit acquisition by an insurer of other or additional securities or property if received as a dividend or lawful distribution of assets, or upon a debt or judgment, or under a lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any security or property so acquired which is not otherwise an eligible investment under this article shall be disposed of by the insurer pursuant to Section 59A-9-23 NMSA 1978 if real property, or pursuant to Section 59A-9-24 NMSA 1978 if personal property or securities.

D. Notwithstanding any other provision of law, a domestic insurance company may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation or the federal reserve book-entry system. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any member bank through which an insurance company holds securities in the federal reserve book-entry system, and the records of any custodian banks through which an

insurance company holds securities in a clearing corporation, shall at all times show that such securities are held for such insurance company and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation or in the federal reserve book-entry system without, in either case, physical delivery of certificates representing such securities. The superintendent of insurance is authorized to promulgate rules and regulations governing the deposit by insurance companies of securities with clearing corporations and in the federal reserve book-entry system.

(1) "Clearing corporation" means a corporation as defined in Section 55-8-102 NMSA 1978, except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "clearing corporation" may include a corporation which is organized or existing under the laws of any foreign country and is legally qualified under such laws to effect transactions in securities by computerized book-entry.

(2) "Direct participant" means a bank or trust company or other institution which maintains an account in its name in a clearing corporation and through which an insurance company participates in a clearing corporation.

(3) "Federal Reserve book-entry system" means the computerized systems sponsored by the United States department of the treasury and certain agencies and instrumentalities of the United States government and such agencies and instrumentalities, respectively, in federal reserve banks through banks which are members of the federal reserve system or which otherwise have access to such computerized systems.

(4) "Member bank" means a national bank, state bank or trust company which is a member of the federal reserve system and through which an insurance company participates in the federal reserve book-entry system.

(5) "Securities" means instruments as defined in Section 55-8-102 NMSA 1978.

History: Laws 1984, ch. 127, § 136; 1987, ch. 259, § 10.

59A-9-4. Authorization and record of investments.

A. An insurer shall not make any particular investment or loan (other than policy loans or annuity contract loans of a life insurer) unless the same is authorized or ratified by the insurer's board of directors, or other appropriate governing body if a reciprocal or Lloyd's insurer, or by a committee thereof charged with supervision of investments and loans. The minutes of any such committee shall be recorded and a report submitted to the board of directors or such other appropriate governing body, at the next meeting thereof.

B. The insurer shall maintain a full record of each investment showing, among other pertinent information, the name of any officer, director or principal stockholder or security holder of the insurer having any direct, indirect or contingent interest in the securities, loan or property constituting the investment, or in the person in whose behalf the investment is made, and the nature of such interest.

History: Laws 1984, ch. 127, § 137.

59A-9-5. Diversification.

An insurer shall invest in or hold as assets categories of investments only within applicable limits as follows:

A. one person: an insurer shall not at any one time have any combination of investments in or loans upon the security of obligations, property or securities of any one person (other than its lawful subsidiary) aggregating over ten percent of the insurer's assets. This shall not apply as to general obligations of the United States or of any state or of Canada or province thereof, or include policy loans made under Section 148 [59A-9-15 NMSA 1978] of this article, or bank deposits or certificates of deposit issued by banks. For purposes of this provision a corporation or other lawful entity together with its subsidiaries and affiliates shall constitute one person;

B. voting stock: an insurer shall not invest in or hold at any one time more than ten percent of the outstanding voting stock of any corporation, except as to voting rights of preferred stock during default of dividends. This subsection does not apply to stock of the insurer's subsidiary acquired under Section 145 [59A-9-12 NMSA 1978] of this article;

C. minimum capital: an insurer shall invest and maintain invested funds not less in amount than the minimum paid-in capital stock required under the Insurance Code of a domestic stock insurer transacting like kinds of insurance, only in cash and the securities provided for under the following sections of this article: Sections 139 [59A-9-6 NMSA 1978] (public obligations), 140 [59A-9-7 NMSA 1978] (obligations, stock of certain federal and international agencies), 141 [59A-9-8 NMSA 1978] (corporate obligations), and 147 [59A-9-14 NMSA 1978] (equipment trust certificates);

D. revenue bonds: an insurer shall not have invested at any time more than twenty percent of its assets in revenue bonds described in Sections 139 and 141 [59A-9-6 and 59A-9-8 NMSA 1978] of this article;

E. equipment trust certificates: an insurer shall not have invested at any time more than fifteen percent of its assets in equipment trust certificates described in Section 147 [59A-9-14 NMSA 1978] of this article;

F. real property encumbrances: an insurer shall not at any one time have more than thirty-five percent of its assets invested in obligations secured by real property

mortgages, trust deeds, contracts of purchase or other similar encumbrances of real property; and

G. other specific limits: limits as to investments in real property shall be as provided in Section 154 [59A-9-21 NMSA 1978] of this article; and other specific limits shall apply as stated in this article dealing with other respective kinds of investments.

History: Laws 1984, ch. 127, § 138.

59A-9-6. Public obligations.

A. Subject to Subsection B, below, an insurer may invest in bonds or other evidences of indebtedness, not in default as to principal or interest, which are valid and legally authorized obligations issued, assumed or guaranteed by the United States government or by any state thereof, or by Canada or any of the provinces thereof; or by any county, city, town, village, municipality or district therein or political subdivision thereof, or public instrumentality of one or more of the foregoing, if by statutory or other legal requirements applicable thereto such obligations are payable as to both principal and interest, from:

(1) taxes levied or required to be levied upon all taxable property or all taxable income within the jurisdiction of such governmental unit; or

(2) adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment; but not including any obligation payable solely out of special assessments on properties benefited by local improvements unless adequate security is evidenced by the ratio of assessment to value of the property or the obligation is additionally secured by an adequate guaranty fund or adequate source of revenue required by law.

B. No such investment shall be made in any bond or evidence of indebtedness rated lower than BAA by Moody's Investment Service, Inc. or BBB by Standard & Poors, Inc.

C. Bonds and similar obligations issued by any such governmental unit payable solely from revenues from special projects undertaken for air pollution control, exploitation of energy and other resources, transportation by pipeline or other means, and other similar projects, to be operated under lease or otherwise by one or more nongovernmental business entities, and such bonds or obligations guaranteed as to payment of principal and interest by such entities, are not deemed public obligations for purposes of this section. They shall be treated as obligations of the guarantors, and as to eligibility for investment of insurer funds are governed by Section 141 [59A-9-8 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 139.

59A-9-7. Obligations, stock of certain federal and international agencies.

An insurer may invest in the obligations, and stock where stated, issued, assumed or guaranteed by the following agencies of the United States government, or in which such government is a participant, whether or not the obligations are guaranteed by it:

A. farm loan bank;

B. commodity credit corporation;

C. federal intermediate credit banks;

D. federal land banks;

E. central bank for cooperatives;

F. federal home loan banks, and stock thereof;

G. federal national mortgage association, and stock thereof when acquired in connection with sale of mortgage loans to such association;

H. international bank for reconstruction and development;

I. inter-American development bank;

J. Asian development bank;

K. African development bank; and

L. any other similar agency of, or participated in by, the United States government and of similar financial quality.

History: Laws 1984, ch. 127, § 140; 1988, ch. 22, § 2.

59A-9-8. Corporate obligations.

A. An insurer may invest in the bonds, debentures or secured obligations of any solvent corporation organized and existing under the laws of any state, or of Canada or province thereof, which has been in existence and active business operation for not less than five (5) years, and which has not defaulted in payment of interest or principal of any of its obligations during the five (5) years prior to investment.

B. No insurer shall invest in any such bonds or evidences of indebtedness in excess of ten percent of any issue and related issues thereof or one hundred thousand dollars

($100,000), whichever is the larger, subject to Paragraph A of Section 138 [59A-9-5 NMSA 1978] (diversification) of this article.

History: Laws 1984, ch. 127, § 141.

59A-9-9. Preferred or guaranteed stocks.

A. An insurer may invest in preferred or guaranteed stocks or shares of any solvent institution existing under the laws of the United States or Canada, or any state or province thereof.

B. No insurer shall invest in any such preferred or guaranteed stock in an amount in excess of ten percent of any issue and related issues thereof, subject to Paragraph A of Section 138 [59A-9-5 NMSA 1978] (diversification) of this article, and subject to the limit of the insurer's investments in preferred, guaranteed and common stocks as stated in Subsection B of Section 143 [59A-9-10 NMSA 1978] (common stocks) of this article.

History: Laws 1984, ch. 127, § 142.

59A-9-10. Common stocks.

A. An insurer may invest in nonassessable (except as to bank or trust company stocks, and except for taxes) common stocks, other than insurance stocks, of any solvent corporation organized and existing under the laws of the United States or Canada, or of any state or province thereof, which has been in existence and active business operation for at least five (5) years prior to the investment; and if such corporation has had net earnings available for dividends on such stock in each of such five (5) years. If the issuing corporation has not been in legal existence for the whole of such five (5) years but was formed as a consolidation or merger of two or more businesses of which at least one was in operation on a date five (5) years prior to the investment, the test of eligibility of the common stock under this section shall be based upon consolidated pro forma statements of the predecessor or constitutuent [constituent] institutions.

B. An insurer shall not at any time have invested in preferred or guaranteed stocks or common stocks an aggregate of more than ten percent of its assets if a life insurer, or thirty-five percent of its assets if transacting kinds of insurance other than life insurance.

History: Laws 1984, ch. 127, § 143.

59A-9-11. Insurance stocks.

A. An insurer may invest in the stocks of other solvent insurers formed under the laws of this or another state, which stocks meet the applicable requirements of Section 142 [59A-9-9 NMSA 1978] (preferred or guaranteed stocks) or 143 [59A-9-10 NMSA 1978] (common stocks) of this article.

B. With the superintendent's advance written consent an insurer may acquire and hold controlling interest in or all outstanding voting stock of another such insurer. The superintendent shall not consent to any such acquisition if he finds it not in the best interests of the insurers involved, or of their respective policyholders or stockholders, or that the acquisition would materially tend to lessen competition or to result in any monopoly in the insurance business in this state.

C. Stock so acquired shall be included with other stock investments for the purpose of the limit of aggregate investments stated in Subsection B of Section 143 of this article.

History: Laws 1984, ch. 127, § 144.

59A-9-12. Investments in subsidiaries.

A. An insurer either by itself or in cooperation with one or more other business entities, may organize or acquire one or more subsidiaries engaged or to be engaged in any of the following businesses:

(1) an insurance business authorized by the jurisdiction in which the subsidiary is incorporated;

(2) acting as insurance producer for its parent or for any of its parent's insurer subsidiaries;

(3) investing, reinvesting or trading in securities for its own account, that of its parent, any subsidiary of its parent or any affiliate or subsidiary;

(4) management of any investment company registered pursuant to the federal Investment Company Act of 1940, as amended, including related sales and services;

(5) acting as a broker-dealer registered pursuant to the federal Securities Exchange Act of 1934, as amended;

(6) rendering investment advice to governments, government agencies, corporations or other organizations or groups;

(7) rendering other services related to operations of an insurance business;

(8) owning and managing assets that the parent corporation could itself own or manage;

(9) acting as administrative agent for a government instrumentality that is performing an insurance function; or

(10) financing insurance premiums, agents and other forms of consumer financing; and

(11) any other business activity determined by the superintendent to be reasonably ancillary to an insurance business.

B. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under all other sections of Chapter 59A, Article 9 NMSA 1978 an insurer may also:

(1) invest, in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries, amounts which unless otherwise approved by the superintendent do not exceed the lesser of ten percent of the insurer's assets or fifty percent of the insurer's surplus as regards policyholders, if, after the investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, there shall be included:

(a) total net money or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary, whether or not represented by the purchase of capital stock or the issuance of other securities; and

(b) all amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities and all contributions to the capital and surplus of a subsidiary subsequent to its acquisition or formation;

(2) if the insurer's total liabilities, as calculated for annual statement purposes, are less than ten percent of assets, invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries, if, after the investment, the insurer's surplus as regards policyholders, considering the investment as if it were a disallowed asset, will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs;

(3) invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries, if each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in Paragraph (1) of this subsection or in Chapter 59A, Article 9 NMSA 1978, applicable to the insurer. For the purpose of this paragraph "the total investment of the insurer" includes:

(a) any direct investment by the insurer in an asset; and

(b) the insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership of the subsidiary;

(4) with the approval of the superintendent, invest any amount in common stock, preferred stock, debt obligations or other securities of one or more subsidiaries, if, after the investment, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs; and

(5) invest any amount in the common stock, preferred stock, debt obligations or other securities of any subsidiary exclusively engaged in holding title to, or holding title to and managing or developing, real or personal property, if, after considering as a disallowed asset so much of the investment as is represented by subsidiary assets, which if held directly by the insurer would be considered as a disallowed asset, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, and if, following such investment, all voting securities of such subsidiary would be owned by the insurer.

C. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to Subsection B of this section shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this article applicable to the investments of the insurer.

D. Whether any investment made pursuant to Subsection B of this section meets the applicable requirements thereof is to be determined immediately after the investment is made, taking into account the then outstanding balance on all previous investments in debt obligations and the value of all previous equity securities as of the date they were made.

E. If an insurer ceases to control a subsidiary, it shall dispose of any investment made in it pursuant to this section within three years from time of the cessation of control or within such further time as the superintendent may prescribe, unless at any time after the investment is made, the investments meet the requirements for investment under any other section of the Insurance Code, and the insurer has so notified the superintendent.

History: Laws 1984, ch. 127, § 145; 2001, ch. 90, § 1; 2016, ch. 89, § 10.

59A-9-13. Common trust funds, mutual funds.

A. An insurer may invest in:

(1) a bank's common trust fund as defined in Section 584 of the United States Internal Revenue Code of 1954; and

(2) the securities of any open-end or closed-end management type investment company or investment trust registered under the federal Investment Company Act of 1940, as from time to time amended, if such investment company or trust has assets of not less than ten million dollars ($10,000,000) at date of the investment.

B. All such investments shall be considered as investment in common stocks for the purpose of the limit on aggregate investments imposed by Subsection B of Section 143 [59A-9-10 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 146.

59A-9-14. Equipment trust certificates.

An insurer may invest in equipment trust obligations or certificates adequately secured and evidencing an interest in transportation equipment, wholly or in part within or principally based within, the United States or Canada, which obligations or certificates carry the right to receive determined portions of rental, purchase or other fixed obligatory payments to be made for use or purchase of such transportation equipment.

History: Laws 1984, ch. 127, § 147.

59A-9-15. Policy loans.

A life insurer may lend to its policyholder or annuity contract holder, upon pledge of the policy or contract as collateral security, any sum not exceeding the cash surrender value of the policy or contract, or may lend against pledge or assignment of any of its supplementary contracts or other contracts or obligations, so long as the loan is adequately secured by such pledge or assignment.

History: Laws 1984, ch. 127, § 148.

59A-9-16. Collateral loans.

An insurer may invest in loans secured by deposits of collateral consisting of securities in which the insurer may otherwise invest under this article, if the current market value of such collateral is not less than twenty percent in excess of the amount of the loan. The amount so loaned shall be included pro rata in determining the maximum of funds permitted under this article to be invested in the respective categories of securities so pledged. The superintendent may by rule or regulation place reasonable limit upon such loans to a parent corporation, subsidiary or affiliate of the insurer.

History: Laws 1984, ch. 127, § 149.

59A-9-17. Savings and share accounts, time certificates.

An insurer may invest in share or savings accounts of state or federal savings and loan or building and loan associations, or in time certificates issued by any such association, and in any one such institution only to the extent that the investment is insured by the Federal Savings and Loan Insurance Corporation or similar federal agency.

History: Laws 1984, ch. 127, § 150.

59A-9-18. Miscellaneous investments.

A. An insurer may make loans or investments not otherwise expressly permitted under this article, in an aggregate amount not exceeding five percent of the insurer's assets and not exceeding one percent of such assets as to any one such loan or investment, if the loan or investment meets the requirements of Section 136 [59A-9-3 NMSA 1978] (general qualifications) of this article and by reason of safety of principal and yield otherwise qualifies as a sound investment. No such loan or investment shall be represented by:

(1) any item described in Section 119 [59A-8-2 NMSA 1978] (assets not allowed) of the Insurance Code or any loan or investment otherwise expressly prohibited;

(2) agents' balances, or amounts advanced to or owing by agents;

(3) any category of loans or investments expressly eligible under any other provision of this article; or

(4) any investment theretofore acquired or held by the insurer under any other category of loans or investments eligible under this article.

B. The insurer shall keep a separate record of all loans and investments made under this section.

History: Laws 1984, ch. 127, § 151.

59A-9-19. Special investments of separate account funds.

The amounts allocated to each separate account established with respect to variable life insurance and variable annuity contracts shall be invested and, together with the accumulations thereon reinvested, as provided for by the respective such contracts and in accordance with the provisions of Section 395 [59A-20-30 NMSA 1978] of the Insurance Code.

History: Laws 1984, ch. 127, § 152.

59A-9-20. Special investments of title insurers.

A. A title insurer having paid-in capital stock paid in cash of not less than one hundred thousand dollars ($100,000), may invest an amount not exceeding fifty percent of its subscribed capital stock, or paid-in basic capital surplus if a mutual insurer, in preparation and purchase of materials or plant necessary to enable it to engage in the title insurance business.

B. In all statements and proceedings for determination of the insurer's financial condition, such investments shall be valued at actual cost thereof or at such lesser value as the insurer may estimate, or be omitted entirely at the insurer's option.

History: Laws 1984, ch. 127, § 153.

59A-9-21. Real property.

A. An insurer may invest in real estate only if used for the purposes or acquired in the manner and within limits as follows:

(1) the building in which the insurer has its principal office and the land on which it stands, if the land is owned by the insurer or occupied under lease the terms of which are satisfactory to the superintendent, and if the superintendent has approved the title to the lands;

(2) such other real estate as is requisite for branch office or other business facilities necessary for the insurer's convenient accommodation in transaction of its business;

(3) real estate acquired in satisfaction or part payment of loans, mortgages, liens, judgments, decrees or debts previously owing to the insurer in due course of its business;

(4) real estate acquired in part payment of the consideration on sale of other real estate owned by the insurer, if such transaction has effected a net reduction in the insurer's real estate investments;

(5) real estate acquired by gift or devise, or through merger, consolidation or bulk reinsurance of another insurer or corporation under the Insurance Code;

(6) additional real estate and equipment incidental thereto, if necessary or convenient for enhancing the sale or other value of real estate previously acquired or held under this section; and

(7) real estate, or any interest therein, acquired or held by purchase, lease or otherwise, other than real estate to be used primarily for agricultural, ranch, mining, development of oil or mineral resources, recreational, amusement, hotel, motel or club

purposes, acquired as an investment for production of income, or acquired to be improved or developed for such investment purposes pursuant to an existing program therefor. The insurer may hold, mortgage, improve, develop, maintain, manage, lease and sell or trade real estate acquired by it under this paragraph. The insurer may elect to hold under the provisions of this paragraph real estate duly acquired or held by it under other provisions of this section.

B. Real estate of the insurer under this section shall not in its respective categories exceed the applicable percentage of the insurer's assets as follows:

(1) under Paragraph A(1), principal office, fifteen percent unless a larger percentage, but not to exceed twenty-five percent, is approved by the superintendent;

(2) under Paragraph A(2), branch office and facilities, five percent;

(3) under Paragraph A(7), investment purposes, ten percent; and

(4) the aggregate of all real estate holdings under all categories, twenty-five percent.

C. Real estate holdings of the insurer shall be subject to disposal as provided in Section 156 [59A-9-23 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 154.

59A-9-22. Real estate mortgages, deeds of trust.

A. An insurer may invest in bonds or notes secured by mortgages or deeds of trust representing first liens upon unencumbered and improved real estate located in this or another state, or in Canada, subject to the following conditions:

(1) the amount loaned, or aggregate amount of bonds issued upon the security of a mortgage or deed of trust, shall not at time of the investment exceed sixty-five percent of the fair market value of the real estate. The value of the real estate shall be substantiated by the appraisal of a recognized real estate appraiser acceptable to the superintendent. Before making the investment, a certificate of the value of the property, based on such appraisal, shall be executed by the insurer's board of directors or by an investment committee of the board of directors making or authorizing the investment on the insurer's behalf;

(2) there shall not have been any default as to payment of any part of the principal or interest of any such bond or note;

(3) the total investment in any one such note, or bond or bonds secured by the same real estate, shall not exceed seventy-five thousand dollars ($75,000) or ten percent of the insurer's assets, whichever is the greater; and

(4) in applying the limitation under this subsection there may be excluded from the amount invested that portion which is guaranteed by the superintendent for veteran affairs pursuant to the Servicemen's Readjustment Act of 1944 [repealed], as amended, or insured by the federal housing administrator or other agency of the United States government, or by an agency of the Canadian government.

B. "Improved real estate" means all real estate within limits of an incorporated village, town or city on which permanent buildings suitable for residence or commercial use are situated, and such other real estate as may be deemed to be "improved" for the purposes of this section under rules and regulations of the superintendent.

C. For purposes of this section real estate shall not be deemed to be encumbered:

(1) by existence of taxes or assessments which are not delinquent, instruments creating or reserving mineral, oil or timber rights, rights-of-way, joint driveways, sewer rights, rights in walls, or by building restrictions or other restrictive covenants; or

(2) when such real estate is subject to lease in whole or in part whereby rents or profits are reserved to the owner, if the security for such investment is a full and unrestricted first lien upon such real estate and there is no condition or rights of reentry or forfeiture under which the investment can be cut off, subordinated or otherwise disturbed.

D. A mortgage or deed of trust shall be deemed to represent a first lien upon the real estate for purposes of this section despite existence of a prior first mortgage or first deed of trust on the same real estate if the lending or investing insurer assumes and agrees to pay such prior first mortgage or deed of trust; and the balance owing on such prior first mortgage or deed of trust at time of the insurer's investment or loan, together with the additional amount loaned by the insurer on the security of the same real estate, shall be deemed to be the aggregate amount so invested by the insurer in the mortgage or deed of trust loan for purpose of limitations imposed thereon by this section and article.

E. Any such mortgage or deed of trust shall require the borrower to maintain insurance of improvements against the hazards of fire and those represented by extended coverage, for not less than seventy-five percent of the appraised value of the improvements.

History: Laws 1984, ch. 127, § 155.

59A-9-23. Time limit for disposal of real property.

A. Except as stated in Subsection B, or unless the insurer elects to hold the real estate as an investment under Paragraph A(7) of Section 154 [59A-9-21 NMSA 1978] of this article:

(1) an insurer shall dispose of real estate acquired under Paragraph A(1) of Section 154 of this article within five (5) years after it has ceased to be necessary for the convenient accommodation of the insurer in conduct of its business; and

(2) an insurer shall dispose of real estate acquired under Paragraphs A(2) through A(6) of Section 154 of this article within five (5) years after date of acquisition, unless used or to be used for the insurer's convenient accommodation in conduct of its business under Paragraph A(1) of that section.

B. Upon proof satisfactory to the superintendent that the interests of the insurer would suffer materially by forced sale thereof, the superintendent may by order grant a reasonable extension of the period, as specified in such order, within which the insurer shall dispose of any particular parcel of such real estate.

History: Laws 1984, ch. 127, § 156.

59A-9-24. Time limit for disposal of other ineligible property and securities.

Any personal property or securities lawfully acquired by an insurer which it could not otherwise have invested in or loaned its funds upon at time of acquisition shall be disposed of by the insurer within three (3) years from date of acquisition unless within such period the property or security has attained to the status of eligibility; but any personal property or security acquired under any agreement of bulk reinsurance, merger or consolidation may be retained for a longer period if so provided in the plan for such reinsurance, merger or consolidation as approved by the superintendent under Article 34 [Chapter 59A, Article 34 NMSA 1978] of the Insurance Code. Upon application by the insurer and proof that forced sale of any such property or security would materially injure the interests of the insurer, the superintendent may extend the disposal period for an additional reasonable time.

History: Laws 1984, ch. 127, § 157.

59A-9-25. Failure to dispose of property or securities; effect; penalty.

A. Any property or securities lawfully acquired, and held by an insurer after expiration of the period for disposal thereof and any extension of such period granted by the superintendent as provided in Sections 156 and 157 [59A-9-23 and 59A-9-24 NMSA 1978] of this article, shall not be allowed as an asset of the insurer.

B. The insurer shall forthwith dispose of any ineligible investments unlawfully acquired by it, and the superintendent shall suspend or revoke the insurer's certificate of authority if the insurer fails to dispose of the investment within such reasonable time as

the superintendent, by order, may specify. No such investment shall be allowed as an asset in determining the insurer's financial condition.

History: Laws 1984, ch. 127, § 158.

59A-9-26. Prohibited investments and investment underwriting.

A. In addition to investments excluded pursuant to other provisions of the Insurance Code, an insurer shall not acquire, invest in or lend upon the security of:

(1) issued shares of its own capital stock, except as provided in Section 568 [59A-34-22 NMSA 1978] of the Insurance Code (purchase of own shares by stock insurer). No such shares shall be deemed an asset of the insurer in any determination of its financial condition;

(2) securities issued by a corporation or enterprise the controlling interest of which is, or will after such acquisition by the insurer be, held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, subsidiaries or controlling stockholders (other than the parent corporation), and the spouses and children of any of the foregoing individuals. Investments in controlled insurance corporations or subsidiaries under Sections 144 and 145 [59A-9-11 and 59A-9-12 NMSA 1978] of this article are not subject to this section;

(3) any note or other evidence of indebtedness of any director, officer, employee or controlling stockholder of the insurer, or of the spouse or child of any of the foregoing individuals, except as to policy loans authorized under Section 148 [59A-9-15 NMSA 1978] of this article; or

(4) any real estate in which any officer or director or controlling stockholder (other than parent corporation) of the insurer has a financial interest.

B. No insurer shall underwrite or participate in underwriting of an offering of securities or property of any other person. This provision shall not prohibit the insurer from having a subsidiary which is a principal underwriter of a registered investment company (mutual fund).

C. No insurer shall enter into an agreement to withhold from sale any of its securities or property, and disposition of its assets shall at all times be within control of the insurer.

History: Laws 1984, ch. 127, § 159.

59A-9-27. Investments of foreign insurers.

The investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile if of a quality substantially equal to that required under this article for similar funds of like domestic insurers.

History: Laws 1984, ch. 127, § 160.

ARTICLE 10
Administration of Deposits; Trusteed Assets of Alien Insurer

59A-10-1. Authorized deposits.

The following deposits of insurers when made with the state treasurer through the superintendent shall be accepted and held in trust, subject to the provisions of Sections 161 through 170 [59A-10-1 to 59A-10-10 NMSA 1978] of this article:

A. deposits required under the Insurance Code for authority to transact insurance in this state;

B. deposits of domestic insurers when made pursuant to laws of other states, provinces or countries as requirement for authority to transact insurance therein; and

C. deposits in such additional amounts as permitted under Section 166 [59A-10-6 NMSA 1978] (excess deposits) of this article.

History: Laws 1984, ch. 127, § 161.

59A-10-2. Purpose of deposit.

A. Deposits made in this state pursuant to Sections 85 [59A-5-18 NMSA 1978] (general deposit), 86 [59A-5-19 NMSA 1978] (special deposit) or 87 [59A-5-20 NMSA 1978] (general deposit of alien insurer) of the Insurance Code shall be held in trust for the respective purposes stated in those sections.

B. A deposit made in this state by a domestic insurer transacting insurance in another state, province or country under the laws thereof shall be held for protection of all the insurer's policyholders or all its policyholders and creditors or for such other purpose or purposes as may be specified pursuant to such laws.

C. Deposits required under Section 100 [59A-5-33 NMSA 1978] (reciprocity provision) of the Insurance Code shall be held for purposes specified by the superintendent's order requiring the deposit to be made.

History: Laws 1984, ch. 127, § 162.

59A-10-3. Securities eligible for deposit.

A. All general deposits required under Section 59A-5-18 NMSA 1978 and special deposits required under Section 59A-5-19 NMSA 1978, in the minimum amount specified therefor, shall consist of public obligations of the type eligible for investment of funds of domestic insurers under Section 59A-9-6 NMSA 1978.

B. All additional general or special deposits required by the superintendent under Section 59A-5-18 or 59A-5-19 NMSA 1978 shall consist of:

(1) public obligations as referred to in Subsection A of this section;

(2) corporate obligations of the kind in which a domestic insurer may invest funds pursuant to Section 59A-9-8 NMSA 1978, if the security has such rating and additional qualifications as the superintendent may from time to time by rule or regulation reasonably prescribe for deposit purposes; and

(3) notes or bonds secured by mortgages insured and debentures issued by the federal housing administrator and obligations of national mortgage associations.

C. Evidences of indebtedness secured by real property shall be eligible for deposit only if the real property securing the indebtedness is situated in New Mexico.

D. Notwithstanding any other provision of law, the securities qualified for deposit under Chapter 59A, Article 10 NMSA 1978 by domestic insurance companies may be deposited with a clearing corporation or held in the federal reserve book-entry system. Securities deposited with a clearing corporation or held in the federal reserve book-entry system and used to meet the deposit requirements set forth in this article shall be under the control of the superintendent and shall not be withdrawn by the insurance company without the approval of the superintendent. Any insurance company holding securities in such manner shall provide to the superintendent evidence issued by its custodian or member bank through which such insurance company has deposited such securities in a clearing corporation or through which such securities are held in the federal reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank and that the records of the custodian, other participant or member bank reflect that such securities are held subject to the order of the superintendent.

E. Notwithstanding any other provision of law, securities eligible for deposit under the insurance laws of this state relating to deposit of securities by a foreign insurance company as a condition of commencing or continuing to do an insurance business in this state may be deposited with a clearing corporation or held in the federal reserve book-entry system. Securities deposited with a clearing corporation or held in the federal reserve book-entry system and used to meet the deposit requirements under the insurance laws of this state shall be under the control of the superintendent and shall not be withdrawn by the insurance company without the approval of the superintendent.

Any insurance company holding such securities in such manner shall provide to the superintendent evidence issued by its custodian or a member bank through which such insurance company has deposited securities with a clearing corporation or held in the federal reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank and evidence that the records of the custodian, other participant or member bank reflect that such securities are held subject to the order of the superintendent.

F. Deposits of a domestic insurer held in this state pursuant to the laws of another state, province or country (other than the general deposit provided for by Section 59A-5-18 NMSA 1978) shall consist of such assets as are required or permitted by the laws of such state, province or country.

G. Deposits of foreign insurers made in this state under Section 59A-5-33 NMSA 1978 shall consist of such assets as are required by the superintendent pursuant to such law.

History: Laws 1984, ch. 127, § 163; 1987, ch. 259, § 11; 2003, ch. 202, § 3.

59A-10-4. State treasurer as depository.

A. Deposits made in this state under the Insurance Code shall be made through the superintendent, and upon the superintendent's written order deposited with the state treasurer, who shall give receipt therefor and hold in trust deposits so made for the purpose or purposes made, subject to the applicable provisions of this article.

B. The state of New Mexico shall be responsible for safekeeping of all assets so deposited with the state treasurer, and shall bear the costs of the depository.

History: Laws 1984, ch. 127, § 164.

59A-10-5. Depositories designated by treasurer.

The state treasurer may designate any solvent trust company or other solvent financial institution having trust powers and with offices located in this state, as the state treasurer's depository to receive and hold any general, special or excess deposit of an insurer under Chapter 59A, Article 10 NMSA 1978. The deposit shall be so handled at the expense, if any, of the insurer, and the state of New Mexico shall not be responsible for safekeeping thereof.

History: Laws 1984, ch. 127, § 165; 2011, ch. 127, § 5.

59A-10-6. Excess deposits.

An insurer may deposit and maintain on deposit with the state treasurer through the superintendent, funds and securities eligible for deposit under this article in amount not over one hundred thousand dollars ($100,000) in excess of its required general deposit or special deposit, as the case may be, for purpose of absorbing fluctuations in value of assets held on deposit, and to facilitate exchange and substitution of such assets.

History: Laws 1984, ch. 127, § 166.

59A-10-7. Insurer's rights during solvency.

A. So long as the insurer remains solvent and is in compliance with the Insurance Code it may:

(1) demand, receive, and sue for and recover the income from the assets deposited;

(2) exchange and substitute eligible assets of equivalent or greater fair market value for the deposited assets; and

(3) at any reasonable time inspect any such deposit.

B. The superintendent may prescribe or approve reasonable arrangements and safeguards under which a solvent insurer may sell a particular deposited asset, immediately reinvest the proceeds of such sale in other assets eligible for deposit under this article, and deposit such other assets in lieu of that sold, in absence of excess deposit of the insurer adequate to cover such exchange.

History: Laws 1984, ch. 127, § 167.

59A-10-8. Replenishment of deposit.

If for any reason the market value of assets of the insurer held on deposit in this state falls below the amount required under the Insurance Code, the insurer shall promptly deposit other or additional eligible assets sufficient to cure the deficiency. If the insurer fails to cure the deficiency within a reasonable time after receipt of notice thereof from the superintendent, the superintendent shall revoke the insurer's certificate of authority.

History: Laws 1984, ch. 127, § 168.

59A-10-9. Release of deposit.

A. All general and special deposits of an insurer under the Insurance Code [Chapter 59A NMSA 1978] shall be released only as follows:

(1) upon extinguishment of all liabilities of the insurer for the security of which the deposit is held, by reinsurance contract or otherwise;

(2) upon the insurer ceasing to transact business in this state, and all of the liabilities for which the deposit was security have been satisfied or terminated, or assumed by another insurer authorized to transact insurance in New Mexico;

(3) if the insurer is subject to delinquency proceedings, upon proper order of a court of competent jurisdiction the insurer's deposited assets shall be released to the receiver, conservator, rehabilitator or liquidator of the insurer;

(4) upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer, and upon request of the domiciliary receiver, the deposit shall be released to the domiciliary receiver or to the applicable New Mexico guaranty association; or

(5) deposits held under Section 59A-10-6 NMSA 1978 shall be released in whole or in part to the insurer on the insurer's request while the insurer is solvent and its general or special deposit, as applicable, is otherwise in amount not less than that required of the insurer under the Insurance Code.

B. If the deposited assets are held pursuant to Section 59A-5-33 NMSA 1978, the deposit shall be released when the basis for such reciprocity no longer exists as to the deposit.

C. Release of a deposit shall be made only on application to and written order of the superintendent, made upon proof satisfactory to the superintendent of the existence of one or more of grounds for release stated in Subsection A of this section. The superintendent, before directing release of deposited assets, may require such evidence as the superintendent deems satisfactory that the release of the deposit, in whole or in part, should be made. In the case of special deposits, prior to release of the deposit pursuant to Paragraphs (3) and (4) of Subsection A of this section, the superintendent may require written assurances from the domiciliary receiver that the deposit will be handled in accordance with Section 59A-5-19 NMSA 1978 and applicable federal law.

History: Laws 1984, ch. 127, § 169; 2012, ch. 9, § 2.

59A-10-10. Special deposit bond in lieu, requirement of new bond.

If in the superintendent's opinion the solvency of any surety on a bond accepted under Section 86 [59A-5-19 NMSA 1978] of the Insurance Code in lieu of a special deposit has become impaired or doubtful, the superintendent shall so notify the principal on the bond and unless within ten (10) days thereafter the solvency of the surety is proved to the superintendent's satisfaction or a new acceptable bond substituted, or

eligible assets deposited in amount required and in lieu of bond, the superintendent shall revoke the certificate of authority of the insurer principal in such bond.

History: Laws 1984, ch. 127, § 170.

59A-10-11. Trusteed assets of alien insurer.

A. An alien insurer may use New Mexico as a state of entry to transact insurance in the United States by making and maintaining in this state a deposit of assets in trust with a bank or trust company domiciled in this state and designated or approved by the state treasurer and the superintendent and by obtaining a certificate of authority to transact the business of insurance in this state in accordance with Chapter 59A, Article 5 NMSA 1978.

B. The deposit shall be in an amount not less than as required of an alien insurer under Section 59A-5-20 NMSA 1978 and shall consist of assets eligible for deposit under Subsection B of Section 59A-10-3 NMSA 1978.

C. Such a deposit may be referred to as "trusteed assets".

History: Laws 1984, ch. 127, § 171; 1991, ch. 125, § 9.

59A-10-12. Purpose and duration.

The deposit of an alien insurer provided for in Section 171 [59A-10-11 NMSA 1978] of this article shall be held in trust for the benefit, security and protection of the policyholders, or policyholders and creditors, of the insurer in the United States, and shall be maintained as long as there is outstanding in the United States any liability of the insurer arising out of its insurance transactions therein.

History: Laws 1984, ch. 127, § 172.

59A-10-13. Trust agreement.

A. The deposit of an alien insurer referred to in Section 171 [59A-10-11 NMSA 1978] of this article shall be made and maintained under a written trust agreement between the insurer and trustee consistent with the requirements of Sections 171 through 179 [59A-10-11 to 59A-10-19 NMSA 1978] of this article, and shall be authenticated in such form and manner as the superintendent may designate or approve.

B. The trust agreement shall not be effective until filed with and approved in writing by the superintendent. The superintendent shall not approve any trust agreement found not in compliance with law, or terms of which do not in fact provide reasonably adequate protection for the insurer's policyholders or policyholders and creditors in the United States to the extent of the amount to be deposited. The trust agreement may be

amended, but amendment shall not be effective until filed with and approved in writing by the superintendent.

C. The superintendent may withdraw approval of a trust agreement or of any amendment thereof if he finds upon hearing, after due notice thereof to the insurer and the trustee, that the requisites for such approval, as provided in Sections 171 through 179 of this article do not in fact exist or no longer exist.

History: Laws 1984, ch. 127, § 173.

59A-10-14. Title; separation; accounting.

A. Title to the trusteed assets of such an alien insurer shall be vested in the trustee and its successors for the purposes of the trust deposit, and the trust agreement shall so provide.

B. The trustee shall keep the trusteed assets separate from its other assets, and shall maintain a record thereof sufficient to identify the trusteed assets at all times.

C. The trustee shall from time to time file with the superintendent its statement, in such form as the superintendent may designate or approve, certifying the character of the assets and the amounts and market value thereof. If the trustee fails to file the statement within a reasonable time after request therefor by the superintendent, the superintendent shall revoke the insurer's certificate of authority and immediately give written notice of such revocation to each other state in which, known to the superintendent, the insurer is transacting insurance business as either an authorized insurer or surplus line insurer.

History: Laws 1984, ch. 127, § 174.

59A-10-15. Examination of assets.

The superintendent may examine trusteed assets of any alien insurer at any time in accordance with the same conditions and procedures as govern examination of insurers in general under the Insurance Code.

History: Laws 1984, ch. 127, § 175; 1991, ch. 125, § 10.

59A-10-16. Withdrawal of assets.

A. The trust agreement of such an alien insurer shall provide in substance that no withdrawal of trusteed assets shall be made by the insurer or permitted by the trustee without written authorization or approval of the superintendent in advance thereof, except as follows:

(1) any or all income, earnings, dividends or interest accumulations of the trusteed assets may be paid over to the insurer's United States manager upon the insurer's written request; or

(2) for substitution, coincidentally with such withdrawal, of other eligible assets of value at least equal to that of assets being withdrawn, if the withdrawal is requested in writing by the insurer's United States manager under general or specific written authority from the insurer's board of directors or other similar governing body and a certified copy of such authority is filed with the trustee; or

(3) for the purpose of making deposits required by law in any state in which the insurer is or thereafter becomes an authorized insurer, for protection of its policyholders or policyholders and creditors in such state or in the United States, if such withdrawal does not reduce the insurer's deposit in this state below the minimum deposit required under Section 87 [59A-5-20 NMSA 1978] of the Insurance Code. The trustee shall transfer any assets so withdrawn and in amount so required to be deposited in the other state directly to the depository required to receive the deposit in the other state, as certified in writing by the public officer having supervision of insurance in that state; or

(4) for the purpose of transferring the trusteed assets to an official conservator, rehabilitator or liquidator under order of a court of competent jurisdiction.

B. The superintendent shall so authorize or approve withdrawal of only such assets as are in excess of the amount required to be held in trust under Section 87 of the Insurance Code, or as may otherwise be consistent with the provisions of Sections 171 through 179 [59A-10-11 to 59A-10-19 NMSA 1978] of this article.

C. If the insurer is no longer authorized to transact insurance under certificate of authority in any state, upon proof satisfactory to the superintendent that all of the insurer's liabilities arising out of its insurance transactions in the United States have been assumed by another insurer in such manner as to provide reasonable protection with respect thereto to the United States policyholders or policyholders and creditors of the withdrawing insurer, or such liabilities have otherwise terminated as to the withdrawing insurer, the superintendent shall authorize release of, and the trustee shall release, the trusteed assets to the withdrawing insurer or its successor in interest, or so much of such trusteed assets as the superintendent finds no longer reasonably required for protection of such policyholders or policyholders and creditors.

D. If the insurer becomes insolvent, or if its assets held in the United States are less than the sum of its liabilities in the United States arising from its insurance transactions therein and the amount of the required deposit, upon determination thereof the superintendent shall in writing order the trustee to suspend the right of the insurer or any other person to withdraw assets as authorized under Paragraphs (1), (2) and (3) of Subsection A of this section, and the trustee shall comply with such order until the superintendent's further order.

History: Laws 1984, ch. 127, § 176.

59A-10-17. Substitution of trustee.

With the superintendent's approval, a new trustee or new trustees may be substituted for the original trustee of trusteed assets of the alien insurer for any proper cause.

History: Laws 1984, ch. 127, § 177.

59A-10-18. Mexican, Canadian insurers.

Sections 171 through 179 [59A-10-11 to 59A-10-19 NMSA 1978] of this article applicable to a United States manager shall, in the case of insurers domiciled in Mexico or Canada, be deemed to refer to the president, vice-president, secretary, treasurer or other comparable officer of the insurer duly authorized by the insurer's board of directors or other similar governing body to act in behalf of the insurer as to the insurer's trusteed assets hereunder.

History: Laws 1984, ch. 127, § 178.

59A-10-19. Levy upon deposit.

No judgment creditor or other claimant of an insurer shall have the right to levy upon any of the assets or securities held in this state as a deposit for protection of the insurer's policyholders or policyholders and creditors. Levy upon deposits made pursuant to Section 100 [59A-5-33 NMSA 1978] (reciprocity provision) of the Insurance Code shall be permitted if so provided by the superintendent's order under which the deposit is required.

History: Laws 1984, ch. 127, § 179.

ARTICLE 11
Licensing Procedures for Producers and Others

59A-11-1. Scope of article.

A. Chapter 59A, Article 11 NMSA 1978 provides procedures for licensing insurance producers, surplus line brokers and adjusters; agents of prepaid dental plans; agents of nonprofit health care plans; bail bondsmen and their solicitors; registration of motor club representatives; licensing of insurance securities salespersons; and applications for, qualifying examinations, and issuance of, duration, continuation, and termination of all such licenses and registrations. For the purposes of that article, all such licenses and registrations are referred to as "licenses".

B. Chapter 59A, Article 11 NMSA 1978 shall also apply to all additional categories of persons operating in insurance fields and related fields as administrators, consultants, appraisers, or in whatever similar capacity, under laws now or hereafter enacted, the licensing and supervision of whom is delegated to the superintendent.

C. Definitions, requirement of licenses, qualifications for license, and other requirements and provisions as to insurance producers, adjusters, bail bondsmen and their solicitors, motor club representatives, and other categories referred to in Subsection B of this section, shall be as provided in subsequent articles in the Insurance Code now or hereafter respectively dealing with such categories; provided that "insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

History: Laws 1984, ch. 127, § 180; 2016, ch. 89, § 11.

59A-11-2. Application for license; individual.

A. Where a license is required under the Insurance Code [Chapter 59A NMSA 1978] for categories referred to in Section 59A-11-1 NMSA 1978, application by an individual shall be filed with, and on a form prescribed by, the superintendent. The application shall be signed by the applicant, under oath if required by the form.

B. The application form may require information about the applicant as to:

(1) name, date of birth, social security number or individual taxpayer identification number, residence and business address, if applicable;

(2) personal history, business experience in general;

(3) experience or special training or education in the kind of business to be transacted under the license applied for;

(4) previous licensing;

(5) type of license applied for and kinds of insurance or transactions to be covered thereby;

(6) proof of applicant's identity; and

(7) such other pertinent information and matters as the superintendent may reasonably require.

C. The application form shall also require information as to additional matters expressly required to be included therein in articles of the Insurance Code relating to particular licenses.

D. The application shall be accompanied by the applicable license application filing fee specified in Section 59A-6-1 NMSA 1978 and by the fee specified in such fee schedule for any examination required under the Insurance Code to be taken and passed by the applicant prior to licensing.

E. The superintendent may require a criminal history background investigation of the applicant for a license by means of fingerprint checks by the department of public safety and the federal bureau of investigation.

F. The superintendent may obtain from the department of public safety and the federal bureau of investigation, at the expense of the applicant for a license, criminal history information concerning each applicant, using the applicant's fingerprints or other identifying information. The information shall be used by the superintendent solely in determining whether to grant the application.

History: Laws 1984, ch. 127, § 181; 1999, ch. 272, § 3; 1999, ch. 289, § 4; 2001, ch. 297, § 1; 2003, ch. 202, § 4; 2021, ch. 70, § 2.

59A-11-3. Application by firm or corporation.

A. Where licensing of a firm (partnership) or corporation is otherwise provided for as to any category of licensees referred to in Section 180 [59A-11-1 NMSA 1978] of this article, application therefor shall be filed with the superintendent by the firm or corporation on form prescribed and furnished by the superintendent. The application shall be signed on behalf of the applicant by a partner or corporate officer thereunto duly authorized, and under oath if so required by the superintendent.

B. The application form may require information about applicant as follows:

(1) if a firm, the name, residence, proof of identity, business record and reputation, business experience of each partner and so much additional information concerning such individuals as required of applicants for license as individuals as the superintendent deems advisable;

(2) if a corporation, the name, residence, proof of identity, business record and reputation, business experience of each officer, member of the board of directors, controlling stockholder, and such additional information concerning such individuals as required of applicants for license as individuals as the superintendent deems advisable;

(3) evidence satisfactory to the superintendent that transaction of business proposed to be transacted under the license applied for is within the partnership agreement, if a firm, or within the corporate powers, if a corporation; and

(4) such further information concerning applicant, appointment of applicant, partners, corporate officers, directors, and stockholders, as the superintendent deems advisable.

C. If a firm, each individual who is not a bona fide general partner and who is to exercise license powers, and if a corporation, each individual, whether or not an officer, director, stockholder or in other relationship to the corporation, who is to exercise the license powers, shall file application as though for an individual license for the same kind of business as that applied for by the firm or corporation.

D. The application shall be accompanied by payment of the fee for filing application, fee for any examination required under the Insurance Code to be taken and passed prior to licensing, as such fees are prescribed in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code, and by any bond otherwise required as to the license applied for. An additional license application filing fee is required as to each individual in excess of one who is to exercise the license powers of a corporation, or license powers of a firm if not a general partner therein.

History: Laws 1984, ch. 127, § 182.

59A-11-4. Temporary licenses.

A. Where temporary license is otherwise provided for in the Insurance Code as to a particular category of licensee, application therefor shall be made in the same manner as applies to permanent license under Chapter 59A, Article 11 NMSA 1978 with such modification therein as the superintendent may prescribe, and without payment of examination fee.

B. The superintendent may issue a temporary insurance producer license for a period not to exceed one hundred eighty days without requiring an examination if the superintendent deems that the temporary license is necessary for the servicing of an insurance business in accordance with the Insurance Code.

History: Laws 1984, ch. 127, § 183; 2016, ch. 89, § 12.

59A-11-5. Vending machine licenses.

A. Where licensing of insurance vending machines is otherwise provided for in the Insurance Code application for the license shall be made by the licensed agent or other person designated by law therefor, and filed with the superintendent on a form as prescribed and furnished by the superintendent. The application form may require, among other matters, information as to the kind of insurance and policies to be so offered, type of vending machine to be used, where the machine is to be located, how the public is to be informed as to the coverage offered and its limitations, and arrangements made or proposed for refund of money retained by defective vending machines when no policy is delivered to the proposed purchaser.

B. The application shall be accompanied by the fee for filing application for vending machine license as prescribed in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code.

History: Laws 1984, ch. 127, § 184.

59A-11-6. Examination of applicant.

Where an applicant for a license is required to take and pass an examination prior to issuance of a license, the examination shall be subject to the following provisions:

A. the examination shall be made available to applicants for particular licenses at least once each month at places within New Mexico designated by the superintendent;

B. the examination shall require answers of the applicant to questions asked. If the applicant requests, the examination shall be administered in the Spanish language;

C. all examinations shall be conducted and graded in a fair and impartial manner and without unfair discrimination as between individuals examined;

D. a grade of not less than seventy is a passing grade;

E. an individual who has failed to pass an examination may take another examination at any subsequent scheduled examination date, except that an individual who has taken and failed to pass four of the same examinations shall not be entitled to take another examination until after six months after the date of the last examination failed;

F. an examination application fee, in the amount stated in Section 59A-6-1 NMSA 1978, or as provided for under Subsection H of this section, shall be paid for each examination;

G. the superintendent may cause to be prepared and made available to applicants a manual showing the general type and scope of the examination for any license for which examination is required;

H. the superintendent may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in Section 59A-6-1 NMSA 1978;

I. examinations shall be developed and conducted under rules promulgated by the superintendent;

J. each individual applying for an examination shall submit a nonrefundable fee as prescribed by the superintendent as set forth in Section 59A-6-1 NMSA 1978;

K. 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; and

L. a resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to Section 59A-12-16 NMSA 1978. 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.

History: Laws 1984, ch. 127, § 185; 2016, ch. 89, § 13.

59A-11-7. Character evaluation, criminal record.

The Criminal Offender Employment Act (28-2-1 to 28-2-6 NMSA 1978) shall govern any consideration of criminal record in connection with application for any license under this article.

History: Laws 1984, ch. 127, § 186.

59A-11-8. Issuance or refusal to issue or renew license.

A. If the superintendent finds that the application is complete, that the applicant has passed all required examinations and is otherwise qualified for the license applied for, the superintendent shall promptly issue, or permit the issuance of, the license.

B. If the superintendent denies an application for initial issuance or renewal of a license, the superintendent shall notify the applicant in writing and advise the applicant of the reason for the denial.

C. Within thirty days of the date of issuance of the denial of an application for initial issuance or renewal of a license, the applicant may request in writing a hearing on the denial. The hearing shall be held within thirty days and shall be held pursuant to the requirements of the Insurance Code.

D. The license of a business entity may be suspended, revoked or refused if the superintendent finds after hearing that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the superintendent nor corrective action taken.

History: Laws 1984, ch. 127, § 187; 2003, ch. 306, § 2; 2011, ch. 127, § 6; 2016, ch. 89, § 14.

59A-11-9. License contents; number required.

A. The license issued by the superintendent under Chapter 59A, Article 11 NMSA 1978 shall contain the licensee's name, business address, personal identification number, date of issue, lines of authority, expiration date and any other information the superintendent requires.

B. The license of an insurance producer shall not specify the name of any particular insurer or underwriter's department by which the licensee is appointed, and the licensee may represent as agent under the one license as many insurers or underwriter's departments as may appoint the licensee as agent under the Insurance Code subject to Section 59A-11-13 NMSA 1978 as to certain life or health insurance producers having unsettled debit balances with an insurer previously represented.

C. The license of a business entity shall also record the name of each individual authorized to exercise the license powers. The superintendent may require the names of each individual to be registered with the office of superintendent of insurance.

History: Laws 1984, ch. 127, § 188; 2016, ch. 89, § 15.

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.

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 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.

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.

History: Laws 1984, ch. 127, § 189; 1999, ch. 272, § 4; 1999, ch. 289, § 5; 2003, ch. 202, § 5; 2016, ch. 89, § 16.

59A-11-11. License and appointment continuation, expiration; staggered dates system.

The dates of continuation, expiration of licenses and appointments stated in Section 189 [59A-11-10 NMSA 1978] of this article notwithstanding, the superintendent may in his discretion and in order to apportion the work of the insurance department and others involved in licensing under this article reasonably throughout a period, by regulations duly promulgated fix the dates for continuance, renewal or expiration of licenses or appointments of the respective categories of licenses. No such change of date shall shorten the period covered by any license then existing and the superintendent may provide in such regulation for payment of a pro rata additional license or appointment fee to cover any extension of the period of the existing license to date of commencement of the new license period under the regulations.

History: Laws 1984, ch. 127, § 190.

59A-11-12. Appointment of insurance producer; continuation.

A. An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed insurance producer of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

B. To appoint an insurance producer as its agent, the appointing insurer shall file in a format approved by the superintendent a notice of appointment within fifteen days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint an insurance producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

C. Upon receipt of the notice of appointment, the superintendent shall verify within a reasonable time not to exceed thirty days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the superintendent shall notify the insurer within five days of its determination.

D. An insurer shall pay a filing appointment fee in the amount and method of payment set forth in Section 59A-6-1 NMSA 1978 for each insurance producer appointed by the insurer.

E. An insurer shall remit in a manner prescribed by the superintendent a continuation of appointment fee in the amount set forth in Section 59A-6-1 NMSA 1978.

F. Appointments shall be continuous subject to payment of any applicable fees. Fees shall be calculated as of a date certain.

History: Laws 1984, ch. 127, § 191; 2016, ch. 89, § 17.

59A-11-13. Insurance producers' rights; cancellation.

A. No insurer shall terminate a contract appointing an individual as an independent insurance producer without giving the insurance producer written notice of the termination, including the specific reason for such action, at least one hundred eighty days prior to the termination.

B. Notwithstanding the provisions of Subsection A of this section, no insurer may cancel a written agreement with an insurance producer with respect to property or casualty insurance because of an adverse loss-ratio experience on that insurance producer's book of business during any three full consecutive calendar years if:

(1) the insurer required the insurance producer to submit the application for underwriting approval, all material information on the application was fully completed and the insurance producer had not omitted or altered any information provided by the applicant; or

(2) the insurer accepted without prior approval policies issued by the insurance producer, if all material information on the application or on the insurer's copy of any policy issued by the insurance producer was fully completed and the insurance producer had not omitted or altered any information provided by the applicant.

C. The provisions of Subsection A or B of this section shall not apply to termination of a contract for insolvency, abandonment, gross or willful misconduct, failure to pay over to the company money due to the company under existing agency or company contract after receipt of a written demand therefor, fraud or intentional misrepresentation by the insurance producer, either to the insurer or to an insured, or after the insurance producer's license is revoked or otherwise terminated by the superintendent.

D. For one year following termination for any reason other than those set forth in Subsection C of this section, the insurance producer may renew, for a term of one year, any policies of the insurer in force at termination if the insureds meet current underwriting standards. The insurance producer shall earn a commission for such renewals at a rate not less than the rate in effect prior to termination.

E. For the purposes of this section:

(1) "independent insurance producer" means an insurance producer that is not an employee of an insurer and represents more than one insurer;

(2) "one insurer" includes any group of insurance companies under substantially the same management and control;

(3) "insurer" means any insurance company authorized to transact property or casualty insurance business in this state; and

(4) "policies" means all kinds of insurance, except life, health, annuities and credit life and health.

F. An individual who has suffered damages as a result of a violation of this section is granted a right to bring an action in district court to recover damages, including reasonable costs and attorney fees, if approved by the court.

G. An insurer or authorized representative of the insurer that terminates the appointment, employment contract or other insurance business relationship with an insurance producer shall notify the superintendent within thirty days following the effective date of the termination in the format prescribed by the superintendent, if the reason for termination is one of the reasons set forth in Section 59A-11-14 NMSA 1978 or the insurer has knowledge that the insurance producer was found by a court, government body or self-regulatory organization authorized by law to have engaged in any of the activities in Section 59A-11-14 NMSA 1978. Upon the written request of the superintendent, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the insurance producer.

H. An insurer or authorized representative of the insurer that terminates the appointment, employment or contract with an insurance producer for any reason not set forth in Section 59A-11-14 NMSA 1978 shall notify the superintendent within thirty days following the effective date of the termination, in the format prescribed by the superintendent. Upon written request of the superintendent, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

I. The insurer or the authorized representative of the insurer shall promptly notify the superintendent in the format prescribed by the superintendent if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the superintendent in accordance with Subsection G of this section had the insurer then known of its existence.

J. The insurer shall provide a copy of the notification of termination or cancellation to the insurance producer.

(1) Within fifteen days after making the notification required by Subsections G, H and I of this section, the insurer shall mail a copy of the notification to the insurance producer at the insurance producer's last known address. If the insurance

producer is terminated for any of the reasons listed in Section 59A-11-14 NMSA 1978, the insurer shall provide a copy of the notification to the insurance producer at the insurance producer's last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within thirty days after the insurance producer has received the original or additional notification of termination, the insurance producer may file written comments concerning the substance of the notification with the superintendent. The insurance producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the superintendent's file and accompany every copy of a report distributed or disclosed for any reason about the insurance producer subject to the conditions provided in Subsection K of this section.

K. The documents and materials related to termination or cancellation of an insurance producer's appointment shall be deemed confidential as follows:

(1) any documents, materials or other information in the control or possession of the office of superintendent of insurance that is furnished by an insurer, insurance producer or an employee or agent thereof acting on behalf of the insurer or insurance producer, or obtained by the superintendent in an investigation pursuant to this section, shall be confidential and shall not be subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. Nothing in this section shall be construed as a grant of privilege or confidentiality or a bar to production of that information by an insurer or the insurance producer in a civil suit, whether or not the superintendent is a party; provided that the superintendent may use the documents, materials or other information in a regulatory or legal action brought in the course of the superintendent's official duties. The documents, materials or other information shall not be made public by the superintendent or any other person, except to insurance departments of other states, unless the superintendent determines that the interests of the policyholders, shareholders or public will be served by the publication of them, in which case the superintendent may publish all or any part of them in the manner the superintendent deems appropriate;

(2) in order to assist in the performance of the superintendent's duties, the superintendent may:

(a) share documents, materials or other information, including the confidential documents, materials or information subject to this section, with other state, federal and international regulatory agencies, with the national association of insurance commissioners, its affiliates or subsidiaries and with state, federal and international law enforcement authorities; provided that the recipient agrees to maintain the confidentiality of the documents, materials or other information;

(b) receive documents, materials or information, including otherwise confidential documents, materials or information from the national association of insurance commissioners, its affiliates or subsidiaries and from regulatory and law

enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) enter into agreements governing sharing and use of information consistent with this subsection. The language in this subsection assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority that would presumably occur in the context of a broader information-sharing agreement;

(3) no waiver of any privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the superintendent under this section or as a result of sharing as authorized in this section; and

(4) nothing in this subsection shall prohibit the superintendent from releasing final adjudicated actions, including for-cause terminations that are open to public inspection pursuant to the Inspection of Public Records Act, to a database or other clearinghouse service maintained by the national association of insurance commissioners, its affiliates or subsidiaries of the national association of insurance commissioners.

L. An insurer, the authorized representative of the insurer or insurance producer that fails to report as required under the provisions of this section or that is found by a court of competent jurisdiction to have reported with actual malice may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with the Insurance Code.

History: Laws 1984, ch. 127, § 192; 1986, ch. 109, § 1; 1987, ch. 259, § 12; 1989, ch. 12, § 1; 2016, ch. 89, § 18.

59A-11-14. Suspension, revocation, refusal to continue license; grounds.

A. In addition to a reason provided under other provisions of the Insurance Code as to particular licenses, the superintendent may place on probation, suspend, revoke or refuse to issue or renew a license issued under Chapter 59A, Article 11 NMSA 1978 for any of the following reasons:

(1) providing incorrect, misleading, incomplete or materially untrue information in the license application;

(2) violating any insurance law or violating any regulation, subpoena or order of the superintendent or of another state's superintendent or commissioner of insurance;

(3) obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) improperly withholding, misappropriating or converting any money or properties received in the course of doing insurance business;

(5) intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(6) having been convicted of a felony;

(7) having admitted or been found to have committed any insurance unfair trade practice or fraud;

(8) using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(9) having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(10) forging another's name to an application for insurance or to any document related to an insurance transaction;

(11) improperly using notes or any other reference material to complete an examination for an insurance license;

(12) knowingly accepting insurance business from an individual who is not licensed;

(13) failing to comply with an administrative or court order imposing a child support obligation;

(14) failing to pay state income tax or comply with any administrative or court order directing payment of state income tax;

(15) any cause for which issuance of the license could have been refused had it then existed and been known to the superintendent;

(16) failure to pass an examination required by the superintendent, subsequent to issue of license, under Subsection D of Section 59A-11-10 NMSA 1978;

(17) aiding, abetting or assisting another person to violate a provision of the Insurance Code; or

(18) the interests of the insureds or the public are not being properly served under the license.

B. The superintendent may require a criminal history background investigation of an applicant or a current license holder by means of fingerprint checks by the department of public safety and the federal bureau of investigation, at the expense of the applicant or license holder, using the applicant's or license holder's fingerprints or other identifying information. The information shall be used by the superintendent solely in determining whether to suspend, revoke or refuse to continue a license.

History: Laws 1984, ch. 127, § 193; 2001, ch. 297, § 2; 2016, ch. 89, § 19.

59A-11-15. Procedure for suspension, revocation or refusal to continue license.

A. If the superintendent denies an initial or renewal application for a license, the superintendent shall notify the applicant in writing and advise the applicant of the reason for the denial or non-renewal of the application. Within thirty days of the date of issuance of the denial of application for initial issuance or renewal of a license, the applicant may request in writing a hearing on the denial. The hearing shall be held within ninety days and shall be held otherwise pursuant to Section 59A-4-15 NMSA 1978.

B. In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to an administrative fine according to Section 59A-1-18 NMSA 1978.

C. The superintendent shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this section against any person who is under investigation for or charged with a violation of this section even if the person's license or registration has been surrendered or has lapsed by operation of law.

D. The state shall participate in the national association of insurance commissioners attachment warehouse personal information capture system alerts or another appropriate mechanism to monitor actions against existing licensees and take necessary action, when warranted based on the information obtained through such notifications.

History: Laws 1984, ch. 127, § 194; 1978 Comp., § 59A-11-15, repealed and enacted by Laws 2016, ch. 89, § 20.

59A-11-16. Duration of suspension.

A. In the order suspending a license issued under this article, the superintendent shall, in addition to other matters required, state the period, not to exceed one (1) year, for which suspension is to be in effect. The period of suspension may be modified by

the superintendent's further order. At the end of the suspension period the license shall reinstate on request of the licensee, unless the superintendent finds that the cause or causes of the suspension, if of a continuing character, still exist or are likely to recur. If the superintendent so finds, he shall forthwith revoke the license by his further order.

B. During the period of suspension the licensee shall not engage in any transaction for which the license is required, other than receipt and remittance of premiums paid as to insurance or other business transacted under the license prior to the suspension.

History: Laws 1984, ch. 127, § 195.

59A-11-17. Administrative fine in lieu [of suspension, etc.].

In lieu of suspension, revocation or refusal to continue a license issued under this article the superintendent may levy an administrative fine upon the licensee in amount of not less than one hundred dollars ($100) nor more than five hundred dollars ($500). In the order levying the fine, the superintendent shall specify the grounds therefor and the period, not to exceed sixty (60) days, within which the licensee shall pay. If at the end of payment period so allowed the licensee has not paid to the superintendent the amount of the fine, the license shall stand suspended, revoked or renewal refused, as the case may be, as at the end of the period and without further order.

History: Laws 1984, ch. 127, § 196.

59A-11-18. Relicensing after revocation or refusal to continue.

The superintendent shall not relicense any former licensee whose license has been revoked or continuation refused until evidence has been presented showing to the superintendent's satisfaction that the former licensee is otherwise qualified for the license desired and that the cause or causes of the prior revocation or refusal to continue, if of continuing character, no longer exist and will not recur.

History: Laws 1984, ch. 127, § 197.

59A-11-19. Repealed.

History: Laws 1984, ch. 127, § 198; repealed by Laws 2016, ch. 89, § 70.

59A-11-20. License records.

The superintendent shall maintain a record of all licenses in force and insurance department transactions relative thereto. In addition to other matters, the record shall show name and address of licensee, date of issuance, kind of business to be transacted, name and address of insurer or other principal represented. Except as to privileged information and other matters withheld by the superintendent pursuant to

Sections 30 [59A-2-12 NMSA 1978] (records; inspection; destruction) or 55 [59A-4-11 NMSA 1978] (examination report; filing for public inspection; confidentiality) of the Insurance Code, the record shall be open to public inspection.

History: Laws 1984, ch. 127, § 199.

59A-11-21. Penalties.

In addition to any administrative penalty provided therefor under this article, any person who in application for license wilfully misrepresents or wilfully withholds requested material information, shall upon conviction thereof be guilty of a misdemeanor punishable by a fine not to exceed five hundred dollars ($500) unless the character of the offense is punishable as a greater offense under the general laws of this state.

History: Laws 1984, ch. 127, § 200.

59A-11-22. Duty to report.

A. A licensee shall report to the superintendent any administrative action taken against the licensee in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. The report shall include a copy of the order, consent to order or other relevant legal documents.

B. Within thirty days of the initial pretrial hearing date, a licensee shall report to the superintendent any criminal prosecution of the licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

History: Laws 2016, ch. 89, § 21.

59A-11-23. Reciprocity.

A. The superintendent shall waive any requirements for a nonresident license applicant with a valid license from the applicant's home state, except the requirements imposed by Section 23 [59A-11-24 NMSA 1978] of this 2016 act, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

B. A nonresident licensee's satisfaction of the nonresident licensee's home state's continuing education requirements shall constitute satisfaction of the continuing education requirements if the nonresident licensee's home state recognizes the satisfaction of its continuing education requirements imposed upon licensees from New Mexico on the same basis.

History: Laws 2016, ch. 89, § 22.

59A-11-24. Nonresident license; requirements.

A. Unless denied a license pursuant to Section 59A-11-14 NMSA 1978, a nonresident person shall receive a nonresident license if:

(1) the person is currently licensed as a resident in good standing in the person's home state;

(2) the person has submitted the proper request for licensure and has paid the fees required by Section 59A-6-1 NMSA 1978;

(3) the person has submitted or transmitted to the superintendent the application for licensure that the person submitted to the person's home state or a completed uniform application; and

(4) the person's home state awards nonresident licenses to residents of this state on the same basis.

B. The superintendent may verify an applicant's insurance producer licensing status through the insurance producer database maintained by the national association of insurance commissioners, its affiliates or subsidiaries.

C. A nonresident licensee who moves from one state to another state or a resident licensee who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty days of the change of legal residence.

D. Notwithstanding any other provision of this section, a person licensed as a surplus lines producer in the person's home state shall receive a nonresident surplus lines producer license pursuant to Subsection A of this section. Except as provided in Subsection A of this section, nothing in this section otherwise amends or supersedes any provision of Chapter 59A, Article 14 NMSA 1978.

E. Notwithstanding any other provision of this section, a person licensed as a limited lines credit insurance or other type of limited lines producer in the person's home state shall receive a nonresident limited lines producer license, pursuant to Subsection A of this section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state that restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to Subsection C of Section 59A-7-1 NMSA 1978.

History: Laws 2016, ch. 89, § 23.

ARTICLE 11A
Insurance Consultants

59A-11A-1. Insurance consultant; license required.

Unless licensed as an insurance consultant under the provisions of this act [59A-11A-1 to 59A-11A-8 NMSA 1978], no person shall:

A. for a fee received or to be received, offer to examine, examine or aid in examining any policy of insurance or any annuity or pure endowment contract for the purpose of giving or offering to give any advice, counsel, recommendation or information in respect to the terms, conditions, benefits, coverage or premium of any such policy or contract or in respect to the expediency or advisability of altering, changing, exchanging, converting, replacing, surrendering, continuing, renewing or rejecting any such policy or contract or of accepting or procuring any such policy or contract from any company; or

B. in or on advertisements, cards, signs, circulars or letterheads or elsewhere or in any other way or manner by which public announcements are made use the title "insurance consultant", "insurance advisor", "insurance specialist", "insurance counselor", "insurance analyst", "policyholders' advisor", "policyholders' counselor" or any other similar title or any title, word or combination of words indicating that he gives or is engaged in the business of giving advice, counsel, recommendation or information to holders of policies of insurance or annuity or pure endowment contracts.

History: Laws 1989, ch. 97, § 1.

59A-11A-2. Insurance consultant license; exemptions.

Nothing in this act [59A-11A-1 to 59A-11A-8 NMSA 1978] shall be construed to:

A. prohibit the customary advice offered by a licensed insurance agent or adjuster;

B. apply to a person admitted to the practice of law or permitted to engage in the practice of public accountancy in this state when the person is acting within the scope of that practice; or

C. require licensure of or otherwise apply to a salaried employee of a group or its service company as defined in the Group Self-Insurance Act [Chapter 52, Article 6 NMSA 1978].

History: Laws 1989, ch. 97, § 2.

59A-11A-3. Insurance consultant license; application; requirements for issuance; fee; renewal.

A. The superintendent shall issue a license as an insurance consultant to a person who:

(1) has reached the age of majority;

(2) files a written application in the manner and form prescribed by the superintendent, stating the lines of insurance for which the applicant desires a license;

(3) passes an examination as provided in Subsection B of this section;

(4) pays an application fee and an examination fee as specified in Section 59A-6-1 NMSA 1978; and

(5) satisfies the superintendent that the person is competent, financially responsible and of good moral character.

B. The superintendent shall examine all initial applicants for a license as an insurance consultant in the manner and form that the superintendent prescribes. The examination shall be of sufficient scope to demonstrate a broad knowledge of insurance contracts and the practices of the insurance industry in the lines of insurance for which the applicant desires a license. However, the superintendent may waive the requirement for the examination for:

(1) property and casualty insurance in the case of an applicant who has been awarded the professional designation of chartered property and casualty underwriter or certified insurance counselor in the property and casualty line;

(2) life and accident insurance in the case of an applicant who has been awarded the professional designation of chartered life underwriter; and

(3) all lines of insurance in the case of an applicant who has been awarded the professional designations of chartered property and casualty underwriter and chartered life underwriter.

C. If an applicant fails an examination, the applicant may be reexamined upon payment of a ten-dollar ($10.00) examination fee for each reexamination.

D. The license as an insurance consultant shall be issued for two years. The license may, at the discretion of the superintendent, be renewed biennially upon application and payment of a fee as specified in Section 59A-6-1 NMSA 1978.

History: Laws 1989, ch. 97, § 3; 2011, ch. 127, § 7.

59A-11A-4. Insurance consultant license; suspension or revocation; appeal; penalty.

A. The superintendent may revoke the license of an insurance consultant or suspend it for a period not exceeding the expiration date of the license for any good cause shown as provided in the Insurance Code. The superintendent shall revoke or suspend a license only upon notice and hearing as provided in the Insurance Code.

B. Any person aggrieved by the action of the superintendent in revoking, suspending or refusing to grant, renew or reissue a license may appeal that action to the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

C. The superintendent may at any time require such information as he deems necessary in respect to the business methods, policies and transactions of a licensee. Any person who fails or refuses to furnish the superintendent in the form he may require any such information within ten days after receiving a written request for it is guilty of a misdemeanor and upon conviction shall be fined not less than fifty dollars ($50.00) or more than five hundred dollars ($500).

History: Laws 1989, ch. 97, § 4; 1998, ch. 55, § 62; 1999, ch. 265, § 66.

59A-11A-5. Insurance consultants; contracts and agreements.

No contract or agreement with an insurance consultant for any advice, counsel, recomendation [recommendation] or other information provided within the scope of his license shall be enforceable by him unless:

A. it is in writing and executed in duplicate by the person to be charged or his legal representative;

B. the duplicate is delivered to or retained by the person to be charged when it is signed by him;

C. it plainly specifies the amount of the fee paid or payable by the person to be charged and the services to be rendered by the insurance consultant; and

D. it is in a form currently approved by the superintendent.

History: Laws 1989, ch. 97, § 5.

59A-11A-6. Insurance consultant; required acknowledgments.

A. An insurance consultant who furnishes any advice or counsel within the scope of his license as such a consultant, makes any recommendation or gives any information except under the terms of a previously executed written contract conforming to Section

4 [59A-11-4 NMSA 1978] of this act and in full force and effect shall upon furnishing such advice, counsel, recommendation or information give to the recipient thereof;

(1) a statement in writing, signed by the consultant, in a form currently approved by the superintendent, specifying the advice, counsel, recommendation or information given; and

(2) a receipt in a form currently approved by the superintendent for the fee paid to him or a statement in a form currently approved by the superintendent of the fee to be received by him.

B. Any person who violates any provision of Subsection A of this section is guilty of a misdemeanor and upon conviction shall be punished by a fine of not less than fifty dollars ($50.00) or more than five hundred dollars ($500).

History: Laws 1989, ch. 97, § 6.

59A-11A-7. Payment from insurers or insurance producers for sale of insurance prohibited; penalty.

A. No insurance consultant serving any person, firm, association, organization or corporation not engaged in the insurance business, for compensation paid or to be paid by the person served, shall directly or indirectly receive any part of any commission or compensation paid by any insurer or insurance producer of any insurer in connection with the sale or writing of any insurance that is within the subject matter of any such service.

B. Any person who violates any provision of Subsection A of this section is guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than five hundred dollars ($500) or by imprisonment in the county jail for a definite term of not less than thirty days or more than ninety days or both.

History: Laws 1989, ch. 97, § 7; 2016, ch. 89, § 24.

59A-11A-8. Acting as insurance consultant without a license prohibited; penalty.

Any person who acts as an insurance consultant without a license or during the suspension of his license is guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than five hundred dollars ($500) or by imprisonment in the county jail for a definite term not exceeding six months or both.

History: Laws 1989, ch. 97, § 8.

ARTICLE 12
Insurance Producers

59A-12-1. Purpose and scope of article.

Chapter 59A, Article 12 NMSA 1978, in conjunction with Chapter 59A, Article 11 NMSA 1978, governs the qualifications and procedures for the licensing of insurance producers. Chapter 59A, Article 12 NMSA 1978 does not apply to surplus lines brokers that are licensed pursuant to Chapter 59A, Article 14 NMSA 1978 and that sell, solicit or negotiate insurance in this state solely for placement with eligible surplus lines insurers, except as provided in Sections 22 and 23 [59A-11-23 and 59A-11-24 NMSA 1978] of this 2016 act.

History: Laws 1984, ch. 127, § 201; 2016, ch. 89, § 25.

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.

History: Laws 1984, ch. 127, § 202; 1978 Comp., § 59A-12-2, repealed and reenacted by Laws 2016, ch. 89, § 26; 2021, ch. 108, § 6.

59A-12-3. "Broker" defined.

For the purpose of the Insurance Code [Chapter 59A NMSA 1978], 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.

History: Laws 1984, ch. 127, § 203; 2016, ch. 89, § 27; 2021, ch. 108, § 7.

59A-12-4. License required.

A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of insurance in accordance with the Insurance Code.

History: Laws 1984, ch. 127, § 205; 1999, ch. 272, § 5; 1999, ch. 289, § 6; 2016, ch. 89, § 28.

59A-12-5. Repealed.

History: Laws 1984, ch. 127, § 206; repealed by Laws 2016, ch. 89, § 70.

59A-12-6. Repealed.

History: Laws 1984, ch. 127, § 207; 2003, ch. 202, § 6; 2007, ch. 282, § 6; repealed by Laws 2016, ch. 89, § 70.

59A-12-7. Exemptions from license requirements.

A. Nothing in Chapter 59A, Article 12 NMSA 1978 shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.

B. A license as an insurance producer shall not be required of the following:

(1) an officer, director or employee of an insurer or of an insurance producer; provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:

(a) the officer's, director's or employee's activities are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance;

(b) the officer's, director's or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(c) the officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

(2) a person who receives no commission and who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance, or enrolls individuals, issues certificates or otherwise assists in administering plans, or performs administrative services related to mass marketed property and casualty insurance;

(3) an employer or association or its officers, directors, employees or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contract;

(4) employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

(5) a person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state; provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(6) person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks

located in more than one state insured under that contract; provided that that person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(7) a salaried full-time employee who counsels or advises the employee's employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer; provided that the employee does not sell or solicit insurance or receive a commission.

History: Laws 1984, ch. 127, § 208; 1978 Comp., § 59A-12-7, repealed and reenacted by Laws 2016, ch. 89, § 29.

59A-12-8. Repealed.

History: Laws 1984, ch. 127, § 209; 1999, ch. 272, § 6; 1999, ch. 289, § 7; repealed by Laws 2016, ch. 89, § 70.

59A-12-9. Repealed.

History: Laws 1984, ch. 127, § 210; 1987, ch. 259, § 13; repealed by Laws 2016, ch. 89, § 70.

59A-12-10. Repealed.

History: 1978 Comp., § 59A-12-10, enacted by Laws 1997, ch. 48, § 1; 1999, ch. 272, § 7; 1999, ch. 289, § 8; 2001, ch. 309, § 1; 2013, ch. 74, § 18; repealed by Laws 2016, ch. 89, § 70.

59A-12-11. No license where shares or interest used as inducement to insurance.

The superintendent shall not license as an insurance producer, or permit any such license to continue, if the superintendent finds that the licensee did, or that the applicant for license intends to offer, give or sell stock or other ownership or participating interest in the agency or brokerage as inducement to or in connection with purchase of insurance.

History: Laws 1984, ch. 127, § 212; 2016, ch. 89, § 30.

59A-12-12. Application and general qualifications for individual insurance producer license.

A. An individual applying for a resident insurance producer license shall apply to the superintendent on the uniform application and declare under penalty of refusal,

suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the applicant's knowledge and belief.

B. Before approving the application, the superintendent shall:

(1) confirm that the applicant:

(a) is at least eighteen years of age;

(b) has not committed any act that is a ground for denial, suspension or revocation under the Insurance Code;

(c) has paid the fees set forth in Section 59A-6-1 NMSA 1978;

(d) has successfully passed the examinations for the lines of authority for which the application is made, if such examination is required; and

(e) is in compliance with other applicable qualifications and requirements of the Insurance Code;

(2) review the applicant's answers to the standard background questions on the uniform application;

(3) obtain the applicant's fingerprints; and

(4) conduct state and federal criminal background checks on the applicant.

C. The superintendent may require any documents reasonably necessary to verify the information contained in an application. The superintendent may obtain fingerprints from licensed resident insurance producers from whom fingerprints were not obtained at the time of application or when adding additional lines of authority to their license.

D. Each insurer that sells, solicits or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting or negotiating limited line credit insurance a program of instruction approved by the superintendent.

History: Laws 1984, ch. 127, § 213; 1999, ch. 272, § 8; 1999, ch. 289, § 9; 1978 Comp., § 59A-12-2, repealed and reenacted by Laws 2016, ch. 89, § 31.

59A-12-13. Special requirements, title insurance producers.

A. The superintendent shall not issue or permit to continue an insurance producer license for title insurance except for an applicant or a licensee who, in addition to other applicable qualifications and requirements, owns, operates or controls an abstract plant consisting of a set of records in which an entry has been made of all documents or

matters that under law impart constructive notice of matters affecting title to real property or any interest therein or encumbrance thereon, which have been filed or recorded in the county for which such title plant is maintained for a period of not less than twenty years immediately prior to date of application for license. Such records shall consist of:

(1) an index or indices in which notations of or references to any documents that describe property affected thereby are posted, entered or otherwise included, according to the property described therein, or copies or briefs of all documents that describe the property affected thereby that are sorted and filed according to such property; and

(2) an index or indices in which all other such documents are posted, entered or otherwise included, according to the name or names of the parties whose title to real property or any interest therein or encumbrances thereon is affected.

B. A license to issue title insurance shall permit the licensee to issue policies only on property located in the county or counties for which the licensee has the necessary abstract plant.

History: Laws 1984, ch. 127, § 214; 2016, ch. 89, § 32.

59A-12-14. Repealed.

History: Laws 1984, ch. 127, § 215; repealed by Laws 2016, ch. 89, § 70.

59A-12-15. Licensing business entities.

A. A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application. Before approving the application, the superintendent shall confirm that:

(1) the business entity has paid the fees set forth in Section 59A-6-1 NMSA 1978;

(2) the business entity has designated a licensed insurance producer responsible for the business entity's compliance with the insurance laws of this state; and

(3) a licensee who is to exercise license powers shall be affiliated by submitting an application. The application must be submitted with payment as required in Section 59A-6-1 NMSA 1978.

B. The application shall be signed on behalf of the applicant by an authorized partner or corporate officer, and under oath if required by the superintendent.

C. The application form may require the following information about the applicant:

(1) if the applicant is a partnership, the name, residence, proof of identity, business record and reputation, business experience of each partner and any other information required by the superintendent;

(2) if the applicant is a corporation, the name, residence, proof of identity, business record and reputation, business experience of each officer, member of the board of directors, controlling stockholder and any other information required by the superintendent;

(3) evidence satisfactory to the superintendent that transaction of business proposed to be transacted under the license applied for is within the partnership agreement, if the applicant is a partnership, or within the corporate powers, if the applicant is a corporation; and

(4) such further information concerning the applicant, appointment of the applicant, partners, corporate officers, directors and stockholders, as the superintendent may require.

D. If the applicant is a partnership, each individual who is not a general partner and who is to exercise license powers, and if the applicant is a corporation, each individual, whether or not an officer, director, stockholder or in other relationship to the corporation, who is to exercise the license powers, shall file an application as though for an individual license for the same kind of business as that applied for by the partnership or corporation.

E. The application shall be accompanied by payment of the application filing fee, fee for any examination required under the Insurance Code to be taken and passed prior to licensing and by any bond otherwise required for the license applied for. A license application filing fee is required for each individual who is to exercise the license powers of a corporation, or license powers of a partnership if not a general partner therein.

F. The business entity shall comply with all other licensing and registration requirements to do business in the state.

History: Laws 1984, ch. 127, § 216; 1999, ch. 272, § 9; 1999, ch. 289, § 10; 2016, ch. 89, § 33.

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.

History: Laws 1984, ch. 127, § 217; 1999, ch. 272, § 10; 1999, ch. 289, § 11; 2001, ch. 309, § 2; 2016, ch. 89, § 34; 2019, ch. 219, § 12; 2021, ch. 108, § 8.

59A-12-17. Scope of license.

A. Unless denied licensure pursuant to Sections 59A-11-8 and 59A-11-14 NMSA 1978, a person who has met the requirements of Sections 59A-12-12 and 59A-12-15 NMSA 1978 shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one or more of the following lines of authority:

(1) life insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;

(2) accident and health or sickness insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income;

(3) property insurance coverage for the direct or consequential loss or damage to property of every kind;

(4) casualty insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property;

(5) variable life and variable annuity products insurance coverage provided under variable life insurance contracts and variable annuities;

(6) personal lines property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(7) limited line credit insurance; and

(8) any other line of insurance permitted under state laws.

B. A licensee as to variable annuities or similar contracts deemed to constitute securities shall also possess license as a security salesman under other applicable state laws.

C. An insurance producer license shall remain in effect unless revoked or suspended as long as the fee set forth in Section 59A-6-1 NMSA 1978 is paid and education requirements for resident insurance producers are met by the due date.

D. An insurance producer who allows the insurance producer's license to lapse may, within twelve months from the due date of the renewal fee, reinstate the same license without the necessity of passing a written examination. However, a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date.

E. A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance may request a waiver of those procedures. The insurance producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

F. The license shall contain the licensee's name, address and personal identification number, the date of issuance, the lines of authority, the expiration date and any other information the superintendent deems necessary.

G. Licensees shall inform the superintendent in the format prescribed by the superintendent of a change of address within thirty days of the change. Failure to timely inform the superintendent of a change in legal name or address shall result in a penalty of fifty dollars ($50.00).

H. The superintendent may contract with non- governmental entities, including the national association of insurance commissioners or any affiliates or subsidiaries that the national association of insurance commissioners oversees, to perform any ministerial functions, including the collection of fees, related to insurance producer licensing that the superintendent and the nongovernmental entity may deem appropriate.

History: Laws 1984, ch. 127, § 218; 1999, ch. 272, § 11; 1999, ch. 289, § 12; 2013, ch. 140, § 1; 2016, ch. 89, § 35.

59A-12-18. Limited lines.

A. The superintendent may issue a limited insurance producer license to individual applicants employed full time by a vendor of merchandise or other property, or by a financial institution making consumer loans on terms with respect to which credit life insurance, credit disability insurance, credit property insurance or credit involuntary unemployment insurance under a master, corporate, group or individual policy is

customarily required of or offered to the purchaser or borrower, covering only that credit life, credit disability, credit property or credit involuntary unemployment insurance.

B. The superintendent may issue a limited insurance producer license to vendors in accordance with the provisions of the Portable Electronics Insurance Act [59A-60-1 to 59A-60-7 NMSA 1978]. The application shall provide:

(1) the name, residence address and other information required by the superintendent for an employee or officer of the vendor that is designated by the applicant as the individual responsible for the vendor's compliance with the requirements of the Portable Electronics Insurance Act. If the vendor derives more than fifty percent of its revenue from the sale of portable electronics insurance, the information noted above shall be provided for all officers, directors and shareholders of record having beneficial ownership of ten percent or more of any class of securities registered under the federal securities law; and

(2) the location of the applicant's home office.

History: Laws 1984, ch. 127, § 219; 2002, ch. 24, § 1; 2002, ch. 87, § 1; 2007, ch. 282, § 7; 2007, ch. 283, § 1; 2011, ch. 136, § 1; 2013, ch. 140, § 2; 2016, ch. 89, § 36.

59A-12-18.1. Limited lines travel insurance producer license.

A. The superintendent may issue a limited lines travel insurance producer license to applicants who are qualified to solicit or sell travel insurance.

B. A travel retailer may offer travel insurance under the license of a limited lines travel insurance producer only if:

(1) the limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

(a) a description of the material terms of the insurance coverage;

(b) a description of the process for filing a claim;

(c) a description of the travel insurance policy's cancellation process; and

(d) the identity and contact information of the insurer and limited lines travel insurance producer;

(2) the limited lines travel insurance producer:

(a) establishes at the time of licensure on a form prescribed by the superintendent a register of each travel retailer that offers travel insurance on behalf of the limited lines travel insurance producer;

(b) includes in the register each travel retailer's federal tax identification number and the name, address and contact information of each travel retailer and an officer or person who directs or controls the travel retailer's operations;

(c) maintains the register and updates it at least once a year;

(d) submits the register to the superintendent upon reasonable request; and

(e) certifies that each travel retailer on the register complies with federal laws;

(3) the limited lines travel insurance producer has selected a designated responsible agent who is one of its licensed individual insurance producer employees and who is responsible for the limited lines travel insurance producer's compliance with the travel insurance laws and rules of this state;

(4) the designated responsible agent, president, secretary, treasurer and all other officers or persons who direct or control the limited lines travel insurance producer's insurance operations comply with the fingerprinting requirements for insurance producers of the resident state of the limited lines travel insurance producer;

(5) the limited lines travel insurance producer has paid all applicable insurance producer licensing fees pursuant to state law; and

(6) the limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training that the superintendent may review and that, at a minimum, contains instructions on the types of insurance offered, ethical sales practices and required disclosures to prospective customers.

C. A travel retailer that offers and disseminates travel insurance shall make available to prospective purchasers brochures or other written materials that:

(1) identify and provide the contact information of the insurer and the limited lines travel insurance producer;

(2) explain that the purchase of travel insurance is not a prerequisite to the purchase of any other product or service of the travel retailer; and

(3) explain that an unlicensed travel retailer may provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

D. A travel retailer's employee or authorized representative who is not licensed as an insurance producer shall not:

(1) evaluate or interpret the technical terms, benefits or conditions of the travel insurance coverage offered;

(2) evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(3) make representation as being a licensed insurer, licensed insurance producer or insurance expert.

E. A travel retailer and its employees and authorized representatives whose insurance-related activities are limited to the offering and disseminating of travel insurance on behalf of and under the direction of a limited lines travel insurance producer that complies with this section may conduct and receive compensation for those activities.

F. A travel retailer may place insurance under an individual policy or under a group or master policy.

G. As the insurer designee, a limited lines travel insurance producer shall be responsible for the acts of the travel retailer and shall use reasonable means to ensure that the travel retailer complies with the provisions of this section.

H. As used in this section:

(1) "limited lines travel insurance producer" means a licensed managing general agent or third-party administrator or a licensed insurance producer;

(2) "offer and disseminate" means providing general information, including a description of coverage and price, processing applications, collecting premiums and performing other nonlicensable activities permitted by this state;

(3) "travel insurance" means insurance coverage for personal risks incident to planned travel, including the interruption or cancellation of a trip or event; the loss of baggage or personal effects; damage to accommodations or rental vehicles; or sickness, accident, disability or death during travel. "Travel insurance" does not include major medical plans that provide comprehensive medical protection for travelers on trips of six months or longer, such as for those working overseas as expatriates or deployed military personnel; and

(4) "travel retailer" means a business entity that makes, arranges or offers travel services.

History: Laws 2013, ch. 140, § 3; 2016, ch. 89, § 37.

59A-12-19. Temporary licenses.

A. The superintendent may issue a temporary insurance producer license for a period not to exceed one hundred eighty days without requiring an examination if the superintendent deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(1) to the surviving spouse or court- appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the insurance producer or for the recovery or return of the insurance producer to the business or to provide for the training and licensing of new personnel to operate the insurance producer's business;

(2) to a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(3) to the designee of a licensed insurance producer entering active service in the armed forces of the United States; or

(4) in any other circumstance where the superintendent deems that the public interest will best be served by the issuance of the license.

B. The superintendent may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The superintendent may require the temporary licensee to have a suitable sponsor who is a licensed insurance producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The superintendent may by order revoke a temporary license if the interest of insureds or the public is endangered. A temporary license shall not continue after the owner or the personal representative disposes of the business.

History: Laws 1984, ch. 127, § 220; 1978 Comp., § 59A-12-19, repealed and reenacted by Laws 2016, ch. 89, § 38.

59A-12-20. Place of business.

An insurance producer shall have and maintain a place of business accessible to the public where the licensee conducts transactions under the license. Nothing in this section shall prohibit maintenance of the place of business in the licensee's residence.

History: Laws 1984, ch. 127, § 221; 1999, ch. 272, § 12; 1999, ch. 289, § 13; 2003, ch. 306, § 3; 2016, ch. 89, § 39.

59A-12-20.1. Repealed.

History: Laws 2003, ch. 306, § 5; repealed by Laws 2016, ch. 89, § 70.

59A-12-21. Records of insurance producer.

A. Every insurance producer shall keep in the insurance producer's place of business complete records of transactions under the license. The record shall show the following information for each insurance policy placed by or through the licensee:

(1) the names of the insurer and insured;

(2) the number and expiration date of each policy;

(3) the premium payable for each policy;

(4) the names of all other persons from whom business is accepted or to whom commissions are promised or paid;

(5) all premiums collected; and

(6) any additional information the superintendent may require.

B. The records shall be open to the superintendent's examination, and the superintendent may at any reasonable time require the licensee to furnish, in the manner or form that the superintendent may require, any information kept or required to be kept in such records.

C. Records as to a particular policy may be destroyed on expiration of three years after the policy's expiration.

History: Laws 1984, ch. 127, § 222; 2016, ch. 89, § 40.

59A-12-22. Fiduciary funds; insurance producers, surplus line brokers, bail bondsmen, motor club agents and others.

A. All funds of others received by a person licensed or acting as an insurance producer, surplus line broker, bail bondsman or their solicitor, motor club agent or agent for a health care plan or prepaid dental plan, or in a similar capacity for which licensing of the person is required under the Insurance Code, are received and held by the person in a fiduciary capacity. Any person who diverts or appropriates funds to the person's own use, or takes or secretes with intent to embezzle, all without consent of the person entitled to the funds, is guilty of larceny by embezzlement.

B. Subject to the terms of any agreement between a person or licensee and the person's or licensee's principal or obligee, each person who does not make immediate remittance of funds to the insurer or other person entitled thereto shall elect and follow

as to funds received for account of a particular insurer or person either of the following methods:

(1) remit received premiums (less applicable commissions, if any) and return premiums to the insurer or other person entitled thereto within fifteen days after receipt; or

(2) establish and maintain in a commercial bank or other established financial institution depositary one or more accounts, separate from accounts holding general personal, firm or corporate funds, and forthwith deposit and retain therein pending transmittal to the insurer or other person entitled thereto all such premiums (net of applicable commissions, if any) and return premiums. Funds belonging to more than one principal may be as deposited and held in the same account so long as the amount held for each principal is readily ascertainable from the records of the depositor. The depositor may commingle with such fiduciary funds in a particular account such additional funds as the licensee deems prudent for advancing premiums, reserves for payment of return commissions or for other contingencies arising in the business of receiving and transmitting premiums or return premiums.

C. The person may commingle with the person's own funds to an unlimited amount funds of a particular principal who has in writing in advance expressly waived the segregation requirements of Subsection B of this section.

D. Any commingling of funds with funds of any person permitted under this section shall not alter the fiduciary capacity of the person as to funds of others.

History: Laws 1984, ch. 127, § 223; 2003, ch. 202, § 7; 2016, ch. 89, § 41.

59A-12-23. Insurance vending machines.

A. A licensed insurance producer may solicit for and issue personal travel accident insurance policies of an authorized insurer by means of mechanical vending machines supervised by the insurance producer and placed at airports and other places of convenience to the traveling public, if the superintendent finds that:

(1) the policy provides reasonable coverage and benefits, is suitable for sale and issuance by vending machine and use of such a machine in a proposed location would be of material convenience to the public;

(2) the type of machine proposed to be used is reasonably suitable for the purpose;

(3) reasonable means are provided for informing prospective purchasers of policy coverages and restrictions;

(4) reasonable means are provided for refund of money inserted in defective machines and for which insurance so paid for is not received; and

(5) the cost of maintaining such a machine at a particular location is reasonable.

B. For each machine to be used the superintendent shall issue to the applicant a special vending machine license. The license shall state the name and address of the insurer and insurance producer, name of the policy to be sold and serial number and operating location of the machine. The license shall be subject to biennial continuation, to expiration, suspension or revocation coincidentally with that of the insurance producer. The superintendent shall also revoke the license as to any machine as to which the superintendent finds that license qualifications no longer exist. Proof of existence of a subsisting license shall be displayed on or about each machine in use in the manner that the superintendent reasonably requires.

History: Laws 1984, ch. 127, § 224; 1999, ch. 272, § 13; 1999, ch. 289, § 14; 2016, ch. 89, § 42.

59A-12-24. Sharing of commissions.

A. An agent or broker shall share a commission or compensation for or on account of the solicitation or negotiation in this state of insurance on individuals or property or risks in this state only with the agent's duly licensed solicitor, or duly licensed agent of the insurer with which the insurance was placed, or duly licensed broker.

B. No such licensee shall share in commission or compensation as to a kind of insurance for which not licensed.

C. Such sharing in commissions and compensation between the same such licensees shall be infrequently only, and shall not unduly obviate the general necessity of appointment of the agent by the insurer with which the insurance is placed.

D. Nothing in the Insurance Code [Chapter 59A NMSA 1978] shall be deemed to prohibit payment, to or for the account of a former owner of an insurance agency or brokerage, of commissions or part thereof currently accruing on business of the agency or brokerage, as part of the purchase price of the agency or brokerage, whether or not such former owner is currently licensed as agent, solicitor or broker.

E. Nothing in the Insurance Code shall be deemed to prohibit the payment of a commission, compensation or other valuable consideration to the personal representative of the estate, their trust or beneficiary, of a deceased agent or broker or the heirs or devisees if the estate has been distributed, if that agent or broker would otherwise be entitled to that payment.

History: Laws 1984, ch. 127, § 225; 1999, ch. 272, § 14; 1999, ch. 289, § 15; 2017, ch. 37, § 1.

59A-12-25. Nonresident insurance producers; retaliation.

A. The superintendent may refuse to issue a license as an insurance producer to a resident of another state or country, who is otherwise qualified under Chapter 59A, Article 12 NMSA 1978 for license as an insurance producer in New Mexico, if under the laws of the other state or country licensed residents of this state are prohibited or prevented from acting as an insurance producer because of their residence.

B. As part of an application for a license, the nonresident applicant shall appoint the superintendent, on a form prescribed and furnished by the superintendent, as agent on whom may be served all legal process issued by a court in this state in any action against or involving the licensee as to transactions under the license. The appointment shall be irrevocable and continue for so long as an action could arise or exist. Duplicate copies of process shall be served upon the superintendent or other individual in apparent charge of the office of superintendent of insurance during the superintendent's absence, accompanied by payment of the process service fee specified in Section 59A-6-1 NMSA 1978. Upon service the superintendent shall promptly forward a copy by certified mail, return receipt requested, to the licensee at the licensee's last address of record with the superintendent. Process served and copy forwarded as so provided shall for all purposes constitute personal service upon the licensee.

C. The licensee shall likewise file with the superintendent written agreement to appear before the superintendent pursuant to notice of hearing, show cause order or subpoena issued by the superintendent and deposited, postage paid, by certified mail in a letter depository of the United States post office, addressed to the licensee at the licensee's last address of record with the superintendent, and that upon failure of the licensee to appear the licensee thereby consents to any subsequent suspension, revocation or refusal of the superintendent to continue the license.

History: Laws 1984, ch. 127, § 226; 1999, ch. 272, § 15; 1999, ch. 289, § 16; 2016, ch. 89, § 43.

59A-12-26. Continuing education.

A. The superintendent shall require as a condition to continuation of an insurance producer license that during the twenty-four months next preceding expiration of the current license period the licensee has attended the minimum number of hours of formal class instruction, lectures or seminars required and approved by the superintendent covering the kinds of insurance for which licensed.

B. Instruction shall be designed to refresh the licensee's understanding of basic principles and coverages involved, recent and prospective changes, applicable laws

and rules of the superintendent, proper conduct of the licensee's business and duties and responsibilities of the licensee.

C. The superintendent may permit licensees who because of remoteness of residence or business cannot with reasonable convenience attend formal instruction sessions to successfully complete an equivalent course of study and instruction online or by mail.

D. The superintendent may impose a penalty not to exceed fifty dollars ($50.00) for a licensee's failure to timely report continuing education credits.

E. The superintendent shall charge, at the time of certifying each licensee's continuing education credits as a condition of continuation of license, a fee of one dollar ($1.00) per credit hour of continuing education; provided that the superintendent may contract with an independent agency to receive and review continuing education compliance reports and, in such a case, the fee shall be a reasonable amount fixed by the superintendent and payable to the contracting agency.

F. This section shall not apply to holders of:

(1) limited license issued under Section 59A-12-18 NMSA 1978; and

(2) self-service storage insurance producer license.

History: Laws 1984, ch. 127, § 227; 1987, ch. 259, § 14; 1988, ch. 112, § 2; 1989, ch. 367, § 1; 1999, ch. 272, § 16; 1999, ch. 289, § 17; 2003, ch. 306, § 4; 2016, ch. 89, § 44; 2019, ch. 219, § 13.

59A-12-26.1. Insurance licensee continuing education fund.

There is created in the state treasury a fund that shall be known as the "insurance licensee continuing education fund". All fees imposed by the provisions of Section 59A-12-26 NMSA 1978 shall be deposited in the insurance licensee continuing education fund for the purpose of administering the continuing education program.

History: Laws 1988, ch. 112, § 1; 2016, ch. 89, § 45.

59A-12-27. Assumed names.

An insurance producer shall not do business under any name other than the insurance producer's legal name without prior written approval of the superintendent.

History: Laws 2016, ch. 89, § 46.

59A-12-28. Commissions.

A. An insurance company or insurance producer shall not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under Chapter 59A, Article 12 NMSA 1978 and is not so licensed.

B. A person shall not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under Chapter 59A, Article 12 NMSA 1978 and is not so licensed.

C. Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if the person was required to be licensed under Chapter 59A, Article 12 NMSA 1978 at the time of the sale, solicitation or negotiation and was so licensed at that time.

D. An insurer or insurance producer shall not pay or assign commissions, service fees, brokerages or other valuable consideration to an insurance agency or to persons who do not sell, solicit or negotiate insurance in this state.

History: Laws 2016, ch. 89, § 47.

59A-12-29. Compensation disclosure.

A. When any insurance producer or any affiliate of the insurance producer receives any compensation from a customer for the placement of insurance or represents the customer with respect to that placement, neither that insurance producer nor the affiliate shall accept or receive any compensation from an insurer or other third party for that placement of insurance unless the insurance producer has, prior to the customer's purchase of insurance:

(1) obtained the customer's documented acknowledgment that such compensation will be received by the insurance producer or affiliate; and

(2) disclosed the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of disclosure, the insurance producer shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount.

B. Subsection A of this section does not apply to an insurance producer who:

(1) does not receive compensation from the customer for the placement of insurance;

(2) represents an insurer that has appointed the insurance producer in connection with that placement of insurance; and

(3) discloses to the customer prior to the purchase of insurance:

(a) that the insurance producer will receive compensation from an insurer in connection with that placement; or

(b) that, in connection with that placement of insurance, the insurance producer represents the insurer and that the insurance producer may provide services to the customer for the insurer.

C. A person shall not be considered a customer for purposes of this section if the person is merely:

(1) a participant or beneficiary of an employee benefit plan; or

(2) covered by a group or blanket insurance policy or group annuity contract sold, solicited or negotiated by the insurance producer or affiliate.

D. This section does not apply to:

(1) a person licensed as an insurance producer who acts only as an intermediary between an insurer and the customer's insurance producer, for example, a managing general agent, a sales manager or wholesale broker; or

(2) a reinsurance intermediary.

E. For purposes of this section:

(1) "compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes or any other form of valuable consideration, whether or not payable pursuant to a written agreement; and

(2) "documented acknowledgment" means the customer's written consent obtained prior to the customer's purchase of insurance. In the case of a purchase over the telephone or by electronic means for which written consent cannot reasonably be obtained, consent documented by the producer shall be acceptable.

History: Laws 2016, ch. 89, § 48.

ARTICLE 12A
Insurance Administrators

59A-12A-1. Scope of the article.

Chapter 59A, Article 12A NMSA 1978 shall apply to all administrators who provide administrative services in connection with insurance or alternatives to insurance or who, in a fiduciary capacity or otherwise, manage or handle funds, money, premiums, fees or other forms of consideration in connection with insurance or alternatives to insurance. That article shall also apply to the claims practices of insurers or alternatives to insurance, whether or not they are administered by a third party.

History: 1978 Comp., § 59A-12A-1, enacted by Laws 1989, ch. 374, § 1.

59A-12A-2. Definitions.

As used in Chapter 59A, Article 12A NMSA 1978:

A. unless otherwise specified in that article, all definitions of the Insurance Code apply;

B. "administrator" or "third party administrator" or "TPA" means a business entity that receives any form of administrative or service fee, consideration, payment, premium, reimbursement or compensation for performing or providing any service, function or duty, or activity respecting insurance or alternatives to insurance in any administrative or management capacity, including but not limited to claims or expense review, underwriting, administration and management under a contract or other agreement to be performed in this state or with respect to risks located or partially located in this state or on behalf of persons in this state for any:

(1) plan;

(2) insurance carrier; or

(3) person that self insures;

C. "administrator" does not include:

(1) an employer on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of that employer as long as only the functions of a group policyholder are performed;

(2) a union on behalf of its members as long as only the functions of a group policyholder are performed;

(3) an insurance company or a corporation that owns more than fifty percent of an insurance company licensed in this state or a health maintenance organization, nonprofit health care plan or a dental plan that is licensed in this state;

(4) an insurance producer licensed in this state acting on behalf of an admitted insurance carrier by whom the insurance producer is appointed and only within

the scope of the insurance producer's license as an insurance producer as defined in the article of the Insurance Code under which the insurance producer is licensed;

(5) a creditor on behalf of its debtors with respect to insurance covering its debtors as long as only the functions of a group policyholder or creditor are performed;

(6) a trust and its trustees, agents and employees acting under the trust, established in conformity with 29 U.S.C. Sec. 186;

(7) a trust exempt from taxations under Section 501(a) of the Internal Revenue Code of 1986, and its trustees and employees acting under the trust, or a custodian and its agents and employees acting pursuant to a custodian account that meets the requirements of Section 401(f) of the Internal Revenue Code of 1986;

(8) a bank that is subject to supervision or examination by federal or state regulatory authorities as long as the bank is only performing the function for which it is licensed;

(9) a company that advances and collects any premium or charge from its credit card holders who have authorized it to do so, provided the company does not adjust or settle claims and acts only in its debtor-creditor relationship with its credit card holders;

(10) a person who adjusts or settles claims in the normal course of practice or employment as an attorney at law who does not collect any charge or premium in connection with life or health coverage or annuities;

(11) an adjuster licensed by the superintendent, when engaged in the performance of duties as an adjuster;

(12) any joint fund, risk management pool or self-insurance pool composed of political subdivisions of this state that participate in such funds or pools through interlocal agreements, and any administrative agency established under the interlocal agreement to administer the fund or pool;

(13) a person providing technical, advisory or consulting services who does not make management or discretionary decisions on behalf of an insurance carrier, plan or person that self-insures;

(14) a full-time salaried employee of an insurance carrier to the extent that the functions performed are only for that insurance carrier or any affiliated carrier;

(15) attorneys in fact for a Lloyd's or reciprocal exchange as authorized respectively in Chapter 38 or 39 NMSA 1978, while acting as attorney in fact for such Lloyd's or reciprocal exchange;

(16) a certified public accountant, attorney at law or actuary when performing duties or undertaking responsibilities within the authority and scope of that particular profession;

(17) an association and any subsidiary, affiliated or related corporations of that association. For the purposes of this subsection, "association" means a bona fide trade or professional association which has been in existence for not less than five years and which enters into agreements to pool its liabilities for workers compensation benefits, pursuant to the Group Self-Insurance Act [Chapter 52, Article 6 NMSA 1978]; or

(18) a home owner warranty corporation provided by a trade association that has been in business in New Mexico for at least five years;

D. "alternatives to insurance" means an agreement to indemnify against loss, risk, damage, liability or other contingency relating to property or persons, whether or not such agreement is deemed to be insurance under applicable law or where persons self insure;

E. "bank" means a bank, savings and loan association, credit union or other financial institution authorized by law to accept and maintain deposits;

F. "business entity" means a corporation, organization, government or governmental subdivision or agency, business trust, estate trust, partnership, association or any other legal entity; and

G. "plan" means any employer-employee, multiple employer-employee, group, member or other employee benefit or welfare program, medical, accident, sickness, injury, indemnity, death or health benefit program contracting to provide indemnification or expense reimbursement in this state to persons domiciled in this state or for risks located or partially located in this state for any type of the following coverages, expenses or benefits: medical, surgical, orthopedic, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, workers' compensation or optometric plan or programs, hospital care or benefit or benefits in the event of sickness, accident, disability, death or unemployment, or prepaid legal services.

History: 1978 Comp., § 59A-12A-2, enacted by Laws 1989, ch. 374, § 2; 2016, ch. 89, § 49.

59A-12A-3. License required; penalty.

A. No administrator shall perform or provide any service, function, duty or activity respecting any insurance, plan, self-insurance or alternatives to insurance in an administrative or management capacity in this state or with respect to risks located or partially located in this state or on behalf of persons in this state unless licensed as an administrator under the Insurance Code.

B. Licensing procedures for administrators shall be in accordance with Chapter 59A, Article 11 NMSA 1978.

C. In addition to any applicable denial, suspension or revocation of a license, refusal to continue license or administrative fine, violation of this section shall be a misdemeanor punishable by a fine not to exceed one thousand dollars ($1,000) and by forfeiture to the state of an amount equal to all compensation for services as administrator received or to be received by the violator by reason of the prohibited transactions.

History: 1978 Comp., § 59A-12A-3, enacted by Laws 1989, ch. 374, § 3; 2016, ch. 89, § 50.

59A-12A-4. Written agreement necessary.

A. No administrator shall act as such without a written agreement between the administrator and the insurer, and the written agreement shall be retained as part of the official records of both the insurer and the administrator for the duration of the agreement and five years thereafter. The written agreement shall contain provisions which include the requirements of Chapter 59A, Article 12A NMSA 1978, except insofar as those requirements do not apply to the functions performed by the administrator.

B. When a policy is issued to a trustee or trustees, a copy of the trust agreement and any amendments thereto shall be furnished to the insurer by the administrator and shall be retained as part of the official records of both the insurer and the administrator for the duration of the policy and five years thereafter.

History: 1978 Comp., § 59A-12A-4, enacted by Laws 1989, ch. 374, § 4.

59A-12A-5. Payment to administrator.

Whenever an insurer utilizes the services of an administrator under the terms of a written contract as required in Section 59A-12A-4 NMSA 1978, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured shall be deemed to have been received by the insurer, and the payment of return premiums or claims by the insurer to the administrator shall not be deemed payment to the insured or claimant until such payments are received by the insured or claimant. Nothing in this section limits any right of the insurer against the administrator resulting from its failure to make payments to the insurer, insured or claimants.

History: 1978 Comp., § 59A-12A-5, enacted by Laws 1989, ch. 374, § 5.

59A-12A-6. Maintenance of information.

Every administrator shall maintain at its principal administrative office for the duration of the written agreement referred to in Section 59A-12A-4 NMSA 1978 and five

years thereafter adequate books and records of all transactions between it, insurers and insured persons. Such books and records shall be maintained in accordance with prudent standards of insurance record keeping. The superintendent shall have access to such books and records for the purpose of examination, audit and inspection. Any trade secrets contained therein, including but not limited to the identity and addresses of policyholders and certificate holders, shall be confidential, except that the superintendent may use such information in any proceedings instituted against the administrator. The insurer shall retain the right to continuing access to such books and records of the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and administrator on the proprietary rights of the parties in such books and records.

History: 1978 Comp., § 59A-12A-6, enacted by Laws 1989, ch. 374, § 6.

59A-12A-7. Approval of advertising.

An administrator may use only such advertising pertaining to the business underwritten by an insurer, plan or alternative to insurance as has been approved by such insurer, plan or alternative to insurance in advance of its use.

History: 1978 Comp., § 59A-12A-7, enacted by Laws 1989, ch. 374, § 7.

59A-12A-8. Underwriting provision.

The agreement required under Section 59A-12A-4 NMSA 1978 shall make provision with respect to the underwriting or other standards pertaining to the business underwritten by such insurer.

History: 1978 Comp., § 59A-12A-8, enacted by Laws 1989, ch. 374, § 8.

59A-12A-9. Premium collection.

A. All insurance charges or premiums collected by an administrator on behalf of or for an insurer or insurers, and return premiums received from such insurer or insurers, shall be held by the administrator in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled thereto or shall be deposited promptly in a fiduciary bank account established and maintained by the administrator. If charges or premiums so deposited have been collected on behalf of or for more than one insurer, the administrator shall cause the bank in which such fiduciary account is maintained to keep records, clearly recording the deposits in and withdrawals from such account on behalf of or for each insurer.

B. The administrator shall promptly obtain and keep copies of all such records and, upon request of an insurer, shall furnish that insurer with copies of all records pertaining to deposits and withdrawals on behalf of or for such insurer.

C. The administrator shall not pay any claim by withdrawals from such fiduciary account. Withdrawals from such account shall be made, as provided in the written agreement between the administrator and the insurer, for:

(1) remittance to an insurer entitled thereto;

(2) deposit in an account maintained in the name of such insurer;

(3) transfer to and deposit in a claims paying account, with claims to be paid as provided in Section 59A-12A-10 NMSA 1978;

(4) payment to a group policyholder for remittance to the insurer entitled thereto;

(5) payment to the administrator of its commission, fees or charges; or

(6) remittance of return premiums to the person or persons entitled thereto.

History: 1978 Comp., § 59A-12A-9, enacted by Laws 1989, ch. 374, § 9.

59A-12A-10. Payment of claims.

All claims paid by the administrator from funds collected on behalf of the insurer shall be paid only on drafts of and as authorized by such insurer.

History: 1978 Comp., § 59A-12A-10, enacted by Laws 1989, ch. 374, § 10.

59A-12A-11. Claim adjustment or settlement.

With respect to any policies where an administrator adjusts or settles claims, the compensation to the administrator with regard to such policies shall in no way be contingent on claim experience. No provision of Chapter 59A, Article 12A NMSA 1978 prevents the compensation of an administrator from being based on premiums or charges collected or number of claims paid or processed.

History: 1978 Comp., § 59A-12A-11, enacted by Laws 1989, ch. 374, § 11.

59A-12A-12. Notification required.

Where the services of an administrator are utilized, the administrator shall provide a written notice approved by the insurer to insured individuals advising them of the identity of and relationship among the administrator, the policyholder and the insurer. Where an administrator collects funds, it shall identify and state separately in writing to the person paying to the administrator any charge or premium for insurance coverage and the amount of any such charge or premium specified by the insurer for such insurance coverage.

History: 1978 Comp., § 59A-12A-12, enacted by Laws 1989, ch. 374, § 12.

59A-12A-13. Business name.

Each administrator shall transact business under its own name. An administrator shall not do business in this state under a false or misleading name or under a name that is the same as or that closely resembles the name of any other administrator licensed in the state.

History: 1978 Comp., § 59A-12A-13, enacted by Laws 1989, ch. 374, § 13.

59A-12A-14. Confidentiality.

A. An administrator shall provide for the confidentiality of personal data identifying an individual covered by a plan or insurance carrier or data concerning a person that self insures. An administrator shall not disclose records containing personal information that may be associated with an identifiable individual covered by a plan or insurance carrier or data relating to a person that self insures to a person other than the individual to whom the information pertains, except as necessary to comply with the superintendent's inquiry or a court order. Other than to comply with the superintendent's inquiry or a court order, an administrator shall not disclose personal data without the prior consent of the covered individual or person that self insures.

B. Subsection A of this section does not apply to information disclosed for any of the following reasons or to an indicated entity:

(1) claims adjudication;

(2) claims verification;

(3) other proper plan or insurance carrier administration;

(4) an audit conducted pursuant to ERISA;

(5) an insurer or plan for the purchase of excess loss insurance and for claims under the excess loss insurance, provided, an insurer obtaining information under this paragraph shall be subject to the requirements of Subsection A of this section;

(6) the plan, insurance carrier, person that self insures or a fiduciary of the plan;

(7) the superintendent or the superintendent's designees; provided the information obtained by the superintendent under this subsection is confidential, except that the superintendent may use the information in any proceeding instituted against the administrator; or

(8) as required by law.

History: 1978 Comp., § 59A-12A-14, enacted by Laws 1989, ch. 374, § 14; 1999, ch. 289, § 18.

59A-12A-15. Prohibited inducements.

An administrator, in order to induce a person that self insures or a plan or insurance carrier to contract or to continue to contract with the administrator, to induce a person that self insures or an insurance carrier or plan to lapse, forfeit or surrender a service contract entered into with an administrator or to induce a person that self insures or an insurance carrier or plan to secure or terminate coverage with an insurance carrier or other person that self insures, shall not directly or indirectly:

A. offer to make an agreement relating to a service contract or issue or deliver to the person money or any other valuable consideration other than as plainly expressed in the service contract;

B. give or pay or offer to give or pay a rebate or adjustment of the fee payable under the service contract or an advantage under a service contract, except as reflected in the fee and expressly provided by the service contract;

C. make, issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of a service contract, the advantages provided under a service contract or the true nature of a service contract; or

D. make a misrepresentation in a comparison, whether oral or written, between service contracts of the administrator and another administrator or between service contracts of the administrator and an insurance carrier.

History: 1978 Comp., § 59A-12A-15, enacted by Laws 1989, ch. 374, § 15.

59A-12A-16. General and claims practices.

A. The claims practices of every administrator, insurer, plan or alternative to insurance, as defined in Chapter 59A, Article 12A NMSA 1978, shall be subject to the provisions of Chapter 59A, Article 16 NMSA 1978.

B. The claims practices of any insurer, plan or alternative to insurance as defined in Chapter 59A, Article 12A NMSA 1978 shall be subject to the provisions of the Insurance Code.

History: 1978 Comp., § 59A-12A-16, enacted by Laws 1989, ch. 374, § 16.

59A-12A-17. Compliance deadline.

An administrator that is operating before the effective date of this act shall apply for a license under Chapter 59A, Article 11 NMSA 1978 not later than the sixtieth day after the effective date of this act. An administrator who has made application as provided by this section may continue to operate if it otherwise complies with applicable law, until such time as the superintendent acts on its application. If denied a license, the third party administrator may not act as a third party administrator but may appeal the superintendent's determination as provided by Chapter 59A, Article 4 NMSA 1978.

History: 1978 Comp., § 59A-12A-17, enacted by Laws 1989, ch. 374, § 17.

ARTICLE 12B
Managing General Agents

59A-12B-1. Short title.

Chapter 59A, Article 12B NMSA 1978 may be cited as the "Managing General Agents Law".

History: 1978 Comp., § 59A-12B-1, enacted by Laws 1993, ch. 320, § 27.

59A-12B-2. Definitions.

As used in the Managing General Agents Law:

A. "actuary" means a person who is a member in good standing of the American academy of actuaries;

B. "insurer" means any person, firm, association or corporation duly authorized in this state pursuant to the Insurance Code to transact the business of insurance;

C. "managing general agent" means any person, firm, association or corporation who:

(1) manages all or part of the insurance business of an insurer, including the management of a separate division, department or underwriting office;

(2) acts as an insurance producer for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following activities related to the business produced:

(a) adjusts or pays claims in excess of an amount determined by the superintendent; or

(b) negotiates reinsurance on behalf of the insurer; and

(3) notwithstanding the above, the following persons shall not be considered as managing general agents for the purposes of the Managing General Agents Law:

(a) an employee of the insurer;

(b) a United States manager of the United States branch of an alien insurer;

(c) an underwriting manager which, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to the Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978], and whose compensation is not based on the volume of premiums written; and

(d) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney; and

D. "underwrite" means the authority to accept or reject risk on behalf of the insurer.

History: 1978 Comp., § 59A-12B-2, enacted by Laws 1993, ch. 320, § 28; 2016, ch. 89, § 51.

59A-12B-3. Licensure.

A. No person, firm, association or corporation shall act in the capacity of a managing general agent with respect to risks located in this state for an insurer authorized in this state unless such person is a licensed agent or broker in this state.

B. No person, firm, association or corporation shall act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as an agent or broker in this state pursuant to the provisions of the Managing General Agents Law.

C. The superintendent may require a bond in an amount acceptable to him for the protection of the insurer.

D. The superintendent may require the managing general agent to maintain an errors and omissions policy.

History: 1978 Comp., § 59A-12B-3, enacted by Laws 1993, ch. 320, § 29; 1999, ch. 272, § 17; 1999, ch. 289, § 19.

59A-12B-4. Required contract provisions.

No person, firm, association or corporation acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, specifies the division of such responsibilities and which contains the following minimum provisions:

A. the insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

B. the managing general agent shall render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis;

C. all funds collected for the account of an insurer shall be held by the managing general agent in the fiduciary capacity in a bank which is a member of the federal reserve system. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months estimated claims payments and allocated loss adjustment expenses;

D. every managing general agent shall maintain at its principal administrative office for the duration of the written agreement referred to in this section and seven years thereafter separate books and records of all transactions between it, insurers and insured persons. Such books and records shall be maintained in accordance with prudent standards of insurance recordkeeping. The superintendent shall have access to such books and records for the purpose of examination, audit and inspection. Any trade secrets contained therein, including but not limited to the identity and addresses of policyholders and certificate holders, shall be confidential, except that the superintendent may use such information in any proceedings instituted against the managing general agent or insurer. The insurer shall retain the right to continuing access to such books and records of the managing general agent sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and the managing general agent on the proprietary rights of the parties in such books and records not inconsistent with fulfilling those obligations;

E. the contract may not be assigned in whole or part by the managing general agent;

F. appropriate underwriting guidelines, including:

(1) the maximum annual premium volume;

(2) the basis of the rates to be charged;

(3) the types of risks which may be written;

(4) maximum limits of liability;

(5) applicable exclusions;

(6) territorial limitations;

(7) policy cancellation provisions; and

(8) the maximum policy period. The insurer shall have the right to cancel or non-renew any policy of insurance subject to the applicable laws and regulations concerning the cancellation and non-renewal of insurance policies;

G. if the contract permits the managing general agent to settle claims on behalf of the insurer:

(1) all claims must be reported to the company in a timely manner;

(2) a copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:

(a) has the potential to exceed an amount determined by the superintendent or exceeds the limit set by the company, whichever is less;

(b) involves a coverage dispute;

(c) may exceed the managing general agent's claims settlement authority;

(d) is open for more than six months; or

(e) is closed by payment of an amount set by the superintendent or an amount set by the company, whichever is less;

(3) all claim files will be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer such files shall become the sole property of the insurer or its estate; the managing general agent shall have reasonable access to and the right to copy the files on a timely basis; and

(4) any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination;

H. where electronic claims files are in existence, the contract must address the timely transmission of the data;

I. if the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits shall not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to Section 59A-12B-5 NMSA 1978; and

J. the managing general agent shall not:

(1) bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines, including for both reinsurance assumed and ceded, a list of reinsures with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules;

(2) commit the insurer to participate in insurance or reinsurance syndicates;

(3) appoint any agent or broker without assuring that the agent or broker is lawfully licensed to transact the type of insurance for which he is appointed;

(4) without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent of the insurer's policyholders' surplus as of December 31 of the last completed calendar year;

(5) collect any payment from a reinsurer or commit the insurer to any claim settlement with a retainer, without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

(6) permit its subagent or broker to serve on the insurer's board of directors;

(7) jointly employ an individual who is employed with the insurer; or

(8) appoint a sub-managing general agent.

History: 1978 Comp., § 59A-12B-4, enacted by Laws 1993, ch. 320, § 30.

59A-12B-5. Duties of insurers.

A. The insurer shall have on file an independent financial examination, in a form acceptable to the superintendent, of each managing general agent with which it has done business.

B. If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

C. The insurer shall periodically, at least semiannually, conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

D. Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

E. Within thirty days of entering into or termination of a contract with a managing general agent, the insurer shall provide written notification of such appointment or termination to the superintendent. Notices of appointment of a managing general agent shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the superintendent may request.

F. An insurer shall review its books and records each quarter to determine if any insurance producer has become a managing general agent. If the insurer determines that an insurance producer has become a managing general agent, the insurer shall promptly notify the insurance producer and the superintendent of such determination and the insurer and insurance producer must fully comply with the provisions of the Managing General Agents Law within thirty days.

G. An insurer shall not appoint to its board of directors an officer, director, employee, insurance producer or controlling shareholder of its managing general agents. This subsection shall not apply to relationships governed by the Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978] or, if applicable, the Broker Controlled Insurer Law [Chapter 59A, Article 12C NMSA 1978].

History: 1978 Comp., § 59A-12B-5, enacted by Laws 1993, ch. 320, § 31; 2016, ch. 89, § 52.

59A-12B-6. Examination authority.

The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

History: 1978 Comp., § 59A-12B-6, enacted by Laws 1993, ch. 320, § 32.

59A-12B-7. Penalties and liabilities.

A. If the superintendent determines that the managing general agent or any other person has not materially complied with the provisions of Chapter 59A, Article 12B NMSA 1978, or any rule or order promulgated thereunder, after notice and opportunity to be heard, the superintendent may order:

(1) for each separate violation, a penalty in an amount not exceeding ten thousand dollars ($10,000);

(2) revocation or suspension of the managing general agent's license; and

(3) if it was found that because of such material noncompliance that the insurer has suffered any loss or damage, the superintendent may maintain a civil action brought by or on behalf of the insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the insurer and its policyholders and creditors or seek other appropriate relief.

B. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to Chapter 59A, Article 41 NMSA 1978, and the receiver appointed under that order determines that the managing general agent or any other person has not materially complied with the provisions of Chapter 59A, Article 12B NMSA 1978, or any regulation or order promulgated thereunder, and the insurer suffered any loss or damage, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

C. Nothing contained in this section shall affect the right of the superintendent to impose any other penalties provided for in the Insurance Code.

D. Nothing contained in the Managing General Agents Law is intended to or shall in any manner limit or restrict the rights of policyholders, claimants or creditors.

History: 1978 Comp., § 59A-12B-7, enacted by Laws 1993, ch. 320, § 33; 2016, ch. 89, § 53.

59A-12B-8. Effective date.

No insurer may continue to utilize the services of a managing general agent on or after July 1, 1993, unless such utilization is in compliance with the Managing General Agents Law.

History: 1978 Comp., § 59A-12B-8, enacted by Laws 1993, ch. 320, § 34.

ARTICLE 12C
Broker Controlled Insurers

59A-12C-1. Short title.

Chapter 59A, Article 12C NMSA 1978 may be cited as the "Broker Controlled Insurer Law".

History: 1978 Comp., § 59A-12C-1, enacted by Laws 1993, ch. 320, § 35.

59A-12C-2. Definitions.

As used in the Broker Controlled Insurer Law:

A. "accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the national association of insurance commissioners;

B. "control" or "controlled" has the meaning ascribed in The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978];

C. "controlled insurer" means an authorized insurer which is controlled, directly or indirectly, by a broker;

D. "controlling broker" means a broker who, directly or indirectly, controls an insurer;

E. "authorized insurer" or "insurer" means any person, firm, association or corporation duly authorized to transact a property or casualty insurance business in this state. The following are not authorized insurers for the purposes of the Broker Controlled Insurer Law:

(1) all risk retention groups as defined in: the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499, 100 Stat. 1613 (1986); the Risk Retention Amendments of 1986, 15 U.S.C. Section 3901 et seq. (1982 & Supp. 1986); and Article 55 of the Insurance Code;

(2) all residual market pools and joint underwriting authorities or associations; and

(3) all captive insurers; for the purposes of the Broker Controlled Insurer Law, captive insurers are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations or group members and their affiliates; and

F. "broker" means an insurance broker or brokers or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, such person, firm, association or corporation acts or aids in any manner in

soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association or corporation.

History: 1978 Comp., § 59A-12C-2, enacted by Laws 1993, ch. 320, § 36.

59A-12C-3. Applicability.

The Broker Controlled Insurer Law shall apply to authorized insurers either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978], to the extent they are not superseded by the Broker Controlled Insurer Law, shall continue to apply to all parties within holding company systems subject to this article.

History: 1978 Comp., § 59A-12C-3, enacted by Laws 1993, ch. 320, § 37.

59A-12C-4. Minimum standards.

A. The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling broker is equal to or greater than five percent of the admitted assets of the controlled insurer, as reported in the controlled insurers' quarterly statement filed as of September 30 of the prior year.

B. The provisions of this section shall not apply if:

(1) the controlling broker:

(a) places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

(b) accepts insurance placements only from non-affiliated subbrokers, and not directly from insureds; and

(2) the controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling broker, a broker controlled by the controlled insurer or a broker that is a subsidiary of the controlled insurer.

C. A controlled insurer shall not accept business from a controlling broker and a controlling broker shall not place business with a controlled insurer unless there is a written contract between the controlling broker and the insurer specifying the

responsibilities of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

(1) the controlled insurer may terminate the contract for cause, upon written notice to the controlling broker. The controlled insurer shall suspend the authority of the controlling broker to write business during the pendency of any dispute regarding the cause for the termination;

(2) the controlling broker shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling broker;

(3) the controlling broker shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety days after the effective date of any public [sic] placed with the controlled insurer under this contract;

(4) all funds collected for the controlled insurer's account shall be held by the controlling broker in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the federal reserve system, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling broker not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling broker's domiciliary jurisdiction;

(5) the controlling broker shall maintain separately identifiable records of business written for the controlled insurer;

(6) the contract shall not be assigned in whole or in part by the controlling broker;

(7) the controlled insurer shall provide the controlling broker with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged and the conditions for the acceptance or rejection of risks. The controlling broker shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a broker other than the controlling broker;

(8) the rates and terms of the controlling broker's commissions, charges or other fees and the purposes for those charges or fees. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by brokers other than controlling brokers. For purposes of this paragraph and Paragraph (7) of this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risk, similar policy limits and similar quality of business;

(9) if the contract provides that the controlling broker, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to Paragraph (1) of Subsection E of this section;

(10) a limit shall be placed on the controlling broker's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or sub-line of business. The controlled insurer shall notify the controlling broker when the applicable limit is approached and shall not accept business from the controlling broker if the limit is reached. The controlling broker shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(11) the controlling broker may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling broker places with the controlled insurer, except that the controlling broker may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines, including, for both reinsurance assumed and ceded, a list of reinsures with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

D. Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants and an independent casualty actuary or other independent loss reserve specialist acceptable to the superintendent to review the adequacy of the insurer's loss reserves.

E. Controlled insurers shall be subject to the following reporting requirements:

(1) in addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the superintendent an opinion of an independent casualty actuary, or such other independent loss reserve specialist acceptable to the superintendent, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including incurred but not reported, on business placed by the broker; and

(2) the controlled insurer shall annually report to the superintendent the amount of commissions paid to the broker, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling brokers for placements of the same kinds of insurance.

History: 1978 Comp., § 59A-12C-4, enacted by Laws 1993, ch. 320, § 38.

59A-12C-5. Disclosure.

The broker, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the broker and the controlled insurer; except that, if the business is placed through a subbroker who is not a controlling broker, the controlling broker shall retain in his records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has or will notify the insured.

History: 1978 Comp., § 59A-12C-5, enacted by Laws 1993, ch. 320, § 39.

59A-12C-6. Penalties.

A. If the superintendent believes that the controlling broker or any other person has not materially complied with the Broker Controlled Insurer Law, or any regulation or order promulgated thereunder, after notice and opportunity to be heard, the superintendent may order the controlling broker to cease placing business with the controlled insurer, and if it was found that because of such material noncompliance that the controlled insurer or any policyholder thereof has suffered any loss or damage, the superintendent may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

B. If an order for liquidation or rehabilitation of the controlled insurer has been entered and the receiver appointed under that order believes that the controlling broker or any other person has not materially complied with the Broker Controlled Insurer Law, or any regulation or order promulgated thereunder, and the insurer suffered any loss or damage, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

C. Nothing contained in this section shall affect the right of the superintendent to impose any other penalties provided for in the Insurance Code.

D. Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors or other third parties.

History: 1978 Comp., § 59A-12C-6, enacted by Laws 1993, ch. 320, § 40.

59A-12C-7. Effective date.

Controlled insurers and controlling brokers who are not in compliance with Section 59A-12C-4 NMSA 1978 on its effective date shall have until July 31, 1993 to come into compliance and shall comply with Section 59A-12C-5 NMSA 1978 beginning with all policies written or renewed on or after August 1, 1993.

History: 1978 Comp., § 59A-12C-7, enacted by Laws 1993, ch. 320, § 41.

ARTICLE 12D
Reinsurance Intermediaries

59A-12D-1. Short title.

Chapter 59A, Article 12D [NMSA 1978] may be cited as the "Reinsurance Intermediary Law".

History: 1978 Comp., § 59A-12D-1, enacted by Laws 1993, ch. 320, § 42.

59A-12D-2. Definitions.

As used in the Reinsurance Intermediary Law:

A. "actuary" means a person who is a member in good standing of the American academy of actuaries;

B. "controlling persons" means any person, firm, association or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control or activities of the reinsurance intermediary;

C. "insurer" means any person, firm, association or corporation duly authorized in this state to transact the business of insurance pursuant to the applicable provisions of the Insurance Code as an insurer;

D. "licensed producer" means an agent, broker or reinsurance intermediary licensed pursuant to the applicable provisions of the Insurance Code;

E. "reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in Subsections F and G of this section;

F. "reinsurance intermediary-broker" means any person, other than an officer or employee of the ceding insurer, firm, association or corporation who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer;

G. "reinsurance intermediary-manager" means any person, firm, association or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such reinsurer whether known as the reinsurance intermediary-manager, a manager or other similar term. Notwithstanding the above, the following persons shall not be considered a reinsurance

intermediary-manager, with respect to such reinsurer, for the purposes of the Reinsurance Intermediary Law:

(1) an employee of the reinsurer;

(2) a United States manager of the United States branch of an alien reinsurer;

(3) an underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978], and whose compensation is not based on the volume of premiums written; and

(4) the manager of a group, association, pool or organization or insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located;

H. "reinsurer" means any person, firm, association or corporation duly authorized in this state pursuant to the applicable provisions of the Insurance Code as an insurer with the authority to assume reinsurance;

I. "to be in violation" means that the reinsurance intermediary, insurer or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of the Reinsurance Intermediary Law; and

J. "qualified United States financial institution" means an institution that:

(1) is organized or, in the case of a United States office of a foreign banking organization, licensed, under the laws of the United States or any state thereof;

(2) is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) has been determined by either the superintendent, or the securities valuation office of the national association of insurance commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the superintendent.

History: 1978 Comp., § 59A-12D-2, enacted by Laws 1993, ch. 320, § 43.

59A-12D-3. Licensure.

A. No person, firm, association or corporation shall act as a reinsurance intermediary-broker in this state if it maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

(1) in this state, unless such reinsurance intermediary-broker is a licensed producer in this state; or

(2) in another state, unless such reinsurance intermediary-broker is a licensed producer in this state or another state having a law substantially similar to this law or such reinsurance intermediary-broker is licensed in this state as a reinsurance intermediary.

B. No person, firm, association or corporation shall act as a reinsurance intermediary-manager:

(1) for a reinsurer domiciled in this state, unless such reinsurance intermediary-manager is a licensed producer in this state;

(2) in this state, if the reinsurance intermediary-manager maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this state, unless such reinsurance intermediary-manager is a licensed producer in this state;

(3) in another state for a nondomestic insurer, unless such reinsurance intermediary-manager is a licensed producer in this state or another state having a law substantially similar to this law or such person is licensed in this state as a reinsurance intermediary.

C. The superintendent may require a reinsurance intermediary-manager subject to the provisions of Subsection B to:

(1) file a bond in an amount from an insurer acceptable to the superintendent for the protection of the reinsurer; and

(2) maintain an errors and omissions policy in an amount acceptable to the superintendent.

D. (1) The superintendent may issue a reinsurance intermediary license to any person, firm, association or corporation who has complied with the requirements of the Reinsurance Intermediary Law. Any such license issued to a firm or association will authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

(2) If the applicant for a reinsurance intermediary license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall designate the superintendent as agent for service of process in the manner, and with the same legal effect, provided for by the Reinsurance Intermediary Law for designation of service of process upon unauthorized insurers; and also shall furnish the superintendent with the name and address of a resident of this state upon whom notices or orders of the superintendent or process affecting such nonresident reinsurance intermediary may be served. Such licensee shall promptly notify the superintendent in writing of every change in its designated agent for service of process and such change shall not become effective until acknowledged by the superintendent.

E. The superintendent may refuse to issue a reinsurance intermediary license if, in his judgment, the applicant, anyone named on the application, or any member, principal, officer or director of the applicant, is not trustworthy, or that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license or has failed to comply with any prerequisite for the issuance of such license. Upon written request by the applicant, the superintendent will furnish a summary of the basis for refusal to issue a license, which document shall be subject to the provisions of Section 59A-11-20 NMSA 1978.

F. Licensed attorneys at law of this state when acting in their professional capacity as such shall be exempt from this section.

History: 1978 Comp., § 59A-12D-3, enacted by Laws 1993, ch. 320, § 44; 1999, ch. 272, § 18; 1999, ch. 289, § 20.

59A-12D-4. Required contract provisions; reinsurance intermediary-brokers.

The transactions between a reinsurance intermediary-broker and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, provide that:

A. the insurer may terminate the reinsurance intermediary-broker's authority at any time;

B. the reinsurance intermediary-broker shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing, to the reinsurance intermediary-broker and remit all funds due to the insurer within thirty days of receipt;

C. all funds collected for the insurer's account shall be held by the reinsurance intermediary-broker in a fiduciary capacity in a bank which is a qualified United States financial institution;

D. the reinsurance intermediary-broker shall comply with Section 59A-12D-5 NMSA 1978;

E. the reinsurance intermediary-broker shall comply with the written standards established by the insurer for the cession or retrocession of all risks; and

F. the reinsurance intermediary-broker shall disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

History: 1978 Comp., § 59A-12D-4, enacted by Laws 1993, ch. 320, § 45.

59A-12D-5. Books and records; reinsurance intermediary-brokers.

A. For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-broker, the reinsurance intermediary-broker shall keep a complete record for each transaction showing:

(1) the type of contract, limits, underwriting restrictions, classes or risks and territory;

(2) period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;

(3) reporting and settlement requirements of balances;

(4) rate used to compute the reinsurance premium;

(5) names and addresses of assuming reinsurers;

(6) rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the reinsurance intermediary-broker, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) financial records, including but not limited to, premium and loss accounts; and

(11) when the reinsurance intermediary-broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(a) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(b) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

B. The insurer shall have access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary-broker related to its business in a form usable by the insurer.

History: 1978 Comp., § 59A-12D-5, enacted by Laws 1993, ch. 320, § 46.

59A-12D-6. Duties of insurers utilizing the services of a reinsurance intermediary-broker.

A. An insurer shall not engage the services of any person, firm, association or corporation to act as a reinsurance intermediary-broker on its behalf unless such person is licensed as required by Subsection A of Section 59A-12D-3 NMSA 1978.

B. An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which it transacts business, unless such reinsurance intermediary-broker is under common control with the insurer and subject to The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978].

C. The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business.

History: 1978 Comp., § 59A-12D-6, enacted by Laws 1993, ch. 320, § 47.

59A-12D-7. Required contract provisions; reinsurance intermediary-managers.

Transactions between a reinsurance intermediary-manager and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least thirty days before such reinsurer assumes or cedes business through such producer, a true copy of the approved contract shall be filed with the superintendent for approval. The contract shall, at a minimum, provide that:

A. the reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination;

B. the reinsurance intermediary-manager shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the reinsurance intermediary-manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis;

C. all funds collected for the reinsurer's account shall be held by the reinsurance intermediary-manager in a fiduciary capacity in a bank which is a qualified United States financial institution as defined in Section 59A-12D-2 NMSA 1978. The reinsurance intermediary-manager may retain no more than three months' estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate bank account for each reinsurer that it represents;

D. for at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, the reinsurance intermediary-manager shall keep a complete record for each transaction showing:

(1) the type of contract, limits, underwriting restrictions, classes or risks and territory;

(2) period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

(3) reporting and settlement requirements of balances;

(4) rate used to compute the reinsurance premium;

(5) names and addresses of reinsurers;

(6) rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the reinsurance intermediary-manager, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) financial records, including but not limited to, premium and loss accounts; and

(11) when the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

(a) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(b) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative;

E. the reinsurer shall have access and the right to copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer;

F. the contract may not be assigned in whole or in part by the reinsurance intermediary-manager;

G. the reinsurance intermediary-manager shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks;

H. rates, terms and purposes of commissions, charges and other fees which the reinsurance intermediary-manager may levy against the reinsurer are set forth;

I. if the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

(1) all claims shall be reported to the reinsurer in a timely manner;

(2) a copy of the claim file shall be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(a) has the potential to exceed the lesser of an amount determined by the superintendent or the limit set by the reinsurer;

(b) involves a coverage dispute;

(c) may exceed the reinsurance intermediary-manager's claims settlement authority;

(d) is open for more than six months; or

(e) is closed by payment of the lesser of an amount set by the superintendent or an amount set by the reinsurer;

(3) all claim files shall be the joint property of the reinsurer and reinsurance intermediary-manager; however, upon an order of liquidation of the reinsurer, such files shall become the sole property of the reinsurer or its estate; the reinsurance

intermediary-manager shall have reasonable access to and the right to copy the files on a timely basis; and

(4) any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination;

J. if the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, that such interim profits shall not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or a later period set by the superintendent for specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified pursuant to Subsection C of Section 59A-12D-9 NMSA 1978;

K. the reinsurance intermediary-manager will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant;

L. the reinsurer shall periodically, at least semi-annually, conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary-manager;

M. the reinsurance intermediary-manager shall disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer pursuant to this contract; and

N. within the scope of its actual or apparent authority the acts of the reinsurance intermediary-manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

History: 1978 Comp., § 59A-12D-7, enacted by Laws 1993, ch. 320, § 48.

59A-12D-8. Prohibited acts.

The reinsurance intermediary-manager shall not:

A. cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsures with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured and commission schedules;

B. commit the reinsurer to participate in reinsurance syndicates;

C. appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed;

D. without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

E. collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report shall be promptly forwarded to the reinsurer;

F. jointly employ an individual who is employed by the reinsurer unless such reinsurance intermediary-manager is under common control with the reinsurer subject to The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978];

G. appoint a sub-reinsurance intermediary-manager.

History: 1978 Comp., § 59A-12D-8, enacted by Laws 1993, ch. 320, § 49.

59A-12D-9. Duties of reinsurers utilizing the services of a reinsurance intermediary-manager.

A. A reinsurer shall not engage the services of any person, firm, association or corporation to act as a reinsurance intermediary-manager on its behalf unless such person is licensed as required by Subsection B of Section 59A-12D-3 NMSA 1978.

B. The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager which such reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the superintendent.

C. If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. This opinion shall be in addition to any other required loss reserve certification.

D. Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the reinsurance intermediary-manager.

E. Within thirty days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of such termination to the superintendent.

F. A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder or subagent or subbroker of its reinsurance intermediary-manager. This subsection shall not apply to relationships governed by The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978] or, if applicable, the Broker Controlled Insurer Law [Chapter 59A, Article 12C NMSA 1978].

History: 1978 Comp., § 59A-12D-9, enacted by Laws 1993, ch. 320, § 50.

59A-12D-10. Examination authority.

A. A reinsurance intermediary shall be subject to examination by the superintendent. The superintendent shall have access to all books, bank accounts and records of the reinsurance intermediary in a form usable to the superintendent.

B. A reinsurance intermediary-manager may be examined as if it were the reinsurer.

History: 1978 Comp., § 59A-12D-10, enacted by Laws 1993, ch. 320, § 51.

59A-12D-11. Penalties and liabilities.

A. If the superintendent determines that the reinsurance intermediary or any other person has not materially complied with the provisions of the Reinsurance Intermediary Law, or any regulation or order promulgated thereunder, after notice and opportunity to be heard, the superintendent may order:

(1) for each separate violation, a penalty in an amount not exceeding ten thousand dollars ($10,000);

(2) revocation or suspension of the reinsurance intermediary's license; and

(3) if it was found that because of such material noncompliance that the insurer or reinsurer has suffered any loss or damage, the superintendent may maintain a civil action brought by or on behalf of the reinsurer or insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the insurer and its policyholders and creditors or seek other appropriate relief.

B. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to Chapter 59A, Article 41 NMSA 1978, and the receiver appointed under that order determines that the reinsurance intermediary or any other person has not materially complied with the provisions of the Reinsurance Intermediary Law or any regulation or order promulgated thereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or another appropriate sanction for the benefit of the insurer.

C. Nothing contained in this section shall affect the right of the superintendent to impose any other penalties provided for in the Insurance Code.

D. Nothing contained in the Reinsurance Intermediary Law is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties.

History: 1978 Comp., § 59A-12D-11, enacted by Laws 1993, ch. 320, § 52.

59A-12D-12. Effective date.

No insurer or reinsurer may continue to utilize the services of a reinsurance intermediary on or after July 1, 1993, unless utilization is in compliance with the Reinsurance Intermediary Law.

History: 1978 Comp., § 59A-12D-12, enacted by Laws 1993, ch. 320, § 53.

ARTICLE 12E
Credit for Reinsurance

59A-12E-1. Short title.

This act [59A-12E-1 to 59A-12E-18 NMSA 1978] may be cited as the "Credit for Reinsurance Act".

History: Laws 2022, ch. 35, § 1.

59A-12E-2. Definitions.

As used in the Credit for Reinsurance Act:

A. "accredited jurisdiction" means a jurisdiction that meets the accreditation standards established by the national association of insurance commissioners;

B. "alien assuming insurer" means an assuming insurer that is formed according to the laws of a foreign country;

C. "assuming insurer" means an insurer assuming risk from another insurer;

D. "ceding insurer" means an insurer that transfers risk by purchasing reinsurance;

E. "qualified United States financial institution" means an institution that:

(1) for purposes of Paragraphs (3) and (4) of Subsection B of Section 16 [59A-12E-16 NMSA 1978] of the Credit for Reinsurance Act:

(a) is organized, or in the case of a United States office of a foreign banking organization, licensed pursuant to laws of the United States or any state thereof;

(b) is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies; and

(c) has been determined by either the superintendent or the securities valuation office of the national association of insurance commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the superintendent; or

(2) for purposes of those provisions of the Credit for Reinsurance Act specifying those institutions that are eligible to act as a fiduciary of a trust:

(a) is organized, or in the case of a United States branch or agency office of a foreign banking organization, licensed, pursuant to the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(b) is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies;

F. "reciprocal jurisdiction" means a jurisdiction that meets one of the following descriptions:

(1) a non-United-States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this paragraph, a "covered agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(2) a United States jurisdiction that meets the requirements for accreditation pursuant to the national association of insurance commissioners financial standards and accreditation program; or

(3) a qualified jurisdiction, as determined by the superintendent pursuant to Section 8 [59A-12E-8 NMSA 1978] and Subsection A of Section 9 [59A-12E-9 NMSA 1978] of the Credit for Reinsurance Act, which is not otherwise described in Paragraph (1) or (2) of Subsection F of Section 2 [59A-12E-2 NMSA 1978] of the Credit for Reinsurance Act and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the superintendent in rule; and

G. "superintendent" means the superintendent of insurance.

History: Laws 2022, ch. 35, § 2.

59A-12E-3. Credit allowed a domestic ceding insurer.

A. Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of the Credit for Reinsurance Act. The superintendent shall adopt and promulgate rules for:

(1) specific additional requirements relating to or setting forth the valuation of assets or reserve credits;

(2) the amount and forms of security supporting reinsurance arrangements described in Section 17 [59A-12E-17 NMSA 1978] of the Credit for Reinsurance Act; and

(3) the circumstances pursuant to which credit shall be reduced or eliminated.

B. Credit for reinsurance shall be allowed a domestic ceding insurer pursuant to this section only for cessions of those kinds or classes of business for which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance.

C. Credit for reinsurance shall be allowed a domestic ceding insurer pursuant to this section only if the applicable requirements of Subsection F of Section 13 [59A-12E-13 NMSA 1978] of the Credit for Reinsurance Act have been satisfied.

D. Credit for reinsurance shall be allowed a domestic ceding insurer when the reinsurance is ceded to an assuming insurer:

(1) that is licensed to transact insurance or reinsurance in this state or is accredited by the superintendent as a reinsurer in this state; or

(2) that is domiciled in, or in the case of a United States branch of an alien assuming insurer, is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable pursuant to the Credit for Reinsurance Act and the assuming insurer or United States branch of an alien assuming insurer maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000) and submits to the authority of the superintendent to examine its books and records; provided that the requirements of this paragraph shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers within a single holding company system; and

(3) that maintains a trust fund in a qualified United States financial institution as defined in Paragraph (2) of Subsection E of Section 2 [59A-12E-2 NMSA 1978] of

the Credit for Reinsurance Act for the payment of the valid claims of its United States ceding insurers, their assigns and successors in interest; provided that to enable the superintendent to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the superintendent information substantially the same as that required to be reported on the national association of insurance commissioners annual statement form by licensed insurers; and further provided that the assuming insurer shall submit to examination of its books and records by the superintendent and bear the expense of examination.

E. Credit for reinsurance shall not be allowed pursuant to Paragraph (3) of Subsection D of Section 3 [59A-12E-3 NMSA 1978] of the Credit for Reinsurance Act unless the form of the trust pursuant to Subsection D of this section and any amendments to the trust have been approved by:

(1) the regulator of insurance of the state where the trust is domiciled; or

(2) the regulator of insurance of another state that, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

History: Laws 2022, ch. 35, § 3.

59A-12E-4. Trusts; trust amendments.

A. The form of the trust pursuant to Subsection D of Section 3 [59A-12E-3 NMSA 1978] of the Credit for Reinsurance Act and any trust amendments shall be filed with the regulator of insurance of every state in which the ceding insurer beneficiaries of the trust are domiciled.

B. The trust instrument shall:

(1) provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States; and

(2) vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns and successors in interest.

C. The trust and the assuming insurer shall be subject to examination as determined by the superintendent.

D. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due pursuant to the reinsurance agreements subject to the trust.

E. No later than February 28 of each year, the trustee of the trust shall report to the superintendent in writing the balance of the trust and a list of the trust's investments at the preceding year's end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

History: Laws 2022, ch. 35, § 4.

59A-12E-5. Accreditation of reinsurers.

Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the superintendent as a reinsurer in this state. To be eligible for accreditation, a reinsurer shall:

A. file with the superintendent evidence of its submission to the state's jurisdiction;

B. submit to the superintendent's authority to examine its books and records;

C. be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;

D. file annually with the superintendent a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

E. demonstrate to the satisfaction of the superintendent that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers, provided that an assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000) and its accreditation has not been denied by the superintendent within ninety days after submission of its application.

History: Laws 2022, ch. 35, § 5.

59A-12E-6. Trust requirements.

A. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars ($20,000,000), except as provided in Subsection B of this section.

B. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the government agency with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall

consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus shall not be reduced to an amount less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

C. In the case of a group including incorporated and individual unincorporated underwriters:

(1) for reinsurance ceded pursuant to reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United-States-domiciled ceding insurers to any underwriter of the group;

(2) for reinsurance ceded pursuant to reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of the Credit for Reinsurance Act, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States;

(3) in addition to the trusts provided for in Paragraphs (1) and (2) of this subsection, the group shall maintain in trust a trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of the United-States-domiciled ceding insurers of any member of the group for all years of account;

(4) the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members; and

(5) within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the superintendent an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

D. In the case of a group of incorporated underwriters under common administration, the group shall:

(1) have continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation;

(2) maintain aggregate policyholders' surplus of at least ten billion dollars ($10,000,000,000);

(3) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United-States-domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(4) maintain a joint trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United-States-domiciled ceding insurers of any member of the group as additional security for these liabilities; and

(5) within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the superintendent an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

History: Laws 2022, ch. 35, § 6.

59A-12E-7. Certified reinsurers; qualifications.

A. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the superintendent as a reinsurer in the state and complies with this section and secures its obligations in accordance with the requirements of Sections 7 [59A-12E-7 NMSA 1978] through 9 [59A-12E-9 NMSA 1978] of the Credit for Reinsurance Act. To be eligible for certification, the assuming insurer shall:

(1) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the superintendent pursuant to Section 8 [59A-12E-8 NMSA 1978] and Subsection A of Section 9 of the Credit for Reinsurance Act;

(2) maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the superintendent pursuant to rule;

(3) maintain financial strength ratings from two or more rating agencies deemed acceptable by the superintendent pursuant to rule;

(4) agree to submit to the jurisdiction of this state, appoint the superintendent as its agent for service of process in the state and agree to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(5) agree to meet applicable information filing requirements as determined by the superintendent, both with respect to an initial application for certification and on an ongoing basis; and

(6) satisfy any other requirements for certification deemed relevant by the superintendent.

B. An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. To be eligible for certification, in addition to satisfying the requirements of Subsection A of this section:

(1) the association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the superintendent to provide adequate protection;

(2) the incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(3) within ninety days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the superintendent an annual certification by the association's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements prepared by independent public accountants, of each underwriter member of the association.

History: Laws 2022, ch. 35, § 7.

59A-12E-8. Qualified jurisdictions.

A. The superintendent shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the superintendent as a certified reinsurer.

B. To determine whether the domiciliary jurisdiction of a non-United-States-assuming insurer is eligible to be recognized as a qualified jurisdiction, the superintendent shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-United-States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share information and cooperate with the superintendent with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction shall not be recognized as a qualified jurisdiction if the superintendent has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the superintendent.

C. The superintendent shall consider a list of qualified jurisdictions published through the national association of insurance commissioners committee process in determining qualified jurisdictions. If the superintendent approves a jurisdiction as qualified that does not appear on a list of qualified jurisdictions, the superintendent shall provide thoroughly documented justification in accordance with criteria to be developed by rule.

D. United States jurisdictions that meet the requirement for accreditation pursuant to the national association of insurance commissioners financial standards and accreditation program shall be recognized as qualified jurisdictions.

History: Laws 2022, ch. 35, § 8.

59A-12E-9. Certified reinsurers; ratings; required security.

A. If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the superintendent may suspend the certified reinsurer's certification indefinitely, in lieu of revocation.

B. The superintendent shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the superintendent pursuant to rule. The superintendent shall publish a list of all certified reinsurers and their ratings.

C. A certified reinsurer shall secure obligations assumed from United States ceding insurers pursuant to this section at a level consistent with its rating, as specified in rules promulgated by the superintendent.

D. For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the superintendent and consistent with the provisions of this section or in a multi-beneficiary trust in accordance with Paragraph (3) of Subsection D and Subsection E of Section 3 [59A-12E-3 NMSA 1978] and Sections 4 [59A-12E-4 NMSA 1978] and 6 [59A-12E-6 NMSA 1978] of the Credit for Reinsurance Act, except as otherwise provided in this section.

E. If a certified reinsurer maintains a trust to fully secure its obligations subject to Paragraph (3) of Subsection D and Subsection E of Section 3 and Sections 4 and 6 of the Credit for Reinsurance Act and chooses to secure its obligations incurred as a certified reinsurer in the form of a multi-beneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred pursuant to reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this section or comparable laws of other United States jurisdictions and for its obligations subject to Paragraph (3) of Subsection D and Subsection E of Section 3 and Sections 4 and 6 of the Credit for Reinsurance Act. It shall be a condition to the grant of certification pursuant to Sections 7 [59A-12E-7 NMSA 1978] through 9 [59A-

12E-9 NMSA 1978] of the Credit for Reinsurance Act that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the government agency with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

F. The minimum trusteed surplus requirements provided in Paragraph (3) of Subsection D and Subsection E of Section 3 and Sections 4 and 6 of the Credit for Reinsurance Act are not applicable with respect to a multi-beneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred pursuant to this section, except that such trust shall maintain a minimum trusteed surplus of ten million dollars ($10,000,000).

G. With respect to obligations incurred by a certified reinsurer pursuant to this section, if the security is insufficient, the superintendent shall reduce the allowable credit by an amount proportionate to the deficiency, and the superintendent may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

H. For purposes of this section, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent of its obligations. As used in this subsection, "terminated" refers to revocation, suspension, voluntary surrender and inactive status.

I. If the superintendent continues to assign a higher rating as permitted by Sections 3 through 15 [59A-12E-15 NMSA 1978] of the Credit for Reinsurance Act, the requirement to secure one hundred percent of its obligations does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

J. If an applicant for certification has been certified as a reinsurer in an accredited jurisdiction, the superintendent may defer to that jurisdiction's certification and may defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

K. A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this section, and the superintendent shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

History: Laws 2022, ch. 35, § 9.

59A-12E-10. Reciprocal jurisdiction reinsurers.

A. Credit shall be allowed when reinsurance is ceded to an assuming insurer meeting each of the following conditions:

(1) the assuming insurer shall have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction;

(2) the assuming insurer shall have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in rules promulgated pursuant to Section 17 [59A-12E-17 NMSA 1978] of the Credit for Reinsurance Act; provided that if the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in rules promulgated pursuant to Section 17 of the Credit for Reinsurance Act;

(3) the assuming insurer shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, which will be set forth in rules promulgated pursuant to Section 17 of the Credit for Reinsurance Act; provided that if the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed;

(4) the assuming insurer shall agree and provide adequate assurance to the superintendent in a form specified by the superintendent pursuant to rule, as follows:

(a) the assuming insurer shall provide prompt written notice and explanation to the superintendent if it falls below the minimum requirements set forth in Paragraphs (2) and (3) of this subsection or if any regulatory action is taken against it for serious noncompliance with applicable law;

(b) the assuming insurer shall consent in writing to the jurisdiction of the courts of this state and to the appointment of the superintendent as agent for service of process; provided that the superintendent may require that consent for service of process be provided to the superintendent and included in each reinsurance agreement; and further provided that nothing in this subparagraph shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable pursuant to applicable insolvency or delinquency laws;

(c) the assuming insurer shall consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(d) each reinsurance agreement shall include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable pursuant to the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(e) the assuming insurer shall confirm that it is not currently participating in any solvent scheme of arrangement that involves this state's ceding insurers and shall agree to notify the ceding insurer and the superintendent and to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement; provided that such security shall be in a form consistent with the provisions of the Credit for Reinsurance Act and as specified by the superintendent in rule;

(5) the assuming insurer or its legal successor shall provide, if requested by the superintendent, on behalf of itself and any legal predecessors, certain documentation to the superintendent as specified by the superintendent in rule;

(6) the assuming insurer shall maintain a practice of prompt payment of claims pursuant to reinsurance agreements pursuant to criteria set forth in rule; and

(7) the assuming insurer's supervisory authority shall confirm to the superintendent on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in Paragraphs (2) and (3) of this subsection.

B. Nothing in this section precludes an assuming insurer from providing the superintendent with information on a voluntary basis.

History: Laws 2022, ch. 35, § 10.

59A-12E-11. Reciprocal jurisdictions.

A. The superintendent shall timely create and publish a list of reciprocal jurisdictions. A list of reciprocal jurisdictions shall be published through the national association of insurance commissioners committee process. The superintendent's list shall include any reciprocal jurisdiction as defined in Paragraphs (1) and (2) of Subsection F of Section 2 [59A-12E-2 NMSA 1978] of the Credit for Reinsurance Act and shall consider any other reciprocal jurisdiction included on the national association of insurance commissioners list. The superintendent may approve a jurisdiction that does not appear on the national association of insurance commissioners list of reciprocal jurisdictions in accordance with criteria to be developed pursuant to rules adopted by the superintendent.

B. The superintendent may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rules adopted by the superintendent, except that the superintendent shall not remove from the list a reciprocal jurisdiction as defined in Paragraphs (1) and (2) of Subsection F of Section 2 of the Credit for Reinsurance Act. Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to the Credit for Reinsurance Act.

History: Laws 2022, ch. 35, § 11.

59A-12E-12. Reciprocal jurisdiction assuming insurers.

A. The superintendent shall timely create and publish a list of reciprocal jurisdiction assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit. The superintendent may add an assuming insurer to the list if a national association of insurance commissioners accredited jurisdiction has added the assuming insurer to its list of assuming insurers or if, upon initial eligibility for credit for reinsurance, the assuming insurer submits the information to the superintendent as required pursuant to Paragraph (4) of Subsection A of Section 10 [59A-12E-10 NMSA 1978] of the Credit for Reinsurance Act and complies with any additional requirements that the superintendent may impose by rule, except to the extent that they conflict with an applicable covered agreement.

B. If the superintendent determines that an assuming insurer no longer meets one or more of the requirements pursuant to this section, the superintendent may revoke or suspend the eligibility of the assuming insurer for recognition pursuant to this section in accordance with procedures set forth in rule.

C. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations pursuant to the contract are secured in accordance with Section 16 [59A-12E-16 NMSA 1978] of the Credit for Reinsurance Act.

D. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations pursuant to the contract are secured in a form acceptable to the superintendent and consistent with the provisions of Section 16 of the Credit for Reinsurance Act.

E. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer or its representative may seek and, if determined

appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

F. Nothing in this section shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by the Credit for Reinsurance Act or other applicable law or rule.

History: Laws 2022, ch. 35, § 12.

59A-12E-13. Agreements of reciprocal jurisdiction reinsurers.

A. With respect to reciprocal jurisdiction reinsurers, credit may be taken pursuant to this section only for reinsurance agreements entered into, amended or renewed on or after the effective date of the Credit for Reinsurance Act and only with respect to losses incurred and reserves reported on or after the later of:

(1) the date on which the assuming insurer has met all eligibility requirements pursuant to Section 10 [59A-12E-10 NMSA 1978] of the Credit for Reinsurance Act; and

(2) the effective date of the new reinsurance agreement, amendment or renewal.

B. This section does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available pursuant to this section, as long as the reinsurance qualifies for credit pursuant to any other applicable provision of the Credit for Reinsurance Act.

C. Nothing in this section shall authorize an assuming insurer to withdraw or reduce the security provided pursuant to any reinsurance agreement except as permitted by the terms of the agreement.

D. Nothing in this section shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

E. Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of Sections 3 [59A-12E-3 NMSA 1978] through 12 [59A-12E-12 NMSA 1978] and Subsections A through D of Section 13 [59A-12E-13 NMSA 1978] of the Credit for Reinsurance Act, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

F. If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the credit permitted by Paragraphs (2) and (3) of Subsection D of Section 3, Section 4 [59A-12E-4 NMSA 1978] and Subsections A

through C of Section 6 [59A-12E-6 NMSA 1978] of the Credit for Reinsurance Act shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(1) that in the event of the failure of the assuming insurer to perform its obligations pursuant to the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States; will comply with all requirements necessary to give the court jurisdiction; and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(2) to designate the superintendent or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer; provided that this subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

G. If the assuming insurer does not meet the requirements of this section, Subsections B and D of Section 3 and Sections 10 [59A-12E-10 NMSA 1978] through 13 of the Credit for Reinsurance Act, the credit permitted by Paragraph (3) of Subsection D of Section 3, Subsection E of Section 3 and Sections 4 and 6 of the Credit for Reinsurance Act shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(1) notwithstanding any other provision in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by Section 6 of the Credit for Reinsurance Act, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings pursuant to the laws of its state or country of domicile, the trustee shall comply with an order of the government agency with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the government agency with regulatory oversight all of the assets of the trust fund;

(2) the assets shall be distributed by and claims shall be filed with and valued by the government agency with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

(3) if the government agency with regulatory oversight determines that the assets of the trust fund or any part of the fund are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part of the assets shall be returned by the government agency with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

(4) the grantor shall waive any right otherwise available to it pursuant to United States law that is inconsistent with this subsection.

History: Laws 2022, ch. 35, § 13.

59A-12E-14. Revocation of accreditation or certification.

A. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the superintendent may suspend or revoke the reinsurer's accreditation or certification.

B. The superintendent shall give the reinsurer notice and opportunity for hearing. The suspension or revocation shall not take effect until after the superintendent's order on hearing unless:

(1) the reinsurer waives its right to hearing;

(2) the superintendent's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer pursuant to Subsection J of Section 9 [59A-12E-9 NMSA 1978] of the Credit for Reinsurance Act; or

(3) the superintendent finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the superintendent's action.

C. While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations pursuant to the contract are secured in accordance with Section 16 [59A-12E-16 NMSA 1978] of the Credit for Reinsurance Act. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance shall be granted after the effective date of the revocation, except to the extent that the reinsurer's obligations pursuant to the contract are secured in accordance with Subsections C through I of Section 9 or Section 16 of the Credit for Reinsurance Act.

History: Laws 2022, ch. 35, § 14.

59A-12E-15. Concentration of risk.

A. A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the superintendent within thirty days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

B. A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the superintendent within thirty days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

History: Laws 2022, ch. 35, § 15.

59A-12E-16. Reduction in liability.

A. An asset or a reduction in liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Sections 3 [59A-12E-3 NMSA 1978] through 15 [59A-12E-15 NMSA 1978] of the Credit for Reinsurance Act shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer; provided that the superintendent may adopt by rule pursuant to Section 17 [59A-12E-17 NMSA 1978] of the Credit for Reinsurance Act specific additional requirements relating to or setting forth:

(1) the valuation of assets or reserve credits;

(2) the amount and forms of security supporting reinsurance arrangements described in Section 17 of the Credit for Reinsurance Act; and

(3) the circumstances pursuant to which credit will be reduced or eliminated.

B. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, pursuant to a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution as defined in Paragraph (2) of Subsection E of Section 2 [59A-12E-2 NMSA 1978] of the Credit for Reinsurance Act. This security may be in the form of:

(1) cash;

(2) securities listed by the securities valuation office of the national association of insurance commissioners, including those deemed exempt from filing as defined by the purposes and procedures manual of the securities valuation office, and qualifying as admitted assets;

(3) clean, irrevocable, unconditional letters of credit issued or confirmed by a qualified United States financial institution effective no later than December 31 of the

year for which the filing is being made and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement;

(4) letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(5) any other form of security acceptable to the superintendent.

History: Laws 2022, ch. 35, § 16.

59A-12E-17. Promulgation of rules.

A. The superintendent shall adopt rules to implement the provisions of the Credit for Reinsurance Act.

B. The superintendent may adopt rules applicable to reinsurance arrangements as set forth in Subsection C of this section.

C. A rule adopted pursuant to Subsections B through G of this section may apply only to reinsurance relating to:

(1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(3) variable annuities with guaranteed death or living benefits;

(4) long-term care insurance policies; or

(5) such other life and health insurance and annuity products as to which the national association of insurance commissioners adopts model regulatory requirements with respect to credit for reinsurance.

D. A rule adopted pursuant to Paragraph (1) or (2) of Subsection C of this section may apply to any treaty containing:

(1) policies issued on or after January 1, 2015; or

(2) policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

E. A rule adopted pursuant to Subsections B through G of this section may require the ceding insurer, in calculating the amounts or forms of security required to be held pursuant to rules promulgated pursuant to the Credit for Reinsurance Act, to use the valuation manual adopted by the national association of insurance commissioners pursuant to Paragraph (1) of Section 11B of the national association of insurance commissioners standard valuation law, including all amendments adopted by the national association of insurance commissioners and in effect on the date as of which the calculation is made, to the extent applicable.

F. A rule adopted pursuant to Subsections B through G of this section shall not apply to cessions to an assuming insurer that:

(1) meets the conditions set forth in Sections 10 [59A-12E-10 NMSA 1978] through 12 [59A-12E-12 NMSA 1978] and Subsections A through D of Section 13 [59A-12E-13 NMSA 1978] of the Credit for Reinsurance Act;

(2) is certified in this state; or

(3) maintains at least two hundred fifty million dollars ($250,000,000) in capital and surplus when determined in accordance with the national association of insurance commissioners accounting practices and procedures manual, including all amendments thereto adopted by the national association of insurance commissioners, excluding the impact of any permitted or prescribed practices; and

(4) is licensed in at least twenty-six states; or

(5) is licensed in at least ten states, and licensed or accredited in at least thirty-five states.

G. The authority to adopt rules pursuant to Subsections B through F of this section shall not limit the superintendent's general authority to adopt rules pursuant to Subsection A of this section.

History: Laws 2022, ch. 35, § 17.

59A-12E-18. Insolvency.

Upon the insolvency of a non-United-States insurer or reinsurer that provides security to fund its obligations in the United States in accordance with the Credit for Reinsurance Act, the assets representing the security shall be maintained in the United States, and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed, in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies.

History: Laws 2022, ch. 35, § 18.

ARTICLE 13
Adjusters

59A-13-1. Scope of article.

This article [Chapter 59A, Article 13 NMSA 1978] defines adjusters, requires license, states qualifications for licensing, and other requirements of adjusters so acting in this state. As to licensing procedures, issuance, duration, suspension, revocation or refusal to continue license in general, refer to Article 11 [Chapter 59A, Article 11 NMSA 1978] of the Insurance Code.

History: Laws 1984, ch. 127, § 229.

59A-13-2. Definitions.

A. For the purposes of Chapter 59A, Article 13 NMSA 1978:

(1) "adjuster" means a person that:

(a) investigates, negotiates, settles or adjusts a loss or claim arising under an insurance contract on behalf of an insurer, insured or self-insurer, for a fee, commission or other compensation; however, an adjuster acting on behalf of an insured shall not investigate, negotiate, settle or adjust a claim involving personal injury to the insured; and

(b) advises the insured of the insured's rights to settlement and the insured's rights to settle, arbitrate and litigate the dispute;

(2) "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims that shall:

(a) only be used by a licensed independent adjuster, licensed agent or supervised individuals operating pursuant to Subsection C of Section 59A-13-3 NMSA 1978;

(b) comply with all claims payment requirements of the Insurance Code [Chapter 59A NMSA 1978]; and

(c) be certified as compliant with the Portable Electronics Insurance Act [59A-60-1 to 59A-60-7 NMSA 1978] by a licensed independent adjuster who is an officer of a licensed business entity pursuant to the Insurance Code;

(3) "business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity;

(4) "home state" means the District of Columbia and any state or territory of the United States in which the adjuster's principal place of residence or principal place of business is located. If neither the state in which the adjuster maintains the principal place of residence nor the state in which the adjuster maintains the principal place of business has substantially similar laws governing adjusters, the adjuster may declare another state in which it becomes licensed and acts as an adjuster to be the home state;

(5) "independent adjuster" means an adjuster who is not a staff adjuster or a public adjuster and includes a representative and an employee of an independent adjuster;

(6) "public adjuster" means an adjuster who acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(7) "resident adjuster" means an adjuster who resides principally in New Mexico and who conducts business primarily in New Mexico; and

(8) "staff adjuster" means an adjuster individual who is a salaried employee of an insurer or affiliate of the employer insurer, representing and adjusting claims solely under the authority of the employer insurer.

B. Except as otherwise provided, "adjuster" does not include:

(1) an attorney-at-law who adjusts insurance losses or claims from time to time incidental to practice of law and who does not advertise or represent as an adjuster;

(2) a licensed agent or general agent of an authorized insurer or an employee of an agent or general agent who adjusts claims or losses under specific authority from the insurer and solely under policies issued by the insurer;

(3) an agent or employee of a life or health insurer who adjusts claims or losses under the insurer's policies or contracts to administer policies or benefits of that type;

(4) a salaried or part-time claims agent or investigator employed by a self-insured person;

(5) an individual who, for purposes of portable electronics insurance claims, collects claim information from, or furnishes claim information to, insureds or claimants, and who conducts data entry, including entering data into an automated claims adjudication system; provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than twenty-five such persons are

under the supervision of one licensed independent adjuster or licensed agent who is exempt from licensure pursuant to Paragraph (2) of this subsection;

(6) a property damage appraiser or other individual who is employed by an insurer, third-party administrator, independent adjuster or self-insurer who inspects and provides monetary estimates of damages sustained by an insured or third party and does not investigate, negotiate, settle or adjust claims;

(7) a person who is employed solely for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to an adjuster, such as a photographer, estimator, private investigator, engineer or handwriting expert;

(8) a licensed health care provider or employee of a licensed health care provider who prepares or files a health claim on behalf of a patient;

(9) a person who settles subrogation claims between insurers;

(10) a person who is employed to investigate suspected fraudulent insurance claims but does not adjust losses or determine claim payments; or

(11) an employee of an insurer who receives loss reports from insureds and who may advise an insured regarding the claim process or coverage available to the insured but who does not act as an adjuster on the claim.

History: Laws 1984, ch. 127, § 230; 1989, ch. 274, § 1; 2003, ch. 306, § 6; 2007, ch. 282, § 8; 2011, ch. 127, § 8; 2013, ch. 140, § 11; 2017, ch. 76, § 1.

59A-13-3. License required.

A. No person shall, in this state, act as, or make any representation as being, an adjuster unless licensed as such by the superintendent under the Insurance Code.

B. No person, regardless of location, shall act as, or make any representation as being, an adjuster with respect to workers' compensation claims of claimants resident or located in New Mexico unless licensed as such by the superintendent under the Insurance Code.

C. Notwithstanding any other provision of law, a nonresident may be licensed as a nonresident independent adjuster for the purposes of portable electronics insurance if that applicant has designated another state as the applicant's home state.

History: Laws 1984, ch. 127, § 231; 1989, ch. 313, § 1; 2013, ch. 140, § 12.

59A-13-3.1. Examination for license.

A. An individual applying for a license as an adjuster shall, prior to issuance of a license, personally take and pass a written examination. The examination shall test the knowledge of the individual concerning the duties and responsibilities of an adjuster 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 an 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 continuation of an existing license, except as provided in Subsection D of Section 59A-11-10 NMSA 1978; or

(2) if the applicant took and passed a similar examination in a state in which the applicant is already licensed, subject to Section 59A-5-33 NMSA 1978.

History: Laws 2016, ch. 89, § 55; 2017, ch. 76, § 2.

59A-13-4. Qualifications for license as adjuster.

A. The superintendent shall license as an adjuster only an individual who is otherwise in compliance with Chapter 59A, Articles 11 and 13 NMSA 1978 and who has furnished evidence satisfactory to the superintendent that the applicant for license:

(1) is not less than eighteen years of age;

(2) is a bona fide resident of this state, or of a state or country that permits residents of this state to act as adjusters therein, except that under circumstances of necessity the superintendent may waive the requirement of reciprocity;

(3) can demonstrate a good business reputation, and intends to engage in a bona fide manner in the business of adjusting insurance claims;

(4) has passed any examination required for licensing; and

(5) has filed the bond required under Section 59A-13-5 NMSA 1978.

B. Paragraphs (2) and (5) of Subsection A of this section shall not apply as to staff adjusters.

C. Individuals holding licenses as adjusters on the effective date of the Insurance Code [Chapter 59A NMSA 1978] shall be deemed to meet the qualifications for the license except as provided in Chapter 59A, Articles 11 and 13 NMSA 1978.

D. A business entity applying for an independent adjuster license for the purposes of portable electronics insurance in New Mexico shall submit the names, addresses, social security numbers or individual taxpayer identification numbers, criminal and administrative histories, background checks, biographical statements and fingerprints of all executive officers and directors of the applicant and of all executive officers and directors of entities owning and any individuals owning, directly or indirectly, fifty-one percent or more of the outstanding voting securities of the applicant. Any nonresident business entity applicant whose resident state has enacted into law provisions that are substantively duplicative of the provisions of this subsection shall not be required to submit criminal histories, background checks, biographical statements and fingerprints for its executive officers, directors and owners of outstanding voting securities.

History: Laws 1984, ch. 127, § 232; 2013, ch. 140, § 13; 2016, ch. 89, § 54; 2017, ch. 76, § 3; 2021, ch. 70, § 3.

59A-13-5. Bond.

A. With application for license as a public adjuster, the applicant shall file with the superintendent a surety bond in favor of the superintendent in aggregate amount of not less than ten thousand dollars ($10,000), conditioned to pay actual damages resulting to the state of New Mexico or any member of the public in New Mexico from violation of law by the licensee while acting as an adjuster. The bond shall be one executed by an authorized surety insurer.

B. The bond shall remain in effect for the duration of the license, or until the surety is released from liability by the superintendent, or until canceled by the surety. Without prejudice to any liability accrued prior to cancellation, the surety may cancel a bond by giving written notice to the superintendent at least thirty days prior to effective date of cancellation.

History: Laws 1984, ch. 127, § 233; 2017, ch. 76, § 4; 2023, ch. 151, § 1.

59A-13-6. Emergency adjusters.

A. In the event of an emergency requiring the immediate expansion of adjuster services in New Mexico, an insurer or a public adjuster licensed in New Mexico may request authority from the superintendent to employ adjusters to assist with the emergency who are not licensed in New Mexico but who have fulfilled all licensing requirements in their home state and are in good standing in their home state. An

insurer or public adjuster requesting such authority shall provide the superintendent with the following information:

(1) the nature of the emergency and the affected region of the state;

(2) a list of the adjusters that the insurer or public adjuster shall use that are not licensed in New Mexico. This list shall include each adjuster's name, home address, last four digits of individual taxpayer identification number or last four digits of social security number, national producer number, home state and the effective date of the contract between the adjuster and the insurer or public adjuster;

(3) the name, contact information, national producer number and New Mexico license number for the individual designated by the insurer or public adjuster who will be responsible for the conduct of these adjusters; and

(4) any other information that the superintendent may require.

B. The adjustment of claims by the adjusters listed in Paragraph (2) of Subsection A of this section shall be limited to claims arising from the emergency.

C. Use of the listed adjusters shall be limited to the ninety days immediately following the emergency, unless an extension of time is requested by the insurer or public adjuster and granted by the superintendent.

D. A request by an insurer or public adjuster to employ adjusters to assist with an emergency who are not licensed in New Mexico but who are currently licensed and in good standing in their home state shall be deemed approved if such a request is not disapproved by the superintendent within three business days of its submission to the superintendent.

E. An insurer or public adjuster that requests authorization pursuant to this section may commence employing the adjusters listed in Paragraph (2) of Subsection A of this section while awaiting the superintendent's decision on their request.

History: Laws 1984, ch. 127, § 234; 2017, ch. 76, § 5; 2021, ch. 70, § 4.

59A-13-7. Separate license; independent, staff adjusters.

Separate licenses shall be required for independent adjusters and staff adjusters, but the same individual may be so separately licensed as both.

History: Laws 1984, ch. 127, § 235.

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 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.

History: Laws 1984, ch. 127, § 236; 2007, ch. 282, § 9.

59A-13-9. Place of business.

A. A resident adjuster shall have and maintain a principal place of business in this state that is easily accessible to the public and is the place where the adjuster principally conducts transactions under the license. The address of the principal place of business shall appear on the application for license and on the license.

B. An adjuster shall promptly notify the superintendent of a change of address. Failure to notify the superintendent of a change of address within twenty days shall subject the licensee to a penalty in the amount of fifty dollars ($50.00).

History: Laws 1984, ch. 127, § 237; 2003, ch. 306, § 7; 2011, ch. 127, § 9.

59A-13-10. Records of independent adjuster.

A. Each independent adjuster shall keep at the business address shown on his license a record of all transactions under the license. The record shall include:

(1) the documents relating to all investigations or adjustments undertaken, and

(2) a statement of any fee, commission or other compensation received or to be received by the adjuster on account of such investigation or adjustment.

B. The adjuster shall make such records available for examination by the superintendent at all reasonable times, and shall retain records as to a particular investigation or adjustment for not less than three (3) years after completion of such investigation or adjustment.

History: Laws 1984, ch. 127, § 238.

59A-13-11. Resident claims representative for payment of workers' compensation claims.

Each workers' compensation insurer shall have at least one claims representative within New Mexico, licensed as an adjuster, to pay workers' compensation claims of claimants resident or located in New Mexico. Such claims shall be paid promptly through such representatives from accounts in financial institutions located within New Mexico.

History: 1978 Comp., § 59A-13-11, enacted by Laws 1989, ch. 313, § 2.

59A-13-12. Continuing education.

A. The superintendent shall require as a condition to continuation of an adjuster license that during the twenty-four months next preceding expiration of the current license period, the licensee has attended the minimum number of hours of formal class instruction, lectures or seminars required and approved by the superintendent.

B. Instruction shall be designed to refresh the licensee's understanding of basic principles and coverages involved, recent and prospective changes, applicable laws and rules of the superintendent, proper conduct of the licensee's business and duties and responsibilities of the licensee.

C. The superintendent may permit licensees to successfully complete an equivalent course of study and instruction online or by mail.

D. The superintendent may impose a penalty not to exceed fifty dollars ($50.00) for a licensee's failure to timely report continuing education credits.

E. The superintendent shall charge, at the time of certifying each licensee's continuing education credits as a condition of continuation of license, a fee of one dollar ($1.00) per credit hour of continuing education; provided that the superintendent may contract with an independent agency to receive and review a continuing education compliance report, and in such a case, the fee shall be a reasonable amount fixed by the superintendent and payable to the contracting agency.

History: Laws 2016, ch. 89, § 56; 2017, ch. 76, § 6.

59A-13-13. Prohibited conduct regarding the adjustment and repair of property damage.

A. An adjuster may not adjust a loss related to physical damage of a property on which the adjuster is also a contractor, acts as a contractor or is employed as a contractor, including a roofing contractor, building contractor or plumbing contractor, or otherwise provides building repairs or products, including building or plumbing repairs or products, for compensation or is a controlling person in a business relating to such contracting.

B. A contractor or a roofing contractor may not act as an adjuster or advertise to adjust claims for any property for which the contractor is providing or may provide roofing, building, plumbing or other contractor services, regardless of whether the contractor is a licensed adjuster.

C. In those instances in which an adjuster who is also a contractor is performing either as an adjuster or as a contractor on behalf of an insured, the adjuster shall provide the insured with a disclaimer, on a form promulgated by the superintendent and signed by the adjuster, indicating in which of these two capacities the adjuster is serving the insured and affirming that the adjuster is not serving the insured in the other capacity. The adjuster shall retain copies of such signed disclaimers and make them available to the superintendent upon the superintendent's request.

History: Laws 2017, ch. 76, § 7.

59A-13-14. Standards of conduct.

A. All adjusters shall adhere to the following standards of conduct:

(1) an adjuster shall not permit an unlicensed employee or representative of the adjuster to conduct business for which a license is required pursuant to the Insurance Code [Chapter 59A NMSA 1978];

(2) an adjuster shall not pay a commission, service fee or other valuable consideration to a person for investigating or settling claims in New Mexico if that person is required to be licensed pursuant to the Insurance Code and is not so licensed;

(3) an adjuster shall not undertake the adjustment of any claim if the adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current experience;

(4) an adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, commission or other consideration established in a written contract; unless, in the case of a public adjuster, full written disclosure has been made to the insured as set forth in Subsection G of Section 9 of this 2017 act;

(5) an adjuster shall not acquire any interest in salvage of property subject to adjustment; unless, in the case of a public adjuster, written permission is obtained from the insured; and

(6) an adjuster shall disclose to an insured if the adjuster has any interest or will be compensated by any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop or any other business entity that performs any work in conjunction with damages caused by the insured loss.

B. Public adjusters shall also adhere to the following standards of conduct:

(1) a public adjuster is obligated, under the public adjuster's license, to serve with objectivity and complete loyalty in the interest of the public adjuster's client alone and to render to the insured such information, counsel and service, as within the knowledge, understanding and opinion in good faith of the public adjuster, as will best serve the insured's insurance claim needs and interest;

(2) a public adjuster shall not solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract;

(3) the public adjuster shall abstain from referring or directing the insured to get needed repairs or services in connection with a loss from any person, unless disclosed to the insured:

(a) with whom the public adjuster has a financial interest; or

(b) from whom the public adjuster may receive direct or indirect compensation for the referral;

(4) any compensation or anything of value in connection with an insured's specific loss that will be received by a public adjuster shall be disclosed by the public adjuster to the insured in writing, including the source and amount of any such compensation;

(5) a public adjuster shall not agree to any settlement without the insured's knowledge and consent;

(6) no public adjuster, while so licensed by the superintendent, shall represent or act as a staff adjuster or an independent adjuster;

(7) the contract shall not be construed to prevent an insured from pursuing any civil remedy after the three-business day revocation or cancellation period; and

(8) a public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.

C. A person shall not accept a commission, service fee or other valuable consideration for investigating or settling claims in New Mexico if that person is required to be licensed under the Insurance Code and is not so licensed.

History: Laws 2017, ch. 76, § 8.

59A-13-15. Contract between public adjuster and insured.

A. Public adjusters shall ensure that all contracts for their service are in writing and contain the following terms:

(1) legible full name of the adjuster signing the contract, as specified in the office of superintendent of insurance records;

(2) permanent home state business name and phone number;

(3) office of superintendent of insurance license number;

(4) title of "Public Adjuster Contract";

(5) the insured's full name, street address, insurance company name and policy number, if known or upon notification;

(6) description of the loss and its location, if applicable;

(7) description of services to be provided to the insured;

(8) signatures of the public adjuster and the insured;

(9) date the contract was signed by the public adjuster and date the contract was signed by the insured;

(10) attestation language stating that the public adjuster is fully bonded; and

(11) full salary, fee, commission, compensation or other considerations the public adjuster is to receive for services.

B. The contract may specify that the public adjuster shall be named as a co-payee on an insurer's payment of a claim.

C. If the compensation is based on a share of the insurance settlement, the exact percentage shall be specified.

D. Initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type, with dollar estimates set forth in the contract and with any additional expenses first approved by the insured.

E. Compensation provisions in the public adjusting contract shall not be redacted in any copy of the contract provided to the superintendent.

F. If the insurer, not later than seventy-two hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall:

(1) inform the insured that, due to the insurer's payment or commitment to pay the policy limit, the loss recovery amount might not be increased by the insurer;

(2) not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve the claim; and

(3) be entitled only to reasonable compensation from the insured for the time spent and expenses incurred on the claim by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

G. A public adjuster shall provide the insured a written disclosure concerning any direct or indirect financial interest that the public adjuster has with any party that is involved in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured, including any ownership of, other than as a minority stockholder, or any compensation expected to be received from, any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop or any other business entity that provides estimates for work, or that performs any work, in conjunction with damages caused by the insured loss on which the public adjuster is engaged.

H. A public adjuster contract may not contain any contract term that:

(1) allows the public adjuster's percentage fee to be collected when money is due from but not yet paid by an insurance company;

(2) allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as percentage of each check issued by an insurance company;

(3) requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster;

(4) imposes collection costs or late fees; or

(5) precludes a public adjuster from pursuing civil remedies.

I. Prior to the signing of the contract, the public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states the following:

"(1) Your public adjuster is forbidden by law from acting as your contractor on this claim.

(2) You must notify your insurance company of your loss and submit a claim. The insurance company will assign an adjuster to handle your claim. You may allow

their adjuster to handle your claim or you may hire a public adjuster at your own expense.

(3) Public adjusters do not work for insurance companies. They work for you to assist you in the preparation, presentation and settlement of your claim. You hire them by signing a contract agreeing to pay them a fee or commission. Their compensation is often based on a percentage of the settlement.

(4) You are not required to hire a public adjuster, but you have the right to do so.

(5) You have the right to contact your attorney, your insurance company, your insurance company's adjuster or attorney, or any other person regarding the settlement of your claim.

(6) The public adjuster does not work for your insurance company and is not paid by your insurance company. You are solely responsible for paying the public adjuster.".

J. Subsection I of this section shall not apply to a public adjuster providing public adjuster services on behalf of a financial institution, a mortgage company or other default servicer.

K. The contract shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the superintendent.

L. The public adjuster shall provide the insurer with a notification letter, which has been signed by the insured, authorizing the public adjuster to represent the insured's interest.

M. The insured has the right to rescind the contract within three business days after the date the contract was signed. The recession shall be in writing and mailed or delivered to the public adjuster at the address in the contract within the three-business-day period.

N. If the insured exercises the right to rescind the contract, anything of value given by the insured under the contract will be returned to the insured within fifteen business days following the receipt by the public adjuster of the cancellation notice.

History: Laws 2017, ch. 76, § 9.

59A-13-16. Escrow or trust accounts.

A public adjuster who receives, accepts or holds any funds on behalf of an insured toward the settlement of a claim for loss or damage shall deposit the funds in a non-interest-bearing escrow or trust account in a financial institution that is insured by an agency of the federal government in the public adjuster's home state or where the loss occurred.

History: Laws 2017, ch. 76, § 10.

59A-13-17. Records of public adjuster.

A. A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this section shall include the following:

(1) the name of the insured;

(2) the date, location and amount of the loss;

(3) a copy of the contract between the public adjuster and the insured;

(4) the name of the insurer, amount, expiration date and number of each policy carried with respect to the loss;

(5) an itemized statement of the insured's recoveries;

(6) an itemized statement of all of the compensation received by the public adjuster, from any source whatsoever, in connection with the loss;

(7) a register of all of the money received, deposited, disbursed or withdrawn in connection with a transaction with an insured, including fees, transfers and disbursements from a trust account and all transactions concerning all interest-bearing accounts;

(8) the name of the public adjuster who executed the contract; and

(9) the name of the attorney representing the insured, if applicable, and the name of the claims representatives of the insurance company.

B. Records shall be maintained for at least five years after the termination of the transaction with an insured and shall be open to examination by the superintendent at all times.

C. Records submitted to the superintendent pursuant to this section that contain information identified in writing as proprietary by the public adjuster and accepted as confidential by the superintendent shall be treated as confidential by the superintendent, shall not be subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA

1978], shall not be subject to subpoena and shall not be subject to discovery or admissible as evidence in any private civil action.

History: Laws 2017, ch. 76, § 11.

ARTICLE 14
Surplus Line Insurance

59A-14-1. Scope of article; purpose; necessity for regulation.

A. Chapter 59A, Article 14 NMSA 1978 governs the placing of insurance where New Mexico is the home state of the insured, through licensed surplus lines brokers, in insurers not otherwise authorized to transact insurance in this state and subject to the conditions for such placing as stated in that article; qualifications, licensing and duties and responsibilities of surplus lines brokers; and other provisions as to such surplus lines business and brokers. As to unauthorized insurers in general, and in respects other than as to surplus lines, refer to Chapter 59A, Article 15 NMSA 1978.

B. Chapter 59A, Article 14 NMSA 1978 shall not apply as to reinsurance or to the following insurances:

(1) any insurance where New Mexico is not the home state of the insured;

(2) wet marine and transportation insurance, as defined in Section 59A-7-5 NMSA 1978 [repealed];

(3) insurance on vehicles or aircraft owned and principally garaged outside this state;

(4) insurance of property and operations of railroads engaged in interstate commerce;

(5) insurance of aircraft of common carriers, or cargo of such aircraft, or against liability, other than employer's liability, arising out of ownership, maintenance or use of such aircraft;

(6) insurance of automobile bodily injury and property damage liability risks when written in Mexican insurers and covering in Mexico and not in the United States; or

(7) insurance independently procured.

C. Chapter 59A, Article 14 NMSA 1978 shall be liberally construed and applied to promote its underlying purposes, which include:

(1) protecting insureds and persons seeking insurance in this state;

(2) permitting surplus lines insurance to be placed with reputable and financially sound unauthorized insurers, but only pursuant to Chapter 59A, Article 14 NMSA 1978;

(3) establishing a system of regulation that will permit controlled access to surplus lines insurance in this state; and

(4) assuring collection of revenues and other amounts due to this state.

History: Laws 1984, ch. 127, § 239; 1991, ch. 125, § 11; 2011, ch. 127, § 10; 2011, ch. 156, § 4.

59A-14-2. Definitions.

As used in Chapter 59A, Article 14 NMSA 1978:

A. "affiliate" means, with respect to an insured, any entity that controls, is controlled by or is under common control with the insured;

B. "affiliated group" means any group of entities that are all affiliated;

C. "association" means the national association of insurance commissioners or any successor entity;

D. "authorized insurer" means, with respect to New Mexico, an insurer holding a valid and subsisting certificate of authority, issued by the superintendent, to transact insurance in New Mexico;

E. "control" means that an entity:

(1) directly or indirectly or acting through one or more other persons owns, controls or has the power to vote twenty-five percent or more of any class of voting securities of another entity; or

(2) controls in any manner the election of a majority of the directors or trustees of another entity;

F. "eligible surplus lines insurer" means a qualified nonadmitted insurer with which a surplus lines broker may place surplus lines insurance pursuant to Section 59A-14-4 NMSA 1978;

G. "exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(1) the person employs or retains a qualified risk manager to negotiate insurance coverage;

(2) the person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding twelve months; and

(3) the person:

(a) possesses a net worth in excess of twenty million dollars ($20,000,000), provided that this amount shall be adjusted every five years by rule of the superintendent to account for the percentage change in the consumer price index;

(b) generates annual revenues in excess of fifty million dollars ($50,000,000), provided that this amount shall be adjusted every five years by rule of the superintendent to account for the percentage change in the consumer price index;

(c) employs more than five hundred full-time or full-time-equivalent employees per insured entity or is a member of an affiliated group employing more than one thousand employees in the aggregate;

(d) is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000), provided that this amount shall be adjusted every five years by rule of the superintendent to account for the percentage change in the consumer price index; or

(e) is a municipality with a population in excess of fifty thousand persons;

H. "export" means to place insurance with a nonadmitted insurer;

I. "home state" means, with respect to an insured:

(1) the state:

(a) in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(b) to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated, if one hundred percent of the insured risk is located out of the state referred to in Subparagraph (a) of this paragraph; or

(2) if more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, "home state" means the home state, as determined pursuant to Paragraph (1) of this subsection, of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract;

J. "independently procured insurance" means insurance procured directly by an insured from a nonadmitted insurer;

K. "nonadmitted insurance" means any property and casualty insurance permitted to be placed through a surplus lines broker with an eligible surplus lines insurer;

L. "nonadmitted insurer" means an insurer not licensed to engage in the business of insurance in New Mexico but does not include a risk retention group, as "risk retention group" is defined in the federal Liability Risk Retention Act of 1986;

M. "premium tax" means, with respect to surplus lines, any tax, fee, assessment or other charge imposed by a government entity directly or indirectly based on any payment made as consideration for an insurance contract for such insurance, including premium deposits, assessments, registration fees and any other compensation given in consideration for a contract of insurance;

N. "principal place of business" means, with respect to determining the home state of the insured, the state where the insured maintains its headquarters and where the insured's high-level officers direct, control and coordinate the business activities of the insured;

O. "producing broker" means the broker or agent dealing directly with the person seeking insurance if the home state of the person seeking insurance is New Mexico;

P. "professional designation" means:

(1) a designation as a chartered property and casualty underwriter issued by the American institute for chartered property and casualty underwriters;

(2) a designation as an associate in risk management issued by the insurance institute of America;

(3) a designation as a certified risk manager issued by the national alliance for insurance education and research;

(4) a designation as a RIMS fellow issued by the global risk management institute; or

(5) any other designation, certification or license determined by the superintendent to demonstrate minimum competency in risk management;

Q. "qualified risk manager" means, with respect to an exempt commercial purchaser, a person who:

(1) is an employee of, or a third-party consultant retained by, the exempt commercial purchaser;

(2) provides skilled services in loss prevention, loss reduction, risk and insurance coverage analysis and purchase of insurance; and

(3) has:

(a) a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics or any other field determined by the superintendent to demonstrate minimum competence in risk management and either: 1) three years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchase of commercial lines of insurance; or 2) a professional designation;

(b) a professional designation and at least seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchase of commercial lines of insurance;

(c) at least ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchase of commercial lines of insurance; or

(d) a graduate degree from an accredited college or university in risk management, business administration, finance, economics or any other field determined by the superintendent to demonstrate minimum competence in risk management;

R. "reinsurance" means the assumption by an insurer of all or part of a risk undertaken originally by another insurer;

S. "surplus lines broker" means an individual, firm or corporation licensed under Chapter 59A, Article 14 NMSA 1978 to place insurance with eligible surplus lines insurers;

T. "surplus lines insurance" means any insurance permitted to be exported through a surplus lines broker in accordance with the provisions of Chapter 59A, Article 14 NMSA 1978;

U. "type of insurance" means one of the types of insurance required to be reported in the annual statement that must be filed with the superintendent by authorized insurers; and

V. "unauthorized insurer" means a nonadmitted insurer.

History: 1978 Comp., § 59A-14-2, enacted by Laws 1991, ch. 125, § 12; 2011, ch. 156, § 5; 2017, ch. 130, § 7.

59A-14-3. Placement of surplus lines insurance.

No surplus lines insurance for an insured whose home state is New Mexico shall be solicited, negotiated, contracted for, effectuated or otherwise transacted within the meaning of Section 59A-1-13 NMSA 1978, unless:

A. the insurance is procured through a surplus lines broker;

B. each nonadmitted insurer providing such insurance is an eligible surplus lines insurer;

C. either:

(1) the full amount or type of insurance cannot be obtained from insurers authorized to do business in this state as determined after making a diligent search among insurers authorized to transact and actually writing the particular type and class of insurance in this state; or

(2) the insurance is being procured for an exempt commercial purchaser and:

(a) the surplus lines broker procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that the insurance may or may not be available from insurers authorized to do business in this state, which may provide greater protection with more regulatory oversight; and

(b) the exempt commercial purchaser has subsequently requested in writing the surplus lines broker to procure or place the insurance from an eligible surplus lines insurer;

D. the surplus lines broker has taken such reasonable steps to ascertain that the insurer is in sound financial condition as may be required by regulations adopted by the superintendent; and

E. all other requirements of Chapter 59A, Article 14 NMSA 1978 are met.

History: 1978 Comp., § 59A-14-3, enacted by Laws 1991, ch. 125, § 13; 1993, ch. 320, § 54; 2011, ch. 156, § 6.

59A-14-4. Eligible surplus lines insurers required.

A. No person shall export insurance on behalf of an insured whose home state is New Mexico except as authorized by and in accordance with Chapter 59A, Article 14 NMSA 1978.

B. No surplus lines broker shall transact surplus lines insurance with an insurer other than an eligible surplus lines insurer.

C. To qualify as an eligible surplus lines insurer, a nonadmitted insurer shall file information demonstrating to the superintendent's satisfaction that:

(1) the insurer is authorized to write the particular line of business in the state in which it is domiciled and:

(a) the insurer has capital and surplus or their equivalent that equals the greater of: 1) fifteen million dollars ($15,000,000); or 2) the minimum capital and surplus required in this state for that particular line of business; or

(b) the insurer has capital and surplus less than the amounts required in Subparagraph (a) of this paragraph but the superintendent affirmatively finds that the insurer is acceptable as an eligible surplus lines insurer. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends and company record and reputation within the industry. In no event shall the superintendent make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000);

(2) the insurer is a member of an "insurance exchange", which is an association of syndicates or insurers created by the laws of individual states, and shall maintain capital and surplus, or the equivalent thereof, of not less than fifty million dollars ($50,000,000) in the aggregate. For insurance exchanges that maintain funds for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the equivalent thereof, of not less than five million dollars ($5,000,000). In the event the insurance exchange does not maintain funds for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of Subparagraph (a) of Paragraph (1) of this subsection;

(3) if the insurer is an alien insurer, the insurer is listed on the quarterly listing of alien insurers maintained by the international insurers department of the association; or

(4) if, pursuant to law, New Mexico has joined a compact or multistate agreement for the regulation of surplus lines insurance and the state, through the compact commission, has adopted nationwide uniform eligibility requirements, the insurer is in compliance with those requirements.

D. The superintendent shall maintain a list of eligible surplus line insurers from those qualified nonadmitted insurers that file information to satisfy the criteria established under Subsection C of this section. In addition to the requirements of Subsection C of this section, in order to appear on the list of eligible surplus lines insurers, a nonadmitted insurer shall provide annually to the superintendent a copy of the insurer's most current annual statement certified and sworn to by the insurer, unless the annual statement is available to the superintendent through the national association

of insurance commissioners or from public sources. The statement shall be provided or made available at the same time it is provided to the insurer's domicile, but in no event more than nine months after the close of the period reported upon, and shall be either:

(1) filed with and approved by the regulatory authority in the insurer's domicile; or

(2) certified as correct and in accordance with applicable accounting principles by a public accounting firm licensed in the insurer's domicile.

In the case of an insurance exchange, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported.

E. The listing described by Subsection D of this section shall not be deemed to constitute or evidence the superintendent's guaranty as to the financial condition or business practices of the insurer, and no insurer or other person shall allege orally or in writing that any such listing constitutes or implies the superintendent's approval.

F. The superintendent may adopt rules fixing reasonable conditions to be met by insurers for the listing. For good cause shown, the superintendent may in writing waive the requirements of this section to permit insurance to be placed as to a particular risk and insurer if the insurance is not otherwise reasonably obtainable.

History: 1978 Comp., § 59A-14-4, enacted by Laws 1991, ch. 125, § 14; 1994, ch. 13, § 2; 2011, ch. 156, § 7; 2017, ch. 130, § 8.

59A-14-4.1. Withdrawal of eligibility from a surplus lines insurer.

The superintendent may at any time declare an eligible surplus lines insurer to be ineligible if the superintendent has reason to believe that the insurer:

A. is in unsound financial condition;

B. is subject to delinquency proceedings in this state or any other jurisdiction;

C. is no longer eligible under Section 59A-14-4 NMSA 1978;

D. has violated the laws of this state, including any violation of the Insurance Code or the superintendent's orders;

E. does not make reasonably prompt payment of loss claims or other obligations in this state or elsewhere;

F. has failed within sixty days to satisfy a final judgment rendered against it or against an insured for which it is legally liable under the terms of a contract of surplus lines insurance; or

G. has failed to satisfy the superintendent that it is fit to be allowed to continue to do business in this state.

The superintendent shall promptly mail notice of all such declarations to the insurer and to every surplus lines broker. Notice sent pursuant to this subsection to a licensed surplus lines broker may, at the option of the surplus lines broker, be sent by the superintendent via electronic mail.

History: 1978 Comp., § 59A-14-4.1, enacted by Laws 1991, ch. 125, § 15; 2017, ch. 130, § 9.

59A-14-5. Signature and special endorsement of surplus lines policy.

Every insurance contract procured and delivered as surplus lines insurance pursuant to Chapter 59A, Article 14 NMSA 1978 shall bear the name, address and signature of the surplus lines broker who procured it and have stamped, printed or otherwise displayed prominently in boldface ten-point or larger type either upon its declarations page or by attachment of an endorsement, the form of which may be promulgated by the superintendent, the following: "This policy provides surplus lines insurance by an insurer not otherwise authorized to transact business in New Mexico. This policy is not subject to supervision, review or approval by the superintendent of insurance. The insurance so provided is not within the protection of any guaranty fund law of New Mexico designed to protect the public in the event of the insurer's insolvency.".

History: Laws 1984, ch. 127, § 243; 1991, ch. 125, § 16; 1999, ch. 111, § 1.

59A-14-6. Surplus line insurance valid.

Insurance contracts procured as surplus line coverage from unauthorized insurers in accordance with the article shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects and to the same effect as like contracts issued by authorized insurers.

History: Laws 1984, ch. 127, § 244.

59A-14-7. Surplus lines broker license required; qualifications for license.

A. No person shall in New Mexico be, act as or hold out to be a surplus lines broker, or place insurance of risks where New Mexico is the home state of the insured in any nonadmitted insurer on behalf of others and for compensation as an independent contractor in any form, unless licensed as a surplus lines broker under Chapter 59A, Article 14 NMSA 1978.

B. The superintendent shall, upon due application and payment of the license fee, issue a license as surplus lines broker to a person qualified as follows:

(1) if the applicant is an individual, the individual must have had experience or special training or education sufficient in duration and character to render the applicant, in the opinion of the superintendent, reasonably competent to engage in business as a surplus lines broker; and

(2) if the applicant is a firm or corporation, all individuals to represent it as a surplus lines broker in this state must be licensed surplus lines brokers.

History: Laws 1984, ch. 127, § 245; 1999, ch. 272, § 19; 1999, ch. 289, § 21; 2011, ch. 127, § 11; 2011, ch. 156, § 8.

59A-14-8. Repealed.

59A-14-9. Surplus line broker may accept business from insurance producers; compensation of others prohibited.

A. A surplus line broker may accept and export surplus line business from and for any insurance producer licensed by this state for the kind of insurance involved, and may compensate the insurance producer therefor.

B. A surplus line broker shall not directly or indirectly compensate any person other than a licensed insurance producer for origination of business. This provision shall not be deemed to prohibit payment of regular salaries to the surplus line broker's employees or sharing of compensation with other persons entitled thereto under firm and corporate agreements and surplus line broker licenses. Violation of this provision is a misdemeanor.

History: Laws 1984, ch. 127, § 247; 2016, ch. 89, § 57.

59A-14-10. Office and records.

A. A surplus line broker shall maintain an office accessible to the public wherein transactions under his license may be transacted. Nothing herein shall be deemed to prohibit maintenance of the office in the surplus line broker's place of residence, subject to accessibility above stated.

B. The surplus line broker shall keep in the office complete records of surplus line insurance business transacted, including, but not limited to, income and disbursements, copies of all policies, endorsements, cancellations, filing documents, reports and other related records. The records shall be made available for examination by the superintendent at all times within seven years after issuance of a coverage to which the record relates.

C. The surplus line broker shall immediately notify the superintendent in writing of any change of office address. Failure to notify the superintendent of a change of address within twenty days shall subject the licensee to a penalty in the amount of fifty dollars ($50.00).

History: Laws 1984, ch. 127, § 248; 2003, ch. 202, § 8.

59A-14-11. Duty to file reports and affidavits.

A. The producing broker shall complete, execute and provide to the surplus lines broker a signed statement in substantially the form required by the superintendent, as to the diligent efforts to place the coverage with authorized insurers and the results thereof. The statement shall affirm that the insured was expressly advised prior to placement of the insurance and in the insurance policy that:

(1) the surplus lines insurer with which the insurance was to be placed is not an authorized insurer in this state and is not subject to the superintendent's supervision; and

(2) in the event the surplus lines insurer becomes insolvent, claims will not be paid nor will unearned premiums be returned by any New Mexico insurance guaranty fund.

B. The surplus lines broker shall preserve the original producing broker statements in compliance with Section 59A-14-11 NMSA 1978. The declaration pages shall be confidential and shall not be subject to public inspection. The superintendent's copy of the statements shall be open to public inspection. If the producing broker has failed to provide the producing broker statement, the surplus lines broker shall at the time of quarterly filing notify the superintendent of the producing broker's failure to comply.

C. Each surplus lines broker shall, within sixty days after expiration of each calendar quarter, file with the superintendent a statement under the surplus lines broker's oath of all surplus lines insurance business transacted during such calendar quarter. The statement shall be on forms as prescribed and furnished by the superintendent and shall contain such information relative to the surplus lines insurance transaction as the superintendent may reasonably require for the purposes of Chapter 59A, Article 14 NMSA 1978.

History: 1978 Comp., § 59A-14-11, enacted by Laws 1991, ch. 125, § 17; 1999, ch. 111, § 2; 2017, ch. 130, § 10.

59A-14-12. Repealed.

History: Laws 1984, ch. 127, § 250; 1999, ch. 111, § 3; 2011, ch. 156, § 9; 2017, ch. 130, § 11; repealed by Laws 2018, ch. 57, § 31.

59A-14-13. Examination of surplus line broker.

A. The superintendent whenever deemed necessary may examine the records and accounts of any surplus line broker for determining whether the surplus line broker is conducting business in accordance with the requirements of this article.

B. The superintendent shall conduct the examination, and the surplus line broker shall pay the cost thereof, as provided in the applicable provisions of Article 4 [Chapter 59A, Article 4 NMSA 1978] (examinations, hearings and appeals) of the Insurance Code.

History: Laws 1984, ch. 127, § 251.

59A-14-14. Evidence of insurance; policy changes; penalties.

A. Upon placing surplus lines insurance, the surplus lines broker shall promptly deliver to the insured evidence of the insurance consisting either of the policy or, if the policy is not then available, a certificate complying with Subsection D of this section, a cover note, a binder or other evidence of insurance. The certificate, cover note, binder or other evidence of insurance shall be completed and signed by the surplus lines broker and shall set forth the description and location of the subject of the insurance, the coverage limits, the name and address of the insured, the name and address of the surplus lines insurer and the name, address and telephone number of the surplus lines broker.

B. No surplus lines broker shall issue or deliver any evidence of insurance or purport to insure or represent that insurance will be or has been written by any eligible surplus lines insurer without the insurer's prior written authorization, via telefax or otherwise, to cause the risk to be insured or documentation from the insurer in the regular course of business that such insurance has been granted.

C. If, after delivery of any evidence of insurance, there is any change in the identity of the insurer, in the proportion of the risk assumed by any insurer or in the coverage, terms or conditions stated in the original evidence of insurance, the surplus lines broker shall promptly issue and deliver to the insured, either directly or through the producing broker, an appropriate substitute for or endorsement of the original document, accurately showing the current status of the coverage and responsible insurers.

D. As soon as reasonably possible after the placement of any surplus lines insurance, and in no event later than thirty days after coverage commences, the surplus lines broker shall deliver a complete copy of the policy or, if the policy is not then available, a certificate of insurance to the insured to replace any evidence of insurance previously issued. Each policy of insurance shall contain or have attached thereto a complete record of all policy declarations and limits, insuring agreements, deductible amounts, conditions, exclusions, clauses, endorsements and all other material terms and conditions.

E. Any surplus lines broker who fails to comply with the requirements of this section shall be subject to the penalties provided in Section 59A-1-18 NMSA 1978 or to any greater applicable penalty otherwise provided by law.

History: 1978 Comp., § 59A-14-14, enacted by Laws 1991, ch. 125, § 18; 2011, ch. 127, § 12.

59A-14-15. Liability of insurer.

A. As to a risk assumed by an unauthorized insurer under Chapter 59A, Article 14 NMSA 1978, and if the premium thereon has been received by the producing broker or the surplus lines broker who placed the insurance, in all questions thereafter arising under the coverage between the insurer and the insured the insurer shall be deemed to have received the premium due it for the coverage; and the insurer shall be liable to the insured for losses covered by the insurance and for unearned premiums that may become payable to the insured upon cancellation of the insurance, whether or not in fact the surplus lines broker is indebted to the insurer as to the insurance or for any other cause.

B. Each unauthorized insurer assuming a surplus lines risk under Chapter 59A, Article 14 NMSA 1978 shall be deemed thereby to have subjected itself to the terms of this section.

History: Laws 1984, ch. 127, § 253; 1991, ch. 125, § 19.

59A-14-16. Legal process against surplus line insurer; venue.

A. An unauthorized insurer shall be sued, upon any cause of action arising in this state under any surplus line insurance policy issued by it, in the district court of the county in which the cause of action arose.

B. Service of legal process against the insurer may be made in any such action by service upon the superintendent as provided for in Section 99 [59A-5-32 NMSA 1978] of the Insurance Code.

C. Each surplus line insurer may file with the superintendent designation in writing of the name and address of the person to whom the superintendent shall forward legal process served upon him as process attorney for the insurer. The insurer may change such designation by filing a new designation with the superintendent. The surplus line broker placing surplus line insurance with an unauthorized insurer shall take reasonable steps to inform the insurer of its right to file such designation.

D. Upon receipt of such process the superintendent shall promptly mail one copy thereof, by certified or registered mail with return receipt requested, to the person currently designated by the insurer pursuant to Subsection C, above; and if no such designation has been made or is not currently in force, the process shall be so mailed

addressed to the insurer at its home office last of record with the superintendent, wherever located. The insurer shall have thirty (30) days from date of service upon the superintendent within which to plead, answer or otherwise defend the action. Upon service of process upon the superintendent and mailing in accordance with this provision the court shall be deemed to have jurisdiction in personam of the insurer.

E. An unauthorized insurer issuing the policy shall be deemed thereby to have authorized service of process against it in the manner and to the effect as provided in this section. Any such policy shall contain a provision stating that service of process against it may be made upon the superintendent as in this section provided.

History: Laws 1984, ch. 127, § 254.

59A-14-17. Certain other provisions applicable.

In addition to provisions generally applicable, the following provisions of the Insurance Code shall also apply as to surplus line brokers:

A. Section 210 [209] [59A-12-8 NMSA 1978[repealed]] (controlled business);

B. Section 218 [59A-12-17 NMSA 1978] (scope of license); and

C. Section 223 [59A-12-22 NMSA 1978] (fiduciary funds).

History: Laws 1984, ch. 127, § 255.

59A-14-18. Repealed.

History: Laws 1984, ch. 127, § 256; repealed by Laws 2018, ch. 57, § 31.

59A-14-19. National database; participation required.

No later than July 21, 2012, the superintendent shall participate in the national insurance producer database of the association, or any other equivalent uniform national database, for the licensure of surplus lines brokers and the renewal of the licenses.

History: Laws 2011, ch. 156, § 10.

ARTICLE 14A
Surplus Lines Insurance Multistate Compliance Compact (Repealed.)

59A-14A-1. Repealed.

History: Laws 2011, ch. 156, § 1; repealed by Laws 2017, ch. 130, § 19.

59A-14A-2. Repealed.

History: Laws 2011, ch. 156, § 2; repealed by Laws 2017, ch. 130, § 19.

ARTICLE 15
Unauthorized Insurers

59A-15-1. Purposes of article.

The purpose of this article [Chapter 59A, Article 15 NMSA 1978] is to subject certain persons and insurers to the jurisdiction of the superintendent and the courts of this state in suits by or on behalf of the state and others. The legislature declares that it is concerned with the protection of residents of this state against acts by insurers not authorized to do an insurance business in this state, by the maintenance of fair and honest insurance markets, by protecting authorized insurers which are subject to regulation from unfair competition by unauthorized insurers, and by protecting against the evasion of the insurance regulatory laws of this state. In furtherance of such state interest, the legislature provides methods in this article for substituted service of process upon such insurers in any proceeding, suit or action in any court and substituted service of any notice, order, pleading or process upon such insurers in any proceeding by the superintendent to enforce or effect full compliance with the insurance laws of this state. In so doing, the state exercises its powers to protect residents of this state and to define what constitutes transacting an insurance business in this state, and also exercises powers and privileges available to this state by virtue of Public Law 79-15, (1945), 79th Congress of the United States, Chapter 20, 1st Sess., S. 340, 59 Stat. 33; 15 U.S.C. Secs. 1011 to 1015, inclusive, as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

History: Laws 1984, ch. 127, § 257.

59A-15-2. Representing or aiding unauthorized insurer prohibited.

A. No person shall in this state directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, any unauthorized insurer in solicitation, negotiation, procurement or effectuation of insurance or renewals thereof, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist such insurer in transaction of insurance in this state.

B. This section shall not apply as to:

(1) matters authorized to be done by the superintendent under service of process provisions of Chapter 59A, Article 15 NMSA 1978;

(2) transactions for which certificate of authority is not required of an insurer under Section 59A-5-11 NMSA 1978;

(3) subject to Subsection B of Section 59A-5-10 NMSA 1978, insurances exempt from the surplus line law under Section 59A-14-1 NMSA 1978;

(4) insurance policies and annuity contracts in force in this state prior to the effective date of the Insurance Code, transactions as to which shall be governed by laws in force immediately prior to such effective date; or

(5) a transaction or transactions in this state involving contracts of insurance to one or more industrial insureds. For the purposes of this section, an industrial insured is an insured:

(a) which procures the insurance of any risk by the use of the services of a full-time employee acting as a risk manager or insurance manager or by utilizing the services of a regularly and continuously qualified insurance consultant;

(b) which has aggregate annual premiums for insurance on all risks of at least twenty-five thousand dollars ($25,000); and

(c) which has at least twenty-five full-time employees.

C. Violation of this section shall be subject to the general penalty provided under Section 59A-1-18 NMSA 1978.

History: Laws 1984, ch. 127, § 258; 1987, ch. 259, § 15.

59A-15-3. Inclusion of unauthorized insurer in coverage.

No insurance agent licensed in this state shall include, or permit inclusion, in any insurance coverage of a subject of insurance resident, located or to be performed in this state and placed by the agent, of an unauthorized insurer among the insurers assuming direct risk under such coverage. This section shall not apply as to coverages exempt under Section 258 [59A-15-2 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 259.

59A-15-4. Insurance independently procured; duty to file returns.

A. Each insured who in this state procures or continues or renews insurance with a nonadmitted insurer on a risk located or to be performed in whole or in part in this state, other than insurance procured through a surplus lines licensee pursuant to Chapter

59A, Article 14 NMSA 1978 shall file returns pursuant to the Insurance Premium Tax Act [7-40-1 to 7-40-10 NMSA 1978].

B. If an independently procured policy covers risks or exposures only partially located or to be performed in this state, the taxes, fees and penalties imposed pursuant to the Insurance Code and the Insurance Premium Tax Act shall be computed on the portion of the premium properly attributable to the risks or exposures located or to be performed in this state and reported to the secretary of taxation and revenue. In no event, however, shall a tax be payable solely because the risk in question, or any portion thereof, is located or to be performed in this state.

C. This section does not abrogate or modify, and shall not be construed or deemed to abrogate or modify, any provision of the Insurance Code.

D. This section does not apply to life insurance, health insurance or annuities.

History: Laws 1984, ch. 127, § 259.1; 2018, ch. 57, § 18; 2023, ch. 85, § 25.

59A-15-5. Validity of contract not impaired; right of insurer as to court action.

Failure of an insurer transacting insurance in this state to have a certificate of authority shall not impair the validity of any act or contract of the insurer and shall not prevent the insurer from defending any action in any court in this state; but no such insurer shall be permitted to maintain an action in any court of this state to enforce any right, claim or demand arising out of any such transaction, other than as to a surplus line coverage duly written through a licensed surplus line broker of this state, until the insurer has obtained a certificate of authority.

History: Laws 1984, ch. 127, § 260.

59A-15-6. Superintendent is attorney of unauthorized insurer for service of process.

Any act of transacting an insurance business in this state by any unauthorized insurer is equivalent to and shall constitute an irrevocable appointment by such insurer, binding upon him, his executor or administrator, or successor in interest if a corporation, of the superintendent or his successor in office, to be the true and lawful attorney of the insurer upon whom may be served all lawful process in any action, suit or proceeding in any court by the superintendent or by the state or others, and upon whom may be served any notice, order, pleading or process in any proceeding before the superintendent, and which arises out of transacting an insurance business in this state by such insurer. Any act of transacting an insurance business in this state by any unauthorized insurer shall be signification of its agreement that any such lawful process in such court action, suit or proceeding and any such notice, order, pleading or process

in such administrative proceeding before the superintendent so served shall be of the same legal force and validity as personal service of process in this state upon the insurer.

History: Laws 1984, ch. 127, § 261.

59A-15-7. Service of process on unauthorized insurer.

A. Service of process in such action or proceeding shall be made by delivering to and leaving with the superintendent, or some person in apparent charge of his office, two (2) copies thereof and by payment to the superintendent of the fee prescribed by Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code. Service upon the superintendent as such attorney shall be service upon the insurer.

B. The superintendent shall forthwith forward by certified mail one of the copies of such process, or such notice, order, pleading or process in proceedings before the superintendent, to the defendant in such court proceeding or to whom the notice, order, pleading or process in such administrative proceeding is addressed or directed, at its principal place of business last known to the superintendent and shall keep a record of all process so served on him which shall show the day and hour of service. Such service is sufficient if:

(1) notice of such service and a copy of the court process or the notice, order, pleading or process in such administrative proceeding are sent within ten (10) days thereafter by certified mail (with return receipt requested) by the plaintiff or the plaintiff's attorney in the court proceeding, or by the superintendent in the administrative proceeding, to the defendant in the court proceeding or to whom the notice, order, pleading or process in such administrative proceeding is addressed or directed, at the last-known principal place of business of the defendant in the court or administrative proceeding, and

(2) the defendant's receipt or receipts issued by the post office with which the letter is certified, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in court proceeding, or of the superintendent in administrative proceeding, showing compliance therewith are filed with the clerk of the court in which such action, suit or proceeding is pending or with the superintendent in administrative proceedings, on or before the date the defendant in the court or administrative proceedings is required to appear or respond thereto, or within such further time as the court or superintendent may allow.

C. No plaintiff shall be entitled to a judgment or determination by default in any court or administrative proceeding in which court process or notice, order, pleading or process in proceedings before the superintendent is served under this section until the expiration of forty-five (45) days from the date of filing of the affidavit of compliance.

D. Nothing in this section limits or affects the right to serve any process, notice, order or demand upon any person or insurer in any other manner permitted by law.

History: Laws 1984, ch. 127, § 262.

59A-15-8. Defense of action by unauthorized insurer; bond.

A. Before any unauthorized insurer files or causes to be filed any pleading in any court action, suit or proceeding or any notice, order, pleading or process in an administrative proceeding before the superintendent instituted against such person or insurer, by service made as provided in Section 262 [59A-15-7 NMSA 1978] of this article, such insurer shall either:

(1) deposit with the clerk of the court in which such action, suit or proceeding is pending, or with the superintendent in administrative proceedings before the superintendent, cash or securities, or file with such clerk or the superintendent a bond with good and sufficient sureties, to be approved by the clerk or the superintendent, in an amount to be fixed by the court or superintendent sufficient to secure the payment of any final judgment which may be rendered in such action or administrative proceeding; or

(2) procure a certificate of authority to transact insurance in this state. In considering the application of an insurer for a certificate of authority, for the purposes of this paragraph the superintendent need not assert the provisions of Section 100 [59A-5-33 NMSA 1978] (reciprocity provision) of the Insurance Code against such insurer with respect to its application if he determines that the insurer would otherwise comply with the requirements for such certificate of authority.

B. The superintendent, in any administrative proceeding in which service is made as provided in Section 262 of this article, may in his discretion order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Paragraph (1) above, and to defend such action.

C. Nothing in Subsection A above, shall be construed to prevent an unauthorized insurer from filing a motion to quash a writ or to set aside service thereof, on the ground that such unauthorized insurer has not transacted insurance in this state.

History: Laws 1984, ch. 127, § 263.

59A-15-9. Enforcement of foreign decrees.

A. As used in this section:

(1) "foreign decree" means any decree or order in equity of a court located in a reciprocal state, including a court of the United States located therein, against any insurer incorporated or authorized to do business in this state;

(2) "qualified party" means a state regulatory agency acting in its capacity to enforce the insurance laws of its state; and

(3) "reciprocal state" means any state the laws of which contain procedures substantially similar to those specified in this section for the enforcement of decrees or orders in equity issued by courts located in other states, against any insurer incorporated or authorized to do business in such state.

B. The attorney general upon request of the superintendent may proceed in the courts of this state or any reciprocal state to enforce an order or decision in any court proceeding or in any administrative proceeding before the superintendent.

C. The superintendent shall determine which states qualify as reciprocal states and shall maintain at all times an up-to-date list of such states.

D. A copy of any foreign decree authenticated in accordance with federal statutes may be filed in the office of the clerk of any district court of this state. The clerk, upon verifying with the superintendent that the decree or order qualified as a foreign decree[,] shall treat the foreign decree in the same manner as a decree of a district court of this state. A foreign decree so filed has the same effect and shall be deemed as a decree of a district court of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating or staying as a decree of a district court of this state and may be enforced or satisfied in like manner.

E. At the time of the filing of the foreign decree, the attorney general shall make and file with the clerk of the court an affidavit setting forth the name and last-known post office address of the defendant.

Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given and to the superintendent and shall make a note of the mailing in the docket. In addition, the attorney general may mail a notice of the filing of the foreign decree to the defendant and to the superintendent and may file proof of mailing with the clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the attorney general has been filed. No execution or other process for enforcement of a foreign decree filing [filed] under this section shall issue until thirty (30) days after the date the decree is filed.

F. If the defendant shows the district court:

(1) that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires or the stay of execution expires or is vacated upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered; or

(2) on any ground upon which enforcement of a decree of any district court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.

G. Any person filing a foreign decree shall pay to the clerk of the court the applicable statutory filing fee. Fees for docketing, transcription or other enforcement proceedings shall be the same as are provided for decrees of the district court.

History: Laws 1984, ch. 127, § 264.

59A-15-10. Penalty for violation.

Any unauthorized insurer which transacts in this state any insurance business in violation of the Insurance Code shall be subject to fine of not to exceed twenty thousand dollars ($20,000) for each such violation.

History: Laws 1984, ch. 127, § 265.

59A-15-11. Unauthorized Insurers False Advertising Process Law; title.

Sections 266 through 268 [59A-15-11 to 59A-15-13 NMSA 1978] of this article constitute and may be referred to as the "Unauthorized Insurers False Advertising Process Law".

History: Laws 1984, ch. 127, § 266.

59A-15-12. Notice to domiciliary supervisory official.

No unauthorized insurer through any estimate, illustration, circular, pamphlet, letter, announcement, statement or any other means or medium shall misrepresent to any person in this state its financial condition or the terms of any contract issued or to be issued by it or the advantages thereof, or the dividends or share to be received thereon. Whenever the superintendent has reason to believe that any such insurer is so misrepresenting, he shall notify the insurer and the insurance supervisory officer of the insurer's domiciliary state or province by registered or certified mail.

History: Laws 1984, ch. 127, § 267.

59A-15-13. Action by superintendent.

A. If within thirty (30) days following the giving of the notice provided for in Section 267 [59A-15-12 NMSA 1978] of the article the insurer has not ceased such dissemination, and if the superintendent has reason to believe that such insurer is

soliciting, issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or performing any other transaction in connection with such insurance, and that a proceeding by him in respect to such matters would be to the interest of the public, he shall take action against such insurer under the provisions of Section 262 [59A-15-7 NMSA 1978] of the article (service of process on unauthorized insurer).

B. If upon such hearing the superintendent finds that the insurer has misrepresented as referred to in Section 267 of the article, he shall by order on such hearing require the insurer to cease and desist from such violation, and shall mail a copy of the order by registered or certified mail to the insurer at its principal place of business last of record with the superintendent, and to the insurance supervisory officer of the insurer's domiciliary state, country or province. Each violation thereafter of such desist order shall subject the insurer to a penalty of two thousand dollars ($2,000), to be recovered by a civil action brought against the insurer by the superintendent. Service of process upon the insurer in such action may be made upon the superintendent pursuant to Section 262 of this article or in any other lawful manner.

History: Laws 1984, ch. 127, § 268.

59A-15-14. Short title; Health Care Benefits Jurisdiction Act.

Sections 59A-15-14 through 59A-15-19 NMSA 1978 may be cited as the "Health Care Benefits Jurisdiction Act".

History: 1978 Comp., § 59A-15-14, enacted by Laws 1991, ch. 125, § 20.

59A-15-15. Purpose.

The purpose of the Health Care Benefits Jurisdiction Act [59A-15-14 to 59A-15-19 NMSA 1978] is to assure the superintendent's jurisdiction over providers of health care benefits in this state; to indicate how each provider of health care benefits may demonstrate under which regulatory jurisdiction it falls; to allow for examinations by the superintendent if the provider of health care benefits is unable to demonstrate that it is subject to another regulatory jurisdiction; and to require disclosure to purchasers of such plans information as to whether the plans are fully insured.

History: 1978 Comp., § 59A-15-15, enacted by Laws 1991, ch. 125, § 21.

59A-15-16. Jurisdiction over health care benefits providers presumed.

Notwithstanding any other provision of law and except as provided in the Health Care Benefits Jurisdiction Act [59A-15-14 to 59A-15-19 NMSA 1978], any person who provides coverage in this state for health benefits, including coverage for medical,

surgical, hospital, osteopathic, acupuncture and oriental medicine, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental or optometric expenses, whether such coverage is by direct payment, reimbursement or otherwise, shall be presumed to be subject to the provisions of the Insurance Code and the jurisdiction of the superintendent unless the person provides evidence satisfactory to the superintendent that he is subject exclusively to the jurisdiction of another agency of this state or the federal government.

History: 1978 Comp., § 59A-15-16, enacted by Laws 1991, ch. 125, § 22; 1993, ch. 158, § 3.

59A-15-17. Demonstrating jurisdiction.

Any person providing coverage for health care benefits as described in Section 59A-15-16 NMSA 1978 may demonstrate that it is subject to the jurisdiction of another agency of this state or the federal government by providing to the superintendent:

A. the appropriate certificate, license or other document issued by the other governmental agency that permits or qualifies it to provide such coverage; or

B. other evidence satisfactory to the superintendent, after consultation with the other governmental agency, if necessary, that the provider is acting pursuant to a federal or state law that grants exclusive jurisdiction to a federal agency or another agency of this state.

History: 1978 Comp., § 59A-15-17, enacted by Laws 1991, ch. 125, § 23.

59A-15-18. Examination.

Any person providing coverage for health care benefits as described in Section 59A-15-16 NMSA 1978 who is unable to demonstrate under Section 59A-15-17 NMSA 1978 that he is subject to the exclusive jurisdiction of another agency of this state or the federal government shall submit to an examination by the superintendent in accordance with Chapter 59A, Article 4 NMSA 1978 to determine the organization and financial condition of the provider and his compliance with the applicable provisions of the Insurance Code.

History: 1978 Comp., § 59A-15-18, enacted by Laws 1991, ch. 125, § 24.

59A-15-19. Disclosure.

Any agent or administrator that advertises, sells, transacts or administers coverage in this state as described in Section 59A-15-16 NMSA 1978 shall, if the coverage is not fully insured or otherwise fully covered by an authorized insurer, advise every purchaser, prospective purchaser and covered person of the lack of insurance or other coverage. Any administrator that advertises or administers such coverage in this state

shall inform any producing agency of the elements of the coverage including the amount of any applicable stop-loss insurance and the insurer affording it.

History: 1978 Comp., § 59A-15-19, enacted by Laws 1991, ch. 125, § 25.

59A-15-20. Multiple-employer welfare arrangements; regulations.

A. The superintendent, after a public hearing, shall, no later than October 1, 2001, adopt reasonable rules and regulations governing any employee welfare benefit plan that is a multiple-employer welfare arrangement. The regulations at a minimum shall provide for:

(1) registration of all such plans and standards requiring the maintenance of specified levels of reserves;

(2) minimum solvency requirements;

(3) accounting standards and reporting requirements;

(4) standards for appropriate investment of assets;

(5) standards for excess or stop-loss insurance coverage;

(6) specified levels of contributions that any such plan, or any trust established under such a plan, must meet;

(7) methods for equitable assessment of member employers for any funding shortfall; and

(8) standards for adequate governance.

B. The rules and regulations shall provide for compliance with the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978] and provide standards for minimum benefits, including coverage of all benefits required of health insurance under other sections of the Insurance Code [Chapter 59A NMSA 1978].

C. The rules and regulations shall provide that all employees or association members shall be eligible for participation in the plan.

D. Any standards for determining or assuring solvency shall not be applicable to plans that are fully insured by carriers authorized to transact insurance in New Mexico. If at any time a plan does not meet the standards established, the superintendent may take action pursuant to the Insurance Code.

History: 1978 Comp., § 59A-15-20, enacted by Laws 1991, ch. 125, § 26; 2001, ch. 223, § 1.

59A-15-21. Short title.

Chapter 59A, Article 15 NMSA 1978 may be cited as the "Unauthorized Insurers Law".

History: 1978 Comp., § 59A-15-21, enacted by Laws 1993, ch. 320, § 55.

ARTICLE 16
Trade Practices and Frauds

59A-16-1. Scope of article.

The provisions of Chapter 59A, Article 16 NMSA 1978 as applicable shall apply as to insurers, fraternal benefit societies, nonprofit health care plans, health maintenance organizations, prepaid dental services organizations, motor clubs, agents, brokers, solicitors, adjusters, providers of services contracts pursuant to the Service Contract Regulation Act [Chapter 59A, Article 58 NMSA 1978] and all other persons engaged in any business which is now or hereafter subject to the superintendent's supervision under the Insurance Code [Chapter 59A NMSA 1978], as well as all alien and foreign insurers delivering or issuing for delivery in New Mexico any certificate or other evidence of coverage. For the purposes of that article, the societies, organizations, clubs and persons shall be included within the meaning of "insurer", and contracts issued by them are included within the meaning of "policy".

History: Laws 1984, ch. 127, § 269; 1985, ch. 164, § 1; 1987, ch. 259, § 16; 2001, ch. 206, § 19.

59A-16-2. Purpose of article.

A purpose of this article is to regulate trade practices in the insurance business and related businesses in accordance in part with the intent of Congress as expressed in the Act of Congress approved March 9, 1945, being c. 20, 59 Stat. 33, also designated as 15 U.S.C. Secs. 1011 to 1015, inclusive, by defining, or providing for determination of, practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices so defined or determined.

History: Laws 1984, ch. 127, § 270.

59A-16-3. Practices and acts prohibited, in general.

No person shall engage in this state in any practice which in this article is defined or prohibited as, or determined to be, an unfair method of competition, or unfair or deceptive act or practice, or fraudulent.

History: Laws 1984, ch. 127, § 271.

59A-16-4. Misrepresentation, false advertising of policies.

No person shall make, publish, issue or circulate any estimate, illustration, circular, statement, sales presentation or comparison which:

A. misrepresents the benefits, advantages, conditions or terms of any policy;

B. misrepresents the premium overcharge commonly called dividends or share of the surplus to be received on any policy;

C. makes any false or misleading statement as to dividends or share of surplus previously paid on any policy;

D. is misleading or a misrepresentation as to the financial condition of any person, or as to the reserve system upon which any life insurer operates;

E. uses any name or title of any policy or class of policies misrepresenting the true nature thereof;

F. misrepresents any policy as being shares of stock; or

G. fails to disclose material facts reasonably necessary to prevent other statements made from being misleading.

History: Laws 1984, ch. 127, § 272.

59A-16-5. False information, advertising.

No person shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, any advertisement, announcement or statement containing any assertion, representation or statement with respect to any business subject to the superintendent's supervision under the Insurance Code, or with respect to any person in the conduct of such business, which is untrue, deceptive or misleading.

History: Laws 1984, ch. 127, § 273.

59A-16-6. "Twisting" prohibited.

No person shall make or issue, or cause to be made or issued in any manner, any written or oral statement misrepresenting or making misleading comparison as to the terms, conditions, benefits or advantages of any policy for the purpose of inducing or

attempting or tending to induce any other person to lapse, forfeit, surrender, borrow against, retain, exchange, convert or otherwise deal with or dispose of any policy.

History: Laws 1984, ch. 127, § 274.

59A-16-7. Replacement of life insurance.

In addition to other powers of the superintendent in respect thereto, the superintendent shall by regulation require persons who replace or offer or propose to replace existing life insurance with other life insurance, to disclose to the policyholder all information the superintendent deems relevant in a form and manner and at a time set by the superintendent.

History: Laws 1984, ch. 127, § 275.

59A-16-7.1. Unclaimed life insurance benefits.

A. As used in this section:

(1) "contract" means an annuity contract but excludes annuity contracts used to fund employment-based retirement plans or programs in which the insurer is not committed by the terms of the annuity contract to pay a death benefit to the beneficiaries of specific plan participants;

(2) "death master file" means the federal social security administration's death master file or another database or service for determining that a person has died and that is at least as comprehensive as the federal social security administration's death master file;

(3) "match" means a search of a death master file that results in a match of the social security number or the name and date of birth of an insured, annuity owner or retained asset account holder; and

(4) "policy" means a policy or certificate of life insurance that provides a death benefit, but excludes policies or certificates of credit life or accidental death insurance, policies or certificates of life insurance used to fund a preneed funeral contract or funeral prearrangement and policies or certificates of life insurance that provide a death benefit pursuant to an employee benefit plan that are:

(a) subject to the federal Employee Retirement Income Security Act of 1974, as amended; or

(b) under a federal employee benefit program.

B. At least twice a year, an insurer shall crosscheck its insureds' in-force life insurance policies and retained-asset accounts against a death master file to identify potential matches. For each potential match, within ninety days, the insurer shall:

(1) make and document a good faith effort to confirm the death of the insured or retained-asset account holder by using other available records and information;

(2) determine whether the applicable policy or contract provides for the payment of a death benefit. If the payment of a death benefit is required, the insurer shall:

(a) make and document a good faith effort to locate the beneficiary or beneficiaries; and

(b) provide to the beneficiary or beneficiaries the appropriate claim forms or instructions for making a claim, including the need to provide an official death certificate if required by the policy or contract; and

(3) in the case of group life insurance, confirm the possible death of an insured; provided that the insurer maintains at least the following information about those covered under a policy or certificate:

(a) social security number, or name and date of birth;

(b) beneficiary designation information;

(c) coverage eligibility;

(d) benefit amount; and

(e) premium payment status.

C. To the extent permitted by law, an insurer may disclose the minimum information about the insured or the beneficiary that is necessary to locate a beneficiary or another person entitled to receive a payment of the claims proceeds to a person whom the insurer reasonably believes could assist the insurer in locating the beneficiary or another person entitled to receive a payment of the claims proceeds. An insurer or its service provider shall not charge an insured, an account holder or a beneficiary for a search or confirmation conducted pursuant to this subsection.

D. The benefits from a life insurance policy or a retained asset account, plus any applicable accrued interest, shall be payable pursuant to the terms of the contract or, if applicable, in accordance with probate law. If the proper recipients of a life insurance policy or a retained asset account cannot be found, the benefits shall escheat to New Mexico as unclaimed property pursuant to the Uniform Unclaimed Property Act (1995) [Chapter 7, Article 8A NMSA 1978]. Upon the expiration of the statutory time period for

escheat, an insurer shall notify the taxation and revenue department that a life insurance policy beneficiary or retained asset account holder has not submitted a claim with the insurer and the insurer has complied with the provisions of Subsection B of this section and has been unable to contact the retained asset account holder, beneficiary or beneficiaries. Upon notifying the taxation and revenue department, the insurer shall submit the unclaimed life insurance benefits or unclaimed retained asset accounts, plus any applicable accrued interest, to the taxation and revenue department pursuant to the Uniform Unclaimed Property Act (1995).

E. To assist the superintendent in identifying lost policies, by July 1, 2016, an insurer that has never conducted a crosscheck of its insureds' policies and contracts issued prior to July 1, 2013 against a death master file for the purpose of identifying deceased insureds shall provide to the superintendent a list of all policies and contracts in force and issued in New Mexico.

F. For an insurer that has never conducted a crosscheck of its insureds' policies and contracts against a death master file for the purpose of identifying deceased insureds, the provisions of this section shall apply only to policies and contracts issued and delivered in New Mexico on or after July 1, 2013.

History: Laws 2013, ch. 100, § 1.

59A-16-8. Falsification, omission of records; misleading financial statements.

A. No person shall make or cause to be made any false entry in any book, report or statement of any insurer with intent to injure or defraud the insurer or any other person, or to deceive any officer of the insurer, or the superintendent or any examiner appointed to examine the affairs of the insurer. Any person who violates this subsection, or with like intent aids or abets any such violation is guilty of a felony.

B. No person shall with intent to deceive the insurer, or the superintendent or any examiner appointed to examine into the insurer's affairs, omit to make a true entry of any material fact pertaining to the insurer's business in any book, report or statement of the insurer. A violation of this subsection shall be subject to the same penalty as prescribed in Subsection A.

C. No person shall knowingly file with any supervisory or other public officer, or make, publish, disseminate, circulate or deliver to any person, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of the financial condition of an insurer.

D. No person shall advertise the capital or assets of an insurer without the same advertisement setting forth the amount of the insurer's liabilities.

History: Laws 1984, ch. 127, § 276.

59A-16-9. Publication of nonstatutory financial statements.

Any other provision of the Insurance Code to the contrary notwithstanding, an insurer may, subject to requirements of regulations promulgated by the superintendent, for proper special purposes prepare and publish financial statements or information based on financial statements prepared on bases which are in accordance with requirements of the Securities and Exchange Commission or other such competent authority, and which differ from the bases of statements filed with the superintendent.

History: Laws 1984, ch. 127, § 277.

59A-16-10. Defamation.

A. No person shall make, publish, disseminate or circulate, directly or indirectly, or aid, abet, counsel, procure or encourage the making, publishing, disseminating, transmission or circulation to another, of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of, or derogatory as to financial condition or otherwise as to an insurer or organization proposing to become an insurer, and which is calculated to injure such insurer, or proposed insurer, or any person engaged or proposing to engage in any of the business of or with an insurer.

B. Any person who violates this section shall be guilty of a misdemeanor and is subject to the penalties prescribed by Section 18 [59A-1-18 NMSA 1978] (general penalty) of the Insurance Code.

History: Laws 1984, ch. 127, § 278.

59A-16-11. Unfair discrimination prohibited; life and health insurance.

No insurer or person shall make or permit any unfair discrimination:

A. between individuals of the same class and equal expectation of life in rates charged for any contract of life insurance or of life annuity, or in dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; or

B. between individuals and risks of the same class and of essentially the same hazard, in amount of premium, fees or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such policy or contract, or in any other manner whatever.

History: Laws 1984, ch. 127, § 279.

59A-16-11.1. Medical Insurance Pool Act; unfair referral.

It is an unfair trade practice for an insurer or other person to refer an individual employee or an employee's eligible dependent to the plan offered pursuant to the Medical Insurance Pool Act [Chapter 59A, Article 54 NMSA 1978] or to arrange for an individual employee or an employee's eligible dependent to apply to the plan, for the purpose of separating that employee or dependent from group health insurance coverage provided in connection with the employee's employment.

History: Laws 2001, ch. 352, § 14.

59A-16-12. Discrimination in insurance.

No insurer shall, on the basis of the race, color, religion or national origin of any individual or group of persons:

A. refuse to make insurance available to any applicant for insurance; or

B. treat any such applicant or insured differently than any other applicant or insured with respect to the terms, conditions, rates, benefits or requirements of any such insurance contract.

This section shall not apply to life insurance contracts or annuities entered into prior to the section's effective date. This section shall not be construed to affect criteria for acceptance into membership of any fraternal benefit society.

History: Laws 1984, ch. 127, § 279.1.

59A-16-12.1. Discrimination on the basis of deterioration in health.

A. No insurer shall cancel or change the premiums, benefits or conditions of an individual health insurance policy or contract as to one insured solely because of a deterioration in the health of that insured occurring after the issuance or delivery of the policy or contract.

B. No conversion of a group health insurance policy that provides hospital, surgical and medical expense benefits shall be made to a conversion policy that has not been approved and found by the superintendent to provide benefits and conditions closely approximating the coverage of the policy from which conversion is exercised.

History: 1978 Comp., § 59A-16-12.1, enacted by Laws 1991, ch. 111, § 12.

59A-16-13. Prohibiting sex discrimination in insurance.

No insurer shall refuse to insure, refuse to continue to insure or limit the amount of coverage available to an individual because of the sex of the individual.

History: Laws 1984, ch. 127, § 279.2.

59A-16-13.1. Craniomandibular and temporomandibular joint disorders.

No insurer or other provider of health care benefits regulated under Articles 22, 23, 24A, 44, 46, 47 or 54 of the Insurance Code shall, after July 1, 1989, issue, deliver or execute in this state any policy, plan, contract or certificate of health, medical, hospitalization, accident or sickness coverage unless the policy, plan, contract, certificate or other evidence of coverage provides for surgical and nonsurgical treatment of temporomandibular joint disorders and craniomandibular disorders, subject to the same conditions, limitations, prior review and referral procedures as are applicable to treatment of any other joint in the body and treatable by any practitioner of the healing arts as defined in Section 59A-22-32 NMSA 1978. The health care coverage for craniomandibular and temporomandibular joint disorders required by this section may be subject to reasonable copayments or coinsurance provisions and need not include coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related.

History: 1978 Comp., § 59A-16-13.1, enacted by Laws 1989, ch. 304, § 1; 1999, ch. 289, § 22.

59A-16-13.2. Discrimination on the basis of blindness.

A. No insurer, including health maintenance organizations, nonprofit health care plans and fraternal benefit societies, shall refuse to insure, or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of blindness, including partial blindness.

B. With respect to the underlying cause of the blindness, persons who are blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons, and blindness may be considered as evidence of the severity or progression of the underlying cause.

C. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses his eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness when such condition exists at the time the policy is issued.

History: 1978 Comp., § 59A-16-13.2, enacted by Laws 1993, ch. 126, § 1.

59A-16-14. Coercion of business prohibited; notice required; charges prohibited.

A. No person engaged in selling real or personal property or in the business of financing the purchase of real or personal property, or of lending money on the security of real or personal property, and no trustee, director, officer, agent or other employee of the person shall require, as a condition precedent, concurrent or subsequent to the sale, or financing the purchase of property, or to lending money upon the security of a mortgage on the property, or as a condition precedent, concurrent or subsequent, for the renewal or extension of the loan or mortgage or for the performance of any other act in connection therewith, that the person purchasing the property, or for whom the purchase is to be financed, or to whom the money is to be loaned, or for whom the extension, renewal or other act is to be granted, or performed, negotiate a policy of insurance or renewal covering the property through a particular insurer or insurance producer. The lender is required to inform the buyer of the buyer's rights regarding the placing of insurance on a form prescribed by the superintendent. The buyer must signify that the buyer has been so informed. This section shall not prevent the exercise by a person of the right to designate the terms and provisions of the policy and the amount of coverage with respect to insurance on property pledged or mortgaged to the person.

B. An insured shall have the option, in addition to the rights granted under the terms and conditions of the insurance contract, at any time to substitute, replace, change or extend the existent policy in force. For the purpose of this section "anniversary date" means the yearly return of the inception of the effective date of policy in force.

C. If the lender signifies that the proposed insurance is acceptable, the buyer must supply the lender with the policy or binder prior to the closing of the loan.

D. If the policy is cancelled by the insurer, the borrower must have a new policy in the hands of the lender twenty-four hours prior to the effective day of the cancellation.

E. The borrower or the borrower's insurance producer must deliver a renewal policy or an annual renewal certificate to the lender at least fifteen days prior to expiration or renewal of the policy in force if required by the lender.

F. When the insured wants to change insurance producers, the insurance producer writing the renewal business must file with the lender a current letter of authority signed by the borrower. If a change of insurance producers is involved in the renewal of the policy, the lender shall notify the insurance producer renewing the insurance and the borrower in writing within five business days after tender of renewal policy, if the renewal policy is not acceptable to the lender.

G. No person engaged in selling real or personal property or in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property shall charge, either directly or indirectly to a borrower or debtor a consideration of any kind to substitute the insurance policy of one insurer of the

property for that of another, or make a charge for a change in the kind, type or amount of the insurance if the change is made at the time the borrower or debtor first becomes a party to the transaction for which the insurance is required, or at an annual renewal date of the policy.

H. No person engaged in the business of selling real or personal property or financing purchase or lending money on security of real or personal property shall share information received in connection with an application for credit in the purchase or for the loan with any parent corporation, subsidiary or affiliate of the person or with an insurer, for the purpose of soliciting insurance, unless the person has written authorization to release the information executed by the purchaser or borrower subsequent to extension of credit or making of the loan.

I. In addition to other penalties provided in Section 59A-1-18 NMSA 1978, a lender who violates this section shall be liable in a civil action brought by a buyer, insured or insurance producer injured by the violation, or each of them, for an amount of liquidated damages equal to the amount of actual damages as a result of coercion prohibited by this section.

History: Laws 1984, ch. 127, § 280; 2016, ch. 89, § 58.

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.

History: Laws 1984, ch. 127, § 281; 2021, ch. 108, § 9.

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.

History: Laws 1984, ch. 127, § 282; 2021, ch. 108, § 10.

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.

History: Laws 1984, ch. 127, § 283; 2009, ch. 80, § 1; 2016, ch. 89, § 59; 2019, ch. 32, § 1; 2021, ch. 108, § 11.

59A-16-18. Receipt of rebates and inducements; penalty.

Any person not a licensed agent, broker, solicitor or other representative, who at any time knowingly receives any rebate of any premium specified in any insurance policy or coverage, or any special favor or advantage of any kind or nature whatsoever not plainly designated in the policy, or receive any dividends or profits, except dividends on participating policies, or agrees to receive such dividends or profits or anything of value whatsoever not specified in the policy other than matters exempted under Sections 282 and 283 [59A-16-16 and 59A-16-17 NMSA 1978] of this article, shall upon conviction thereof be guilty of a misdemeanor punishable by a fine of not over one thousand dollars ($1,000).

History: Laws 1984, ch. 127, § 284.

59A-16-19. Monopolistic practices prohibited.

No person shall enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting or tending to result in unreasonable restraint of, or monopoly in, the business of insurance in this state, or in the business of health care services, prepaid dental services, motor clubs or bail bondsmen.

History: Laws 1984, ch. 127, § 285.

59A-16-20. Unfair claims practices defined and prohibited.

Any and all of the following practices with respect to claims, by an insurer or other person, knowingly committed or performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited:

A. misrepresenting to insureds pertinent facts or policy provisions relating to coverages at issue;

B. failing to acknowledge and act reasonably promptly upon communications with respect to claims from insureds arising under policies;

C. failing to adopt and implement reasonable standards for the prompt investigation and processing of insureds' claims arising under policies;

D. failing to affirm or deny coverage of claims of insureds within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured;

E. not attempting in good faith to effectuate prompt, fair and equitable settlements of an insured's claims in which liability has become reasonably clear;

F. failing to settle all catastrophic claims within a ninety-day period after the assignment of a catastrophic claim number when a catastrophic loss has been declared;

G. compelling insureds to institute litigation to recover amounts due under policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds when such insureds have made claims for amounts reasonably similar to amounts ultimately recovered;

H. attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

I. attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his representative, agent or broker;

J. failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;

K. making known to insureds or claimants a practice of insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

L. delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

M. failing to settle an insured's claims promptly where liability has become apparent under one portion of the policy coverage in order to influence settlement under other portions of the policy coverage;

N. failing to promptly provide an insured a reasonable explanation of the basis relied on in the policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

O. violating a provision of the Domestic Abuse Insurance Protection Act [59A-16B-1 to 59A-16B-10 NMSA 1978].

History: Laws 1984, ch. 127, § 286; 1993, ch. 82, § 1; 1997, ch. 141, § 11.

59A-16-20.1. Homeowner's casualty insurance; premium rate and policy; protection after natural disaster.

A. A homeowner's casualty insurance policy shall not be canceled or denied renewal because of a homeowner's claim made as a result of damages caused by a

natural disaster to the homeowner's private residence, provided that the homeowner's policy expressly provides for such coverage.

B. The provisions of this section apply to all insurance carriers authorized under the Insurance Code [Chapter 59A NMSA 1978] to transact homeowner's casualty insurance policies. For the purposes of this section, "natural disaster" means any hurricane, tornado, storm, flood, high water, wind-driven water, earthquake, landslide, mudslide, snowstorm, drought, fire, explosion or other catastrophe that results in substantial damage to property, hardship, suffering or loss of life.

History: Laws 1993, ch. 350, § 1; 2007, ch. 282, § 10.

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 [Chapter 59A NMSA 1978], 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.

History: Laws 1984, ch. 127, § 287; 1986, ch. 109, § 2; 1987, ch. 259, § 17; 2017, ch. 15, § 1; 2017, ch. 130, § 12; 2021, ch. 108, § 12.

59A-16-21.1. Health plan requirements.

A. As used in this section:

(1) "clean claim" means a manually or electronically submitted claim from an eligible provider that:

(a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health plan's system;

(b) is not materially deficient or improper, including lacking substantiating documentation currently required by the health plan; and

(c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the health plan within fourteen days of receipt of a claim for prescription drugs and related fees if submitted electronically by a pharmacy, thirty days of the date of receipt of any other electronically submitted claim or forty-five days if submitted manually;

(2) "eligible provider" means an individual or entity that:

(a) is a participating provider;

(b) a health plan has credentialed after assessing and verifying the provider's qualifications; or

(c) a health plan is obligated to reimburse for claims in accordance with the provisions of: 1) Subsection G of Section 59A-22-54 NMSA 1978; 2) Subsection G of Section 59A-23-14 NMSA 1978; 3) Subsection G of Section 59A-46-54 NMSA 1978; or 4) Subsection G of Section 59A-47-49 NMSA 1978;

(3) "health plan" means one of the following entities or its agent: health maintenance organization, nonprofit health care plan, provider service network or third-party payer; and

(4) "participating provider" means an individual or entity participating in a health plan's provider network.

B. A health plan shall provide for payment of interest on the plan's liability at the rate of one and one-half percent a month on:

(1) the amount of a clean claim electronically submitted by the eligible provider and not paid within thirty days of the date of receipt and within fourteen days of the date of receipt of a claim for prescription drugs and related fees if the eligible provider is a pharmacy; and

(2) the amount of a clean claim manually submitted by the eligible provider and not paid within forty-five days of the date of receipt.

C. If a health plan is unable to determine liability for or refuses to pay a claim of an eligible provider within the times specified in Subsection B of this section, the health plan shall make a good-faith effort to notify the eligible provider by fax, electronic or other written communication within fourteen days of receipt of a claim for prescription drugs and related fees if submitted electronically by a pharmacy, thirty days of receipt of any other electronically submitted claim or forty-five days if submitted manually, of all specific reasons why it is not liable for the claim or that specific information is required to determine liability for the claim.

D. No contract between a health plan and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

E. The office of superintendent of insurance, with input from interested parties, including health plans and eligible providers, shall promulgate rules to require health plans to provide:

(1) timely eligible provider access to claims status information;

(2) processes and procedures for submitting claims and changes in coding for claims;

(3) standard claims forms; and

(4) uniform calculation of interest.

History: Laws 2000, ch. 58, § 1; 1978 Comp., § 59A-2-9.2, recompiled as § 59A-16-21.1 by Laws 2003, ch. 202, § 15; 2013, ch. 74, § 19; 2016, ch. 20, § 1; 2021, ch. 45, § 1.

59A-16-21.2. Health benefits plans; prohibition; unlicensed health benefits plans; unapproved health benefits plans.

A. No person or entity shall sell or issue, or cause to be sold or issued, a health benefits plan that is unlicensed or unapproved for sale or delivery in the state.

B. No person or entity shall sell or issue, or cause to be sold or issued, health insurance coverage that is not permitted health insurance coverage.

C. As used in this section:

(1) "health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; and

(2) "health insurance carrier" means an entity subject to the insurance laws and regulations of this state, including a health insurance company, a health

maintenance organization, a hospital and health services corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefits plans or managed health care plans in this state.

History: Laws 2019, ch. 235, § 7.

59A-16-21.3. Health care providers; surprise billing prohibited.

A. A provider shall not knowingly submit to a covered person a surprise bill for health care services, which surprise bill demands payment for any amount in excess of the cost-sharing amounts that would have been imposed by the covered person's health benefits plan if the health care service from which the surprise bill arises had been rendered by a participating provider.

B. It shall be an unfair practice for a health care provider to knowingly submit a surprise bill to a collection agency.

C. As used in this section:

(1) "covered person" means:

(a) an enrollee, policyholder or subscriber;

(b) the enrolled dependent of an enrollee, policyholder or subscriber; or

(c) another individual participating in a health benefits plan;

(2) "emergency care" means a health care procedure, treatment or service, excluding ambulance transportation service, which procedure, treatment or service is delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person;

(3) "facility" means an entity providing a health care service, including:

(a) a general, special, psychiatric or rehabilitation hospital;

(b) an ambulatory surgical center;

(c) a cancer treatment center;

(d) a birth center;

(e) an inpatient, outpatient or residential drug and alcohol treatment center;

(f) a laboratory, diagnostic or other outpatient medical service or testing center;

(g) a health care provider's office or clinic;

(h) an urgent care center;

(i) a freestanding emergency room; or

(j) any other therapeutic health care setting;

(4) "freestanding emergency room" means a facility licensed by the department of health that is separate from an acute care hospital and that provides twenty-four-hour emergency care to patients at the same level of care that a hospital-based emergency room delivers;

(5) "health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided that "health benefits plan" does not include any of the following:

(a) an accident-only policy;

(b) a credit-only policy;

(c) a long- or short-term care or disability income policy;

(d) a specified disease policy;

(e) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

(f) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act [27-2-1 to 27-2-34 NMSA 1978];

(g) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

(h) a fixed or hospital indemnity policy;

(i) a dental-only policy;

(j) a vision-only policy;

(k) a workers' compensation policy;

(l) an automobile medical payment policy; or

(m) any other policy specified in rules of the superintendent;

(6) "health care services":

(a) means any service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or other disease, including physical or behavioral health services, to the extent offered by a health benefits plan; and

(b) does not mean ambulance transportation services;

(7) "health insurance carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services or that provides, offers or administers a health benefit policy or managed health care plan in the state;

(8) "hospital" means a facility offering inpatient health care services, nursing care and overnight care for three or more individuals on a twenty-four-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions;

(9) "nonparticipating provider" means a provider who is not a participating provider;

(10) "participating provider" means a provider or facility that, under express contract with a health insurance carrier or with a health insurance carrier's contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost sharing;

(11) "prior authorization" means a pre-service determination made by a health insurance carrier regarding a covered person's eligibility for health care services, medical necessity, benefit coverage and the location or appropriateness of services, pursuant to the terms of a health benefits plan that the health insurance carrier offers;

(12) "provider" means a health care professional, hospital or other facility licensed to furnish health care services; and

(13) "surprise bill":

(a) means a bill that a nonparticipating provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider: 1) emergency care provided by the nonparticipating provider; or 2) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where a: participating provider is unavailable; a nonparticipating provider renders unforeseen services; or a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render the particular services rendered; and

(b) does not mean a bill: 1) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization; or 2) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency care.

History: Laws 2019, ch. 227, § 14.

59A-16-21.4. Unfair trade practices on the basis of disability prohibited.

A. Any of the following practices with respect to a health benefits plan are defined as unfair and deceptive practices and are prohibited:

(1) canceling or changing the premiums, benefits or conditions of a health benefits plan on the basis of an insured's actual or perceived disability;

(2) denying a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity;

(3) failure to apply the most recent version of treatment and fit criteria developed by the professional association with the most relevant clinical specialty when performing a utilization review for a request for coverage of prosthetic or orthotic benefits; and

(4) failure to apply medical necessity review standards developed by the professional association with the most relevant clinical specialty when conducting utilization management review or processing appeals regarding benefit denial.

B. For purposes of this section, "health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse the costs of health care services; provided that "health benefits plan" does not include the following:

(1) an accident-only policy;

(2) a credit-only policy;

(3) a long- or short-term care or disability income policy;

(4) a specified disease policy;

(5) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

(6) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act;

(7) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

(8) a fixed or hospital indemnity policy;

(9) a dental-only policy;

(10) a vision-only policy;

(11) a workers' compensation policy;

(12) an automobile medical payment policy; or

(13) any other policy specified in rules of the superintendent.

History: Laws 2023, ch. 196, § 2.

59A-16-21.5. Health benefits plan disclosure.

Each producer, plan administrator or pharmacy benefits manager licensed in this state shall not produce a health benefits plan for sale or pharmacy benefits services for contract without prior disclosure to the purchaser of the plan or services of the option to contract for pharmaceutical drug cost-sharing protections.

History: Laws 2023, ch. 206, § 2.

59A-16-22. Record of complaints required.

An insurer shall maintain a complete record of all complaints it has received during the next preceding three (3) years, or since date of last examination by the superintendent or other similar supervisory authority, whichever period is shorter. The record shall show the total number of complaints, classification by line of coverage, nature of each complaint, disposition of the complaint and time it took to process each complaint. For purposes of this section "complaint" means any written communication primarily expressing a grievance.

History: Laws 1984, ch. 127, § 288.

59A-16-23. False applications, claims, proofs of loss.

A. An agent, broker, solicitor, examining physician, applicant or other person shall not knowingly or willfully:

(1) make a false or fraudulent statement or representation as to a material fact in or with reference to an application for insurance or other coverage;

(2) for the purpose of obtaining money or benefit, present or cause to be presented a false or fraudulent claim or proof in support of such a claim for payment of loss under a policy;

(3) prepare, make or subscribe a false or fraudulent account, certificate, affidavit or proof of loss or other document with intent that the same may be presented or used in support of such a claim; or

(4) make a false or fraudulent statement or representation on or relative to an application for a policy for the purpose of obtaining a fee, commission or benefit from an insurer, agent, broker or individual.

B. A false statement or representation made under oath shall constitute and be punishable as perjury. A violation of the provisions of this section when the purported loss or potential loss to the victim insurer is:

(1) two hundred fifty dollars ($250) or less is a petty misdemeanor;

(2) over two hundred fifty dollars ($250) but not more than five hundred dollars ($500) is a misdemeanor;

(3) over five hundred dollars ($500) but not more than two thousand five hundred dollars ($2,500) is a fourth degree felony;

(4) over two thousand five hundred dollars ($2,500) but not more than twenty thousand dollars ($20,000) is a third degree felony; or

(5) over twenty thousand dollars ($20,000) is a second degree felony.

History: Laws 1984, ch. 127, § 290; 2006, ch. 29, § 27.

59A-16-24. Illegal dealing in premiums; excess charges for coverage.

A. No person shall wilfully collect any sum as premium or charge for insurance or other coverage, which insurance or coverage is not then provided or in due course to be provided (subject to acceptance of the risk by the insurer) by a policy issued by an insurer as authorized by the Insurance Code.

B. No person shall wilfully collect as premium, administration fee or other charge for insurance or coverage any sum in excess of the premium or charge applicable thereto as specified in the policy, in accordance with the insurer's applicable classifications and rates then lawfully in effect. This subsection shall not be deemed to prohibit:

(1) the charging and collection by surplus line brokers licensed as such under Article 14 [Chapter 59A, Article 14 NMSA 1978] of the Insurance Code, of the amount of applicable taxes, if any, and policy fee, if any, in addition to the premium required by the insurer; or

(2) the charging and collection by a life insurer of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

History: Laws 1984, ch. 127, § 291.

59A-16-25. Knowledge of insurer of prohibited acts.

An insurer shall be held guilty of having committed any of the acts prohibited by this article by reason of the act of any agent, solicitor or employee not an officer, director or department head thereof, if an officer, director or department head of the insurer has authorized or knowingly permitted such act or has had prior knowledge thereof.

History: Laws 1984, ch. 127, § 292.

59A-16-26. Insurer name; deceptive use prohibited.

No person who is not an insurer shall assume or use in this state any name which deceptively implies or suggests that it is an insurer.

History: Laws 1984, ch. 127, § 293.

59A-16-27. Desist orders for prohibited practices.

A. If the superintendent has cause to believe that any unfair method of competition or act or practice defined or prohibited in Chapter 59A, Article 16 NMSA 1978 is being engaged in by any person, he shall order such person to cease and desist therefrom. The superintendent shall deliver such order to such person directly or by certified mail. If the person fails to comply therewith within twenty days after receipt of the cease and desist order, and does not make written request for a hearing thereon within such twenty days, he shall be subject to the penalties referred to in Section 59A-16-29 NMSA 1978, for each violation committed theretofore or thereafter. In any event, if the person does not make a written request for hearing thereon within such twenty days the order shall be final and not subject to review or appeal.

B. If a hearing is so requested, the superintendent shall hold a hearing, and proceed as provided under Chapter 59A, Article 4 NMSA 1978 as to hearings in general.

C. If after such a hearing the violation is confirmed by final order of the superintendent, the violator shall be subject to the penalty referred to in Subsection A of this section, together with payment of the costs of the hearing as determined by the superintendent.

D. If the alleged violator fails to comply with the superintendent's order after expiration of the twenty-day period to request a hearing referred to in Subsection A of this section or after hearing referred to in Subsection C of this section, the superintendent may cause an action for injunction to be filed in the district court of the county in which the violation occurred.

E. No order of the superintendent pursuant to this section or order of court to enforce it, shall in any way relieve or absolve any person affected by such order from any other liability, penalty or forfeiture applicable under law.

F. Nothing in this section shall be construed as relieving any violator from penalties prescribed in Section 59A-16-29 NMSA 1978 whether or not such a cease and desist order is issued or other action hereunder taken by the superintendent.

History: Laws 1984, ch. 127, § 294; 1993, ch. 320, § 56.

59A-16-28. Procedure as to undefined practices.

A. If the superintendent believes that any person engaged in any business which is subject to the superintendent's supervision under the Insurance Code, is in the conduct of such business engaging in this state in any method of competition or in any act or practice not defined in this article which is unfair or deceptive and that a proceeding by him in respect thereto would be in the public interest, the superintendent shall, after a hearing of which notice and of the charges against such person are given him, make a written report of his findings of fact relative to such charges and serve a copy thereof upon such person and any intervenor at the hearing.

B. If such report charges a violation of this article and if such method of competition, act or practice has not been discontinued, the superintendent may at any time after twenty (20) days after the service of such report cause an action to be instituted in the district court of the county wherein the person resides or has his principal place of business to enjoin and restrain such person from engaging in such method, act or practice. The court shall have jurisdiction of the proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue such writs or orders as are ancillary to its jurisdiction or necessary in its judgment to prevent injury to the public pendente lite; but the state of New Mexico shall not be required to give security before the issuance of any such order or injunction under this section. A certified transcript of the record of the proceedings in the hearing before the superintendent, including all evidence taken and the report and findings, shall be received in evidence in such action.

C. If the court finds that:

(1) the method of competition complained of is unfair or deceptive; and

(2) the proceedings of the superintendent with respect thereto are to the interest of the public; and

(3) the findings of the superintendent are supported by the weight of the evidence, it shall issue its order enjoining and restrainting [restraining] the continuance of such method of competition, act or practice.

D. Either party may appeal from such final judgment or order or decree of court in a like manner as provided for appeals in civil cases.

E. If the superintendent's report or order on hearing made under Subsection A does not charge a violation of this article, then any intervenor in the proceedings may appeal therefrom within the time and in the manner provided in the Insurance Code for appeals from the superintendent generally.

History: Laws 1984, ch. 127, § 295.

59A-16-29. Penalties.

In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for violation of any provision of this article may be imposed by the superintendent in accordance with Section 59A-1-18 NMSA 1978.

History: 1978 Comp., § 59A-16-29, enacted by Laws 1991, ch. 111, § 13.

59A-16-30. Private right of action.

Any person covered by Chapter 59A, Article 16 NMSA 1978 who has suffered damages as a result of a violation of that article by an insurer or agent is granted a right to bring an action in district court to recover actual damages. Costs shall be allowed to the prevailing party unless the court otherwise directs. The court may award attorneys' fees to the prevailing party if:

A. the party complaining of the violation of that article has brought an action that he knew to be groundless; or

B. the party charged with the violation of that article has willfully engaged in the violation.

The relief provided in this section is in addition to remedies otherwise available against the same conduct under the common law or other statutes of this state; provided, however, that the Workers' Compensation Act [Chapter 52, Article 1 NMSA 1978] and the New Mexico Occupational Disease Disablement Law provide exclusive remedies.

History: Laws 1984, ch. 127, § 296.1; 1990 (2nd S.S.), ch. 2, § 91.

ARTICLE 16A
Insurance Fraud Reporting Immunity (Repealed.)

59A-16A-1 to 59A-16A-4. Repealed.

ARTICLE 16B
Domestic Abuse Insurance Protection

59A-16B-1. Short title.

Sections 1 through 10 [59A-16B-1 to 59A-16B-10 NMSA 1978] of this act may be cited as the "Domestic Abuse Insurance Protection Act".

History: Laws 1997, ch. 141, § 1.

59A-16B-2. Purpose of act.

The purpose of the Domestic Abuse Insurance Protection Act is to prohibit insurers from unlawfully discriminating on the basis of domestic abuse by using the fact of domestic abuse or the insurer's determination of a person's abuse status as an insurance criterion or rating factor. The Domestic Abuse Insurance Protection Act protects victims of domestic abuse, domestic abuse shelters and others from being unlawfully discriminated against in insurance matters.

History: Laws 1997, ch. 141, § 2.

59A-16B-3. Definitions.

As used in the Domestic Abuse Insurance Protection Act:

A. "abuse-related medical condition" means a medical condition sustained by a victim of domestic abuse that arises in whole or in part out of an act or pattern of abuse;

B. "abuse status" means the fact or the determination by the insurer that a person is a victim of domestic abuse, irrespective of whether the person has sustained abuse-related medical conditions;

C. "confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship;

D. "domestic abuse" means an act of abuse against a person, an abuse-related medical condition suffered by a person or the abuse status of a person, including a minor, that was caused by a family member or a current or former household member, intimate partner or caretaker, including the following:

(1) attempting to cause or intentionally, knowingly or recklessly causing bodily injury to, physical harm to, severe emotional distress to, psychological trauma to or sexual assault on or attempting to rape or raping another person;

(2) knowingly engaging in a course of conduct or repeatedly committing acts, including harassment or stalking, that are intended to or would cause a reasonable person, or do cause a person, to feel terrorized or seriously threatened that death, bodily harm, sexual assault, confinement or restraint may result;

(3) subjecting another person to false imprisonment; or

(4) attempting to cause or intentionally, knowingly or recklessly causing damage to property for the purpose of intimidating or attempting to control the behavior of another person;

E. "insured" means an individual named on a policy as the one with legal rights to the benefits provided by the policy, except for life insurance, for which "insured" means the individual whose life is covered by the policy. For group insurance, "insured" includes an individual who is a beneficiary covered by a group policy. For any insurance policy, "insured" does not include a person who commits an act of domestic abuse;

F. "insurer" means every person engaged as principal or indemnitor, surety or contractor in the business of entering into contracts of insurance, including life insurance, health insurance, automobile insurance, disability insurance and property and casualty insurance, and includes the insurance services offered by fraternal benefit societies, nonprofit health care plans, health maintenance organizations, prepaid dental services organizations, motor clubs, agents, brokers, solicitors, adjusters and all other persons engaged in a business that is now or later becomes subject to the superintendent's supervision pursuant to the Insurance Code, as well as all alien and foreign insurers delivering or issuing for delivery in New Mexico a certificate or other evidence of insurance coverage;

G. "person" means an individual or entity;

H. "policy" means a contract of insurance, certificate, indemnity, suretyship or annuity issued by an insurer, including endorsements or riders to an insurance policy or contract, and includes a contract, certificate or agreement offered by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of insurance services. As applied to a health plan, "policy" includes a plan that is accident only, credit health, dental, vision, medicare supplement or long-term care insurance, coverage issued as a supplement to liability insurance, short-term or catastrophic health insurance plan and a plan that pays on a cost-incurred basis; and

I. "victim of domestic abuse" means a person against whom domestic abuse is directed.

History: Laws 1997, ch. 141, § 3.

59A-16B-4. Unfair discrimination on the basis of a person's abuse status prohibited.

A. An insurer or any person employed by or contracting with an insurer shall not engage in an unfair discriminatory act or practice against a person on the basis of a person's abuse status, including:

(1) denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy on the basis of a person's abuse status;

(2) terminating group health coverage for a victim of domestic abuse because coverage was originally issued in the name of an alleged abuser who has divorced, separated from or lost custody of a victim of domestic abuse or because the alleged abuser's coverage has terminated voluntarily or involuntarily. Nothing in this paragraph prohibits an insurer from requiring a victim of domestic abuse to pay the full premium for health insurance coverage or from requiring as a condition of coverage that a victim of domestic abuse reside or work within the insurer's service area, if the requirements are applied to all insureds. The insurer may terminate group health coverage for a victim of

domestic abuse after the continuation coverage required by this subsection has been in force for eighteen months if the insurer offers conversion to an equivalent individual plan. The continuation coverage required in this subsection may be satisfied by coverage that is provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 to a victim of domestic abuse and is not intended to be in addition to coverage provided under that act;

(3) disclosing or transferring confidential abuse information when the insurer or its employee or contractor has information in its possession that clearly indicates that the applicant or insured is a subject of domestic abuse. The provisions of this paragraph do not prohibit disclosure of information:

(a) to a victim of domestic abuse or an individual specifically designated in writing by the victim, and nothing in this section prohibits a victim of domestic abuse from obtaining the victim's own insurance records;

(b) to a health care provider for the direct provision of health care services;

(c) to a licensed physician identified and designated by the victim of domestic abuse;

(d) pursuant to an order of the superintendent or a court of competent jurisdiction, or as otherwise required by law;

(e) when necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship or that is relevant to processing a claim, provided the recipient has agreed to be bound by the provisions of the Domestic Abuse Insurance Protection Act in all respects and to be subject to enforcement of that act in the courts of this state, and the information is disclosed or transferred only: 1) to a reinsurer that seeks to indemnify or indemnifies all or part of a policy covering a victim of domestic abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without the information; 2) to a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer; 3) to medical or claims personnel contracting with the insurer, its parent or affiliated companies that have service agreements with the insurer, but only when necessary to process an application or claim, perform the insurer's duties under the policy or protect the safety or privacy of a victim of domestic abuse; or 4) with respect to address and telephone number, to entities with which the insurer transacts business when the business cannot be transacted without the address or telephone number;

(f) to an attorney who needs the information to represent the insurer effectively, provided the insurer notifies the attorney of its obligations under the Domestic Abuse Insurance Protection Act and requires that the attorney exercise due diligence to protect confidential abuse information consistent with the attorney's obligation to represent the insurer;

(g) to the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or

(h) to any other entities deemed appropriate by the superintendent; or

(4) requesting information about an applicant's or insured's abuse status, or making use of this information, however obtained, except:

(a) for the limited purpose of complying with legal obligations;

(b) when verifying a person's claim to be a victim of domestic abuse or to be suffering from an abuse-related medical condition; or

(c) when cooperating with a victim of domestic abuse in seeking protection from abuse or facilitating the treatment of an abuse-related medical condition.

B. An insurer may deny a claim when the damage or loss is the result of intentional conduct by a named insured who commits an act of domestic abuse, except that the insurer shall make a payment on such a claim to an innocent insured victim of domestic abuse to the extent of that insured's interest in the property and within the limits of coverage where the damage was proximately related to and in furtherance of domestic abuse. An insurer paying such a claim for property damage shall be subrogated to the rights of the innocent insured claimant to recover for any damages paid by the insurance.

C. The provisions of this section apply to and protect the following applicants for insurance or insured persons, excluding a person who commits an act of domestic abuse, from an unfair discriminatory act or practice on the basis of any person's abuse status:

(1) a victim of domestic abuse;

(2) a person that provides shelter, counseling or protection to victims of domestic abuse;

(3) a person who employs or is employed by a victim of domestic abuse;

(4) a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship;

(5) a beneficiary of an insurance contract; or

(6) a participant in an insurance plan.

D. Nothing in the Domestic Abuse Insurance Protection Act prohibits a life insurer from declining to issue a life insurance policy if the applicant or prospective owner of the policy is or would be designated as a beneficiary of the policy and if:

(1) the applicant or prospective owner of the policy lacks an insurable interest in the insured;

(2) the applicant or prospective owner of the policy is known, on the basis of medical, police or court records, to have committed an act of domestic abuse against the proposed insured; or

(3) the insured or prospective insured is a victim of domestic abuse, and that person, or a person who has assumed the care of that person if a minor or incapacitated, has objected to the issuance of the policy on the ground that the policy would be issued to or for the direct or indirect benefit of the abuser.

E. An insurer shall not be civilly or criminally liable for the death of or injury to an insured resulting from an action taken in a good faith effort to comply with the requirements of the Domestic Abuse Insurance Protection Act. The provisions of this subsection do not, however, prevent an action by the superintendent to investigate a violation of that act or to assert any other claims authorized by law.

F. Nothing in the Domestic Abuse Insurance Protection Act prohibits an insurer from asking about a medical condition, claims history or other underwriting information or from using that information to underwrite or to carry out its duties under the policy, even if the information is related to a condition or event that the insurer knows or has reason to know is abuse-related.

G. An insurer shall not be liable for a violation of the Domestic Abuse Insurance Protection Act by a person who is a contractor with the insurer unless the insurer directed the act or omission that constitutes the violation.

History: Laws 1997, ch. 141, § 4.

59A-16B-5. Justification of adverse insurance underwriting decisions.

An insurer that takes an underwriting action that adversely affects a victim of domestic abuse on the basis of a medical condition, claims history or other underwriting information that the insurer knows is abuse-related shall explain the reason for its action to the applicant or insured in writing and, upon request, shall be able to demonstrate that its action and any applicable plan provision:

A. does not treat abuse status as a medical condition or underwriting criterion;

B. is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar condition or claims history without regard to whether the condition, history or claim is abuse-related; and

C. is based on a determination, made in conformance with sound actuarial principles and supported by reasonable statistical evidence, or related to actual or reasonably anticipated experience, that there is a correlation between the medical condition, claims history or other underwriting information and a material increase in insurance risk.

History: Laws 1997, ch. 141, § 5.

59A-16B-6. Insurance company procedures to protect the safety and privacy of victims of domestic abuse.

The superintendent, in consultation with public safety officials who specialize in domestic abuse matters or with a recognized domestic abuse advocacy group, shall adopt regulations that specify procedures to be followed by an insurer's employees, contractors, agents and brokers for the purpose of protecting the safety and privacy of victims of domestic abuse involved in an insurance action, including claims investigation and subrogation.

History: Laws 1997, ch. 141, § 6.

59A-16B-7. Rules and regulations.

The superintendent may adopt, in accordance with Section 59A-2-9 NMSA 1978, rules and regulations necessary to administer provisions of the Domestic Abuse Insurance Protection Act.

History: Laws 1997, ch. 141, § 7.

59A-16B-8. Lawful policy terms and conditions preserved.

Nothing in the Domestic Abuse Insurance Protection Act shall be construed to alter, modify or prohibit the application of any policy provision that excludes coverage for intentional or criminal acts or any other policy conditions, exclusions or limitations that are clearly stated in the policy and that are not in violation of any provisions of the Domestic Abuse Insurance Protection Act.

History: Laws 1997, ch. 141, § 8.

59A-16B-9. Applicability.

The provisions of the Domestic Abuse Insurance Protection Act apply to all insurers as defined in that act, including the following:

A. fraternal benefit societies pursuant to Chapter 59A, Article 44 NMSA 1978;

B. health maintenance organizations and their promoters, sponsors, directors, officers, employees, agents, solicitors and other representatives pursuant to Chapter 59A, Article 46 NMSA 1978;

C. health care plans and their promoters, sponsors, directors, officers, employees, agents, solicitors and other representatives pursuant to Chapter 59A, Article 47 NMSA 1978;

D. prepaid dental plan organizations and their sponsors, directors, officers, personnel and representatives and member contracts pursuant to Chapter 59A, Article 48 NMSA 1978; and

E. motor clubs and their sponsors, directors, officers, representatives, personnel and operations pursuant to Chapter 59A, Article 50 NMSA 1978.

History: Laws 1997, ch. 141, § 9.

59A-16B-10. Civil administrative penalty; superintendent's orders.

A. In lieu of the civil administrative penalty provided for in Subsection B of Section 59A-1-18 NMSA 1978, and except as otherwise provided in this section, a separate civil administrative penalty may be assessed for a second or subsequent violation of the Domestic Abuse Insurance Protection Act. That administrative penalty shall be not over ten thousand dollars ($10,000) for each violation, except that if the violation is to be found willful and intentional, the penalty may be up to twenty thousand dollars ($20,000) for each violation. Every administrative penalty shall be imposed by written order of the superintendent made after hearing held as provided in Chapter 59A, Article 4 NMSA 1978.

B. A monetary penalty imposed may be in addition to any applicable suspension, revocation or denial of a license or certificate of authority.

C. The superintendent may issue any order he deems necessary or appropriate to prevent or correct any violation, including a first-time violation, of the Domestic Abuse Insurance Protection Act, except the initial order on a first-time violation may not require a suspension, revocation or denial of a license or certificate of authority. If, however, that initial order of the superintendent is violated, he may then impose the monetary penalty authorized in this section in addition to any applicable suspension, revocation or denial of a license or certificate of authority or take any other action authorized in the Insurance Code.

History: Laws 1997, ch. 141, § 10.

ARTICLE 16C
Insurance Fraud

59A-16C-1. Short title.

Chapter 59A, Article 16C NMSA 1978 may be cited as the "Insurance Fraud Act".

History: Laws 1998, ch. 115, § 1; 2018, ch. 42, § 1.

59A-16C-2. Findings; purpose.

A. The legislature finds that insurance fraud is pervasive and expensive, and has the potential for increasing premium rates, placing businesses at risk, reducing the ability of consumers to raise their standard of living and decreasing the economic vitality of the state. Therefore, the legislature believes that the state must aggressively confront the problem of insurance fraud.

B. The purpose of the Insurance Fraud Act is to permit the full utilization of the expertise of the superintendent of insurance to investigate and detect insurance fraud more effectively, to halt insurance fraud and to work with state, local and federal law enforcement and regulatory agencies against the commission of insurance fraud.

History: Laws 1998, ch. 115, § 2.

59A-16C-3. Definitions.

As used in the Insurance Fraud Act:

A. "fund" means the insurance fraud fund;

B. "insurance fraud" means any act or practice in connection with an insurance transaction that constitutes a crime under the Criminal Code or the Insurance Code;

C. "insurance transaction" means any act or practice relating to insurance and includes complying with the Insurance Code or any rule adopted under its authority; and

D. "superintendent" means the superintendent of insurance.

History: Laws 1998, ch. 115, § 3.

59A-16C-4. Superintendent's duties.

The superintendent shall:

A. initiate inquiries and conduct investigations when the superintendent has reason to believe that insurance fraud may have been or is being committed;

B. respond to notifications or complaints of suspected insurance fraud generated by state and local police or other law enforcement authorities and governmental units, including the federal government and any other person;

C. review notices and reports of insurance fraud submitted by authorized insurers, their employees, agents or producers or by public adjusters and select those incidents of alleged fraud that, in the superintendent's judgment, require further investigation and conduct the investigations;

D. conduct independent investigations and examinations of insurance transactions and alleged insurance fraud, conduct studies to determine the extent of insurance fraud, deceit or intentional misrepresentation of any kind in the insurance process and publish information and reports on the office of superintendent of insurance's examinations and studies;

E. report incidents of alleged insurance fraud supported by investigations and examinations to the appropriate district attorney and any other appropriate law enforcement, administrative, regulatory or licensing agency and assemble evidence, prepare charges and otherwise assist any prosecutorial authority having jurisdiction over insurance fraud enforcement;

F. assist any official or agency of this state, any other state or the federal government that requests assistance in investigating insurance fraud;

G. maintain records and information in order to produce an annual report of the superintendent's activities undertaken in connection with carrying out the provisions of the Insurance Fraud Act;

H. conduct, in cooperation with the attorney general and the department of public safety, public outreach and awareness programs on the costs of insurance fraud to the public and how members of the public can assist themselves, the superintendent and law enforcement officials in preventing and prosecuting insurance fraud; and

I. assign staff and maintain the automobile theft prevention authority.

History: Laws 1998, ch. 115, § 4; 2017, ch. 76, § 12; 2018, ch. 42, § 3.

59A-16C-5. Superintendent's authority.

The superintendent may:

A. select and contract with investigative personnel and prosecutors to discharge the superintendent's duties pursuant to the provisions of the Insurance Fraud Act;

B. conduct statewide investigations and prosecutions related to automobile theft;

C. coordinate with law enforcement agencies to investigate and with the attorney general and district attorneys to prosecute cases involving stolen vehicles and insurance fraud; and

D. promulgate rules relating to the creation and operation of the automobile theft prevention authority.

History: Laws 1998, ch. 115, § 5; 2018, ch. 42, § 4.

59A-16C-6. Notice and cooperation required; tolling period.

A. Every insurer or licensed insurance professional that has a reasonable belief that an act of insurance fraud will be, is being or has been committed shall furnish and disclose knowledge and information about it to the superintendent and shall cooperate fully with any investigation conducted by the superintendent. Failure to comply with this subsection shall constitute grounds for the superintendent to impose an administrative penalty pursuant to Section 59A-1-18 NMSA 1978 in addition to any applicable suspension, revocation or denial of a license or certificate of authority.

B. A person who has a reasonable belief that an act of insurance fraud will be, is being or has been committed, or any person who collects, reviews or analyzes information concerning insurance fraud, may furnish and disclose any information in his possession concerning the insurance fraud to the superintendent or to an authorized representative of an insurer that requests the information for the purpose of detecting, prosecuting or preventing insurance fraud.

C. If an insurer has a reasonable belief or probable cause to believe that an insurance fraud has been committed and has properly notified the superintendent of its suspicion, that notification shall toll any applicable time period in any unfair claims proceeding based on the alleged fraud until thirty days after determination by the superintendent and notice to the insurer that the superintendent will not recommend action on the claim. The determination by the superintendent shall not be admissible in any subsequent civil proceeding.

D. The superintendent, in cooperation with insurers or others, may establish a voluntary fund to reward persons not connected with the insurance industry who provide information or furnish evidence leading to the arrest and conviction of persons responsible for insurance fraud.

History: Laws 1998, ch. 115, § 6.

59A-16C-7. Immunity from civil liability; private insurance fraud reports and enforcement actions.

A. The provisions of Section 59A-4-21 NMSA 1978 regarding immunity from civil liability for enforcement actions performed in good faith by the superintendent, his authorized representatives and examiners shall apply to the Insurance Fraud Act.

B. Except when a person intentionally communicates false information he actually believes to be false, a person shall not be subject to liability by virtue of reporting or furnishing, orally or in writing, information concerning suspected, anticipated or completed insurance fraud acts when the report or information is provided to:

(1) the department of insurance, the superintendent or law enforcement agencies, their officials, agents or employees;

(2) the national association of insurance commissioners, a federal or state governmental agency or office established to detect and prevent insurance fraud, any other organization established for the same purpose and their agents, employees or designees; or

(3) the anti-fraud unit of an insurer.

C. A person identified in Subsection B of this section or any of the person's officers, employees or agents when performing authorized activities, including the publication or dissemination of any related bulletin or reports, shall not be subject to civil liability for libel, slander or any other relevant tort or a civil cause of action of any nature, except if the person, officer, employee or agent intentionally communicates false information he actually believes to be false.

D. This section shall not abrogate or modify in any way any privilege or immunity recognized by common law or statute.

E. The court shall award attorney fees and costs to any person identified in Subsection B of this section or any of that person's officers, employees or agents who is a prevailing party in a civil cause of action against him for libel, slander or any other relevant tort arising out of conduct pursuant to the Insurance Fraud Act if the party bringing the action was not substantially justified in bringing such action. For the purposes of this subsection, "substantially justified" means having a reasonable basis in law or fact at the time a proceeding was initiated.

F. The relief provided in this section is in addition to remedies otherwise available against the same conduct under the common law or other laws of this state.

History: Laws 1998, ch. 115, § 7.

59A-16C-8. Warning required.

Within six months of the effective date of the Insurance Fraud Act all claim forms and applications for insurance shall contain a statement permanently affixed to the application or claim form which states substantially as follows:

"ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

The failure to include that statement shall not constitute a defense against prosecution for commission of insurance fraud.

History: Laws 1998, ch. 115, § 8.

59A-16C-9. Report of conviction.

If any person licensed by any agency of any state or the federal government or holding credentials from any professional organization is convicted of insurance fraud in this state, the superintendent shall notify the appropriate licensing or credentialing authority of the judgment for appropriate disciplinary action.

History: Laws 1998, ch. 115, § 9.

59A-16C-10. Insurer anti-fraud initiatives; special investigative units.

A. Within six months of the effective date of the Insurance Fraud Act and by July 1 of each succeeding year every insurer who in the previous calendar year reported ten million dollars ($10,000,000) or more in direct written premiums in New Mexico shall establish, prepare, implement and submit to the superintendent an anti-fraud plan that is reasonably calculated to detect, prosecute and prevent insurance fraud. Any subsequent amendments to the plan shall be submitted to the superintendent at the time they are adopted.

B. Each insurer's anti-fraud plan shall outline, at a minimum, guidelines appropriate to the type of insurance the insurer writes, to:

(1) prevent, detect and investigate all forms of insurance fraud;

(2) educate appropriate employees on fraud detection and the insurer's anti-fraud plan;

(3) provide for the hiring or contracting of fraud investigators;

(4) report insurance fraud to appropriate law enforcement and regulatory authorities; and

(5) pursue restitution, where appropriate, for financial loss caused by insurance fraud.

C. The superintendent may review each insurer's anti-fraud plan to determine if it adequately complies with the requirements of this section. The superintendent may examine the insurer to assure its compliance with anti-fraud plans submitted to the superintendent. The superintendent may require reasonable modifications to the insurer's anti- fraud plan or may require other reasonable remedial action if the review or examination reveals substantial noncompliance with the plan.

D. The superintendent may require each insurer to file a summary of the insurer's anti-fraud activities and results. Anti-fraud plans and summaries submitted to the superintendent shall be privileged and confidential, shall not be a public record and shall not be subject to discovery or subpoena in any civil or criminal action; provided, however, that the superintendent may make summaries of aggregate data available to the public.

E. This section confers no private right of action.

History: Laws 1998, ch. 115, § 10.

59A-16C-11. Investigators' powers.

A. The superintendent's investigators shall be peace officers pursuant to the provisions of Chapter 29, Article 1 NMSA 1978.

B. An investigator who meets the requirements for certification for law enforcement training pursuant to Section 29-7-6 NMSA 1978 shall be authorized to carry a firearm.

History: Laws 1998, ch. 115, § 11; 2005, ch. 245, § 1.

59A-16C-12. Attorney general's duties.

When so requested by the superintendent, the attorney general shall commission as a special assistant attorney general any attorney employed by the superintendent or contracted with by the superintendent and approved by the attorney general to assist the superintendent in carrying out his duties, including providing legal advice and prosecuting offenders. The actual costs associated with the assignment of assistant attorneys general to the superintendent shall be paid out of the fund.

History: Laws 1998, ch. 115, § 12.

59A-16C-13. Insurance fraud policy advisory group.

The superintendent may create an insurance fraud policy advisory group consisting of representatives of authorized insurers, consumers of insurance products not

otherwise connected with the insurance industry and other appropriate persons. The superintendent shall appoint the members of the advisory group and shall provide by rule for the creation, governance, duties and termination of the advisory group. Any advisory group so created shall advise the superintendent with respect to the implementation of and other matters related to the Insurance Fraud Act when so requested by the superintendent.

History: Laws 1998, ch. 115, § 13.

59A-16C-14. Insurance fraud fund created; appropriation.

A. There is created an "insurance fraud fund" in the state treasury. All fees collected pursuant to the provisions of the Insurance Fraud Act shall be deposited in the fund and are subject to appropriation for use in paying the expenses incurred by the superintendent in carrying out the provisions of the Insurance Fraud Act. Interest on the fund shall be credited to the fund. The fund is a continuing, nonreverting fund.

B. To implement the provisions of the Insurance Fraud Act, the superintendent shall determine a rate of assessment and collect a fee from authorized insurers in an amount not less than two hundred dollars ($200) and not exceeding one-tenth of one percent of the correctly reported direct written premiums on policies written in New Mexico by the authorized insurers. The fee shall be due annually pursuant to rules promulgated by the superintendent. The failure of an insurer to pay this fee when due shall subject the insurer to a penalty of one thousand dollars ($1,000) per month or part thereof in which the fee remains unpaid. The superintendent, after taking into account unexpended money produced by collection of the fee, shall adjust the rate of assessment each year to produce the amount of money that the superintendent estimates will be necessary to pay expenses incurred by the superintendent in carrying out the provisions of the Insurance Fraud Act.

C. In calculating the direct written premiums for an insurer pursuant to the provisions of this section, all direct written premiums for workers' compensation insurance and for all types of insurance that are exempted by federal law shall be excluded from the calculation.

D. The fees required by this section are in addition to all other taxes and fees now imposed or that may be subsequently imposed.

History: Laws 1998, ch. 115, § 14; 1999, ch. 131, § 1; 2017, ch. 130, § 13.

59A-16C-15. Application of act to other acts.

A. No authority granted the superintendent under the Insurance Fraud Act shall be construed to abrogate or interfere with the authority of the safety and fraud division of the workers' compensation administration under the Workers' Compensation Act

[Chapter 52, Article 1 NMSA 1978] or of the medicaid fraud control unit under the Medicaid Fraud Act [Chapter 30, Article 44 NMSA 1978].

B. Nothing in the Insurance Fraud Act shall:

(1) preempt the authority of or relieve the duty of any other law enforcement agencies to investigate and prosecute alleged violations of law;

(2) prevent or prohibit a person from voluntarily disclosing any information concerning insurance fraud to any law enforcement agency;

(3) limit any of the powers granted elsewhere by law to the superintendent to investigate alleged violations of law and take appropriate action; or

(4) interfere with the duties and authority of the workers' compensation administration.

History: Laws 1998, ch. 115, § 15.

59A-16C-16. Rules.

The superintendent may promulgate rules deemed necessary or appropriate by the superintendent for the administration of the Insurance Fraud Act.

History: Laws 1998, ch. 115, § 16.

59A-16C-17. Automobile theft prevention authority; created; board; powers; duties.

A. The "automobile theft prevention authority" is created in the office of superintendent of insurance. The automobile theft prevention authority shall be governed by a board of directors. The board shall consist of nine members as follows:

(1) the superintendent;

(2) the director of the administrative office of the district attorneys or the director's designee; and

(3) seven members appointed by the superintendent as follows:

(a) four representatives from different insurance companies who are authorized by the office of superintendent of insurance to issue motor vehicle insurance policies in New Mexico;

(b) two representatives from different law enforcement agencies; and

(c) a representative from the public.

B. Prior to August 1, 2018, the appointing authorities shall appoint all initial members of the board. Board members shall serve six-year terms; except that of the initial members representing insurance companies appointed to the board, the superintendent shall select one member whose initial term is four years and one member whose initial term is two years; and of the initial members representing law enforcement agencies appointed to the board, the superintendent shall select one member whose initial term is two years. The initial public member shall serve an initial term of four years.

C. No appointed member shall serve more than two terms. If a member fails to complete the member's term, the member shall be replaced as soon as practicable by the original appointing authority.

D. Board members shall serve without compensation.

E. The authority shall solicit, review and approve applications for grants to improve and support automobile theft prevention programs or programs for the enforcement or prosecution of automobile theft crimes. The authority shall give priority to applications representing multi-jurisdictional programs. Each application, at a minimum, shall describe the type of theft prevention, enforcement or prosecution program to be implemented.

F. In selecting grant recipients, when practicable, the authority shall award grants to law enforcement agencies.

G. The authority shall not require as a condition of the award of a grant that an agency or political subdivision provide other funding to operate an automobile theft prevention program or a program for the enforcement or prosecution of automobile theft crimes.

H. On or before December 1 of every year, a law enforcement agency that received a grant pursuant to this section in the previous twelve months shall submit a report to the authority concerning the implementation of the program funded through the grant.

I. On or before November 1 of every year, the authority shall report to the appropriate interim legislative committee on the implementation of the programs receiving grants pursuant to this section. The report to the committee shall include:

(1) the number and geographic jurisdiction of law enforcement agencies that received grants under the authority and the amount and duration of the grants;

(2) the change in the number of automobile thefts in areas of the state; and

(3) recommendations for legislative changes to assist in the prevention, enforcement and prosecution of automobile-theft-related criminal activities.

J. On or before November 1 of every year, the authority shall report to the legislative finance committee on the finances of the authority.

K. The authority may seek and receive grant funding from federal, state or local governments or private philanthropic organizations to defray the costs of operating automobile theft prevention programs or programs for the enforcement or prosecution of automobile theft crimes.

L. A law enforcement agency may apply for grants to assist in improving and supporting automobile theft prevention programs or programs for the enforcement or prosecution of automobile theft crimes through statewide planning and coordination.

History: Laws 2018, ch. 42, § 2.

ARTICLE 17
Insurance Rates and Rating

59A-17-1. Short title.

Chapter 59A, Article 17 NMSA 1978 may be cited as the "Insurance Rate Regulation Law".

History: Laws 1984, ch. 127, § 299; 2007, ch. 367, § 1.

59A-17-2. Scope of article; exemptions.

A. The Insurance Rate Regulation Law applies to all kinds and lines of direct insurance written on risks or operations in this state by any authorized insurer, except:

(1) wet marine and transportation insurance, as defined in Section 59A-7-5 NMSA 1978 [repealed];

(2) life insurance;

(3) variable and fixed annuities; and

(4) health insurance.

B. For purposes of the Insurance Rate Regulation Law, "workers' compensation" insurance includes employer's liability insurance.

C. The superintendent may by order exempt any person or class of persons or any market segment from any or all of the provisions of the Insurance Rate Regulation Law to the extent that the superintendent finds the provision or provisions unnecessary to achieve the purposes of that law.

History: Laws 1984, ch. 127, § 297; 2007, ch. 367, § 2.

59A-17-3. Purposes of article.

A. The purposes of this article are:

(1) to promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate or unfairly discriminatory, and to protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

(2) in general to permit and encourage, as an effective way to produce rates that conform to the foregoing, independent action by and reasonable price competition among insurers;

(3) to provide formal regulatory controls for use where independent actions and price competition fail;

(4) to authorize cooperative action among insurers in the rate-making process, and to regulate such cooperation in order to prevent practices tending to create monopoly or to lessen or destroy competition;

(5) to encourage efficient and economic marketing practices; and

(6) to regulate that part of the insurance business which is subject to this article, in a manner to preclude application of federal antitrust laws.

B. The provisions of this article shall be liberally interpreted to effectuate the above purposes.

History: Laws 1984, ch. 127, § 298.

59A-17-4. Definitions.

As used in the Insurance Rate Regulation Law:

A. "advisory organization" means an entity, including its affiliates or subsidiaries, that either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, and that assists insurers in the promulgation of policy forms; in ratemaking activities, such as the collection, compilation and furnishing of loss or expense statistics; or in the recommendation, making or filing of rates, prospective loss

costs, supplementary rate information, policy forms or endorsements. Two or more insurers having a common ownership or operating in New Mexico under common management or control constitute a single insurer for purposes of this definition;

B. "commercial insurance" means any line or kind of property or casualty insurance not for personal, family or household needs;

C. "market" means any line or kind of insurance or any subdivision thereof or any class of risks or combination of classes;

D. "residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance that may be afforded applicants who are unable to obtain insurance through ordinary methods;

E. "reverse competition" means a marketplace situation where the placement of a line, kind or class of insurance with insurers is determined primarily or exclusively by parties other than the policyholders;

F. "supplementary rate information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule and any other information needed to determine the applicable rate in effect or to be in effect; and

G. "supporting information" means:

(1) the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer;

(2) the interpretation of any other data relied upon by the filer;

(3) descriptions of methods used in making the rates; and

(4) any other information required by the superintendent to be filed.

History: Laws 1984, ch. 127, § 300; 2007, ch. 367, § 3.

59A-17-5. Administration of insurance rate regulatory law.

The provisions of Chapter 59A, Article 17 NMSA 1978 shall be administered by the superintendent.

History: Laws 1984, ch. 127, § 301; 1999, ch. 289, § 23.

59A-17-5.1. Underwriting guidelines.

A. The superintendent may direct an insurer writing homeowners insurance, private passenger non-fleet automobile insurance or other lines, kinds or classes of noncommercial insurance in New Mexico to file with the superintendent underwriting guidelines that determine the acceptance of applicants and tiering guidelines that determine the placement of applicants and insureds into rating tiers, regardless of whether such tiers exist within the insurer or within a group of insurers under common ownership or management.

B. The superintendent, after notice and hearing, may order an insurer to cease using underwriting or tiering guidelines that are unfairly discriminatory or that fail to place applicants and insureds into tiers in a clear, objective, risk-based and mutually exclusive manner.

C. Filings made pursuant to this section shall be considered confidential trade secrets under the Uniform Trade Secrets Act [57-3A-1 to 57-3A-7 NMSA 1978].

History: Laws 2007, ch. 367, § 7.

59A-17-6. Rate standards.

A. Rates shall not be excessive, inadequate or unfairly discriminatory, nor shall an insurer charge any rate that, if continued, will have or tend to have the effect of destroying competition or creating a monopoly.

B. In a competitive market, rates are presumed not to be excessive.

C. In a noncompetitive market, rates are excessive if they are likely to produce a profit that is unreasonably high in relation to the riskiness of the line, kind or class of business, or if expenses are unreasonably high in relation to the services rendered.

D. Rates are inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the line, kind or class of business to which they apply.

E. There is unfair discrimination if one rate is unfairly discriminatory in relation to another in the same line, kind or class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise or blanket policy or a mass marketing plan.

History: Laws 1984, ch. 127, § 302; 2007, ch. 367, § 8.

59A-17-6.1. Competitive market.

A competitive market is presumed to exist unless the superintendent, after notice and hearing, determines that a reasonable degree of competition does not exist within a market and issues a ruling to that effect. The ruling shall expire three years after issue unless rescinded earlier by the superintendent or unless the superintendent renews the ruling after a hearing and a finding as to the continued lack of a reasonable degree of competition. Any ruling that finds that competition does not exist shall identify the factors that cause the market not to be competitive and may also include a plan for enhancing competition. The superintendent shall monitor the degree and continued existence of competition in New Mexico on an ongoing basis. An interested party may petition the superintendent to initiate a hearing to examine whether a particular market is competitive or whether a particular market is no longer noncompetitive.

History: 2007, ch. 367, § 4.

59A-17-6.2. Reverse competitive market.

A reverse competitive market for a line, kind or class of insurance is presumed to exist wherever the placement of a line, kind or class of insurance with insurers is determined primarily or exclusively by parties other than the policyholders. The superintendent may, by notice and hearing, establish rules for determining the specific lines, kinds or classes of insurance that, for the purposes of the Insurance Rate Regulation Law, are reversely competitive.

History: Laws 2007, ch. 367, § 5.

59A-17-7. Rating methods.

In determining whether rates comply with the rate standards, the following criteria shall be applied:

A. due consideration shall be given to past and prospective loss and expense experience within and without this state, to catastrophic hazards and contingencies, to trends within and without this state, to loadings for leveling premium rates over time or for dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers and to all other relevant factors, including the judgment of technical personnel;

B. risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that classifications may not be based on race, color, creed or national origin;

C. the expense provisions included in the rates to be used by an insurer may reflect the operating methods of the insurer and, so far as it is credible, its own expense experience; and

D. the rates may contain an allowance permitting a profit that is not unreasonable in relation to the riskiness of the line, kind or class of business. Profit shall include investment income attributable to such rates.

History: Laws 1984, ch. 127, § 303; 2007, ch. 367, § 9.

59A-17-7.1. Motor vehicle liability; not-at-fault accidents.

A. The rates of a motor vehicle liability insurer shall not provide for an increase in the premium if based upon an accident in which the insured is not at fault in any manner as determined by either the accident report or the insurer. If the insurer determines that its insured is at fault contrary to the specific finding of an accident report that the insured is not at fault, the insurer shall reach its conclusion only after an investigation.

B. A motor vehicle liability insurer shall not cancel, or use as a basis for nonrenewal, an insurance policy if such cancellation or nonrenewal is based upon an accident in which the insured is not at fault in any manner as determined by either the accident report or the insurer. If the insurer determines that its insured is at fault contrary to the specific finding of an accident report that the insured is not at fault, the insurer shall reach its conclusion only after an investigation.

C. As used in this section, "motor vehicle liability insurer" means an insurer authorized to transact in this state the business of automobile and motor vehicle bodily injury, property damage liability and physical damage insurance.

D. This section shall not apply if other factors exist, exclusive of the accident in which the insured is not at fault, that allow for a premium increase, cancellation or nonrenewal of an insurance policy under the Insurance Code or rules pursuant to the Insurance Code.

History: 1978 Comp., § 59A-17-7.1, enacted by Laws 1987, ch. 80, § 1; 2007, ch. 367, § 10.

59A-17-8. Making of rates; workers' compensation; rate calculations; rate classifications.

A. A workers' compensation insurer shall adhere to a uniform classification system and uniform experience rating system filed with the superintendent by an advisory organization designated by the superintendent.

B. A workers' compensation insurer shall report its experience in accordance with the statistical plans and other reporting requirements in use by the advisory organization designated by the superintendent.

C. Workers' compensation premium rates shall be equalized and calculated on a basis that does not discriminate against or penalize employers who pay higher wages

than other employers to workers in the same job classification. The legislature finds that calculating workers' compensation premium rates strictly on the basis of an employer's wages paid discriminates against and penalizes higher-paying employers. The legislature accordingly directs that the superintendent shall:

(1) investigate alternatives to the current method of computing workers' compensation premiums, including but not limited to:

(a) split classification;

(b) payroll cap;

(c) hours worked; and

(d) premium credits;

(2) immediately conduct hearings on the issue, including consideration of other alternatives; and

(3) adopt regulations, to become effective no later than April 1, 1991, to equalize the workers' compensation premium rates employers must pay for workers who perform the same job.

Nothing in this subsection shall be construed to prohibit the use of experience rating or scheduled credits.

D. A workers' compensation insurer may develop subclassifications of the uniform classification system upon which rates may be made. Such subclassifications and their filing shall be subject to all applicable provisions of the Insurance Rate Regulation Law. Data produced from such subclassifications shall be reported in accordance with the statistical plans, uniform classification system and experience rating system in use by the advisory organization designated by the superintendent.

E. Classification assignments may be changed within sixty days of the effective date or renewal date of the policy, provided the employer is given reasonable prior notice of the proposed change in order to object and provided further that the change is based upon an appropriate audit or investigation. The same provisions apply to initial classification assignments for new operations added by the employer so that they may be changed within sixty days of the date the classification assignments are initially established. No subsequent changes shall be made unless the insurer proves, after conducting an audit or investigation, that:

(1) there has been a substantial change in the nature of the work performed; or

(2) the initial assignment was in error due to withheld or inaccurate material information provided by the employer.

F. A workers' compensation insurer may develop rating plans that identify loss experience as a factor to be used. The rating plans and their filing shall be subject to all applicable provisions of the Insurance Rate Regulation Law.

G. The superintendent shall disapprove subclassifications, rating plans or other variations from supplementary rate information filed by a workers' compensation insurer if the insurer fails to demonstrate that the data produced can be reported consistent with the uniform classification system and experience rating system and in such a fashion so as to allow for the application of experience rating filed by the advisory organization designated by the superintendent.

History: Laws 1984, ch. 127, § 304; 1987, ch. 244, § 1; 1990 (2nd S.S.), ch. 2, § 92; 2007, ch. 367, § 11.

59A-17-9. Filing of rates.

A. In regard to filings in competitive markets:

(1) for purposes of this section, reverse competitive markets and residual markets are not competitive markets;

(2) for filings by insurers:

(a) an insurer shall file with the superintendent rates and supplementary rate information prior to their use in New Mexico;

(b) rates to be used in a competitive market for commercial insurance other than workers' compensation and medical professional liability need not be filed; and

(c) insurers that wish to use workers' compensation subclassifications, rating plans, loss costs or other supplementary rate information that differs from items filed by the advisory organization designated by the superintendent shall file with the superintendent relevant subclassifications, rating plans, rates, loss costs, other supplementary rate information and supporting information in accordance with the requirements and provisions of Subsection B of this section; and

(3) for filings by advisory organizations:

(a) with the exception of workers' compensation filings, an advisory organization shall file with the superintendent rates, supplementary rate information and supporting information prior to their use in New Mexico; and

(b) regarding workers' compensation filings, the advisory organization designated by the superintendent shall file with the superintendent rates, supplementary rate information and supporting information in accordance with the requirements and provisions of Subsection B of this section.

B. In regard to filings in noncompetitive, reverse competitive and residual markets:

(1) an insurer or advisory organization shall file with the superintendent rates, supplementary rate information and supporting information for noncompetitive, reverse competitive and residual markets at least thirty days before the proposed effective date;

(2) the superintendent may give written or electronic notice, within thirty days of receipt of the filing, that the superintendent needs additional time, not to exceed thirty days from the date of such notice, to consider the filing;

(3) upon written or electronic application of the insurer or advisory organization, the superintendent may authorize rates to be effective before the expiration of the waiting period or an extension of the waiting period;

(4) a filing shall be deemed to meet the requirements of this section and to become effective unless disapproved pursuant to Section 59A-17-13 NMSA 1978 by the superintendent before the expiration of the waiting period or an extension of the waiting period;

(5) the operation of the deemer provision shall be suspended during a period of not more than sixty days upon written or electronic notice to the insurer or advisory organization that made the filing that additional information is needed to complete the review of the filing. The suspension of the deemer provision may occur only once for a filing. Failure of the insurer or advisory organization to provide the requested information within sixty days shall be deemed a request to withdraw the filing from further consideration. The superintendent shall either approve or disapprove the filing within thirty days of receipt of the requested additional information. Failure of the superintendent to act within the thirty-day period shall result in the filing being deemed to meet the requirements of the Insurance Rate Regulation Law. Neither the insurer nor the superintendent may waive the timeliness requirements of the deemer provisions of this section; and

(6) residual market mechanisms or advisory organizations may file residual market rates.

C. In regard to reference filings, an insurer may file its rates either by filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by Section 59A-17-17 NMSA 1978. Such reference filings shall be made prior to their use or by other methods the superintendent may allow by rule. An insurer that chooses to adopt the prospective loss costs or rates that

have been filed by an advisory organization on its behalf for a competitive commercial line other than workers' compensation or medical professional liability need not file.

D. All filings submitted pursuant to this section shall be filed electronically. The superintendent may designate an entity to receive the electronic filings submitted pursuant to this section.

History: Laws 1984, ch. 127, § 305; 1987, ch. 244, § 2; 2003, ch. 202, § 9; 2007, ch. 367, § 12; 2009, ch. 182, § 1.

59A-17-10. Repealed.

History: Laws 1984, ch. 127, § 306; 1987, ch. 244, § 3; repealed by Laws 2007, ch. 367, § 38.

59A-17-10.1. Workers' compensation insurance; policy and rate required for employers not domiciled in state.

No insurer insuring a workers' compensation risk arising from the employment of a worker performing work for an employer in New Mexico, when that employer is not domiciled in New Mexico, shall issue any workers' compensation insurance contract or endorsement of a workers' compensation insurance contract to cover the described risk except in accordance with filings and rates which are lawfully in effect for the insurer as provided in Sections 59A-17-10 and 59A-18-12 NMSA 1978.

History: Laws 1978 Comp., § 59A-17-10.1, enacted by Laws 1988, ch. 119, § 2.

59A-17-11. Filings open to inspection.

A filing and supporting information filed under Sections 59A-17-9 and 59A-17-10 NMSA 1978 shall, as soon as filed, be open to public inspection at a reasonable time. A copy of a filing and supporting information may be obtained by a person on request to the superintendent and payment of a reasonable charge. If the insurer or advisory organization believes that information contained in the filing contains material that it considers to be a trade secret, it shall include that information in a separate section of the filing and include a request for the superintendent to consider whether that information should be kept confidential.

History: Laws 1984, ch. 127, § 307; 1987, ch. 244, § 4; 2007, ch. 367, § 13.

59A-17-11.1. Consumer information.

A. The superintendent shall use, develop or cause to be developed a consumer information system that will provide and disseminate price and other relevant information on a readily available basis to purchasers of homeowners, private

passenger non-fleet automobile or property insurance for personal, family or household needs as well as for title insurance, including escrow, closing and settlement charges for one to four family residential property transactions, and for any other types of personal or commercial insurance designated by the superintendent. To the extent deemed necessary and appropriate by the superintendent, insurers, advisory organizations and other persons or organizations involved in conducting the business of insurance in New Mexico, to which this section applies, shall cooperate in the development and utilization of a consumer information system.

B. An insurer writing homeowners insurance or private passenger non-fleet automobile insurance in New Mexico shall, upon renewal or upon the transfer of a policy to another insurer under the same ownership or management as the transferring insurer, provide its policyholders with written notification of their right to obtain from the insurer a detailed written explanation of the reasons why their policy premium has changed or is about to change.

History: Laws 2007, ch. 367, § 6; 2009, ch. 80, § 2.

59A-17-12. Insurer must adhere to rates; consent to rate.

A. No insurer shall make or issue a contract or policy of insurance except in accordance with filings or rates that are lawfully in effect for the insurer as provided in the Insurance Rate Regulation Law.

B. Upon written application of the insured stating the underlying reasons that is filed with and approved by the superintendent, a rate in excess of or below that otherwise applicable may be used as to a specific risk.

History: Laws 1984, ch. 127, § 308; 2007, ch. 367, § 14.

59A-17-13. Grounds and procedures for disapproval of rates.

A. The superintendent shall disapprove a rate for use in a competitive market if the superintendent finds that the rate is inadequate or unfairly discriminatory under the rate standards set forth in Section 59A-17-6 NMSA 1978. The superintendent shall disapprove a rate for use in a noncompetitive, reverse competitive or residual market if the superintendent finds that the rate is excessive, inadequate or unfairly discriminatory under the rate standards set forth in Section 59A-17-6 NMSA 1978.

B. The superintendent may at any time disapprove a filing submitted under the "file and use" provisions of Subsection A of Section 59A-17-9 NMSA 1978 after giving notice of hearing pursuant to the provisions of Subsection A of Section 59A-4-16 NMSA 1978 to every insurer and advisory organization that adopted the rate.

C. The superintendent may disapprove a filing submitted under the "prior approval" provisions of Subsection B of Section 59A-17-9 NMSA 1978:

(1) without a hearing prior to the expiration of the waiting period or an extension of the waiting period. An insurer or advisory organization whose rates are disapproved under this subsection may request a hearing before the superintendent by filing a written request within thirty days of the date of the disapproval notice; or

(2) at any time after the expiration of the waiting period or an extension of the waiting period, after giving notice of hearing pursuant to the provisions of Subsection A of Section 59A-4-16 NMSA 1978 to every insurer and advisory organization that adopted the rate.

D. The superintendent's notice or order of disapproval shall specify the respects in which the rate fails to meet the standards set forth in Section 59A-17-6 NMSA 1978. The notice or order shall state an effective date no sooner than thirty business days after the date of the notice or order when the insurer shall discontinue the use of the rate. The notice or order shall not affect any policy made before the effective date of the notice or order.

History: Laws 1984, ch. 127, § 309; 1987, ch. 244, § 5; 2007, ch. 367, § 15.

59A-17-13.1. Discounts on homeowners' policies for burglary protections.

Any insurer licensed to write homeowner's insurance, as defined by the superintendent, within the state shall provide a minimum premium discount of ten percent for houses with electronic alarm systems designed to prevent unauthorized entry into the house. The insurer shall also provide a minimum premium discount of five percent for houses with wrought iron bars covering all the doors and windows of the house. These discounts shall apply to comprehensive coverage and shall be part of the insurer's rate filing. Some or all of the premium discounts required by this section may be omitted upon demonstration to the superintendent in an insurer's rate filing that the discounts are duplicative of other discounts provided by the insurer.

History: Laws 1993, ch. 103, § 1; 2007, ch. 367, § 17.

59A-17-13.2. Large commercial policyholders.

A. The superintendent may, by rule, establish a class of large commercial policyholders, to be known as exempt commercial policyholders, that shall be exempt from the rate and form requirements of Chapter 59A, Articles 17 and 18 NMSA 1978, except for form provisions relating to workers' compensation mandatory coverage provisions.

B. In the promulgation of this rule, the superintendent shall consider the following factors in establishing an exempt commercial policyholder class:

(1) the characteristics of insureds that are likely to study and understand the details of their business risks, insurance coverages and exclusions;

(2) the characteristics of insureds that are likely to avail themselves of regular price comparisons between competing insurers and are likely to study and understand the differences and details of pricing proposals that they receive;

(3) the characteristics of insureds that are likely to require individually written policies, as contrasted to insureds that can customarily have their coverage needs met through a compilation of forms with applicability to other insureds as well;

(4) the characteristics of insureds for which filed rates and rating plans are less likely to provide the lowest premiums otherwise consistent with the provisions of the Insurance Rate Regulation Law;

(5) the favorable or adverse experiences with exemptions from regulatory requirements, especially the experience in New Mexico;

(6) the extent to which commercial insureds primarily located in another jurisdiction are subject to similar exemptions or waivers in that jurisdiction; and

(7) any other relevant factors.

C. The superintendent may, by rule, waive some or all of the diligent search requirements related to placement of risks in the approved surplus lines market for some or all of the exempt commercial policyholders.

History: Laws 2007, ch. 367, § 16.

59A-17-14. Repealed.

History: Laws 1984, ch. 127, § 310; 1987, ch. 244, § 6; repealed by Laws 2007, ch. 367, § 38.

59A-17-15. Repealed.

59A-17-16. Requirement for supporting information.

A. By rule, the superintendent may require the filing of supporting data as to any or all kinds or lines of insurance or subdivisions thereof or classes of risks or combinations thereof as the superintendent deems necessary for the proper functioning of the rate monitoring and regulating process. The supporting data shall include:

(1) the experience and judgment of the filer and, to the extent it wishes or the superintendent requires, of other insurers or advisory organizations;

(2) its interpretation of any statistical data relied upon;

(3) descriptions of the actuarial and statistical methods employed in setting the rates; and

(4) any other relevant matters required by the superintendent.

B. Whenever a filing is not accompanied by the information as the superintendent has required under Subsection A of this section, the superintendent may inform the insurer and the filing shall be deemed to be made when the information is furnished.

History: Laws 1984, ch. 127, § 312; 1987, ch. 244, § 7; 2007, ch. 367, § 18.

59A-17-17. Use of advisory organization filings.

A. An insurer may itself establish rates and supplementary rate information for a market segment based on the factors set forth in Section 59A-17-7 NMSA 1978 or it may in its rate filing incorporate by reference loss costs and other supplementary rate information prepared by an advisory organization, with modification for its own loss experience as the credibility of that experience allows.

B. Nothing in the Insurance Rate Regulation Law shall be construed as requiring an insurer to become a member of or subscriber to any advisory organization.

C. The superintendent may adopt rules establishing standards and administrative procedures to carry out the provisions of this section.

History: Laws 1984, ch. 127, § 313; 1987, ch. 244, § 8; 1990 (2nd S.S.), ch. 2, § 93; 2003, ch. 202, § 10; 2007, ch. 367, § 19.

59A-17-17.1. Experience modification factor; workers' compensation claims; New Mexico Works Act.

A. Workers' compensation claims by participants as defined in the New Mexico Works Act [Chapter 27, Article 2B NMSA 1978] shall be separately recorded and maintained in the calculation of the experience modification factor used to calculate premiums for the participating employer so that the experience modification factor attributable to claims by participants can be separated from the remainder of the employer's experience modification factor.

B. The separately calculated experience modification factor for the first year of employment of each participant shall not be considered as part of the experience modification factor of any employer. The superintendent of insurance shall promulgate rules to implement this section.

C. For the purpose of this section, "participants" means participants as defined in the New Mexico Works Act.

History: Laws 1999, ch. 181, § 1.

59A-17-18. Advisory organizations; license required; obligation to provide service.

A. No advisory organization shall provide a service relating to the statistical collection or the rates of an insurance subject to the Insurance Rate Regulation Law, and no insurer shall use the services of the organization for such purposes, unless the organization has obtained a license as required by Section 59A-17-19 NMSA 1978.

B. No advisory organization shall refuse to supply a service for which it is licensed in this state to an authorized insurer offering to pay the fair and usual compensation for the services.

History: Laws 1984, ch. 127, § 314; 2007, ch. 367, § 20.

59A-17-19. Advisory organizations; licensing.

A. A person, whether domiciled within or outside this state, may apply to the superintendent for license as an advisory organization for the kinds of insurance or subdivisions thereof as are specified in its application. The application shall include:

(1) a copy of its constitution, charter, articles of organization, agreement, association or incorporation and a copy of its bylaws, plan of operation and other rules governing conduct of its business;

(2) a list of its members and subscribers;

(3) the name and address of one or more residents of this state upon whom notices, process affecting it or orders of the superintendent may be served;

(4) a statement showing its technical qualifications for acting in the capacity for which it seeks a license;

(5) payment of the license application fee in an amount specified in Section 59A-6-1 NMSA 1978; and

(6) any other relevant information and documents that the superintendent may require.

B. Every advisory organization that has applied for a license shall promptly notify the superintendent in writing of every material change in the facts or in the documents on which its application was based, or of change in name, address of its process agent

under Paragraph (3) of Subsection A of this section. No amendment to a document referred to in Paragraph (1) of Subsection A of this section shall be effective until not less than thirty days after the amendment is filed with the superintendent.

C. If the superintendent finds that the applicant and the individuals through whom it acts are competent, trustworthy and technically qualified to provide the services proposed, and that all requirements of law are met, the superintendent shall within sixty days after completion of the application issue a license to the applicant specifying the authorized activity; otherwise, the superintendent shall refuse to issue the license and shall promptly notify the applicant, specifying the grounds for refusal. The superintendent shall not issue a license if the proposed activity would tend to create a monopoly or lessen or destroy price competition.

D. Licenses issued pursuant to this section shall remain in effect until the licensee withdraws from the state or until the license is suspended or revoked, subject to annual continuation on May 1 of each year by payment of the continuation fee specified in Section 59A-6-1 NMSA 1978.

History: Laws 1984, ch. 127, § 315; 2007, ch. 367, § 21.

59A-17-20. Suspension, revocation of license.

The superintendent shall promptly revoke the license of an advisory organization if it ceases business or withdraws from this state, and the superintendent may suspend or revoke the license if the superintendent finds after a hearing that:

A. the organization no longer meets the qualifications for licensing; or

B. the organization has failed to file amended documents as required under Section 59A-17-19 NMSA 1978, or has violated or failed to comply with any other material requirement of the Insurance Rate Regulation Law or any other law.

History: Laws 1984, ch. 127, § 316; 2007, ch. 367, § 22.

59A-17-21. Conduct of advisory organization.

A. An advisory organization shall furnish its services without discrimination to its members and subscribers.

B. An advisory organization shall not adopt any rule, the effect of which would be to prohibit or regulate payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

History: Laws 1984, ch. 127, § 317; 2007, ch. 367, § 23.

59A-17-22. Repealed.

History: Laws 1984, ch. 127, § 318; repealed by Laws 2007, ch. 367, § 38.

59A-17-22.1. Repealed.

History: Laws 1986, ch. 22, § 100; repealed by Laws 2007, ch. 367, § 38.

59A-17-23. Advisory organizations; appeal by minority.

A member of or subscriber to an advisory organization may appeal to the superintendent from the action or decision of the advisory organization in approving or rejecting a proposed change in or addition to the filings of the advisory organization and the superintendent shall, after a hearing, issue an order approving the action or decision of the advisory organization or directing it to give further consideration to the proposal; or, if the appeal is from the action or decision of the advisory organization in rejecting a proposed addition to its filings, the superintendent may, in the event the superintendent finds that the action or decision was unreasonable, issue an order directing the advisory organization to make an addition to its filings, on behalf of its members and subscribers, in a manner consistent with the superintendent's findings, within a reasonable time after the issuance of the order.

History: Laws 1984, ch. 127, § 319; 2007, ch. 367, § 24.

59A-17-24. Repealed.

History: Laws 1984, ch. 127, § 319a; repealed by Laws 2007, ch. 367, § 38.

59A-17-25. Joint underwriting, joint reinsurance pool and residual market mechanisms.

A. A group, association or other organization of insurers that engages in joint underwriting, joint reinsurance pools or residual market mechanisms through the group, association or organization or by standing agreement among the members, shall file with the superintendent:

(1) a copy of its constitution, its articles of incorporation, agreement or association and its bylaws and rules governing its activities, all duly certified by the custodian of the originals;

(2) a list of its members; and

(3) the name and address of a resident of this state upon whom notices or orders of the superintendent or process affecting the group, association or organization may be served.

B. Every such group, association or other organization shall notify the superintendent promptly in writing of changes in its constitution, its articles of incorporation, agreement or association, its bylaws and rules governing conduct of its business, its list of members or the name and address of its process agent referred to in Paragraph (3) of Subsection A of this section.

C. Every such group, association or organization shall be subject to regulation as herein provided, subject, however, as to joint underwriting to applicable provisions of the Insurance Rate Regulation Law, and as to joint reinsurance to Sections 59A-17-13, 59A-17-32, 59A-17-34 and 59A-17-35 NMSA 1978.

D. No group, association or organization shall engage in an unfair or unreasonable practice with respect to its activities. If, after a hearing, the superintendent finds that an activity or practice of a group, association or organization is unfair or unreasonable or otherwise inconsistent with the provisions of the Insurance Rate Regulation Law, the superintendent may issue an order specifying the respects in which the activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of the Insurance Rate Regulation Law and requiring discontinuance of the activity or practice.

History: Laws 1984, ch. 127, § 320; 1999, ch. 289, § 24; 2007, ch. 367, § 25.

59A-17-26. Binding agreements by insurers.

No insurer shall assume an obligation to a person other than a policyholder or other insurers that with it are under common control or management or are members of a joint underwriting organization subject to the provisions of Section 59A-17-25 NMSA 1978, to use or adhere to certain rates or rules, and no other person shall impose a penalty or other adverse consequence for failure of an insurer to adhere to certain rates or rules except as to action by the superintendent in enforcement of Section 59A-17-12 NMSA 1978.

History: Laws 1984, ch. 127, § 321; 2007, ch. 367, § 26.

59A-17-27. Cooperative activities authorized.

Cooperation among advisory organizations or among organizations and insurers in rate making or in other matters within the scope of the Insurance Rate Regulation Law is hereby authorized, provided the filings resulting from the cooperation are subject to provisions of the Insurance Rate Regulation Law applicable to filings generally. The superintendent may review the cooperative activities and practices and if, after a hearing, the superintendent finds that the activity or practice is unfair or unreasonable or otherwise inconsistent with the Insurance Rate Regulation Law, the superintendent may issue an order specifying the respects in which the activity or practice is unreasonable or otherwise inconsistent with the Insurance Rate Regulation Law and requiring discontinuance of the activity or practice.

History: Laws 1984, ch. 127, § 322; 2007, ch. 367, § 27.

59A-17-28. Recording, reporting of experience.

The superintendent shall promulgate or approve reasonable rules, including rules providing statistical plans, for use by all insurers in the recording and reporting of loss and expense experience, so that the experience of an insurer may be made available to the superintendent at least annually in such form and detail as may be necessary to aid the superintendent in determining whether rating systems comply with applicable rate standards and requirements. In promulgating the rules and plans the superintendent shall give due consideration to the rating systems on file with the superintendent and, so that the rules and plans may be as uniform as practicable among the several states, to the rules and form of plans used for rating systems in other states. No insurer shall be required to record or report its experience on a classification basis inconsistent with its own rating system. The superintendent may designate one or more advisory organizations to assist the superintendent in gathering that experience and making compilations of that experience, which shall be made available to insurers, advisory organizations and the public.

History: Laws 1984, ch. 127, § 323; 2007, ch. 367, § 28.

59A-17-29. Exchange of data, consultation authorized.

A. The superintendent may promulgate reasonable rules and plans for interchange among insurers, advisory organizations and others, of data necessary for application of rating plans.

B. For furtherance of uniformity in administration of rate regulatory laws, the superintendent and every insurer and advisory organization may exchange information and experience data with insurance regulatory officials, insurers and advisory organizations in this and other states and may consult with them as to rate making and the application of rating systems.

History: Laws 1984, ch. 127, § 324; 2007, ch. 367, § 29.

59A-17-30. Information to be furnished insureds; hearings and appeals of insureds.

A. Every advisory organization and every insurer that makes its own rates shall, within time frames promulgated by the superintendent or, in the absence of time frames, within a reasonable time after receiving written request, furnish to an insured affected by a rate made by it, or to the authorized representative of the insured, all pertinent information as to the rate.

B. Every advisory organization and every insurer that makes its own rates shall provide within this state reasonable means whereby a person aggrieved by the application of its rating system may be heard, in person or by the person's authorized representative, on the person's written request to review the manner in which the rating system has been applied in connection with the insurance afforded the person. If the advisory organization or insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if the application had been rejected. A party affected by the action of the rate service organization or the insurer on the request may, within thirty days after written notice of the action, appeal to the superintendent, who, after a hearing, may affirm or reverse the action. If, after the hearing, it is determined that the rates charged by an insurer are in excess of the otherwise appropriate rate, the overcharge shall be refunded to the insured.

History: Laws 1984, ch. 127, § 325; 2007, ch. 367, § 30.

59A-17-31. False or misleading information.

No person shall willfully withhold information from, or knowingly give false or misleading information to, the superintendent or statistical agency designated by the superintendent or advisory organization or insurer that will affect rates or rating plans under the Insurance Rate Regulation Law. Violation of this section shall be subject to the penalties provided under Section 59A-1-18 NMSA 1978.

History: Laws 1984, ch. 127, § 326; 2007, ch. 367, § 31.

59A-17-32. Examination of advisory and joint underwriting organizations, joint reinsurance pools and residual market mechanisms.

A. To be informed about any matter related to enforcement of provisions of the Insurance Code [Chapter 59A NMSA 1978], the superintendent may examine the affairs and condition of any advisory or joint underwriting organization, joint reinsurance pool or residual market mechanism. The superintendent shall examine every advisory organization and conduct the examinations at intervals established by rules promulgated by the superintendent.

B. In lieu of all or part of an examination, or in addition to an examination, the superintendent may order an independent audit by certified public accountants or actuarial evaluation by actuaries approved by the superintendent, or may accept the report of an audit already made by certified public accountants or actuarial evaluation by actuaries approved by the superintendent, or the report of an examination made by the insurance supervisory official of another state.

C. Conduct of the examination, examiners and other personnel used by the superintendent in making the examinations, payment of costs of the examination by the

examinee, examination report and review and adoption and the examination in general shall be subject to the applicable provisions of Chapter 59A, Article 4 NMSA 1978.

History: Laws 1984, ch. 127, § 327; 2007, ch. 367, § 32.

59A-17-33. Enforcement; cease and desist, injunctions; penalties.

A. The superintendent shall enforce compliance with the provisions of the Insurance Rate Regulation Law. Whenever the superintendent believes that there is a violation of the Insurance Rate Regulation Law and that such violation is continuing, the superintendent shall serve upon the advisory, joint underwriting, joint reinsurance pool, residual market mechanism or insurer or other person violating, as the case may be, notice of a hearing before the superintendent to be held not less than twenty days after service of the notice, and requiring the organization or person to show cause why the superintendent should not order the organization or person to cease and desist from the violation.

B. The superintendent, through the attorney general, may maintain an action to enjoin a continuing violation of the Insurance Rate Regulation Law.

C. After hearing, the superintendent may suspend the license of an advisory organization or insurer that fails to comply with the superintendent's order within the time limited by the order or an extension of time that the superintendent may grant. The suspension shall not become effective until the time prescribed for an appeal has expired, or if an appeal has been taken, until the order has been affirmed; otherwise, the superintendent may determine when the suspension shall become effective, and the suspension shall remain in effect for the period fixed unless the superintendent modifies or rescinds the suspension, or until the order on which suspension is based is modified, rescinded or reversed.

D. If the superintendent finds that a person has violated any provision of the Insurance Rate Regulation Law, the superintendent may impose a penalty of not more than ten thousand dollars ($10,000) for each violation; but if the superintendent finds the violation to be willful, the superintendent may impose a penalty of not more than twenty-five thousand dollars ($25,000) for each violation. Such penalties may be in addition to any other penalty provided by law, and, if not paid voluntarily by the violator, may be collected through civil action in the district court of Santa Fe county in the name of the state of New Mexico on the relation of the insurance board.

E. For the purposes of this section, an insurer using a rate for which the insurer has failed to file the rate, supplementary rate information or supporting information, if Section 59A-17-9 NMSA 1978 requires the materials to be filed, shall have committed a separate violation for each day the failure continues.

History: Laws 1984, ch. 127, § 328; 2007, ch. 367, § 33.

59A-17-34. Hearings.

A. Any person aggrieved by any action, threatened action or failure to act of the superintendent or otherwise under Chapter 59A, Article 17 NMSA 1978 shall have the same right to a hearing before the superintendent with respect thereto as provided for in general under Section 59A-4-15 NMSA 1978. Notice of hearing shall be given, the hearing conducted, rights and powers exercised and the superintendent's order on hearing made and given as provided as to hearings in general under the applicable provisions of Chapter 59A, Article 4 NMSA 1978.

B. Any person aggrieved by the superintendent's order issued pursuant to this section or by the superintendent's refusal to hold the hearing may appeal the order or refusal to the court of appeals.

History: Laws 1984, ch. 127, § 329; 1990, ch. 110, § 1; 1999, ch. 289, § 25; 2011, ch. 127, § 13; 2013, ch. 74, § 20.

59A-17-35. Appeals from superintendent.

Any order made by the superintendent pursuant to Section 59A-17-34 NMSA 1978, or by the superintendent's refusal to hold a hearing, shall be subject to review by appeal to the court of appeals. The decision of the superintendent shall be set aside only if it is shown that the decision is arbitrary or capricious or reflects an abuse of discretion; is not supported by substantial evidence; or is otherwise not in accordance with the law. Upon institution of the appeal and for good cause shown upon motion and hearing, the court may, in the following cases, stay operation of the superintendent's order:

A. where, pursuant to the Insurance Rate Regulation Law, an advisory organization has been refused a license or an insurer has been refused a certificate of authority or had its license or certificate of authority suspended, it may, with leave of court, be allowed to continue to engage in business, subject to the provisions of the Insurance Rate Regulation Law, pending final disposition of its application for review; or

B. where any order of the superintendent shall provide for a change in a rate or rating system that results in an increase or decrease in rates, an insurer affected may, with leave of court pending final disposition of the proceedings in the court of appeals, continue to charge rates that existed prior to the order, on condition that the difference in the rates be deposited in a special escrow or trust account with a reputable financial institution by the insurer affected, to be held in trust by the insurer and to be retained by the insurer or paid to the holders of policies issued after the order of the court, as the court may determine.

History: Laws 1984, ch. 127, § 330; 1990, ch. 110, § 2; 1998, ch. 55, § 63; 1999, ch. 265, § 67; 1999, ch. 289, § 26; 2007, ch. 367, § 34; 2013, ch. 74, § 21.

59A-17-36. Rate filing; failure to submit data; penalty.

A. An insurer or advisory organization that makes a rate filing under the Insurance Rate Regulation Law and fails, without reasonable cause, to provide the data requested by the superintendent within thirty working days from the date of the request shall be subject to an administrative penalty as provided in Section 59A-1-18 NMSA 1978.

B. The superintendent may, for good cause shown, grant an extension of the thirty-day time period provided for in Subsection A of this section.

C. The insurer or advisory organization may, within ten days after entry of the order, request a hearing before the superintendent as provided in Section 59A-17-34 NMSA 1978.

History: 1978 Comp., § 59A-17-36, enacted by Laws 1989, ch. 145, § 2; 2007, ch. 367, § 35.

ARTICLE 17A
Personal Insurance Credit Information Act

59A-17A-1. Short title.

This act [59A-17A-1 to 59A-17A-11 NMSA 1978] may be cited as the "Personal Insurance Credit Information Act".

History: Laws 2005, ch. 275, § 1.

59A-17A-2. Purpose and application.

The Personal Insurance Credit Information Act regulates the use of credit information in the underwriting, rating or renewal of personal insurance for the protection of consumers and applies to personal insurance written by an insurer or a group of affiliated insurers authorized to do business in this state or written pursuant to the FAIR Plan Act [59A-29-1 to 59A-29-9 NMSA 1978], but does not apply to commercial insurance or any other types of insurance.

History: Laws 2005, ch. 275, § 2.

59A-17A-3. Definitions.

As used in the Personal Insurance Credit Information Act:

A. "adverse action" means a denial or cancellation of, an increase in a charge for or a reduction or other adverse or unfavorable change in the terms of coverage or amount of insurance, existing or applied for, in connection with the underwriting, rating or renewal of personal insurance, which adverse action occurs when an insurer offers

insurance at less favorable terms than it would have offered a consumer if the consumer's credit information had been more favorable;

B. "affiliate" means a company that directly or indirectly controls, is controlled by or is under the common ownership or control of another company;

C. "company placement" means the assignment of a consumer to a particular insurer within a group of affiliates;

D. "consumer" means an individual applicant or insured whose credit information is relied upon or used to calculate an insurance score for underwriting, rating or renewing a personal insurance coverage;

E. "consumer reporting agency" means a person or entity that, for monetary fees, dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties;

F. "credit information" means a written, oral or other communication of information prepared by a consumer reporting agency or provided by the consumer on an application for or renewal of credit, bearing on a consumer's credit worthiness, credit standing or credit capacity, that is used or expected to be used or collected in whole or in part for the purpose of underwriting, rating or renewing a personal insurance coverage;

G. "insurance score" means a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit information and is used for underwriting, rating or renewing personal insurance coverage; and

H. "personal insurance" means private passenger automobile, homeowners', motorcycle, mobile-homeowners', boat, personal watercraft, snowmobile, recreational vehicle, noncommercial dwelling fire, personal umbrella or any other type of insurance policy that is individually underwritten for personal, family or household use.

History: Laws 2005, ch. 275, § 3; 2013, ch. 74, § 22.

59A-17A-4. Use of credit information; limits on use.

An insurer or group of affiliated insurers authorized to do business in New Mexico that uses credit information to underwrite, rate or renew personal insurance coverage shall not:

A. use an insurance score that is calculated using income, gender, address, race, color, national origin, religion or marital status of the consumer as a factor;

B. deny, cancel or fail to renew coverage, or base a consumer's company placement, tier placement or rates, on the basis of credit information or an insurance score without consideration of other underwriting factors permitted by state law;

C. consider an absence of credit information or an inability to calculate an insurance score in underwriting, rating or renewing personal insurance coverage unless the insurer:

(1) classifies the consumer as having average or better than average credit information for that insurer or group of affiliated insurers; or

(2) excludes the use of credit information as a factor in rating or underwriting personal insurance coverage;

D. take adverse action against a consumer based upon credit information, or upon an insurance score calculated from credit information, submitted more than ninety days before the date of notice of the adverse action;

E. use credit information upon renewal unless the insurer obtains current credit information and recalculates the insurance score at least every thirty-six months. Upon the request of a consumer, an insurer that uses credit information upon renewal shall obtain current credit information and recalculate an insurance score. An insurer shall not be required to obtain current credit information or recalculate an insurance score more frequently than every twelve months except for the correction of an error as described in Section 6 [59A-17A-6 NMSA 1978] of the Personal Insurance Credit Information Act. The Personal Insurance Credit Information Act does not require an insurer to obtain current credit information or recalculate an insurance score if:

(1) an improved insurance score would not cause the consumer to be placed in a more favorably priced company or tier of the insurer; or

(2) the insurer does not rely upon credit information or an insurance score to underwrite, rate or renew the consumer's personal insurance coverage;

F. use an insurance score in whole or in part to deny, restrict or alter the fees charged for a premium payment plan; or

G. use credit inquiries as a factor in any insurance scoring methodology or to underwrite, rate or renew personal insurance coverage.

History: Laws 2005, ch. 275, § 4.

59A-17A-5. Exception procedures.

A. As used in this section, "extraordinary life circumstance" means:

(1) an acute or chronic medical condition, illness, injury or disease;

(2) divorce;

(3) death of a spouse, child or parent;

(4) involuntary loss of employment for more than three consecutive months;

(5) identity theft;

(6) total or other loss that makes a home uninhabitable; or

(7) other circumstances prescribed by the superintendent in a rule.

B. Insurers that use credit information to calculate an insurance score or to underwrite, rate or renew personal insurance coverage shall, upon written request from a consumer, provide a reasonable exception to the insurer's rates, rating classifications, company placement, tier placement or underwriting policies, procedures or guidelines when that consumer's credit information has been adversely impacted by an extraordinary life circumstance that has occurred within three years of the date of application for or renewal of personal insurance coverage.

C. Insurers shall file their extraordinary life circumstances exception policies and procedures and amendments to the policies and procedures with the superintendent. Filings shall include the following:

(1) a list of extraordinary life circumstances;

(2) procedures describing how a consumer may apply for the extraordinary life circumstances exception;

(3) a description of the required substantiating information;

(4) general guidelines for when an extraordinary life circumstances exception will be granted;

(5) a description of how a consumer's treatment in underwriting or rating would be modified by the granting of an extraordinary life circumstances exception;

(6) time frames for considering the extraordinary life circumstances exception request; and

(7) any other information prescribed by the superintendent in a rule.

D. An insurer's extraordinary life circumstances exception policies and procedures shall be effective for use upon filing with the superintendent.

E. The superintendent may disapprove an insurer's extraordinary life circumstances exception policies or procedures at any time upon providing the insurer with a sixty-day written notice setting forth the reasons for the disapproval. Disapproval shall be based upon a determination that the extraordinary life circumstances exception policies and procedures as contained in the filing are inadequate pursuant to this section, and the notice of disapproval shall specify the respects in which they are inadequate. An insurer affected by a disapproval may request a hearing before the superintendent pursuant to Section 59A-4-15 NMSA 1978, and the request for a hearing stays the effectiveness of the disapproval. No disapproval shall affect an action or determination made by an insurer concerning an application or policy of insurance made prior to the date of a notice of final determination of the disapproval.

F. An insurer may require the consumer to provide reasonable, independently verifiable written documentation of the event and the direct effect of the event on the consumer's credit before granting an exception.

G. An insurer that grants an extraordinary life circumstances exception shall maintain that exception for an amount of time that is reasonable for the particular circumstance. Once that reasonable amount of time is exhausted, the insurer is not required to grant another exception for the same specific extraordinary life circumstance.

H. An insurer is not out of compliance with a law or rule relating to underwriting, rating or rate filing as a result of granting an exception under this section.

History: Laws 2005, ch. 275, § 5.

59A-17A-6. Error correction.

If it is determined by a consumer reporting agency that a consumer's credit information is inaccurate or incomplete and the insurer is notified of this determination by the consumer reporting agency or the consumer, the insurer or its group of affiliated insurers shall re-underwrite and rerate the consumer's personal insurance coverage within thirty days of receiving the notice, refund any overpaid premium and, if necessary, make a related adjustment, including company placement, consistent with its filed underwriting and rating guidelines.

History: Laws 2005, ch. 275, § 6.

59A-17A-7. Initial notification of use of credit information.

A. If an insurer uses credit information to calculate an insurance score to underwrite, rate or renew personal insurance coverage, the insurer shall disclose to the consumer at least once, either at the time of application or upon the first renewal subsequent to December 31, 2005, in writing or in the same medium as the application or renewal, that it uses that information.

B. An insurer may use the following disclosure language to comply with the requirements of this section: "In connection with your application for insurance coverage, we may review and use information contained in your credit report to help determine your premium or your eligibility for coverage.".

History: Laws 2005, ch. 275, § 7.

59A-17A-8. Adverse action notification.

A. If an insurer takes an adverse action based upon credit information, the insurer shall notify the consumer in writing, or in the same medium as the application or renewal, of the nature of the adverse action, the reasons for the adverse action and the insurer's extraordinary life circumstances exception policies and procedures as provided by Section 5 [59A-17A-5 NMSA 1978] of the Personal Insurance Credit Information Act.

B. The notification shall identify, in clear and simple language and in descending order of importance, the four most important factors that prevented the consumer from receiving a more favorable insurance score. The factors shall be identified with sufficient specificity that a consumer can identify the factors on a standard credit report.

C. In addition to the information described in Subsections A and B of this section, the notification shall include any other language prescribed by rule issued by the superintendent.

History: Laws 2005, ch. 275, § 8.

59A-17A-9. Insurance scoring filings.

A. Insurers and groups of affiliated insurers that use credit information or insurance scores to underwrite, rate or renew personal insurance coverage shall, prior to implementation or amendment, file with the superintendent their scoring models and all scoring ingredients and processes, including all criteria, matrices, weightings and score ranges, as well as all resulting rating factors and rating elements, and all resulting guidelines for accepting coverage, for company placement and for tier placement. A filing shall provide examples, either through electronic spreadsheets, formulas, tables or detailed written documentation, of how scores and underwriting and rating results can be obtained. The filing shall be provided on an affiliated group basis whenever an insurer is an affiliate of an insurance group.

B. A filing that includes credit information or insurance scoring shall include loss experience justifying the design and use of the model.

C. If an insurer files a scoring model that has already been filed with the superintendent by a rate service organization licensed by the superintendent pursuant to Section 59A-17-19 NMSA 1978, the insurer may reference the rate service organization's filing of the model. In such circumstances, if the insurer deviates in any

way from the referenced model filed by the rate service organization, the insurer must explain in detail the nature of such deviations.

D. Scoring models, processes and guidelines shall become effective and may be used on the date of filing with the superintendent.

E. The superintendent may issue an order to disapprove a filing at any time upon providing the insurer with a sixty-day written notice of the disapproval. Any such disapproval shall be based upon a determination that the filing under this section is either inadequate pursuant to Subsection A of this section, will result in rates that do not comply with the applicable requirements of the Insurance Rate Regulation Law [Chapter 59A, Article 17 NMSA 1978] or will result in uses not compliant with Section 4 [59A-17A-4 NMSA 1978] of the Personal Insurance Credit Information Act. The notice of disapproval shall specify the bases for the disapproval and the date on which the filing shall be deemed no longer effective. An insurer affected by such a disapproval may request a hearing before the superintendent pursuant to Section 59A-4-15 NMSA 1978, and the request for hearing stays the effectiveness of the disapproval. No disapproval shall affect an action or determination made by an insurer concerning applications or policies of insurance made prior to the date of notice of final determination of the disapproval.

F. Filings made pursuant to this section shall be considered confidential trade secrets under the Uniform Trade Secrets Act [57-3A-1 to 57-3A-7 NMSA 1978].

History: Laws 2005, ch. 275, § 9.

59A-17A-10. Rulemaking authority.

The superintendent may adopt rules the superintendent deems necessary to implement and ensure full compliance with the provisions of the Personal Insurance Credit Information Act.

History: Laws 2005, ch. 275, § 10.

59A-17A-11. Severability.

If any part or application of the Personal Insurance Credit Information Act is held invalid, the remainder or its application to other situations or persons shall not be affected.

History: Laws 2005, ch. 275, § 11.

ARTICLE 18
The Insurance Contract

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.

History: Laws 1984, ch. 127, § 331; 1988, ch. 119, § 3; 2011, ch. 127, § 14; 2021, ch. 108, § 13.

59A-18-2. "Policy" defined.

As used in this article "policy" means any contract of insurance, indemnity, health care, suretyship or annuity between the insurer and the insured, by whatever name such contract is called, and includes all clauses, riders, endorsements and papers which are a part thereof.

History: Laws 1984, ch. 127, § 332.

59A-18-3. "Premium" defined.

As used in the Insurance Code "premium" means the consideration for insurance or for an annuity, by whatever name called. Any "assessment," or any "membership," "policy," "survey," "inspection," "service" or similar fee or other charge in consideration for an insurance or annuity contract or procurement thereof is part of the premium.

History: Laws 1984, ch. 127, § 333.

59A-18-3.1. Closed block of business.

As used in Chapter 59A, Article 18 NMSA 1978, "closed block of business" means a policy or group of policies that division rules identify as closed because an insurer no longer markets or sells the policy or group of policies or because the policy's or group of policies' enrollment has decreased.

History: Laws 2011, ch. 144, § 10.

59A-18-3.2. "Block of business" defined.

As used in Chapter 59A, Article 18 NMSA 1978, "block of business" means a particular policy or pool that provides health insurance, that an insurer issues to one or more individuals and that includes distinct benefits, services and terms.

History: Laws 2011, ch. 144, § 11.

59A-18-4. Insurable interest; personal insurance.

A. Any individual of competent legal capacity may procure or effect an insurance contract upon his own life or body for the benefit of any person. No person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under such contract are payable to the individual insured or his personal representatives, or to a person having, at the time such contract was made, an insurable interest in the individual insured.

B. If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the individual insured, the individual insured or personal representative may maintain an action to recover such benefits from the person so receiving them.

C. As used in this section, "insurable" interest as to such personal insurance means that every person has an insurable interest in the life, body and health of himself, if an individual, and in the life, body and health of other individuals as follows:

(1) in the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection; and

(2) in the case of other persons, a lawful and substantial economic interest in having the life, health or bodily safety of the insured individual continue, as distinguished from an interest which would arise only, or would be enhanced in value, by the death, disablement or injury of the individual insured.

D. An individual party to a contract or option for purchase or sale of an interest in a business partnership or firm, or of shares of stock of a corporation or of an interest in such shares, has an insurable interest in the life, body and health of each individual party to such contract and for the purposes of such contract only, in addition to any insurable interest which may otherwise exist as to such individual.

E. An insurer shall be entitled to rely upon all statements, declarations and representations made by an applicant for insurance relative to the insurable interest of the applicant in the insured; and no insurer shall incur legal liability, except as set forth

in the policy, by virtue of any untrue statements, declarations or representations so relied upon in good faith by the insurer.

History: Laws 1984, ch. 127, § 334.

59A-18-5. Insurable interest, life insurance; exception when certain institutions designated beneficiary.

A. Life insurance contracts may be entered into in which the person paying the consideration for the insurance has no insurable interest in the life of the individual insured, where charitable, benevolent, educational or religious institutions or their agencies are designated irrevocably as the beneficiaries thereof.

B. In making such contracts the person paying the premium shall make and sign the application therefor as owner, and shall designate irrevocably a charitable, benevolent, educational or religious institution or an agency thereof as the beneficiary or beneficiaries of such contract. The application shall be signed also by the individual whose life is to be insured.

C. Nothing in this section shall prohibit any combination of the applicant, premium payer, owner and beneficiary from being the same person.

D. Such a contract shall be valid and binding among the parties thereto, notwithstanding the absence otherwise of an insurable interest in the life of the individual insured.

History: Laws 1984, ch. 127, § 335.

59A-18-6. Insurable interest, property.

A. No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss.

B. "Insurable interest" as used in this section means any actual, lawful and substantial economic interest in the safety and preservation of the subject of the insurance free from loss, destruction, pecuniary damage or impairment.

History: Laws 1984, ch. 127, § 336.

59A-18-7. Power to contract for insurance; purchase of insurance or annuity by minor.

A. Any person of competent legal capacity may contract for insurance.

B. Any minor not less than fifteen (15) years of age may, notwithstanding his minority, contract for annuities or for insurance upon his own life or health, or on the person of another individual in whom the minor has an insurable interest. Such a minor shall, notwithstanding such minority, be deemed competent to exercise all rights and powers with respect to or under any such contract as might be exercised by an individual of full legal age, and may at any time surrender his interest in any such contract and give valid discharge for any benefit accruing or money payable thereunder. Such a minor shall not, by reason of his minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such a minor not otherwise emancipated, shall not be bound by any unperformed agreement to pay by promissory note or otherwise, any premium on any such annuity or insurance contract. Any annuity or insurance contract procured by or for a minor under this subsection shall be made payable either to the minor or his estate or to a person having an insurable interest in the minor's life.

History: Laws 1984, ch. 127, § 337.

59A-18-8. Consent of insured; life, health insurance.

No life or health insurance contract upon an individual, except a contract of group life insurance or of group or blanket health insurance, shall be made or effectuated unless at the time of the making of the contract, such individual applies therefor or has consented thereto in writing, except in the following cases:

A. A spouse may effectuate such insurance upon the other spouse;

B. Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of or pertaining to such minor; and

C. Family policies may be issued insuring any two (2) or more members of a family on an application signed by either parent, a stepparent, a guardian, or by a husband or wife.

History: Laws 1984, ch. 127, § 338.

59A-18-9. Alteration of application; life, health insurance.

No alteration of any written application for any life or health insurance policy or annuity contract shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer for administrative purposes only in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

History: Laws 1984, ch. 127, § 339.

59A-18-10. Application as evidence.

A. The insured shall not be bound by any statement made in the application, and no application for issuance of any life or health insurance policy or annuity contract shall be admissible in evidence in any action relative to such policy or contract, unless a true copy of the application was attached to or otherwise made a part of the policy or contract when issued. This subsection does not apply to industrial life insurance policies.

B. If any policy of life or health insurance or annuity contract delivered in this state is reinstated or renewed, and the insured, beneficiary, annuitant or assignee of the policy or contract makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within fifteen (15) days after receipt of such request at its home office or any of its branch offices, deliver or mail a copy of the application to the person making the request. If such copy is not so delivered or mailed, the insurer shall be precluded from introducing the application as evidence in any action or proceeding based upon or involving such policy or contract or its reinstatement or renewal. If such a request is from a beneficiary or assignee, the time within which the insurer is required to furnish a copy of the application shall not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's or assignee's vested interest in the policy or contract.

C. As to kinds of insurance other than life or health insurance or annuity contract, no application for insurance signed by or on behalf of the insured shall be admissible in evidence in any action between the insured and the insurer arising out of the policy so applied for, if the insurer has failed, at expiration of thirty (30) days after receipt by the insurer at its home office or branch office, of a written demand therefor by or on behalf of the insured, to furnish to the insured a copy of the application reproduced by any legible means.

History: Laws 1984, ch. 127, § 340.

59A-18-11. Representation in application.

A. The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed and the insured or the beneficiary or assignee of such policy shall make written request to the insurance company for a copy of the application, if any, for such reinstatement or renewal, the insurance company shall within fifteen days after the receipts of such request at its home office or any branch office of the insurance company, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurance company shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

B. No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurance company, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

C. The falsity of any statement in the application for any policy covered by this Code may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or hazard assumed by the insurance company.

History: Laws 1984, ch. 127, § 341.

59A-18-12. Filing of forms and classifications; review of effect upon insured.

A. An insurance policy, health care plan or annuity contract shall not be delivered or issued for delivery in this state, nor shall an assumption certificate, endorsement, rider or application that becomes a part of a policy or health care plan be used, until a copy of the form and the classification of risks pertaining to the policy or health care plan has been filed with the superintendent. Except for a filing for health insurance or health care plan rates, a filing shall be made at least sixty days before its proposed effective date. A filing made pursuant to this section shall not become effective nor shall it be used until approved by the superintendent pursuant to Section 59A-18-14 NMSA 1978, at which time it may be used. A filing related to health insurance or health care plan or rates shall be subject to the provisions of Section 5 [59A-18-13 NMSA 1978] of this 2011 act. A filing for any kind of insurance other than life insurance, health care plans or health insurance, as defined in the Insurance Rate Regulation Law, shall be deemed to meet the requirements of Chapter 59A, Article 18 NMSA 1978 to become effective unless disapproved pursuant to Section 59A-18-14 NMSA 1978 by the superintendent before the expiration of the waiting period or an extension of the waiting period; provided, that:

(1) this subsection shall not apply as to policies, contracts, endorsements or riders of unique and special character not for general use or offering but designed and used solely as to a particular insured or risk;

(2) if the superintendent has exempted a person or a class of persons or a market segment from a part or all of the provisions of the Insurance Rate Regulation Law pursuant to Subsection C of Section 59A-17-2 NMSA 1978, the superintendent also may exempt by rule that person, class of persons or market segment from a part or all of the provisions of this subsection;

(3) an insurer subject to the Insurance Rate Regulation Law may authorize an advisory organization to file policy forms, endorsements and other contract language and related attachment rules on its behalf. Reference filings shall be made prior to their use or by other methods the superintendent may allow by rule; and

(4) the superintendent may, by rule, exempt various lines and kinds of commercial insurance, as defined in the Insurance Rate Regulation Law, from some or all of the requirements of this subsection.

B. A workers' compensation insurance policy covering a risk arising from the employment of a worker performing work for an employer in New Mexico when that employer is not domiciled in New Mexico shall not be issued or become effective, nor shall any endorsement or rider covering such a risk be issued or become effective, until a copy of the form and the classification of risks pertaining thereto have been filed with the superintendent.

C. An insured, a beneficiary or, in the public interest of the state, the attorney general, may in writing request the insurer to review the manner in which its filing has been applied as to insurance or health care plan afforded the insured, the beneficiary, or the attorney general. If the insurer fails to make a review and grant appropriate relief within thirty days after the request is received, the insured, the beneficiary or the attorney general may file a written complaint and request for a hearing with the superintendent stating grounds relied upon. If the complaint charges a violation of the Insurance Code and the superintendent finds that the complaint was made in good faith and that the insured, the beneficiary or the attorney general would be aggrieved if the violation is proved, the superintendent shall hold a hearing, with notice to the insured, the beneficiary or the attorney general and insurer stating the grounds of complaint. If upon the hearing the superintendent finds the complaint justified, the superintendent shall order the insurer to correct the matter complained of within a reasonable time specified but not less than twenty days after a copy of the order was mailed to or served upon the insurer.

D. All filings submitted pursuant to this section shall be filed electronically. The superintendent may designate an entity to receive the electronic filings submitted pursuant to this section.

E. As used in this section, "health insurance" or "health care plan" means a hospital and medical expense-incurred policy, plan or contract offered by a health insurer; nonprofit health service provider; health maintenance organization; managed care organization; or provider service organization; "health insurance" or "health care plan" does not include an individual policy intended to supplement major medical group-type coverage such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

History: Laws 1984, ch. 127, § 342; 1987, ch. 244, § 9; 1988, ch. 119, § 4; 1993, ch. 320, § 57; 2002, ch. 64, § 1; 2003, ch. 202, § 11; 2007, ch. 367, § 36; 2009, ch. 182, § 2; 2011, ch. 144, § 2.

59A-18-13. Approval or disapproval of health insurance forms.

A. With policy, endorsement, rider and application forms and classification of risks filed by the insurer with the superintendent under Section 59A-18-12 NMSA 1978 as to health insurance and health care plans, the insurer shall also file with the superintendent its rates applicable to such health insurance forms. An insurer shall not use any form that has not been approved by the superintendent or that is not in effect in accordance with Section 59A-18-14 NMSA 1978.

B. All filings submitted pursuant to this section shall be filed electronically. The superintendent may designate an entity to receive the electronic filings submitted pursuant to this section.

History: Laws 1984, ch. 127, § 343; 1987, ch. 244, § 10; 2003, ch. 397, § 1; 2009, ch. 182, § 3; 2011, ch. 144, § 3.

59A-18-13.1. Adjusted community rating.

A. Every insurer, fraternal benefit society, multiple employer welfare arrangement, health maintenance organization or nonprofit health care plan that provides primary health insurance or health care coverage insuring or covering major medical expenses shall, in determining the initial year's premium charged for an individual, use only the rating factors of age, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment.

B. Separately for an insurer's individual and group policies, no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under nineteen years of age or children nineteen to twenty-five years of age who are full-time students may have rates that are lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, multiple employer welfare arrangement, fraternal benefit society, health maintenance organization or nonprofit health care plan from offering rates that differ depending upon family composition. For the purposes of this subsection, "family composition" refers only to whether coverage covers an individual or a family.

C. The provisions of this section do not preclude an insurer, multiple employer welfare arrangement, fraternal benefit society, health maintenance organization or nonprofit health care plan from using health status or occupational or industry classification in establishing the amount a large group health benefits plan may be charged for coverage.

D. As used in Subsection C of this section, "health status" does not include genetic information.

E. The superintendent shall adopt regulations to implement the provisions of this section.

History: Laws 1994, ch. 75, § 26; 1997, ch. 22, § 1; 1997, ch. 243, § 18; 1998, ch. 41, § 1; 2010, ch. 95, § 1; 2019, ch. 259, § 1.

59A-18-13.2. Health insurance; health care plan rates filing requirements.

A. All health insurance or health care plan rates filed by an insurer with the superintendent pursuant to Section 59A-18-12 NMSA 1978 shall include all related forms.

B. An insurer shall not use a rate without prior approval of the superintendent pursuant to Section 6 [59A-18-13.3 NMSA 1978] of this 2011 act and compliance with the provisions of that act.

C. Upon making a filing pursuant to Subsection A of this section, an insurer shall provide written notice to policyholders and beneficiaries potentially affected by the insurer's filing. The language of the notice shall meet the minimum language simplification standards in the Policy Language Simplification Law [59A-19-1 to 59A-19-7 NMSA 1978]. The insurer shall provide, at a minimum, the following in its notice:

(1) a summary of the rates, including any percentage changes in the rates;

(2) a summary of all related form changes;

(3) an explanation of form and rate changes; and

(4) the policyholder or beneficiary rights under the Insurance Code [Chapter 59A NMSA 1978], including the right to comment on the filing for the thirty days following the posting on the division's web site as required by Subsection D of this section.

D. Within twelve days of the filing, the superintendent shall make available on the division's web site in language that shall meet the minimum language simplification standards in the Policy Language Simplification Law the following information provided by the insurer that relates to each block of business included in the filing:

(1) the information required by Subsection C of this section;

(2) the proposed rates;

(3) a brief description of how the revised rates were determined, including the general description and source of each assumption used;

(4) the expected medical loss ratio and, for blocks of business in existence for at least three years, the medical loss ratio for the three years preceding the date of filing, accompanied by supporting information as to how the blocks of business will meet the requirements for medical loss ratio in state and federal law;

(5) if medical costs, including utilization and compensation rates, are alleged to justify a rate increase, the filing shall identify in the aggregate the types of expenditures in those categories that support the premium rate increase in the geographic area covered;

(6) for blocks of business in existence for at least three years, premium revenues, claims history, losses and reserves for the three years preceding the date of filing, accompanied by supporting documentation; and

(7) whether the insurer has ceased to actively offer or sell to new applicants a block of business for which it seeks a rate increase.

E. Regarding an insurer's overall insurance operations in the state for the three years preceding the date of filing, the superintendent shall make available on the division's web site, at a minimum, the following information that the insurer provides:

(1) a list detailing which blocks of business are open and which are closed to new enrollment;

(2) reserves and surpluses for all product lines sold in the state and a reasonable estimate of the expected reserves and surpluses; and

(3) changes in total medical and administrative costs over the previous three years.

F. The superintendent shall post a link on the division's web site to the most recent annual financial statement and actuarial memorandum that the insurer has filed with the division.

G. Notwithstanding any other provision of this section, upon request by an insurer, the superintendent may exempt from disclosure any part of the filing that the superintendent determines to contain proprietary information and that would, if disclosed, harm competition. Pending the superintendent's determination under this subsection, the superintendent shall not disclose the part of a filing that is the subject of an insurer's request.

H. On the date that the superintendent posts a filing pursuant to Subsection D of this section, the superintendent shall open a thirty-day public comment period for policyholders and the general public, during which the policyholders and the general public may make comments online or in writing. The superintendent shall post on the

division's web site in a manner easily accessible to the public all comments made during the thirty-day public comment period.

I. All filings submitted pursuant to this section shall be filed electronically. The superintendent may designate an entity to receive the electronic filings submitted pursuant to this section.

J. As used in this section, "health insurance" or "health care plan" means a hospital and medical expense-incurred policy, plan or contract offered by a health insurer; nonprofit health service provider; health maintenance organization; managed care organization; or provider service organization; "health insurance" or "health care plan" does not include an individual policy intended to supplement major medical group-type coverage such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

History: Laws 2011, ch. 144, § 5.

59A-18-13.3. Health insurance filings; grounds and procedure for approval or disapproval.

A. The superintendent shall issue a final order within sixty days of the filing date for health insurance filings made on rates. The superintendent shall consider any public comment made pursuant to Subsection H of Section 59A-18-13.2 NMSA 1978. The superintendent shall issue findings and shall approve any rates on the following grounds:

(1) the proposed rate is in compliance with federal law and the Insurance Code;

(2) the proposed rate does not contain, or incorporate by reference, any inconsistent, ambiguous or misleading clause, exception or condition that deceptively affects the risk purported to be assumed in the general coverage of the contract or that encourages misrepresentation of the policy or its benefits;

(3) the proposed rate is actuarially sound and is supported by the actuarial memorandum submitted;

(4) the proposed rate is reasonable, not excessive or inadequate and not unfairly discriminatory; and

(5) the proposed rate is based upon administrative expenses that are permitted by federal and state law.

B. In order to determine whether the proposed rates are reasonable, actuarially sound and based on reasonable administrative expenses, the superintendent shall consider, at a minimum:

(1) the financial position of the insurer's insurance operations in the state, including surplus and reserves as reported in the latest three years' financial statements filed by the insurer;

(2) information provided to the superintendent for calculation of the amount of the insurer's direct services reimbursement pursuant to Section 59A-22-50, 59A-23C-10, 59A-46-51 [repealed] or 59A-47-46 NMSA 1978 [repealed];

(3) any anticipated change in the number of enrollees if the proposed rate is approved;

(4) changes to covered benefits or health benefit plan design;

(5) the insurer's compliance with all federal and state requirements for pooling risk and for participation in risk adjustment programs in effect under federal and state law; and

(6) the reliability and accuracy of the information provided in order to assure a meaningful review.

C. No final order shall be issued until after the close of the public comment period pursuant to Subsection H of Section 59A-18-13.2 NMSA 1978.

D. In rate filings for which the superintendent holds a hearing on reconsideration pursuant to Section 59A-4-15 NMSA 1978, the superintendent shall issue a final order within sixty days of the hearing.

E. A final order of the superintendent under this section may be appealed to the court of appeals pursuant to the provisions of Section 59A-18-13.5 NMSA 1978 within twenty days.

F. As used in this section, "health insurance" or "health care plan" means a hospital and medical expense- incurred policy, plan or contract offered by a health insurer; nonprofit health service provider; health maintenance organization; managed care organization; or provider service organization; "health insurance" or "health care plan" does not include an individual policy intended to supplement major medical group-type coverage such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

History: Laws 2011, ch. 144, § 6; 2013, ch. 74, § 23.

59A-18-13.4. Repealed.

History: Laws 2011, ch. 144, § 7; repealed by Laws 2013, ch. 74, § 40.

59A-18-13.5. Review of health insurance or plan rates; appeal to court of appeals from superintendent.

A. In a matter arising from an order of the superintendent on appeal pursuant to Section 59A-18-13.3 NMSA 1978, an aggrieved party may appeal to the court of appeals.

B. The court of appeals shall consider the superintendent's order on appeal and reverse the order only if the court determines:

(1) after evaluation of the record of evidence as a whole, that the superintendent's decision was not based on substantial evidence as to whether the proposed rates are reasonable, actuarially sound and based on reasonable administrative expenses;

(2) that the superintendent's decision was arbitrary, capricious or an abuse of discretion; or

(3) that the superintendent's decision on appeal is otherwise not in accordance with law.

History: Laws 2011, ch. 144, § 8; 2013, ch. 74, § 24.

59A-18-13.6. Pooling of closed blocks of business.

For the purpose of determining the rate of any policy within a closed block of business, the superintendent may require an insurer to pool the experience of a closed block of business with all appropriate blocks of business that are not closed in accordance with Section 59A-18-13.1 NMSA 1978. An insurer shall not apply a rate penalty or surcharge beyond that which reflects the experience of a pool combined in accordance with this section.

History: Laws 2011, ch. 144, § 9.

59A-18-14. Grounds, procedure for disapproval.

A. The superintendent shall review any filing, except any filing by a health insurance issuer for a change in rate, made pursuant to Section 59A-18-12 or 59A-18-13 NMSA 1978 within sixty days of the filing date. The superintendent shall approve any form if the superintendent finds that it complies with the Insurance Code [Chapter 59A NMSA

1978] and shall disapprove any form, classification of risks or rate only on one or more of the following grounds:

(1) if the form is in any respect in violation of or does not comply with the Insurance Code;

(2) if the form contains, or incorporates by reference where such incorporation is otherwise permissible, any inconsistent, ambiguous or misleading clauses or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract, or that encourage misrepresentation of the policy or its benefits;

(3) if the benefits offered are unreasonably restricted in relation to the premium charged;

(4) if the form has a title, heading or other indication of its provisions that is misleading or if the form is printed in such type or manner of reproduction as to be difficult to read; or

(5) if purchase of the form is being solicited by advertising, communication or dissemination of information that is deceptive or misleading.

B. If the superintendent disapproves any form during the sixty-day review period, the superintendent shall give the insurer written notice of the disapproval, stating the grounds for the disapproval.

C. After expiration of the sixty-day review period referred to in Subsection A of this section or at any time after having approved a form, the superintendent may, after a hearing thereon, disapprove a form or withdraw a previous approval on any of the grounds stated in Subsection A of this section. The superintendent's order issued on such hearing shall state the grounds for disapproval or withdrawal of previous approval and the date, not less than twenty days after the date of the order, when disapproval or withdrawal of approval shall become effective.

D. Any filing for a rate by a health insurance issuer shall be reviewed pursuant to the provisions of Section 6 [59A-18-13.3 NMSA 1978] of this 2011 act.

E. As used in this section, "health insurance issuer" means a health insurer; nonprofit health service provider; health maintenance organization; managed care organization; or provider service organization that offers a hospital and medical expense-incurred policy, plan or contract; "health insurance issuer" does not include a person that offers an individual policy intended to supplement major medical group-type coverage such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

History: Laws 1984, ch. 127, § 344; 1987, ch. 244, § 11; 2011, ch. 144, § 4.

59A-18-15. Repealed.

59A-18-16. Continuation of coverage and conversion rights; accident and health insurance policies; notice.

Subject to the provisions of the Health Insurance Portability Act:

A. every accident and health insurance policy that provides hospital, surgical and medical expense benefits and that is delivered, issued for delivery or renewed in this state on or after January 1, 1985 shall provide:

(1) if an individual policy, covered family members the right to continue such policy as the named insured or through a conversion policy upon the death of the named insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the named insured; or

(2) if a group policy:

(a) each member or employee of the group insured the right to continue such coverage for a period of six months and thereafter through a conversion policy upon termination of membership or employment with the group insured; and

(b) covered family members of an employee or member of the group insured the right to continue such coverage through a converted or separate policy upon the death of the member or employee of the group insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the member or employee of the group insured.

Where a continuation of coverage or conversion is made in the name of the spouse of the named insured or the spouse of the employee or member of the group insured, such coverage may, at the option of the spouse, include coverage for dependent children for whom the spouse has responsibility for care and support;

B. the right to a continuation of coverage or conversion pursuant to this section shall not exist with respect to any member or employee of the group insured or any covered family member in the event the coverage terminates for nonpayment of premium, nonrenewal of the policy or the expiration of the term for which the policy is issued. With respect to any member or employee of the group insured or any covered family member who is eligible for medicare or any other similar federal or state health insurance program, the right to a continuation of coverage or conversion shall be limited to coverage under a medicare supplement insurance policy as defined by the rules and regulations adopted by the superintendent;

C. coverage continued through the issuance of a converted or separate policy shall be provided at a reasonable, nondiscriminatory rate to the insured and shall consist of a form of coverage then being offered by the insurer as a conversion policy in the jurisdiction where the person exercising the conversion right resides that most nearly approximates the coverage of the policy from which conversion is exercised. Continued and converted coverages shall contain renewal provisions that are not less favorable to the insured than those contained in the policy from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a medicare supplement insurance policy, as defined by the rules and regulations adopted by the superintendent, after the attainment of the age of eligibility for medicare or any other similar federal or state health insurance program;

D. at the time of inception of coverage, the insurer shall furnish to each covered family member who is eighteen years of age or over and to each employee or member of the group insured a statement setting forth in summary form the continuation of coverage and conversion provisions of the policy;

E. the insurer shall notify in writing each employee or member, upon that employee's or member's termination of employment or membership with the group insured, of the continuation and conversion provisions of the policy. The employer may give the written notice specified herein. The employer should notify the insurer of the employee's or member's change of status and last known address. Under no circumstances shall the employer have any civil liability under the conversion provisions of the Insurance Code;

F. the eligible employee or member of the group insured or covered family member exercising the continuation or conversion right shall notify the employer or insurer and make payment of the applicable premium within thirty days following the date of the notification given by the insurer pursuant to Subsection E of this section. There shall be no lapse of coverage during the period in which conversion is available;

G. coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations;

H. benefits otherwise payable under a converted or separate policy may be reduced so they are not, during the first policy year of the converted or separate policy, in excess of those that would have been payable under the policy from which conversion is exercised. Benefits, if any, otherwise payable under a converted or separate policy are not payable for a loss claimed under the policy from which conversion is exercised; and

I. any probationary or waiting period set forth in the converted or separate policy is deemed to commence on the effective date of the applicant's coverage under the original policy.

History: Laws 1984, ch. 127, § 345.1; 1987, ch. 259, § 18; 1997, ch. 243, § 19; 2019, ch. 259, § 2.

59A-18-16.1. Group coverage discontinuance and replacement.

The superintendent may promulgate reasonable rules and regulations to establish requirements for group coverage discontinuance and replacement.

History: 1978 Comp., § 59A-18-16.1, enacted by Laws 1993, ch. 320, § 58.

59A-18-16.2. Health insurance or health plan form and rate filings; superintendent; rulemaking; compliance with federal law.

A. A small group health plan and a health insurance issuer or multiple employer welfare arrangement offering a small group or individual health insurance plan that provides benefits other than excepted benefits shall:

(1) provide the essential health benefits defined by the superintendent under Subsection B of this section;

(2) limit cost sharing for such coverage in accordance with Subsection D of this section; and

(3) provide coverage without cost sharing for preventive benefits in accordance with Subsection E of this section.

B. The superintendent shall define by rule the essential health benefits package to include at least the following general categories and the items and services covered within the categories:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

(5) mental health and substance use disorder services, including behavioral health treatment;

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

(9) preventive and wellness services and chronic disease management; and

(10) pediatric services, including oral and vision care.

C. In defining the essential health benefits pursuant to Subsection B of this section, the superintendent shall:

(1) ensure that such essential health benefits reflect an appropriate balance among the categories described in that subsection, so that benefits are not unduly weighted toward any category;

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs or design benefits in ways that discriminate against individuals because of their age, disability or expected length of life;

(3) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities and other groups;

(4) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency or quality of life;

(5) provide that if a plan is offered through the New Mexico health insurance exchange, another health insurance plan offered through the New Mexico health insurance exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the standalone plan that are otherwise required; and

(6) periodically update the essential health benefits under Subsection B of this section to address any gaps in access to coverage or changes in the evidence base identified by the superintendent.

D. A group health plan and a health insurance issuer offering a group or individual health insurance plan shall not establish a restricted lifetime or annual limit on the dollar value of benefits for any participant or beneficiary with respect to benefits that are essential health benefits, as determined by the superintendent. The provisions of this subsection shall not be construed to prevent a group health plan or health insurance plan from placing annual or lifetime per-beneficiary limits on specific covered benefits that are not essential health benefits, to the extent that these limits are otherwise permitted under federal or state law.

E. The superintendent shall adopt and promulgate rules specifying the maximum cost-sharing amounts for which an insured may be held liable for payment of covered benefits under any health insurance plan that provides benefits other than excepted benefits, including deductibles, coinsurance, copayments or similar charge, and any

other expenditure required of an insured individual with respect to essential health benefits covered under the plan, but not including premiums, balance billing amounts for non-network providers or spending for non-covered services.

F. Any rules that the office of superintendent of insurance intends to adopt and promulgate pursuant to this section shall be adopted no later than the first day of February of the year prior to the first plan year for which the rules would be effective.

G. A group health plan and a health insurance issuer offering a group or individual health insurance plan that provides benefits other than excepted benefits shall provide coverage for and shall not impose any cost-sharing requirements for:

(1) items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States preventive services task force;

(2) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the federal centers for disease control and prevention, with respect to the insured for which immunization is considered;

(3) with respect to infants, children and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the health resources and services administration of the United States department of health and human services; and

(4) with respect to women, additional preventive care and screenings to those described in Paragraph (1) of this subsection, as provided for in comprehensive guidelines supported by the health resources and services administration of the United States department of health and human services.

H. The provisions of Subsection G of this section shall not be construed to prohibit a health insurance plan or health insurance issuer from providing coverage for services in addition to those recommended by the United States preventive services task force or to deny coverage for services that are not described in this section. The superintendent shall establish by rule a minimum interval between the date on which a recommendation described in Paragraphs (1) and (2) of Subsection G of this section or a guideline under Paragraph (3) of Subsection G of this section is issued and the plan year with respect to which the requirement described in Subsection G of this section is effective with respect to the service described in such recommendation or guideline; provided that the interval shall not be less than one year from the date the federal recommendation or guideline is published.

I. If a health insurance plan is offered as a qualified health plan through the New Mexico health insurance exchange, the insurer offering the qualified health plan shall also offer that plan through the health insurance exchange as a plan that restricts enrollment to individuals who, as of the beginning of a plan year, have not attained the age of twenty-one years.

J. The superintendent shall adopt rules:

(1) to define terms used regarding forms, rates, reviews and blocks of business that an insurer or health care plan submits in filing matters;

(2) to govern any additional filing requirements the superintendent deems appropriate;

(3) to provide notice of hearings and the grounds on which the hearings have been requested;

(4) to meet criteria for review in accordance with federal law; and

(5) that the superintendent deems appropriate to carry out the provisions of Chapter 59A, Article 18 NMSA 1978.

K. Except as provided by state or federal rule or law, nothing in this section shall be construed to prohibit a health insurance carrier from appropriately using reasonable health care cost management techniques.

L. As used in this section, "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 benefits;

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

History: Laws 2011, ch. 144, § 12; 2019, ch. 259, § 3.

59A-18-17. Standard provisions, in general.

A. Insurance contracts shall contain such standard or uniform provisions as are required by applicable provisions of the Insurance Code [Chapter 59A NMSA 1978] pertaining to contracts of particular kinds of insurance.

B. No policy shall contain a provision inconsistent with or contradictory to a standard or uniform provision used or required to be used, but the superintendent may approve a substitute provision that is, in the superintendent's opinion, not less favorable in any particular to the insured, owner or beneficiary than the provision otherwise required or that is designed to comply with Chapter 59A, Article 19 NMSA 1978.

C. Insurance coverage provided in residential property insurance policies shall provide coverage for the cost to repair or replace without deduction for depreciation. If the insured elects to effectuate repairs to the property by the insured's own self, a reasonable overhead expense shall be allowed.

D. In lieu of the provisions required by the Insurance Code for contracts for particular kinds of insurance, substantially similar provisions required by the laws of the domicile of a foreign or alien insurer may be used when approved by the superintendent.

E. A policy issued by a domestic insurer for delivery in another jurisdiction may contain any provision required or permitted under the laws of such jurisdiction.

F. To protect consumers as well as enhance the value of consumer information systems, the superintendent may specify minimum coverage provisions that

homeowners insurance policies, private passenger non-fleet automobile insurance policies or other lines or kinds of insurance policies that are priced in a consumer information system shall contain, provided that such minimum coverage provisions are contained in the majority of policies in force in New Mexico for that line or kind of insurance. An insurer that does not offer a policy that contains the minimum coverage provisions specified by the superintendent for a line or kind of insurance shall not be included in a consumer information system for that line or kind of insurance. The superintendent shall not compel an insurer to offer a policy containing minimum coverage provisions specified by the superintendent.

History: Laws 1984, ch. 127, § 346; 1993, ch. 85, § 1; 2007, ch. 367, § 37.

59A-18-18. Charter, bylaw provisions.

No policy shall contain any provision purporting to make any portion of the charter, bylaws or other constituent document of the insurer (other than the subscriber's agreement or power of attorney of a reciprocal insurer) a part of the contract unless such portion is set forth in full in the policy.

History: Laws 1984, ch. 127, § 347.

59A-18-19. Execution of policies.

A. Every policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee or representative duly authorized by the insurer.

B. A facsimile signature of any such executing individual may be used in lieu of an original signature.

C. No policy which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy.

History: Laws 1984, ch. 127, § 348.

59A-18-20. Underwriters' and combination policies.

A. Two (2) or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names. Any one insurer may issue policies in the name of an underwriter's department and such policy shall plainly show the true name of the insurer.

B. Two (2) or more insurers may, with the superintendent's approval, issue a combination policy containing additional provisions substantially as follows:

(1) that the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy; and

(2) that service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy shall constitute service upon all such insurers.

C. This section does not apply to cosurety obligations.

History: Laws 1984, ch. 127, § 349.

59A-18-21. Validity, construction of noncomplying forms.

A. A policy delivered or issued for delivery after the effective date of the Insurance Code [Chapter 59A NMSA 1978] to any person in this state in violation of the Insurance Code but otherwise binding on the insurer, shall be held valid, but shall be construed as provided in the Insurance Code.

B. Any condition, omission or provision not in compliance with the requirements of the Insurance Code and contained in any policy, rider or endorsement issued after the effective date of the Insurance Code and otherwise valid shall not thereby be rendered invalid but shall be interpreted and applied in accordance with such condition, omission or provision as would have applied had the same been in full compliance with the Insurance Code.

History: Laws 1984, ch. 127, § 350.

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.

History: Laws 1984, ch. 127, § 351; 2021, ch. 108, § 14.

59A-18-23. Delivery of policy, motor vehicle vendors, mortgagees, pledgees.

A. If the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee or pledgee of any motor vehicle, in which policy any interest of the vendee, mortgagor or pledgor in or with respect to such vehicle is insured, a duplicate of the policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same information, shall be delivered by the vendor, mortgagee or pledgee to each such vendee, mortgagor or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability of the vendee, mortgagor or pledgor for injury to persons or damage to property of third parties, a statement of such fact shall be printed, written or stamped conspicuously on the face of the duplicate policy or memorandum.

B. This section does not apply to inland marine floater policies.

History: Laws 1984, ch. 127, § 352.

59A-18-24. Insurance producers; whom they represent.

A licensed insurance producer appointed as insurance producer by an insurer shall, in any controversy between the insured or the insured's beneficiary and the insurer, be held to be the agent of the insurer that issued the insurance solicited or applied for, anything in the application or policy to the contrary notwithstanding; and a broker licensed to transact insurance business in this state, in any controversy between the insured or the insured's beneficiary and the insurer issuing the insurance through its licensed insurance producer at request of the broker, shall be held to be the agent of the insured, anything in the application or policy to the contrary notwithstanding, unless under particular circumstances it is found that the broker is representing the insurer. This section shall not apply as to surplus line brokers, nor as to acts of the insurance producer in fraud or attempted fraud of the insurer or acts of the broker in fraud or attempted fraud of the insured.

History: Laws 1984, ch. 127, § 353; 2016, ch. 89, § 60.

59A-18-25. Allowance for inflation.

Where amounts of insurance under group, blanket or other forms of life, annuity or health insurance coverage are now or hereafter limited to specified dollar amounts by any provision of the Insurance Code, the insurer may, with the superintendent's approval and notwithstanding the statutory limit otherwise applicable, increase the dollar amount of coverage in particular policies or contracts as reasonably necessary to offset devaluation of dollar purchasing power because of inflation, and to provide current coverage in amount reasonably related to dollar purchasing power at the time such statutory limit was enacted. The superintendent may promulgate reasonable rules and regulations for effectuation of this section under which the increased amounts of coverage may be applied generally and without approval by the superintendent of increases in each instance.

History: Laws 1984, ch. 127, § 354.

59A-18-26. Payment discharges insurer.

Whenever the proceeds of or payments under a life or health insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of the policy or contract, or exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy, contract or assignment as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor; and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.

History: Laws 1984, ch. 127, § 355.

59A-18-27. Forms of proof of loss to be furnished.

Upon receiving due notice of a claim of loss under an insurance contract issued or assumed by it, an insurer shall promptly furnish to the insured claimant such forms of proof of loss as it may require for completion by such person, but the insurer shall not have any responsibility for or with respect to completion of such proof or the manner of any such completion or attempted completion.

History: Laws 1984, ch. 127, § 356.

59A-18-27.1. Universal claim forms.

A. The superintendent shall devise or designate universal forms to be utilized by every health insurer, including health maintenance organizations, nonprofit health plans and fraternal organizations offering any type of health coverage for individuals residing in this state, for the purpose of receiving claims under their policies. In preparing the

forms, the superintendent may consult with insurers, trade associations and other interested parties. Upon adoption of the final forms by the superintendent, he shall notify the insurers affected by sending them a specimen copy of the adopted forms and an explanation of the requirements of this section. Every covered insurer shall begin using the adopted forms not later than six months following the date of the superintendent's notification.

B. A health insurer may not refuse to accept a claim submitted on uniform claim forms adopted pursuant to Subsection A of this section, but may accept claims submitted on any other form.

C. A health insurer does not violate this section by using a claim form that the insurer has been required to use by the state or federal government.

History: 1978 Comp., § 59A-18-27.1, enacted by Laws 1993, ch. 126, § 2.

59A-18-28. Notice; waiver.

The acknowledgment by any insurance company of the receipt of notice given under any policy covered by this code [Chapter 59A NMSA 1978], or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurance company in defense of any claim arising under such policy.

History: Laws 1984, ch. 127, § 357.

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.

History: Laws 1984, ch. 127, § 358; 2021, ch. 108, § 15.

59A-18-30. Disclosure of premium and claim data.

A. An insurer shall for a policy of insurance coverage provide the named insured of the policy with premium and claim data within sixty days of receipt of a written request from the named insured.

B. As used in this section "premium and claim data" shall include:

(1) the sum of all premiums charged or billed by the insurer for the insurance policy;

(2) the sum of all amounts paid out pursuant to claims covered under the policy;

(3) a list of all pending claims against the policy which are open; and

(4) cumulative loss or claim reserves chargeable to the policy.

C. None of the provisions of this section shall be applicable to life insurance policies or group insurance policies.

History: 1978 Comp., § 59A-18-31, enacted by Laws 1987, ch. 281, § 1.

59A-18-31. Accident and health policy or certificate provisions relating to individuals who are eligible for medical benefits under the medicaid program.

A. Each individual or group policy or certificate of accident or health insurance that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy or certificate to be paid to the human services department [health care authority department] when:

(1) the human services department [health care authority department] has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;

(2) payment for the services in question has been made by the human services department [health care authority department] to the medicaid provider; and

(3) the insurer is notified that the insured individual receives benefits under the medicaid program and that benefits must be paid directly to the human services department [health care authority department].

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the human services department [health care authority department] for insurance benefits when the claim is first submitted by the human services department [health care authority department] to the insurer.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any individual or group policy or certificate of accident or health insurance for health care services provided to insured individuals who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy or certificate shall be made payable to the provider. The insurer may be notified that the insured individual is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the insurer.

D. No individual or group accident or health policy or certificate delivered, issued for delivery or renewed in this state on or after the effective date of this section shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where an insurer has a legal liability to make payments, the state is

considered to have acquired the rights of the individual to payment by the insurer for those health care items or services.

History: 1978 Comp., § 59A-18-31, enacted by Laws 1989, ch. 183, § 1; 1994, ch. 64, § 1.

59A-18-32. Certificates of property or casualty insurance.

A. As used in this section:

(1) "certificate of insurance" means any document or instrument prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage, but excludes an insurance policy, insurance binder, policy endorsement or automobile insurance identification or information card; and

(2) "insurance producer" means a person required to be licensed pursuant to the laws of New Mexico to sell, solicit or negotiate property or casualty insurance.

B. A person shall not prepare, issue or require the issuance of a certificate of insurance on property, operations or risks located in New Mexico unless an insurer or an agent of an insurer has filed the certificate of insurance form with the superintendent at least sixty days before its proposed effective date. The superintendent shall review any filing made pursuant to this subsection within sixty days of the filing date. The superintendent shall prohibit the use of a certificate of insurance form if the form:

(1) is unfair, misleading or deceptive;

(2) violates public policy; or

(3) violates any law, including any rule promulgated by the superintendent.

C. If the superintendent prohibits a certificate of insurance form during the sixty-day review period, the superintendent shall give the insurer written notice of the disapproval, stating the grounds for disapproval. After the expiration of the sixty-day review period, a filing shall be deemed to meet the requirements of this section to become effective unless prohibited pursuant to this section.

D. An individual insurer shall not be required to file a certificate of insurance form if that form is:

(1) the current edition of a standard certificate of insurance form that is promulgated by the association for cooperative operations research and development, the American association of insurance services or the insurance services office and that is filed with and approved by the superintendent pursuant to Subsection E of this section; or

(2) a certificate of insurance form whose content and wording are specifically provided for by federal law or regulation or a law or rule of New Mexico.

E. The superintendent shall review any filing made pursuant to Paragraph (1) of Subsection D of this section within sixty days of the filing date. A filing made pursuant to Paragraph (1) of Subsection D of this section shall not be used until approved by the superintendent. The superintendent shall approve any form if the superintendent finds that it complies with the Insurance Code. After the expiration of the sixty-day review period, a filing shall be deemed to meet the requirements of this section to become effective unless disapproved pursuant to this subsection.

F. A filing submitted pursuant to this section shall be filed electronically. The superintendent may designate an entity to receive the electronic filings submitted pursuant to this section.

G. A certificate of insurance is not an insurance policy and does not affirmatively or negatively amend, extend or alter the coverage afforded by the policy to which the certificate of insurance refers. A certificate of insurance shall not confer to any person new or additional rights beyond the express provisions of the insurance policy to which it refers.

H. A person shall not:

(1) alter or modify a certificate of insurance form filed with the superintendent; or

(2) prepare, issue or require the issuance of a certificate of insurance that:

(a) contains any false or misleading information concerning the insurance policy to which the certificate of insurance refers; or

(b) purports to affirmatively or negatively alter, amend or extend the coverage provided by the insurance policy to which the certificate of insurance refers.

I. A contract number or description in a certificate of insurance shall not indicate that the insurance policy complies with the insurance or indemnification requirements of a contract. A person shall not certify in a certificate of insurance that the insurance policy to which it refers complies with the insurance or indemnification requirements of a contract.

J. An insurer or insurance producer shall notify a person of the cancellation or nonrenewal of or material change to an insurance policy only if that person has the right to notice pursuant to the terms of the insurance policy or an endorsement to an insurance policy. The insurance policy or endorsement to an insurance policy shall govern the terms and conditions of the notice. A certificate of insurance shall not alter the terms and conditions of the notice.

K. The provisions of this section apply to all certificates of insurance issued in connection with property, operations or risks in New Mexico, regardless of the location of the policyholder, insurer, insurance producer or person requiring the issuance of a certificate of insurance.

L. A certificate of insurance or any other document or correspondence prepared, issued or required in violation of this section shall be void.

History: Laws 2013, ch. 100, § 2.

59A-18-33. Notice.

A. An organization that publishes information regarding the effectiveness of community fire protection or building code information, including public protection classifications, community grading, building code effectiveness classifications or fire suppression rating schedules for use by residential property insurers in this state, shall provide notice of any unfavorable change in a community's classification to the office of superintendent of insurance.

B. Upon receiving notice of an unfavorable change in a community's public protection classification, community grading, building code effectiveness classification or fire suppression rating schedule, the office of superintendent of insurance shall issue a bulletin notifying insurers of the change and the communities affected and instructing insurers to notify customers who may be adversely affected by the unfavorable change within ninety days of the publication of the bulletin.

History: Laws 2019, ch. 84, § 1.

ARTICLE 19
Policy Language Simplification

59A-19-1. Short title; exclusive control.

A. This article [59A-19-1 to 59A-19-7 NMSA 1978] may be referred to as the "Policy Language Simplification Law".

B. No other statute of this state setting language simplification standards shall apply as to any policy forms.

History: Laws 1984, ch. 127, § 360.

59A-19-2. Scope of article.

A. This article applies as to all policies, group certificates, benefit or service certificates, contracts, plans or agreements providing coverage as to life or health of

human beings, and delivered or issued for delivery in this state by any insurer, fraternal benefit society, nonprofit health service corporation, prepaid health care plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization and all similar organizations now or hereafter authorized to transact business in this state under any law of this state. The superintendent shall, by regulation, make this article applicable to any other policy, certificate, contract, plan or agreement of insurance when he determines that person delivering or issuing can reasonably comply with the provisions of this article.

B. This article shall not apply as to:

(1) any policy which is a security subject to federal jurisdiction;

(2) any group policy covering a group of one thousand (1,000) or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy; except, that any certificate issued pursuant to a group policy and delivered or issued for delivery in this state is not exempt;

(3) any group annuity contract which is a funding vehicle for a pension, profit-sharing or deferred compensation plan;

(4) any form used in connection with, or as a conversion from, or as an additon [addition] to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery in this state on an initial form approved or permitted to be issued prior to the date such initial form must be approved under this article; or

(5) the renewal of a policy delivered or issued for delivery prior to the date such policy form must be approved under this article.

History: Laws 1984, ch. 127, § 359.

59A-19-3. Definitions.

For the purposes of this article:

A. "issuer" means the insurer, fraternal benefit society, nonprofit health service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization or other organization referred to in Subsection A of Section 359 [59A-19-2 NMSA 1978] of this code; and

B. "policy" means any policy, group certificate, benefit or service contract, plan or agreement referred to in Subsection A of Section 359 of this code.

History: Laws 1984, ch. 127, § 361.

59A-19-4. Minimum language simplification standards.

A. In addition to any other requirements of law, no policy forms shall be delivered or issued for delivery in New Mexico on or after the dates such form must be approved under this article, unless:

(1) the text achieves a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on any other comparable test as provided in Subsection C of this section;

(2) it is printed, except for specification pages, schedules and tables, in not less than ten-point type, one point leaded;

(3) the style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and

(4) it contains a table of contents or an index of the principal sections of the policy if the policy has more than three thousand (3,000) words printed on three (3) or fewer pages of text, or if the policy has more than three (3) pages regardless of the number of words.

B. For the purpose of this section, a Flesch reading ease test score shall be measured by the following method:

(1) for policy forms containing ten thousand (10,000) words or less of text, the entire form shall be analyzed. For policy forms containing more than ten thousand (10,000) words, the readability of two (2) two-hundred-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least twenty (20) printed lines;

(2) the number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015;

(3) the total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6;

(4) the sum of the figures computed under Paragraphs (2) and (3) of this subsection subtracted from 206.835 equals the Flesch reading ease score for the policy form;

(5) for the purposes of Paragraphs (2), (3) and (4) of this subsection the following procedures shall be used:

(a) a contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;

(b) a unit of words ending with a period, semicolon or colon, but excluding headings and captions, shall be counted as a sentence; and

(c) a syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two (2) or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used; and

(6) as used in this section, "text" includes all printed matter except the following:

(a) the name and address of the issuer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages, schedules or tables; and

(b) any policy language which is drafted to conform to the requirements of any federal law, regulation or agency interpretation; any policy language required by any collectively bargained agreement; any medical terminology; any words which are defined in the policy; and any policy language required by law or regulation; provided, however, the issuer identifies the language or terminology excepted by this subparagraph and certifies in writing that the language or terminology is entitled to be excepted from this subparagraph.

C. Any other reading test may be approved by the superintendent for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

D. Filings subject to this section shall be accompanied by a certificate signed by an officer of the issuer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with Section 364 [59A-19-6 NMSA 1978] of this article. To confirm the accuracy of any certification, the superintendent may require the submission of further information to verify the certification in question.

E. At the option of the issuer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

History: Laws 1984, ch. 127, § 362.

59A-19-5. Superintendent may allow lower reading ease score.

The superintendent may, in his sole discretion, authorize use of a policy form having a lower score than the Flesch reading ease score required in Paragraph A(1) of Section 362 [59A-19-4 NMSA 1978] of this article if he finds that a lower score:

A. will provide a more accurate reflection of the readability of a policy form;

B. is warranted by the nature of a particular policy form or type or class of policy forms; or

C. is caused by certain policy language which is drafted to conform to requirements of any state law, regulation or agency interpretation.

History: Laws 1984, ch. 127, § 363.

59A-19-6. Approval of forms.

A. A policy form meeting the requirements of Subsection A of Section 362 [59A-19-4 NMSA 1978] of this article shall be approved notwithstanding the provisions of any other laws which specify the contents of policies, if the policy form provides for policyholders and claimants protection not less favorable than they would be entitled to under such laws.

B. Any non-English language policy shall be deemed to be in compliance with Paragraph (1), Subsection A, of Section 362 of this article if the issuer certifies to the superintendent in writing that the policy is translated from an English-language policy which complies with such paragraph.

History: Laws 1984, ch. 127, § 364.

59A-19-7. Effective date of approval requirement.

A. This article applies to all policy forms filed with the superintendent on or after July 1, 1984. No policy form shall be delivered or issued for delivery in New Mexico on or after July 1, 1987 unless approved by the superintendent or permitted to be issued under this article. Any policy form which has been approved by the superintendent or permitted to be issued prior to July 1, 1987 and which meets the standards set by this article need not be refiled with the superintendent for approval, but may continue to be delivered or issued for delivery in this state upon the issuer filing with the superintendent a list of such forms identified by form number and accompanied by a certificate as to each such form in the manner provided in Subsection D of Section 362 [59A-19-4 NMSA 1978] of this article.

B. The superintendent, in his sole discretion, may extend the dates referred to in Subsection A of this section.

History: Laws 1984, ch. 127, § 365.

ARTICLE 20
Life Insurance and Annuity Contracts

59A-20-1. Scope of article.

This article [Chapter 59A, Article 20 NMSA 1978] applies only to contracts of life insurance, endowments and annuities, other than reinsurance, group life insurance and group annuities; except that Section 395 [59A-20-30 NMSA 1978] (variable contract law) shall also apply as to group life and group annuity contracts.

History: Laws 1984, ch. 127, § 366.

59A-20-2. "Annuity", "industrial life insurance" defined.

For the purposes of the Insurance Code:

A. an "annuity" is a contract under which obligation is assumed by the issuer to make periodic payments for a specific term or terms where the making or continuance of all or some such payments or the amount of any such payment is dependent upon continuance of human life, except payments made pursuant to optional modes of settlement under authority of Section 108 [59A-7-2 NMSA 1978] ("life" insurance defined) of the Insurance Code. Such a contract which includes extra benefits of the kinds set forth in Section 108 ("life" insurance defined) or Section 109 [59A-7-3 NMSA 1978] ("health" insurance defined) of the Insurance Code shall nevertheless be deemed to be an annuity if such extra benefits constitute a subsidiary or incidental part of the entire contract; and

B. "industrial life insurance" is that form of life insurance written under policies in face amount of two thousand five hundred dollars ($2,500) or less, and bearing the words "industrial policy" or "weekly premium policy" or words of similar import imprinted on the face thereof as part of descriptive matter, and under which premiums are payable monthly or more often.

History: Laws 1984, ch. 127, § 367.

59A-20-3. Standard provisions required.

A. No insurer shall deliver or issue for delivery in this state any life insurance policy unless the policy contains in substance all of the applicable standard provisions required by Sections 369 through 380 [59A-20-4 to 59A-20-15 NMSA 1978] of this article, subject to Section 346 [59A-18-17 NMSA 1978] of the Insurance Code as to waiver or use of substitute provisions with the superintendent's approval.

B. This section does not apply as to group or pure endowment policies, annuity contracts or any provision of a life insurance policy or contract supplemental thereto relating to disability benefits or additional benefits in event of death by accident or accidental means.

C. Any of such provisions or portions thereof not applicable to single premium or nonparticipating or term policies, or insurance granted in exchange for lapsed or surrendered policies, shall to that extent not be incorporated therein.

History: Laws 1984, ch. 127, § 368.

59A-20-4. Grace period.

There shall be a provision that a grace period of thirty (30) days, or, at the option of the insurer, of one month of not less than thirty (30) days, or of four (4) weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force. The insurer may impose an interest charge not in excess of six percent per annum for the number of days of grace elapsing before the payment of the premium, and whether or not such interest charge is imposed, if a claim arises under the policy during such period of grace the amount of any premium due or overdue, together with interest and any deferred installment of the annual premium, may be deducted from the policy proceeds.

History: Laws 1984, ch. 127, § 369.

59A-20-5. Incontestability.

There shall be a provision that the policy (exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means) shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two (2) years from its date of issue.

History: Laws 1984, ch. 127, § 370.

59A-20-6. Entire contract.

There shall be a provision that the policy, or the policy and the application therefor if a copy of such application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties and that statements contained in such an application shall, in the absence of fraud, be deemed representations and not warranties.

History: Laws 1984, ch. 127, § 371.

59A-20-7. Misstatement of age.

There shall be a provision that if the age of the insured, or of any other person whose age is considered in determining the premium or benefit, has been misstated,

any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.

History: Laws 1984, ch. 127, § 372.

59A-20-8. Dividends, participating policies.

A. There shall be a provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy, provided the policy is in force and all premiums to that date are paid. Except as hereinafter provided, any dividend becoming payable shall at the option of the party entitled to elect such option be either:

(1) payable in cash; or

(2) applied to any one of such other dividend options as may be stated in the policy and approved by the superintendent.

B. If any such other dividend options are provided the policy shall further state which option shall be automatically effective if such party shall not have elected some other option. If the policy specifies a period within which such other dividend option may be elected, such period shall be not less than thirty (30) days following the date on which such dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash within the meaning of Paragraph (1) above even though the policy provides that payment of such dividend is to be deferred for a specified period, provided such period does not exceed one year from the date of apportionment; however, interest will not be added to the dividend but shall be paid out annually.

C. If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus becoming payable or apportioned while the insurance is in force under such nonforfeiture provision shall be applied in the manner set forth in the policy.

D. In participating industrial life insurance policies, in lieu of the provision required otherwise in this section, there shall be a provision that, beginning not later than the end of the fifth policy year, the policy shall participate annually in the divisible surplus, if any, in the manner set forth in the policy.

History: Laws 1984, ch. 127, § 373.

59A-20-9. Policy loans.

A. There shall be a provision that after three (3) full years' premiums have been paid, and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will advance, on proper assignment or

pledge of the policy and on the sole security thereof, at a rate of interest not exceeding that allowable under Section 375 [59A-20-10 NMSA 1978] of this article, an amount equal to or, at the option of the party entitled thereto, less than the loan value of the policy. Before approving any policy language providing for a rate of interest in excess of eight percent, the superintendent shall require certification by the insurer that the holders of such policies will benefit through higher dividends or lower premiums, or both. The interest rate provided for by this section shall not impair the terms and conditions of any policy in force before the effective date of the Insurance Code. The loan value of the policy shall be at least equal to the cash surrender value at the end of the then current policy year, provided that the insurer may deduct, either from such loan value or from the proceeds of the loan, any existing indebtedness not already deducted in determining such cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year and interest on the loan to the end of the current policy year. The policy may also provide that if interest on any indebtedness is not paid when due it shall then be added to the existing indebtedness and shall bear interest at the same rate, and that if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value thereof, then the policy shall terminate and become void. The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six (6) months after application therefor. The policy, at the insurer's option, may provide for automatic premium loan, subject to an election of the party entitled to elect.

B. This section shall not apply to term policies nor to term insurance benefits provided by rider or supplemental policy provisions, or to industrial life insurance policies.

History: Laws 1984, ch. 127, § 374.

59A-20-10. Policy loan interest rates.

A. For purposes of this section the "published monthly average" means:

(1) the Moody's Corporate Bond Yield Average - Monthly Average Corporates as published by Moody's Investors Service, Inc. or any successor thereto; or

(2) if such publication is no longer published, a substantially similar average established by regulations of the superintendent.

B. Maximum rate of interest on policy loans.

(1) Policies issued on or after April 7, 1983 shall provide for policy loan interest rates as follows:

(a) a provision permitting a maximum interest rate of not more than eight percent per annum; or

(b) a provision permitting an adjustable maximum interest rate established from time to time by the insurer as permitted by this section.

(2) The rate of interest charged under Subparagraph (1)(b) of this subsection shall not exceed the higher of the following:

(a) the published monthly average for the calendar month ending two (2) months before the date on which the rate is determined; or

(b) the rate used to compute the cash surrender values under the policy during the applicable period plus one percent per annum.

(3) If the maximum rate of interest is determined pursuant to Subparagraph (1)(b) of this subsection, the policy shall contain a provision stating the frequency at which the rate is to be determined for that policy.

(4) The maximum rate for each policy shall be determined at regular intervals at least once every twelve (12) months, but not more frequently than once in any three (3) month period. At the intervals specified in the policy:

(a) the rate being charged may be increased whenever such increase as determined under paragraph (2) of this Subsection B would increase the rate by one-half percent or more per annum; and

(b) the rate charged must be reduced whenever such reduction as determined under such paragraph (2) of this Subsection B would decrease that rate by one-half percent or more per annum.

(5) The insurer shall:

(a) notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(b) notify the policyholder of the initial rate of interest on the loan as soon as reasonably practical after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in (c) below;

(c) send to policyholders with loans reasonable advance notice of any increase in the interest rate; and

(d) include in the notices required above the substance of the pertinent provisions of Paragraphs (1) and (3) of this Subsection B.

(6) The loan value of the policy shall be determined in accordance with Section 374 [59A-20-9 NMSA 1978] (policy loans) of this article, but no policy shall terminate in a policy year as the sole result of change in the interest rate during that

policy year, and the insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(7) The substance of the pertinent provisions of Paragraphs (1) and (3) of this Subsection B shall be set forth in the policies to which they apply.

(8) For the purposes of this Subsection B:

(a) the rate of interest on policy loans permitted under this Subsection B includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy;

(b) "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the insurer as they fell due;

(c) "policyholder" includes the owner of the policy or person designated to pay premiums as shown by the records of the insurer; and

(d) "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(9) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

C. This section shall not apply to any insurance contract issued before April 7, 1983 unless the policyholder agrees in writing to the applicability of such provisions.

History: Laws 1984, ch. 127, § 375.

59A-20-11. Table of installments.

If the policy provides that the proceeds may be payable in installments which are determinable at issue of the policy, there shall be a table showing the amount of the guaranteed installments.

History: Laws 1984, ch. 127, § 376.

59A-20-12. Reinstatement.

There shall be a provision that unless:

A. the policy has been surrendered for its cash surrender value; or

B. its cash surrender value has been exhausted; or

C. the paid-up term insurance, if any has expired;

the policy will be reinstated at any time within three (3) years (or two (2) years in the case of industrial life insurance policies) from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears with interest at a rate not exceeding six percent per annum compounded annually and the payment or reinstatement of any other indebtedness to the insurer upon the policy with interest at the applicable policy loan interest rate.

History: Laws 1984, ch. 127, § 377.

59A-20-13. Premium.

There shall be a provision stating the amount of premium and the time and manner payable.

History: Laws 1984, ch. 127, § 378.

59A-20-14. Payment of claims.

There shall be a provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and, at the insurer's option, surrender of the policy or proof of the interest of the claimant. If an insurer shall specify a particular period prior to the expiration of which settlement shall be made, such period shall not exceed two months from the receipt of such proofs.

History: Laws 1984, ch. 127, § 379.

59A-20-15. Beneficiary, industrial policies.

An industrial life insurance policy shall have the name of the beneficiary designated thereon with a reservation of the right to change the beneficiary after the issuance of the policy. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer, and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. The policy may also provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than thirty (30) days after the death of the insured, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make any payment thereunder to the executor or administrator of the insured, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary or by reason of having incurred expense for the maintenance,

medical attention or burial of the insured. The policy may also include a similar provision applicable to any other payment due under the policy.

History: Laws 1984, ch. 127, § 380.

59A-20-16. Incontestability; excluded or restricted coverage; after reinstatement.

A. A clause in any life insurance policy providing that the policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such exclusions or restrictions are excepted in such clause.

B. The reinstatement of a life insurance policy, whether heretofore or hereafter issued in this state, shall be incontestable after the same period following reinstatement and with the same conditions and exceptions, as provided in the policy with respect to incontestability thereof.

History: Laws 1984, ch. 127, § 381.

59A-20-17. Standard provisions, annuity and pure endowment contracts.

A. No annuity or pure endowment contract, other than a reversionary annuity (also called survivorship annuities) or group annuities and except as stated in this section, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions as specified in Sections 383 through 388 [59A-20-18 to 59A-20-23 NMSA 1978] of this article. Any of such provisions not applicable to single-premium annuities or single-premium pure endowment contracts shall not, to that extent, be incorporated therein.

B. This section does not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies.

History: Laws 1984, ch. 127, § 382.

59A-20-18. Annuities, grace period.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that there shall be a period of grace of one month, but not less than thirty (30) days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding six percent per annum for the number of days of grace elapsing before such payment,

during which period of grace the contract shall continue in full force; but in case a claim arises under the contract on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

History: Laws 1984, ch. 127, § 383.

59A-20-19. Annuities, incontestability.

If any statements other than those relating to age, sex and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity and subject to Section 386 [59A-20-21 NMSA 1978] of this article, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two (2) years from its date of issue, except for nonpayment of stipulated payments to the insurer, and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means.

History: Laws 1984, ch. 127, § 384.

59A-20-20. Annuities, entire contract.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that the contract shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties.

History: Laws 1984, ch. 127, § 385.

59A-20-21. Annuities, misstatement of age or sex.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that if the age or sex of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex and that if the insurer makes or has made any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding six percent per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

History: Laws 1984, ch. 127, § 386.

59A-20-22. Annuities, dividends.

If an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

History: Laws 1984, ch. 127, § 387.

59A-20-23. Annuities, reinstatement.

In any annuity or pure endowment contract, other than a reversionary or group annuity, there shall be a provision that the contract may be reinstated at any time within one year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract but not exceeding six percent per annum payable annually, and in cases where applicable the insurer may also include a requirement of evidence of insurability satisfactory to the insurer.

History: Laws 1984, ch. 127, § 388.

59A-20-24. Standard provisions; reversionary annuities.

A. Except as stated in this section, no contract for a reversionary annuity shall be delivered or issued for delivery in this state unless it contains in substance each of the following provisions:

(1) the provisions specified in Sections 383 through 387 [59A-20-18 to 59A-20-22 NMSA 1978] of this article, except that under Section 383 (grace period) the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue payment in lieu of providing for deduction of such payments from an amount payable upon settlement under the contract; and

(2) there shall be a provision that the contract may be reinstated at any time within three (3) years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the insurer on account of the contract are paid, or, within the limits permitted by the then cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding six percent per annum compounded annually.

B. This section does not apply to group annuities or to annuities included in life insurance policies, and any of such provisions not applicable to single premium annuities shall not to that extent be incorporated therein.

History: Laws 1984, ch. 127, § 389.

59A-20-25. Limitation of liability.

A. No policy of life insurance shall be delivered or issued for delivery in this state if it contains any of the following provisions:

(1) a provision for a period of not less than five years within which an action at law or in equity may be commenced after the cause of action shall accrue; or

(2) a provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein in the event of death under any one or more of the following circumstances:

(a) death as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces, or of any act or hazard of such war or action, or of service in the military, naval or air forces or in civilian forces auxiliary thereto, or from any cause while a member of such military, naval or air forces of any country engaged in such military action;

(b) death as a result of aviation or any air travel or flight;

(c) death as a result of a specified hazardous occupation or occupations;

(d) death while the insured is a resident outside the continental United States and Canada; or

(e) death within two years from the date of issue of the policy as a result of suicide, while sane or insane.

B. A policy which contains any exclusion or restriction pursuant to Subsection A of this section shall also provide that in the event of death under the circumstances to which any such exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the national association of insurance commissioners reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits (or if the policy provides for no such benefits, computed according to a mortality table and interest rate determined by the insurer and either specified in the policy or filed with the superintendent) with adjustment for indebtedness or dividend credit.

C. This section shall not apply to group life insurance, health insurance, reinsurance or annuities, or to any provision in a life insurance policy or contract supplemental thereto relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

D. Nothing contained in this section shall prohibit any provision which in the opinion of the superintendent is more favorable to the policyholder than a provision permitted by this section.

History: Laws 1984, ch. 127, § 390; 1987, ch. 259, § 19.

59A-20-26. Prohibited provisions.

A. No life insurance policy shall be delivered or issued for delivery in this state if it contains any of the following provisions:

(1) a provision by which the policy purports to be issued or to take effect more than one year before the original application for the insurance was made;

(2) a provision for any mode of settlement at maturity of the policy of less value than the amount insured under the policy, plus dividend additions, if any, less any indebtedness to the insurer on or secured by the policy and less any premium that may by the terms of the policy be deducted; or

(3) a provision to the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of such agent binding upon the insured.

B. No policy of industrial life insurance shall contain any of the following provisions:

(1) a provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer;

(2) a provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within two (2) years prior to the issuance of the policy, received institutional, hospital, medical or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention as revealed in the application was not of a serious nature or was not material to the risk; or

(3) a provision giving the insurer the right to declare the policy void because the insured has been rejected for insurance, unless such right be conditioned upon a

showing by the insurer that knowledge of such rejection would have led to a refusal by the insurer to make such contract.

History: Laws 1984, ch. 127, § 391.

59A-20-27. Provisions required by other jurisdictions.

A. The policies of a foreign life insurer may contain any provision which the law of the insurer's state or country of domicile prescribes shall be in such policies when issued in this state; and the policies of a domestic life insurer when issued or delivered in any other state or country may contain any provisions required by the law of such other state or country, anything in this article notwithstanding.

B. If any policy or contract subject to this article is issued by a domestic insurer for delivery to a person residing in another state, and if the administrator of the insurance laws of the other state informs the superintendent that such policy or contract is not subject to approval by him, the superintendent may by ruling require that such policy or contract contain the applicable standard provisions set forth in this article.

History: Laws 1984, ch. 127, § 392.

59A-20-28. Special requirements as to participating policies.

Beginning as of January 1, 1964:

A. no life insurer shall issue both participating and nonparticipating policies unless at least eighty percent of the gains from the participating policies innure [inure] to the benefit of the holders of the participating policies;

B. any insurer having both participating and nonparticipating policies in force shall keep a separate accounting for each such class of business and make and include in its annual statement filed with the superintendent a separate statement showing the gains, losses and expenses attributable to participating and nonparticipating business respectively, and showing how any general expense of the insurer has been apportioned to each such class; and

C. this section shall not apply to any insurer whose life insurance in force consists of ninety percent or more in either participating or nonparticipating business, as measured by premiums received; nor shall it apply as to business in force in other states or jurisdictions, nor to paid-up, temporary insurance, or pure endowment benefits issued or granted pursuant to the provisions of the Standard Nonforfeiture Law as set out in Section 396 [59A-20-31 NMSA 1978] of this article, nor as to reinsurance or annuity contracts.

History: Laws 1984, ch. 127, § 393.

59A-20-29. Prohibited policy plans.

A. No life insurer shall deliver or issue for delivery in this state:

(1) as part of or in combination with any life insurance, endowment or annuity contract, any agreement or plan, additional to the rights, dividends and benefits arising out of any such contract, which provides for accumulation of profits over a period of time and for payment of all or part of such accumulated profits only to members or policyholders of a designated group or class who continue as members or policyholders until the end of a specified or ascertainable period;

(2) any "registered" policy; that is, any policy (other than one "registered" as a security under applicable state or federal law) purporting to be "registered" or otherwise specially recorded, with any agency of this or any other state or jurisdiction, or with any bank, trust company, escrow company or other institution other than the insurer, or purporting that any reserves, assets or deposits are held, or will be so held, for the special benefit or protection of the holder of such policy by or through any such agency or institution;

(3) any policy or contract under which any part of the premium or of funds or values arising from the policy or contract or from investment of reserves, or from mortality savings, lapses or surrenders, in excess of the normal reserves or amounts required to pay death, endowment and nonforfeiture benefits in respective amounts as specified in or pursuant to the policy or contract, are on a basis not involving insurance or life contingency features:

(a) to be placed in special funds or segregated accounts or specially designated places; or

(b) to be invested in specially designated investments or types thereof, and the funds or earnings thereon to be divided among the holders of such policies or contracts, or their beneficiaries or assignees. This paragraph does not apply to any policy or contract authorized under Section 395 [59A-20-30 NMSA 1978] (Variable Contract Law) of this article;

(4) any policy providing for segregation of policyholders into mathematical groups and providing benefits for a surviving policyholder arising out of the death of another policyholder of such group, or under any other similar plan;

(5) any policy providing benefits or values for surviving or continuing policyholders contingent upon lapse or termination of the policies of other policyholders whether by death or otherwise;

(6) any policy providing that on death of anyone not specifically named therein, the owner or beneficiary of the policy shall receive the payment or granting of anything of value. This provision shall not be deemed to prohibit family policies insuring

unspecified members of a family, nor to prohibit payment to unspecified beneficiaries of a class which has been expressly designated as such by the insured or policy owner;

(7) any policy containing or referring to one or more of the following provisions or statements:

(a) investment returns or profit sharing, other than as participation in divisible surplus of the insurer under a regular participation provision as provided for in Section 373 or Section 387 [59A-20-8 or 59A-20-22 NMSA 1978] of this article.

(b) special treatment in determination of any dividend that may be paid as to such policy;

(c) reference to premiums as "deposits";

(d) relating policyholder interest or returns to those of stockholders; or

(e) that the policyholder as a member of a select group will be entitled to extra benefits or extra dividends not available to policyholders generally.

B. This section does not prohibit provision, payment, allowance, or apportionment of regular dividends or "savings" under regular participating forms of policies or contracts, or any values, benefits or returns lawfully provided under Section 395 [59A-20-30 NMSA 1978] (Variable Contract Law) of this article.

History: Laws 1984, ch. 127, § 394.

59A-20-30. Variable contract law.

A. A domestic life insurer may establish one or more separate accounts and may allocate thereto amounts (including without limitation proceeds applied under optional modes of settlement or under dividend options) to provide for life insurance or annuities (and benefits incidental thereto), payable in fixed or variable amounts or both, subject to the following:

(1) the income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains or losses of the insurer;

(2) except as may be provided with respect to reserves for guaranteed benefits and funds referred to in Paragraph (3) of this subsection:

(a) amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurers; and

(b) the investments in such separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the insurer;

(3) except with the approval of the superintendent and other conditions as to investments and other matters as he may prescribe which shall recognize the guaranteed nature of the benefits provided, reserves for:

(a) benefits guaranteed as to dollar amount and duration; and

(b) funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account;

(4) unless otherwise approved by the superintendent, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account; provided, that unless otherwise approved by the superintendent, the portion of any of the assets of such separate account equal to the insurer's reserve liability with regard to the guaranteed benefits and funds referred to in Paragraph (3) of this subsection shall be valued in accordance with the rules otherwise applicable to the insurer's assets;

(5) amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the insurer, and the insurer shall not be, nor hold itself out to be, a trustee with respect to such amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the insurer may conduct;

(6) no sale, exchange or other transfer of assets may be made by an insurer between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made:

(a) by a transfer of cash; or

(b) by a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the superintendent. The superintendent may approve other transfers among such accounts if in his opinion such transfers would not be inequitable; and

(7) to the extent such insurer deems it necessary to comply with any applicable federal or state laws, such insurer, with respect to any separate account,

including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants and the selection of a committee, the members of which need not be otherwise affiliated with such insurer, to manage the business of such account.

B. Any contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurer in determining the dollar amount of such variable benefits. Any such contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will so vary and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

C. No insurer shall deliver or issue for delivery within this state variable contracts unless it is licensed or organized to do a life insurance or annuity business in this state, and the superintendent is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the superintendent shall consider:

(1) the history and financial condition of the insurer;

(2) the character, responsibility and fitness of the officers and directors of the insurer; and

(3) the law and regulations under which the insurer is authorized in the state of domicile to issue variable contracts.

If the insurer is a subsidiary of an authorized life insurer, or affiliated with such insurer through common management or ownership, it may be deemed by the superintendent to have met the provisions of this subsection if either it or the parent or the affiliated insurer meets the requirements hereof.

D. Except for Sections 59A-20-4, 59A-20-9 through 59A-20-12, 59A-20-31 and 59A-21-12 NMSA 1978, in the case of a variable life insurance policy and except for Sections 59A-20-18, 59A-20-22 and 59A-20-23 NMSA 1978 in the case of a variable annuity contract and except as otherwise provided in this section, all pertinent provisions of the insurance laws of this state shall apply to separate accounts and contracts relating thereto. Subject to approval by the superintendent, any individual variable annuity contract, delivered or issued for delivery in this state shall contain grace, reinstatement and nonforfeiture provisions appropriate to such a contract, and any group variable life insurance contract delivered or issued for delivery in this state

shall contain a grace provision appropriate to such a contract. The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

E. Notwithstanding any other provision of law, the superintendent shall have sole authority to regulate the issuance and sale of variable contracts and to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of this section.

History: Laws 1984, ch. 127, § 395; 1987, ch. 259, § 20.

59A-20-31. Standard Nonforfeiture Law; life insurance.

A. In the case of policies issued on and after the operative date of this section, as defined in Subsection K of this section, no policy of life insurance, except as stated in Subsection J of this section, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions that in the opinion of the superintendent are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with Subsection I of this section:

(1) that, in the event of default in any premium payment the insurer will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits;

(2) that, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified;

(3) that a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default;

(4) that, if the policy shall have become paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit that became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the insurer will pay, upon

surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified;

(5) in the case of policies that cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or that provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy; and

(6) a statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

Any of the provisions in this subsection or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

B. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by Subsection A of this section, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits that would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(1) the then present value of the adjusted premiums as defined in Subsections D, E and F of this section, corresponding to premiums that would have fallen due on or after such anniversary; and

(2) the amount of any indebtedness to the insurer on the policy.

Provided, however, that for any policy issued on or after the operative date of Subsection F of this section, as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in Paragraph (1) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy that provides only the benefits otherwise provided by such rider or supplemental policy provision.

Provided, further, that for any family policy issued on or after the operative date of Subsection F of this section as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age of seventy-one, the cash surrender value referred to in Paragraph (1) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy that provides only the benefits otherwise provided by such term insurance on the life of the spouse. Any cash surrender value available within thirty days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by Subsection A of this section, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

C. Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value that would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

D. This subsection shall not apply to policies issued on or after the operative date of Subsection F of this section. Except as provided in Paragraph (2) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of: (a) the then present value of the future guaranteed benefits provided for by the policy; (b) two percent of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (c) forty percent of the adjusted premium for the first policy year; (d) twenty-five percent of

either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. Provided, however, that in applying the percentages specified in (c) and (d), no adjusted premium shall be deemed to exceed four percent of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(1) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy; provided, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten.

(2) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to: (1) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable by (2) the adjusted premiums for such term insurance, the foregoing items (1) and (2) being calculated separately and as specified in the first two paragraphs (the first paragraphs and Paragraph (1)) of this subsection except that, for the purposes of (b), (c) and (d) of the first such paragraph, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (2) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (1).

(3) Except as otherwise provided in Paragraph (4) of this subsection and Subsection E of this section, all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the national association of insurance commissioners 1941 standard ordinary mortality table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 standard industrial mortality table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of

mortality assumed may be not more than one hundred thirty percent of the rates of mortality according to such applicable table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the superintendent.

(4) This paragraph shall not apply to ordinary policies issued on or after the operative date of Subsection F of this section. In the case of ordinary policies issued on or after the operative date of this paragraph as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the commissioners 1958 standard ordinary mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided that such rate of interest shall not exceed three and one-half percent a year, except that a rate of interest not exceeding four percent a year may be used for policies issued on or after July 1, 1973 and prior to July 1, 1977 and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after July 1, 1977, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per annum may be used, and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1958 extended term insurance table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the superintendent.

After June 9, 1961, any insurer may file with the superintendent a written notice of its election to comply with the provisions of Paragraph (4) of this subsection after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date (which shall be the operative date of this subsection for such insurer), this subsection shall become operative with respect to the ordinary policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1966.

E. This subsection shall not apply to industrial policies issued on or after the operative date of Subsection F of this section.

In the case of industrial policies issued on or after the operative date of this subsection as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the bases of the commissioners 1961 standard industrial mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided that such rate of interest shall not exceed three and one-half percent a year except that a rate of interest

not exceeding four percent a year may be used for policies issued on or after July 1, 1973 and prior to July 1, 1977 and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after July 1, 1977, except that, for any single premium whole life or endowment insurance policy, a rate of interest not exceeding six and one-half percent per annum may be used. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1961 industrial extended term insurance table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the superintendent.

After June 7, 1963, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of this subsection for such insurer), this subsection shall become operative with respect to the industrial policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1968.

F. This subsection shall apply to all policies issued on or after the operative date of this subsection. Except as provided in Paragraph (6) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairment or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of the then present value of the future guaranteed benefits provided for by the policy; one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and one hundred twenty-five percent of the nonforfeiture net level premium as hereinafter defined. Provided, however, that, in applying the last percentage specified above, no nonforfeiture net level premium shall be deemed to exceed four percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined; and

(1) the nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due;

(2) in the case of policies that cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or that provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change;

(3) except as otherwise provided in Paragraph (6) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of the sum of the then present value of the then future guaranteed benefits provided for by the policy and the additional expense allowance, if any, over the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy;

(4) the additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of one percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and one hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium;

(5) the recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (a) by (b) where:

(a) equals the sum of: (1) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and (2) the present value of the increase in future guaranteed benefits provided for by the policy; and

(b) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due;

(6) notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis;

(7) all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the commissioners 1980 standard ordinary mortality table or, at the election of the insurer for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; shall for all policies of industrial insurance be calculated on the basis of the commissioners 1961 standard industrial mortality table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection, for policies issued in that calendar year. Provided, however, that:

(a) at the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year;

(b) under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by Subsection A of this section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any;

(c) an insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions under the policy, on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values;

(d) in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1980 extended term insurance table for policies of ordinary insurance and not more than the commissioners 1961 industrial extended term insurance table for policies of industrial insurance;

(e) for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables;

(f) for a policy issued prior to the operative date of the valuation manual, any commissioners standard ordinary mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the superintendent for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioners 1980 extended term insurance table;

(g) for a policy issued on or after the operative date of the valuation manual, the commissioners standard mortality table in the valuation manual shall be used to determine the minimum nonforfeiture standard that may be substituted for the commissioners 1980 standard ordinary mortality table, either with or without ten-year select mortality factors, or for the commissioners 1980 extended term insurance table. If the superintendent adopts through rulemaking a commissioners standard ordinary mortality table that was adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard shall substitute for the minimum nonforfeiture standard provided in the valuation manual;

(h) for a policy issued prior to the operative date of the valuation manual, any commissioners standard industrial mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the superintendent for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table; and

(i) for a policy issued on or after the operative date of the valuation manual, the commissioners standard mortality table in the valuation manual shall be used to determine the minimum nonforfeiture standard that may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table. If the superintendent adopts through rulemaking a commissioners standard industrial mortality table that was adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard shall substitute for the minimum nonforfeiture standard provided in the valuation manual;

(8) the nonforfeiture interest rate per annum for a policy issued in a calendar year:

(a) prior to the operative date of the valuation manual shall be equal to one hundred twenty-five percent of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearest one-fourth of one percent; provided, however, that the nonforfeiture interest rate per annum shall not be less than four percent; and

(b) on or after the operative date of the valuation manual shall be determined by the valuation manual;

(9) notwithstanding any other provision in the laws relating to insurance to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form; and

(10) after the effective date of this subsection, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1989.

G. In the case of any plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurer based on the then estimates of future experience, or in the case of any plan of life insurance that is of such a nature that minimum values cannot be determined by the methods described in Subsection A, B, C, D, E or F of this section, then:

(1) the superintendent must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by Subsection A, B, C, D, E or F of this section;

(2) the superintendent must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(3) the cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this section, as determined by regulations promulgated by the superintendent.

H. Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in Subsections B, C, D, E and F of this section may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of Subsection B of this section, additional benefits payable (a) in the event of death or dismemberment by accident or accidental means; (b) in the event of total and permanent disability; (c) as reversionary annuity or deferred reversionary annuity benefits; (d) as term insurance benefits provided by a rider or supplemental policy

provision to which, if issued as a separate policy, this section would not apply; (e) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one and has not become paid up by reason of the death of a parent of the child; and (f) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

I. This subsection, in addition to all other applicable sections of this law, shall apply to all policies issued on or after January 1, 1985. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount that does not differ by more than two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (a) the greater of zero and the basic cash value hereinafter specified; and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits that would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums that would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in Subsection B or D of this section, whichever is applicable, shall be the same as are the effects specified therein.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in Subsection D or F of this section, whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage:

(1) must be the same percentage for each policy year between the second policy anniversary and the later of the fifth policy anniversary and the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(2) must be such that no percentage after the later of the two policy anniversaries specified in Paragraph (1) of this subsection may apply to fewer than five consecutive policy years.

Provided that no basic cash value may be less than the value that would be obtained if the adjusted premiums for the policy, as defined in Subsection D or F of this section, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in Subsections A, B, C, F and H of this section. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (a) through (d) in Subsection H of this section shall conform with the principles of this subsection.

J. This section shall not apply to any reinsurance, group insurance, pure endowment, annuity or reversionary annuity contract, nor to any term policy of uniform amount that provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one for which uniform premiums are payable during the entire term of the policy, nor to any term policy of decreasing amount, that provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in Subsections D, E and F of this section, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, that provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy, nor to any policy, that provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in Subsections B, C, D, E and F of this section, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year; nor to any policy that shall be delivered outside this state through an agent or other representative of the insurer issuing the policy.

For purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy shall be the age of expiry of the oldest life.

K. After the effective date of this act, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1952. After the filing of such notice, then upon such specified date (which shall be the operative date for such insurer), this section shall become

operative with respect to policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this section for such insurer shall be January 1, 1952.

L. As used in this section:

(1) "operative date of the valuation manual" means the January 1 of the first calendar year following the first July 1 after which the following have occurred:

(a) the valuation manual has been adopted by the national association of insurance commissioners by an affirmative vote of at least forty-two members or three-fourths of the members voting, whichever is greater;

(b) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by states that collectively represent more than seventy-five percent of written direct premiums, as reported in the life, accident and health annual statements, the health annual statements and the fraternal annual statements submitted for 2008; and

(c) the Standard Valuation Law of the national association of insurance commissioners, as amended in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions: 1) the fifty states of the United States; 2) American Samoa; 3) the Virgin Islands of the United States; 4) the District of Columbia; 5) Guam; and 6) Puerto Rico; and

(2) "valuation manual" means the most recent version of the manual of valuation instructions adopted by the national association of insurance commissioners.

History: Laws 1984, ch. 127, § 396; 2014, ch. 59, § 27.

59A-20-32. Nonforfeiture benefits, cash surrender values; life policies issued prior to operative date of 1943 Standard Nonforfeiture Law.

A. This section shall apply only to those life insurance policies issued prior to the operative date of the Standard Nonforfeiture Law as first enacted by Laws of 1943, Chapter 109.

B. A nonforfeiture benefit shall be available to the owner of the policy in event of default in premium payments, after a premium shall have been paid for three (3) years and shall be a stipulated form of insurance effective from the due date of the premium, the net value of which shall be at least equal to the reserve at the date of default on the policy and on any dividend additions thereto, less a sum of not more than two and one-half percent of the amount insured by the policy and of any existing dividend additions

thereto, and less any existing indebtedness to the insurer on or secured by the policy. The policy shall specify the mortality table and rate of interest adopted from computing such reserves and shall stipulate that it may be surrendered to the insurer at its home office within one (1) month from date of default, for a specified cash value at least equal to the sum which would otherwise be available for the purchase of insurance as above stated.

History: Laws 1984, ch. 127, § 397.

59A-20-33. Standard nonforfeiture law; individual deferred annuities.

A. This section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code of 1986, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced or reversionary annuity, nor to any contract that shall be delivered outside this state through an agent or other representative of the insurer issuing the contract.

B. In the case of contracts issued on or after the operative date of this section as defined in Subsection P of this section, no contract of annuity, except as stated in Subsection A of this section, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions that in the opinion of the superintendent are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) that upon cessation of payment of considerations under a contract or upon the written request of the contract owner, the insurer shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Subsections H, I, J, K and M of this section;

(2) if a contract provided for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in Subsections H, I, K and M of this section. The insurer may reserve the right to defer the payment of such cash surrender benefit for a period not to exceed six months after demand therefor with surrender of the contract after making written request and receiving written approval of the superintendent. The request shall address the necessity and equatability to all policyholders of the deferral;

(3) a statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are

guaranteed under the contract, together with sufficient information to determine the amounts of such benefits; and

(4) a statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract or any prior withdrawals from or partial surrenders of the contract.

C. Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than twenty dollars ($20.00) monthly, the insurer may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

D. The minimum values as specified in Subsections H, I, J, K and M of this section of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section. The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in Subsection E of this section of the net considerations, as hereinafter defined, paid prior to such time, decreased by the sum of Paragraphs (1) through (4) of this subsection:

(1) any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection E of this section;

(2) an annual contract charge of fifty dollars ($50.00), accumulated at rates of interest as indicated in Subsection E of this section;

(3) any tax pursuant to the Insurance Premium Tax Act [7-40-1 to 7-40-10 NMSA 1978] paid by the insurer for the contract, accumulated at rates of interest as indicated in Subsection E of this section; and

(4) the amount of any indebtedness to the insurer on the contract, including interest due and accrued.

E. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent of the gross considerations credited to the contract during that contract year. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of

interest determined as the lesser of three percent per annum and the following, which shall be specified in the contract if the interest rate will be reset:

(1) the five-year constant maturity treasury rate reported by the federal reserve as of a date, or average over a period, rounded to the nearest one-twentieth percent, specified in the contract no longer than fifteen months prior to the contract issue date or redetermination date pursuant to Paragraph (2) of this subsection reduced by one hundred twenty-five basis points, where the resulting interest rate is not less than one percent; and

(2) the interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.

F. Notwithstanding the provisions of Subsections D and E of this section, during the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Paragraph (1) of Subsection E of this section by up to an additional one hundred basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The superintendent may require a demonstration that the present value of the reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the superintendent, the superintendent may disallow or limit the additional reduction.

G. The superintendent may adopt rules to implement the provisions of Subsection F of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the superintendent determines adjustments are justified.

H. Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

I. For contracts that provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent higher than the

interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the insurer on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the insurer to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

J. For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the insurer to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the bases of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

K. For the purpose of determining the benefits calculated under Subsections I and J of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

L. Any contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

M. Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

N. For any contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if

any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Subsections H, I, J, K and M of this section, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

O. The superintendent may adopt rules to implement the provisions of this section.

P. After July 1, 2003, an insurer may elect to apply its provisions to annuity contracts on a contract-form by contract-form basis before July 1, 2005. In all other instances this section shall become operative with respect to annuity contracts issued by the insurer after June 30, 2005.

History: Laws 1984, ch. 127, § 398; 2003, ch. 415, § 1; 2018, ch. 57, § 19.

59A-20-34 to 59A-20-36. Repealed.

ARTICLE 20A
Viatical Settlements

59A-20A-1. Short title.

This act [59A-20A-1 to 59A-20A-11 NMSA 1978] may be cited as the "Viatical Settlements Act".

History: Laws 1999, ch. 246, § 1.

59A-20A-2. Definitions.

As used in the Viatical Settlements Act:

A. "broker" means a person or his authorized representative who on behalf of a viator and for a fee, commission or other valuable consideration offers or attempts to negotiate viatical settlements between a viator and one or more providers. "Broker" does not include an attorney, accountant or financial planner retained by the viator to represent him;

B. "financing entity" means an underwriter, placement agent, lender, purchaser of securities, credit enhancer, purchaser of a policy or certificate from a provider or any other person who may be a party to a contract and who has a direct ownership in a

policy or certificate that is the subject of a contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a provider to act as a participant in a financing transaction;

C. "financing transaction" means a transaction in which a provider or a financing entity obtains financing for contracts or viaticated policies or interests in such contracts or policies, including any secured or unsecured financing, any securitization transaction or any securities offering either registered or exempt from registration under federal and state securities law, or any direct purchase of interests in a policy or certificate;

D. "provider" means a person or his authorized representative who obtains financing from a financing entity for the purchase, acquisition, transfer or other assignment of one or more viatical settlement contracts or viaticated policies or interests in such contracts or policies, or otherwise sells, assigns, transfers, pledges, hypothecates or otherwise disposes of one or more viatical settlement contracts or viaticated policies or interests in such contracts or policies. Provider does not include:

(1) a bank, savings bank, savings and loan association, credit union or other lending institution that takes an assignment of a life insurance policy as collateral for a loan;

(2) the issuer of a life insurance policy providing accelerated benefits under and pursuant to the contract; or

(3) a natural person who enters into no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

E. "viatical settlement contract" means a written agreement entered into between a provider and a viator;

F. "viaticated policy" means a life insurance policy or certificate that has been acquired by a provider pursuant to a viatical settlement contract; and

G. "viator" means the owner of a life insurance policy or a certificate holder under a group policy insuring the life of a person with a catastrophic, life-threatening or chronic illness or condition who enters or seeks to enter into a viatical settlement contract.

History: Laws 1999, ch. 246, § 2.

59A-20A-3. License requirements; fees.

A. A person shall not operate as a provider or broker without a license from the superintendent.

B. Application for a provider or broker license shall be made to the superintendent by the applicant on a form prescribed by the superintendent.

C. An application or renewal shall be accompanied by the applicable fee as specified in Section 59A-6-1 NMSA 1978.

D. Licenses may be renewed from year to year on the anniversary date of licensure upon payment of the annual renewal fee. Failure to pay the fee by the renewal date shall result in revocation of the license.

E. The applicant shall provide information on forms required by the superintendent. The superintendent may require the applicant to fully disclose the identity of all stockholders, partners, officers, members and employees and representatives, and the superintendent may refuse to issue a license if not satisfied that a stockholder, partner, officer, member, employee or representative who may materially influence the applicant's conduct meets the standards of the Viatical Settlements Act.

F. A license issued to an applicant authorizes all members, officers, representatives and designated employees to act as providers or brokers, as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

G. Upon the filing of an application and the payment of the license fee, the superintendent may make an investigation of each applicant and issue a license if the superintendent finds that the applicant:

(1) has provided a detailed plan of operation;

(2) is competent and trustworthy and intends to act in good faith in the capacity provided by the license applied for;

(3) has a good business reputation and has had experience, training or education so as to be qualified in the business for which licensure is sought; and

(4) if not a natural person, provides a certificate of good standing from the state of its domicile.

H. The superintendent shall not issue a license to an applicant unless a written designation of an agent for service of process is filed and maintained with the superintendent or the applicant has filed with the superintendent the applicant's written irrevocable consent that any action against the applicant may be commenced by service of process on the superintendent.

History: Laws 1999, ch. 246, § 3; 2011, ch. 127, § 15.

59A-20A-4. License denial, suspension, revocation or refusal to renew.

A. The superintendent may deny, suspend, revoke or refuse to renew the license of a provider or broker if the superintendent finds that:

(1) there was any material misrepresentation in the application for the license;

(2) the licensee, including any officer, partner, member, key management personnel or representative of the licensee, has been convicted of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

(3) the licensee has pleaded guilty or nolo contendere, or been found guilty of, any felony or a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(4) the licensee no longer meets the requirements for initial licensure;

(5) the licensee has performed any act prohibited by the Viatical Settlements Act;

(6) the provider demonstrates a pattern of unreasonable payments to viators;

(7) the provider has entered into a viatical settlement contract that has not been approved in accordance with the Viatical Settlements Act;

(8) the provider has failed to honor contractual obligations set out in a viatical settlement contract; or

(9) the provider has assigned, transferred or pledged a viaticated policy to a person other than another provider licensed in New Mexico or a financing entity.

B. Before the superintendent suspends, revokes or refuses to renew the license of a provider or broker, the superintendent shall conduct a hearing in accordance with Chapter 59A, Article 4 NMSA 1978.

C. Any person aggrieved by denial of an application may request a hearing before the superintendent in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978.

History: Laws 1999, ch. 246, § 4.

59A-20A-5. Approval of viatical settlement contracts and disclosure statements; contract terms.

A. A person shall not use a viatical settlement contract or provide a disclosure statement form to a viator in New Mexico unless filed with and approved by the superintendent. The superintendent shall disapprove a viatical settlement contract or disclosure statement form if, in the superintendent's opinion, it is unreasonable, contrary to the interests of the public or otherwise misleading or unfair to the viator.

B. The viatical settlement contract shall establish the terms under which the provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise or bequest to the provider of the death benefit or ownership of all or a portion of the insurance policy or certificate. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

History: Laws 1999, ch. 246, § 5.

59A-20A-6. Reporting requirements and confidentiality.

A. Each licensee shall file with the superintendent on or before March 1 of each year an annual statement containing such information as the superintendent by rule may prescribe.

B. Except as otherwise allowed, a provider, broker, insurance company, insurance agent, insurance broker, information bureau, rating agency or company or any other person with actual knowledge of a viator's or insured's identity shall not disclose that identity to any other person unless the disclosure is:

(1) necessary to effect a viatical settlement between the viator and a provider and the viator has given written consent and, if the insured's identity is being disclosed and the insured is competent, the insured has given written consent to the disclosure;

(2) provided in response to an investigation by the superintendent or any other governmental officer or agency; or

(3) a term of or condition to the transfer of a viaticated policy by one provider to another provider.

History: Laws 1999, ch. 246, § 6.

59A-20A-7. Examination.

A. The superintendent may examine the business and affairs of a licensee or applicant. The superintendent shall have the authority to order a licensee or applicant to produce any records, books, files or other information reasonably necessary to

ascertain whether the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting an examination shall be paid by the licensee or applicant.

B. Names and identification data for all viators or insureds shall be considered confidential information and shall not be disclosed by the superintendent unless required by law.

C. Records of all transactions of viatical settlement contracts shall be maintained by the provider and shall be available to the superintendent for inspection during reasonable business hours. A provider shall maintain records of each viatical settlement until five years after the death of the viator.

History: Laws 1999, ch. 246, § 7.

59A-20A-8. Disclosure.

A. A provider or broker shall provide a written disclosure statement form containing the following information to the viator no later than the time of application:

(1) possible alternatives to viatical settlement contracts for persons with catastrophic, life-threatening or chronic illnesses, including any accelerated death benefits offered under the viator's life insurance policy;

(2) that some or all of the proceeds of the viatical settlement may be free from federal income tax and from state franchise and income taxes, and that assistance should be sought from a professional tax adviser;

(3) that the viator has a right to rescind a viatical settlement contract within fifteen calendar days after receipt of the viatical settlement proceeds;

(4) that money will be sent to the viator within two business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated pursuant to the viatical settlement contract;

(5) that proceeds of the viatical settlement could be subject to the claims of creditors;

(6) that receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for medicaid or other government benefits or entitlements, and that advice should be obtained from the appropriate government agencies; and

(7) that entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist

under the policy or certificate, to be forfeited by the viator and that assistance should be sought from a financial adviser.

B. A provider shall disclose in writing the following information to the viator prior to the date the viatical settlement contract is signed by all parties:

(1) the affiliation, if any, between the provider and the issuer of an insurance policy to be viaticated;

(2) if an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the viator, the possible loss of coverage on the other lives and the advisability of consulting with the insurance producer or the company issuing the policy for advice on the proposed viatication; and

(3) the dollar amount of the current death benefit payable to the provider under the policy or certificate and the availability of any additional guaranteed insurance benefits and the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the provider's interest in those benefits.

History: Laws 1999, ch. 246, § 8.

59A-20A-9. General rules.

A. A provider entering into a viatical settlement contract shall first obtain:

(1) if the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract;

(2) a witnessed document in which the viator:

(a) consents to the viatical settlement contract;

(b) acknowledges that the insured has a catastrophic, life-threatening or chronic illness or condition;

(c) represents that the viator has a full and complete understanding of the viatical settlement contract;

(d) asserts that he has a full and complete understanding of the benefits of the life insurance policy; and

(e) acknowledges that he has entered into the viatical settlement contract freely and voluntarily; and

(3) a document in which the insured consents to the release of his medical records to a provider or broker.

B. All medical information solicited or obtained by a licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information.

C. All viatical settlement contracts entered into in New Mexico shall provide the viator with an unconditional right to rescind the contract for at least fifteen calendar days from the receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the provider of all viatical settlement proceeds.

D. Immediately upon the provider's receipt of documents to effect the transfer of the insurance policy, the provider shall pay the proceeds of the viatical settlement to an escrow or trust account in a state or federally chartered financial institution whose deposits are insured by the federal deposit insurance corporation. The account shall be managed by a trustee or escrow agent independent of the parties to the contract. The trustee or escrow agent shall transfer the proceeds to the viator immediately upon the provider's receipt of acknowledgment of the transfer of the insurance policy.

E. Failure to pay the viator within the time specified in Paragraph (4) of Subsection A of Section 8 of the Viatical Settlements Act [59A-20A-8 NMSA 1978] renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator.

F. Contacts with the viator or insured for the purpose of determining the health status of the insured by the provider or broker after the viatical settlement has occurred shall only be made by the provider or broker licensed in New Mexico and shall be limited to once every three months for insureds with a life expectancy of more than one year and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured under a viaticated policy for reasons other than determining the viator's health status.

History: Laws 1999, ch. 246, § 9.

59A-20A-10. Rules and standards.

The superintendent may:

A. promulgate rules to implement the provisions of the Viatical Settlements Act;

B. establish standards for evaluating reasonableness of payments under viatical settlement contracts, including regulation of discount rates used to determine the

amount paid in exchange for assignment, transfer, sale, devise or bequest of a benefit under a life insurance policy;

C. establish appropriate licensing requirements and standards for continued licensure for providers and brokers;

D. require a bond or other mechanism for financial accountability for viatical settlement providers; and

E. adopt rules governing the relationship and responsibilities of both insurers and providers and brokers during the viatication of a life insurance policy or certificate.

History: Laws 1999, ch. 246, § 10.

59A-20A-11. Relationship to other laws.

The provisions of the Insurance Code other than the Viatical Settlements Act shall not apply to viatical settlements unless expressly provided. The following articles and provisions of the Insurance Code shall also apply to viatical settlements and providers and their promoters, sponsors, directors, officers, employees, agents, solicitors, brokers and other representatives. For the purposes of such applicability, a provider may be referred to as an insurer in:

A. Chapter 59A, Article 1 NMSA 1978;

B. Chapter 59A, Article 2 NMSA 1978;

C. Chapter 59A, Article 4 NMSA 1978; and

D. Chapter 59A, Article 16 NMSA 1978.

History: Laws 1999, ch. 246, § 11.

ARTICLE 21
Group Life Insurance

59A-21-1. Short title; purpose.

A. This article [Chapter 59A, Article 21 NMSA 1978] may be cited as the "Group Life Insurance Law".

B. The purpose of this article is to define group life insurance and to prescribe standard provisions required in policies of group life insurance, in order to promote the peace, health and safety of the inhabitants of this state by providing reasonable

standards for issuance, delivery and terms of any policy of group life insurance, and exercise of certain rights relative thereto.

History: Laws 1984, ch. 127, § 399.

59A-21-2. Group contracts must meet requirements.

A. No life insurance policy shall be delivered or issued for delivery in this state insuring the lives of more than one individual unless to a group defined in this article and otherwise in compliance with this article.

B. Subsection A hereof does not apply to life insurance policies insuring only individuals:

(1) related by blood, marriage or legal adoption; or

(2) having a common interest through ownership of a business enterprise, or a substantial legal interest or equity therein, and who are actively engaged in management thereof; or

(3) otherwise having an insurable interest in each other's lives.

History: Laws 1984, ch. 127, § 400.

59A-21-3. "Group policy" defined.

For the purposes of the Insurance Code "policy of group life insurance" or "group life policy" mean the contract of group life insurance delivered to the policyholder and not the certificate of insurance delivered to individuals insured under such contract.

History: Laws 1984, ch. 127, § 401.

59A-21-4. Employee groups.

A policy of group life insurance may be issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

A. the employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the

individual proprietor or partners if the employer is an individual proprietorship or a partnership. The policy may provide that the term "employees" shall include retired employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

B. the premium for the policy shall be paid either from the employer's funds or from funds contributed to by the insured employees, or from both. Except as provided in Subsection C, below, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing; and

C. the insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History: Laws 1982, ch. 127, § 402.

59A-21-5. Debtor groups.

A policy of group life insurance may be issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor, or creditors, subject to the following requirements:

A. the debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include (1) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction; (2) the debtors of one or more subsidiary corporations; and (3) the debtors of one or more affiliated corporations, proprietorships, or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships, or partnerships is under common control;

B. the premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in Subsection C, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors;

C. an insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer;

D. the amount of the insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor;

E. the insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment; and

F. notwithstanding the provisions of the above subsections, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

History: Laws 1984, ch. 127, § 403.

59A-21-6. Labor union groups.

A policy of group life insurance may be issued to a labor union or similar organization, which shall be deemed the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:

A. the members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof;

B. the premium for the policy shall be paid by the policyholder, either wholly from the union's or organization's funds, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in Subsection C, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing; and

C. an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History: Laws 1984, ch. 127, § 404.

59A-21-7. Trustee groups.

A. A policy of group life insurance may be issued to a trust or to the trustee of a fund established by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustee shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(1) the persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or

classes thereof. The policy may provide that the term "employees" shall include retired employees, the individual proprietor or partners if an employer is an individual proprietor or a partnership, and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(2) the premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in Paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing; and

(3) an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

B. No such policy or certificate of group life insurance may be renewed, delivered or issued for delivery in this state unless the superintendent has approved the issuance. The superintendent shall not grant his approval unless he finds that:

(1) the benefits of the policy are reasonable in relation to the premium charged; and

(2) the group to which the policy is issued is organized and operated in a fiscally sound manner.

C. The provisions of this section apply to the offering in this state of a policy issued in another state or its certificates.

History: Laws 1984, ch. 127, § 405; 1991, ch. 125, § 27.

59A-21-8. Association groups.

A policy of group life insurance may be issued to any association organized in this state by any group of professional or business persons required to be licensed under the laws of the state in order to engage in such profession or business, or to any agricultural association organized under the laws of this state, and maintained in good faith for purposes other than that of obtaining insurance, insuring at least twenty-five (25) members of the association for the benefit of persons other than the association or its officers or trustees, as such. The association is deemed the policyholder.

History: Laws 1984, ch. 127, § 406.

59A-21-9. Discretionary groups.

A policy of group life insurance may be issued to any other group that, in the discretion of the superintendent, may be subject to the issuance of a group life insurance contract.

History: Laws 1984, ch. 127, § 406a; 2013, ch. 74, § 25.

59A-21-10. Dependents' coverage.

Insurance under any group life insurance policy issued pursuant to Sections 59A-21-4 and 59A-21-6 through 59A-21-8 NMSA 1978 may be extended to insure the dependents, or any class or classes thereof, of each employee or member who so elects. The term "dependent" means the spouse of the employee or member and an employee's or member's minor child, including a child beyond the age of majority up to a maximum of twenty-five years of age while attending an educational institution, and such other children of the employee or member as provided within the group life insurance policy. The premiums for the insurance on such dependents may be paid by the group policyholder or by the employee or member or by the group policyholder and the employee or member jointly.

History: Laws 1984, ch. 127, § 407; 1993, ch. 126, § 3.

59A-21-11. Standard and required provisions.

A. No policy of group life insurance shall be delivered in this state unless it contains in substance the provisions as required by Sections 409 through 419 [59A-21-12 to 59A-21-22 NMSA 1978] of this article or provisions which, in the superintendent's opinion, are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder.

B. The provisions set out in Sections 414 through 418 [59A-21-17 to 59A-21-21 NMSA 1978] of this article do not apply to policies issued to a creditor to insure debtors of such creditor.

C. The standard provisions required for individual life insurance shall not apply to group life insurance policies.

D. If a group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which, in the superintendent's opinion, is or are equitable to the insured persons and to the policyholder; but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

History: Laws 1984, ch. 127, § 408.

59A-21-12. Grace period.

A group life insurance policy shall contain in substance a provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

History: Laws 1984, ch. 127, § 409.

59A-21-13. Noncontestability.

A group life insurance policy shall contain in substance a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue; and that no statement made by any person insured under the policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two (2) years during such person's lifetime nor unless contained in a written instrument signed by him; provided, however, that no such provision shall preclude assertion at any time of defenses based upon provisions in the policy which relate to eligibility for coverage.

History: Laws 1984, ch. 127, § 410.

59A-21-14. Statements by insured.

A group life insurance policy shall contain in substance a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or in the event of death or incapacity of the insured person, to his beneficiary or personal representative.

History: Laws 1984, ch. 127, § 411.

59A-21-15. Evidence of insurability.

A group life insurance policy shall contain in substance a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

History: Laws 1984, ch. 127, § 412.

59A-21-16. Misstatement of age.

A group life insurance policy shall contain in substance a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used.

History: Laws 1984, ch. 127, § 413.

59A-21-17. Payment to beneficiary; funeral expenses.

A group life insurance policy shall contain in substance a provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except that where the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding two thousand dollars ($2,000) to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

History: Laws 1984, ch. 127, § 414.

59A-21-18. Certificate or statement of insurance protection.

A. A group life insurance policy shall contain in substance a provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which he is entitled, to whom the insurance benefits are payable and the rights and conditions set forth in Sections 416, 417, and 418 [59A-21-19, 59A-21-20, and 59A-21-21 NMSA 1978] of this article.

B. A group life insurance policy issued to a creditor to insure debtors of such creditor, shall contain in substance a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a form which will contain a statement that the life of the debtor is insured under the policy and that any death benefit paid thereunder by reason of his death shall first be applied to reduce or extinguish the indebtedness.

History: Laws 1984, ch. 127, § 415.

59A-21-19. Conversion privilege; termination of membership in group or by death of employee.

A group life insurance policy shall contain in substance a provision that if the insurance, or any portion of it, on a person covered under the policy or on the dependent of such person ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after such termination, and such individual policy shall be subject to the following requirements:

A. the individual policy shall, at the option of such person be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for;

B. the individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination, less the amount of any life insurance for which such person becomes eligible under the same or any other group policy within thirty-one (31) days after such termination, provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

C. the premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs and to his age attained on the effective date of the individual policy.

D. subject to the same conditions set forth above, the conversion privilege shall be available (1) to a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy which terminates by reason of such death and (2) to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member, by divorce or otherwise, under the group policy.

History: Laws 1984, ch. 127, § 416.

59A-21-20. Conversion privilege; termination of group policy.

A group life insurance policy shall contain in substance a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least five (5) years prior to such termination date shall be entitled to have issued to him by the insurer an individual policy of life insurance, subject

to the same conditions and limitations as are provided by Section 416 [59A-21-19 NMSA 1978] of this article, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

A. the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one (31) days after such termination; and

B. ten thousand dollars ($10,000).

History: Laws 1984, ch. 127, § 417.

59A-21-21. Conversion privilege; death benefit.

A group life insurance policy shall contain in substance a provision that if a person insured under the group policy, or the insured dependent of a covered person, dies during the period within which he would have been entitled to have an individual policy issued to him in accordance with Sections 416 or 417 [59A-21-19 or 59A-21-20 NMSA 1978] above and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued to him under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

History: Laws 1984, ch. 127, § 418.

59A-21-22. Conversion privilege; extension by failure to give notice.

If any individual insured under a group life insurance policy hereafter delivered in this state becomes entitled under the terms of such policy to have an individual policy of life insurance issued to him without evidence of insurability, subject to making of application and payment of the first premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least fifteen (15) days prior to the expiration date of such period, then in such event the individual shall have an additional period within which to exercise such right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in such policy. This additional period shall expire fifteen (15) days next after the individual is given such notice but in no event shall such additional period extend beyond sixty (60) days next after the expiration date of the period provided in such policy. Written notice presented to the individual or mailed by the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this section.

History: Laws 1984, ch. 127, § 419.

59A-21-23. Continuance of coverage during total disability.

Where active employment is a condition of insurance, a group life insurance policy shall contain a provision in substance that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred. The continuation shall be on a premium paying basis for a period of six (6) months from the date on which the total disability started, but not beyond the earlier of (1) approval by the insurer of continuation of the coverage under any disability provision which the group insurance policy may contain or (2) the discontinuance of the group insurance policy.

History: Laws 1984, ch. 127, § 420.

59A-21-24. Assignment of interest under policy.

A. Subject to the terms of the policy relating to assignment of incidents of ownership, a person whose life is insured under any policy of group life insurance can assign all or any part of his incidents of ownership under the policy including any right to designate a beneficiary under the policy and any right to have an individual policy issued to him in accordance with Sections 416 through 419 [59A-21-19 to 59A-21-22 NMSA 1978] of this article.

B. Subject to the terms of the policy relating to assignment of incidents of ownership, an assignment of the incidents of ownership by an insured, made either before or after March 8, 1969, is valid for the purpose of vesting in the assignee, in accordance with any provisions included in the assignment about the time at which it is to be effective, all of the incidents of ownership assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue in accordance with Sections 418 and 420 [59A-21-21 and 59A-21-23 NMSA 1978] of this article prior to receipt of notice of the assignment.

History: Laws 1984, ch. 127, § 421.

59A-21-25. Coverage under group policy issued in another state.

A. No group life insurance coverage shall be offered in this state by an insurer under a policy issued in another state if the superintendent, or the appropriate insurance supervisory public official of another state, has determined that:

(1) issuance of the group policy was contrary to the best interests of the public;

(2) issuance of the group policy was not actuarially sound;

(3) issuance of the group policy did not result in economies of acquisition and administration; or

(4) benefits provided under the group policy are not reasonable in relation to the premiums charged.

B. Upon the superintendent's request the insurer shall promptly furnish to the superintendent a copy of any such group policy and of the certificate of insurance to be issued thereunder.

History: Laws 1984, ch. 127, § 421a.

59A-21-26. Purpose.

The purpose of this act [59A-21-26 to 59A-21-28 NMSA 1978] is to permit and set guidelines for life insurers to include in life insurance policies issued after the effective date of this act a provision for periodic adjustment of policy loan interest rates.

History: 1978 Comp., § 59-16-44, enacted by Laws 1983, ch. 283, § 1; 1978 Comp., § 59-16-44, recompiled as § 59A-21-26 by Laws 1987, ch. 259, § 32.

59A-21-27. Definition.

For the purposes of this act [59A-21-26 to 59A-21-28 NMSA 1978], "published monthly average" means "Moody's corporate bond yield average-monthly average corporates" as published by Moody's Investors Service, Inc. or any successor thereto or in the event that "Moody's corporate bond yield average-monthly average corporates" is no longer published, a substantially similar average as established by regulation of the superintendent of insurance.

History: 1978 Comp., § 59-16-45, enacted by Laws 1983, ch. 283, § 2; 1978 Comp., § 59-16-45, recompiled as § 59A-21-27 by Laws 1987, ch. 259, § 32.

59A-21-28. Maximum rate of interest on policy loans.

A. Policies issued on or after the effective date of this act shall provide for policy loan interest rates as follows:

(1) a provision permitting a maximum interest rate of not more than eight percent per year; or

(2) a provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law.

B. The rate of interest charged on a policy loan made under Paragraph (2) of Subsection A of this section shall not exceed the higher of the following:

(1) the published monthly average for the calendar month ending two months before the date on which the rate is determined; or

(2) the rate used to compute the cash surrender values under the policy during the applicable period plus one percent per year.

C. If the maximum rate of interest is determined pursuant to Paragraph (2) of Subsection A of this section, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

D. The maximum rate for each policy must be determined at regular intervals at least once every twelve months but not more frequently than once in any three-month period. At the intervals specified in the policy:

(1) the rate being charged may be increased whenever such increase as determined under Subsection B of this section would increase that rate by one-half of one percent or more per year; and

(2) the rate being charged must be reduced whenever such reduction as determined under Subsection B of this section would decrease that rate by one-half of one percent or more per year.

E. The life insurer shall:

(1) notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(2) notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in Paragraph (3) of this subsection;

(3) send to policyholders with loans reasonable advance notice of any increase in the rate; and

(4) include in the notices required above the substance of the pertinent provisions of Subsections A and C of this section.

F. The loan value of the policy shall be determined in accordance with Subsection F of Section 59-16-2 NMSA 1978 [repealed], but no policy shall terminate in a policy year as the sole result of change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

G. The substance of the pertinent provisions of Subsections A and C of this section shall be set forth in the policies to which they apply.

H. For purposes of this section:

(1) the rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy;

(2) the term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due;

(3) the term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer; and

(4) the term "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

I. No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

History: 1978 Comp., § 59-16-46, enacted by Laws 1983, ch. 283, § 3; 1978 Comp., § 59-16-46, recompiled as § 59A-21-28 by Laws 1987, ch. 259, § 32.

ARTICLE 22
Health Insurance Contracts

59A-22-1. Scope of article.

Chapter 59A, Article 22 NMSA 1978 applies generally to policies of individual health insurance, including student health plan policies. Nothing in that article shall apply to or affect:

A. any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein;

B. life insurance, endowment or annuity contracts or contracts supplemental thereto that contain only such provisions relating to health insurance as:

(1) provide additional benefits in case of death by accident; and

(2) operate to safeguard such contracts against lapse or to give a special surrender value or special benefit or annuity in event the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

C. group or blanket health insurance, except as stated in Chapter 59A, Article 23 NMSA 1978; or

D. reinsurance.

History: Laws 1984, ch. 127, § 422; 2017, ch. 130, § 14.

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.

History: Laws 1984, ch. 127, § 423; 2021, ch. 108, § 16.

59A-22-3. Required provisions.

A. Except as provided in Subsection B of this section, each such policy delivered or issued for delivery in this state shall contain the provisions specified in Sections 425 through 436 [59A-22-4 to 59A-22-15 NMSA 1978], inclusive, of this article; except, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the superintendent which are in each instance not less favorable in any respect to the insured or beneficiary. Such required provisions shall be preceded individually by the applicable caption shown or, at the insurer's option, by such appropriate individual or group captions or subcaptions as the superintendent may approve.

B. If any provision of this article is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the superintendent's approval, shall omit from such policy any inapplicable provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

History: Laws 1984, ch. 127, § 424.

59A-22-4. Entire contract; changes.

There shall be a provision as follows:

This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

History: Laws 1984, ch. 127, § 425.

59A-22-5. Time limit on certain defenses.

A. There shall be a provision for comprehensive major medical policies as follows: As of the date of issue of this policy, no misstatements, except willful or fraudulent misstatements, made by the applicant in the application for this policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy). In the event a misstatement in an application is made that is not fraudulent or willful, the issuer of the policy may prospectively rate and collect from the insured the premium that would have been charged to the insured at the time the policy was issued had such misstatement not been made.

B. There shall be a provision for policies other than comprehensive major medical policies as follows: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy shall be used to void the policy or to deny a claim for loss

incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

C. The foregoing policy provisions shall not be so construed as to affect any initial two-year period nor to limit the application of Sections 59A-22-17 through 59A-22-19, 59A-22-21 and 59A-22-22 NMSA 1978 in the event of misstatement with respect to age or occupation or other insurance.

D. A policy that the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty or (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision, from which the clause in parentheses may be omitted at the insurance company's option, under the caption "Incontestable":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

History: Laws 1984, ch. 127, § 426; 1990, ch. 110, § 3; 1993, ch. 126, § 4; 1994, ch. 75, § 27; 2008, ch. 87, § 1; 2019, ch. 259, § 4.

59A-22-6. Grace period.

There shall be a provision as follows:

A grace period of . . . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "Unless not less than five days prior to the premium due date the insurance company has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

History: Laws 1984, ch. 127, § 427.

59A-22-7. Reinstatement.

There shall be a provision as follows:

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurance company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however,

that if the insurance company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the thirtieth day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurance company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.)

History: Laws 1984, ch. 127, § 428.

59A-22-8. Notice of claim.

There shall be a provision as follows:

Written notice of claim must be given to the insurance company within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurance company at . . . . . (insert the location of such office as the insurer may designate for the purpose) or to any authorized agent of the insurance company, with information sufficient to identify the insured, shall be deemed notice to the insurance company.

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurance company may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurance company on account of such claim or any denial of liability in whole or in part by the insurance company shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would

otherwise have accrued during the period of six months preceding the date on which such notice is actually given.)

History: Laws 1984, ch. 127, § 429.

59A-22-9. Claim forms.

There shall be a provision as follows:

The insurance company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

History: Laws 1984, ch. 127, § 430.

59A-22-10. Proofs of loss.

There shall be a provision as follows:

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

History: Laws 1984, ch. 127, § 431.

59A-22-11. Time of payment of claims.

There shall be a provision as follows:

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . . . (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the terminatiion [termination] of liability will be paid immediately upon receipt of due written proof.

History: Laws 1984, ch. 127, § 432.

59A-22-12. Payment of claims.

There shall be a provision as follows:

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurance company.)

(If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give valid release, the insurance company may pay such indemnity, up to an amount not exceeding $. . . . (insert an amount which shall not exceed one thousand dollars ($1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurance company to be equitably entitled thereto. Any payment made by the insurance company in good faith pursuant to this provision shall fully discharge the insurance company to the extent of such payment.)

(Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurance company's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.)

History: Laws 1984, ch. 127, § 433.

59A-22-13. Physical examination and autopsy.

There shall be a provision as follows:

The insurance company at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

History: Laws 1984, ch. 127, § 434.

59A-22-14. Legal actions.

There shall be a provision as follows:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

History: Laws 1984, ch. 127, § 435.

59A-22-15. Change of beneficiary.

There shall be a provision as follows:

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

History: Laws 1984, ch. 127, § 436.

59A-22-16. Optional provisions.

Except as provided in Section 424 [59A-22-3 NMSA 1978] of this article, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in Sections 438 to 446 [59A-22-17 to 59A-22-25 NMSA 1978], inclusive, of this article, unless such provisions are in the words in which the same appear in the applicable such section; except, that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the superintendent which is not less favorable in any respect to the insured or the beneficiary. Any such provisions contained in the policy shall be preceded individually by the appropriate caption appearing with the section in which the provision is set forth or, at the insurer's option, by such appropriate individual or group captions or subcaptions as the superintendent may approve.

History: Laws 1984, ch. 127, § 437.

59A-22-17. Change of occupation.

There may be a provision as follows:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurance company as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so

classified, the insurance company will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurance company for such more hazardous occupation. If the insured changes his occupation to one classified by the insurance company as less hazardous than that stated in this policy, the insurance company, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess premium calculated on a basis approved by the superintendent from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification for occupational risk and the premium rates shall be used as have been last filed by the insurance company prior to the occurrence of the loss for which the insurance company is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurance company in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

History: Laws 1984, ch. 127, § 438.

59A-22-18. Misstatement of age.

There may be a provision as follows:

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

History: Laws 1984, ch. 127, § 439.

59A-22-19. Other insurance in this insurance company.

There may be a provision as follows:

If an accident or sickness or accident and sickness policy or policies previously issued by the insurance company to the insured be in force concurrently herewith, making the aggregate indemnity for . . . . . (insert type of coverage or coverages) in excess of $. . . . . (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate, or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurance company is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurance company will return all premiums paid for all other such policies.

History: Laws 1984, ch. 127, § 440.

59A-22-20. Insurance with other insurance companies.

There may be a provision as follows:

If there be other valid coverage, not with this insurance company, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurance company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurance company had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase ". . . . . EXPENSE INCURRED BENEFITS." The insurance company may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employers' liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurance company has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage."

History: Laws 1984, ch. 127, § 441.

59A-22-21. Insurance with other insurance companies [; alternative provision].

As an alternative to the provision set out in Section 441 [59A-22-20 NMSA 1978] of this article, there may be a provision as follows:

If there be other valid coverage, not with this insurance company, providing benefits for the same loss on other than an expense incurred basis and of which this insurance company has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurance company had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision of the phrase ". . . . . OTHER BENEFITS." The insurance company may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefits provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurance company has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage.")

History: Laws 1984, ch. 127, § 442.

59A-22-22. Relation of earnings to insurance.

There may be a provision as follows:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurance company will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage

upon the insured below the sum of two hundred ($200.00) dollars, or the sum of the monthly benefits specified in such coverages, whichever is the lesser, not [nor] shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurance company may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the superintendent or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) or benefits provided by union welfare plans or by employer or employee benefit organizations.)

History: Laws 1984, ch. 127, § 443.

59A-22-23. Unpaid premium.

There may be a provision as follows:

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

History: Laws 1984, ch. 127, § 444.

59A-22-24. Cancellation.

There may be a provision as follows:

The insurance company may cancel this policy only pursuant to the provisions of Section 59A-23E-19 NMSA 1978.

History: Laws 1984, ch. 127, § 445; 1998, ch. 41, § 2.

59A-22-25. Conformity with state statutes.

There may be a provision as follows:

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

History: Laws 1984, ch. 127, § 446.

59A-22-26. Order of certain policy provisions.

The provisions which are the subject of Sections 424 through 446 [59A-22-3 to 59A-22-25 NMSA 1978], inclusive, of this article, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the insurer's option, any such provision may appear as a unit in any part of the policy with other provisions to which it may logically be related, provided that the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse or likely to mislead a person to whom the policy is offered, delivered or issued.

History: Laws 1984, ch. 127, § 447.

59A-22-27. Third party ownership.

The word "insured" as used in this article shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

History: Laws 1984, ch. 127, § 448.

59A-22-28. Requirements of other jurisdictions.

A. Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this article, and which is prescribed or required by the law of the state or country in which the insurer is domiciled.

B. Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such state or country.

History: Laws 1984, ch. 127, § 449.

59A-22-29. Conforming to statute.

A. Other policy provisions. No policy provision which is not subject to Sections 424 through 446 [59A-22-3 to 59A-22-25 NMSA 1978], inclusive, of this article shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this article.

B. Policy conflicting with this article. A policy delivered or issued for delivery in this state in violation of this article shall be held valid but shall be construed as provided in this article. When any provision in a policy subject to this article is in conflict with any provision of this article, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this article.

History: Laws 1984, ch. 127, § 450.

59A-22-30. Age limit.

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

History: Laws 1984, ch. 127, § 451.

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.

History: Laws 2005, ch. 41, § 1; 2021, ch. 108, § 17.

59A-22-31. Industrial health insurance.

A. The term "industrial health insurance" as used herein means sickness and accident insurance under individual policies for which the premium is payable weekly, and includes any such policy which covers sickness only or accident only.

B. Any insurer authorized to write health insurance in this state shall have the power to issue industrial health policies.

C. No policy of industrial health insurance may be delivered or issued for delivery in the state unless it has printed thereon the words "industrial policy."

D. Each such policy shall be subject to the provisions of this article except that no such policy shall be required to contain any of the policy provisions set forth in Sections 424 through 446 [59A-22-3 to 59A-22-25 NMSA 1978], inclusive, of this article, other than the provisions relating to the presence of a preexisting disease or physical condition; provided, however, that no such policy shall contain any 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, which in the opinion of the superintendent is less favorable to the insured than would be permitted by such policy provisions; and provided further, that such policy may contain a provision that upon proper written request, a named beneficiary shall be designated in or by endorsement on the policy to receive the proceeds thereof on the death of the insured, and there shall be reserved to the insured the power to change the beneficiary at any time by written notice to the insurer at its home office, accompanied by the policy for endorsement of the change thereon by the insurer; the insurer shall have the right to refuse to designate a beneficiary if evidence satisfactory to the insurer of such beneficiary's insurable interest in the life of the insured is not furnished on request. Any such policy may provide in substance that any payment thereunder may be made to the insured or the insured's estate or to any relative by blood or connection by marriage of the insured, or, to the extent of such portion of any payment under the policy as may reasonably appear to the insurer to be due to such person, to any other person equitably entitled thereto by reason of having incurred expense occasioned by the maintenance or illness or burial of the insured; provided that, if the policy shall be in force at the death of the insured, the proceeds thereof shall be payable to the named beneficiary if living, but upon the expiration of fifteen (15) days after the death of the insured, unless proof of the claim in the manner and form required by the policy, accompanied by the policy for surrender, has theretofore been made by such beneficiary, the insurer may pay to any other person permitted by the policy.

History: Laws 1984, ch. 127, § 452.

59A-22-32. Freedom of choice of hospital and practitioner.

A. Within the area and limits of coverage offered an insured and selected by the insured in the application for insurance, the right of a person to exercise full freedom of choice in the selection of a hospital for hospital care or of a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice, as defined in Subsection B of this section, for treatment of an illness or injury within that person's scope of practice shall not be restricted under any new policy of health insurance, contract or health care plan issued after June 30, 1967 in this state or in the processing of a claim thereunder. A person insured or claiming benefits under any such health insurance policy, contract or health care plan providing within its coverage for payment of service benefits or indemnity for hospital care or treatment of persons for the cure or correction of any physical or mental condition shall be deemed to have complied with the requirements of the policy, contract or health care plan as to submission of proof of loss upon submitting written proof supported by the certificate of any hospital currently licensed by the department of health or any practitioner of the healing arts or

optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice.

B. As used in this section:

(1) "hospital care" means hospital service provided through a hospital that is maintained by the state or a political subdivision of the state or a place that is currently licensed as a hospital by the department of health and has accommodations for resident bed patients, a licensed professional registered nurse always on duty or call, a laboratory and an operating room where surgical operations are performed, but "hospital care" does not include a convalescent or nursing or rest home;

(2) "practitioner of the healing arts" means a person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition pursuant to:

(a) the Chiropractic Physician Practice Act [Chapter 61, Article 4 NMSA 1978];

(b) the Dental Health Care Act [Chapter 61, Article 5A NMSA 1978];

(c) the Medical Practice Act [Chapter 61, Article 6 NMSA 1978];

(d) Chapter 61, Article 10 NMSA 1978; and

(e) the Acupuncture and Oriental Medicine Practice Act [Chapter 61, Article 14A NMSA 1978];

(3) "optometrist" means a person holding a license provided for in the Optometry Act [Chapter 61, Article 2 NMSA 1978];

(4) "podiatrist" means a person holding a license provided for in the Podiatry Act [Chapter 61, Article 8 NMSA 1978];

(5) "psychologist" means a person who is duly licensed or certified in the state where the service is rendered and has a doctoral degree in psychology and has had at least two years of clinical experience in a recognized health setting or has met the standards of the national register of health service providers in psychology;

(6) "physician assistant" means a person who is licensed by the New Mexico medical board to practice as a physician assistant and who provides services to patients under the supervision and direction of a licensed physician;

(7) "certified nurse-midwife" means a person licensed by the board of nursing as a registered nurse and who is registered with the public health division of the department of health as a certified nurse-midwife;

(8) "registered lay midwife" means a person who practices lay midwifery and is registered as a registered lay midwife by the public health division of the department of health; and

(9) "registered nurse in expanded practice" means a person licensed by the board of nursing as a registered nurse approved for expanded practice pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978] as a certified nurse practitioner, certified registered nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or clinical nurse specialist in private practice and who has a master's degree or doctorate in a defined clinical nursing speciality and is certified by a national nursing organization.

C. This section shall apply to any such policy that is delivered or issued for delivery in this state on or after July 1, 1979 and to any existing group policy or plan on its anniversary or renewal date after June 30, 1979 or at expiration of the applicable collective bargaining contract, if any, whichever is later.

History: Laws 1984, ch. 127, § 454; 1985, ch. 192, § 1; 1987, ch. 81, § 1; 1987, ch. 259, § 21; 1989, ch. 96, § 1; 2003, ch. 343, § 2; 2008, ch. 9, § 5.

59A-22-32.1. Freedom of choice.

A. Within the area and limits of coverage offered an insured and selected by him in the application for insurance, the right of any person to exercise full freedom of choice in the selection of any independent social worker as defined in Subsection B of this section, for treatment within his scope of practice shall not be restricted under any new policy of health insurance, contract or health care plan issued after July 1, 1989 in this state or in the processing of any claim thereunder. Any person insured or claiming benefits under any such health insurance policy, contract or health care plan providing within its coverage for payment of service benefits or indemnity for treatment of persons for the cure or correction of any mental condition shall be deemed to have complied with the requirements of the policy, contract or health care plan as to submission of proof of loss upon submitting written proof supported by any independent social worker.

B. As used in this section "independent social worker" means a person licensed as an independent social worker by the board of social work examiners pursuant to the Social Work Practice Act [61-31-1 to 61-31-24 NMSA 1978].

History: Laws 1989, ch. 51, § 25.

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.

History: Laws 1984, ch. 127, § 455; 2021, ch. 108, § 18.

59A-22-34. Newly born children coverage.

A. All individual and group health insurance policies delivered or issued for delivery in this state and which provide coverage on an expense-incurred basis for a family member of the insured shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.

B. All individual and group health insurance policies delivered or issued for delivery in this state that do not provide coverage for a family member of the insured shall provide for an option to add to the coverage any newly born child of the insured provided that the requirements of Subsection D of this section have been met.

C. The coverage for newly born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, where necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care facility for newly born infants.

D. If payment of a specific premium is required to provide coverage for a child, the policy may require that a notification of birth of a newly born child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth in order to have the coverage from birth.

E. As used in this section and in Section 59A-22-35 NMSA 1978, "tertiary care facility" means a hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

History: Laws 1984, ch. 127, § 456; 1993, ch. 169, § 1.

59A-22-34.1. Coverage for adopted children.

A. No individual or group health insurance policy or contract or health care plan shall be offered, issued or renewed in New Mexico on or after July 1, 1988, unless the policy, plan or contract covers adopted children of the insured, subscriber or enrollee on the same basis as other dependents.

B. The coverage required by this section is effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

C. As used in this section, "placement" means in the physical custody of the adoptive parent.

History: Laws 1978 Comp., § 59A-22-34.1, enacted by Laws 1988, ch. 89, § 1.

59A-22-34.2. Coverage of children.

A. An insurer shall not deny enrollment of a child under the health plan of the child's parent on the grounds that the child:

(1) was born out of wedlock;

(2) is not claimed as a dependent on the parent's federal tax return; or

(3) does not reside with the parent or in the insurer's service area.

B. When a child has health coverage through an insurer of a noncustodial parent, the insurer shall:

(1) provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(3) make payments on claims submitted in accordance with Paragraph (2) of this subsection directly to the custodial parent, the provider or the state medicaid agency.

C. When a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage, the insurer shall be required:

(1) to permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) if the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

(3) not to disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(a) the court or administrative order is no longer in effect; or

(b) the child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.

D. An insurer shall not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the medicaid program and covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

E. An insurer shall provide coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the early childhood education and care department, provided eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars ($3,500) annually for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel who are working in early intervention programs approved by the early childhood education and care department. No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.

History: 1978 Comp., § 59A-22-34.2, enacted by Laws 1994, ch. 64, § 2; 2005, ch. 157, § 2; 2019, ch. 48, § 30.

59A-22-34.3. Childhood immunization coverage required.

A. Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state shall provide coverage for childhood immunizations, as well as coverage for medically necessary booster doses of all immunizing agents used in child immunizations, in accordance with

the current schedule of immunizations recommended by the American academy of pediatrics.

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

C. Coverage for childhood immunizations and necessary booster doses may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same policy, plan or certificate.

History: 1978 Comp., § 59A-22-34.3, enacted by Laws 1997, ch. 250, § 1.

59A-22-34.4. Coverage of circumcision for newborn males.

An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall provide coverage for circumcision for newborn males.

History: Laws 2004, ch. 122, § 4.

59A-22-34.5. Hearing aid coverage for children required.

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 a hearing aid and any related service for the full cost of one hearing aid per hearing-impaired ear up to two thousand two hundred dollars ($2,200) every thirty-six months for hearing aids for insured children under eighteen years of age or under twenty-one years of age if still attending high school. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two-thousand-two-hundred-dollar ($2,200) limit as provided in this subsection without financial or contractual penalty to the insured or to the provider of the hearing aid.

B. An insurer that delivers, issues for delivery or renews in this state an individual or group health insurance policy, health care plan or certificate of health insurance may make available to the policyholder the option of purchasing additional hearing aid coverage that exceeds the services described in this section.

C. Hearing aid coverage offered shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a physician, licensed in New Mexico.

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

E. Coverage for hearing aids may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

F. For the purposes of this section, "hearing aid" means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

History: Laws 2007, ch. 356, § 2.

59A-22-35. Maternity transport required.

All individual and group health insurance policies delivered or issued for delivery in this state which provide maternity coverage on an expense-incurred basis, shall also provide, where necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility (as defined in Section 456 [59A-22-34 NMSA 1978] of this article) for newly-born infants.

History: Laws 1984, ch. 127, § 457.

59A-22-36. Home health care service option required.

A. Each insurer which delivers or issues for delivery in this state an individual or group hospital expense or major medical expense insurance policy shall make available to the policyholder the option of home health care coverage which includes benefits for the services described in this section.

B. Home health care coverage offered shall include:

(1) services provided by a registered nurse or a licensed practical nurse;

(2) health services provided by physical, occupational and respiratory therapists and speech pathologists;

(3) health services provided by a home health aide; and

(4) medical supplies, drugs and medicines and laboratory services, to the extent they would have been covered if provided to the insured on an in-patient basis.

C. Home health care coverage may be limited to:

(1) services provided on the written order of a licensed physician, provided such order is renewed at least every sixty (60) days;

(2) services provided, directly or through contractual agreements, by a home health agency licensed in the state in which the home health services are delivered; and

(3) services, as set forth in Subsection B of the section, without which the insured would have to be hospitalized.

D. Coverage shall be provided for at least one hundred (100) home visits per insured per year, with each home visit including up to four (4) hours of home health care services.

E. For the purposes of this section, "home health care" means health services provided on a part-time, intermittent basis to an individual confined to his home due to physical illness.

History: Laws 1984, ch. 127, § 458.

59A-22-37. Repealed.

History: Laws 1984, ch. 127, § 459; 1987, ch. 259, § 22; repealed by Laws 2019, ch. 259, § 22.

59A-22-38. Individual health insurance; policy provisions relating to individuals who are eligible for medical benefits under the medicaid program.

A. Each individual health insurance policy that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy to be paid to the human services department [health care authority department] when:

(1) the human services department [health care authority department] has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;

(2) payment for the services in question has been made by the human services department [health care authority department] to the medicaid provider; and

(3) the insurer is notified that the insured individual receives benefits under the medicaid program and that benefits must be paid directly to the human services department [health care authority department].

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the human services department [health care authority department] for insurance benefits when the claim is first

submitted by the human services department [health care authority department] to the insurer.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any individual health insurance policy for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy shall be made payable to the provider. The insurer may be notified that the insured individual is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the insurer.

D. No individual health insurance policy delivered, issued for delivery or renewed in this state on or after the effective date of this section shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where an insurer has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by the insurer for those health care items or services.

History: 1978 Comp., § 59A-22-38, enacted by Laws 1989, ch. 183, § 2; 1994, ch. 64, § 3.

59A-22-39. Coverage for mammograms.

Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state shall provide coverage for low-dose screening mammograms for determining the presence of breast cancer. Such coverage shall make available one baseline mammogram to persons age thirty-five through thirty-nine, one mammogram biennially to persons age forty through forty-nine and one mammogram annually to persons age fifty and over. After July 1, 1992, coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American college of radiology accreditation standards for mammography. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or tax-favored plans as defined pursuant to 26 USC Section 223(c)(2).

History: 1978 Comp., § 59A-22-39, enacted by Laws 1990, ch. 5, § 2; 2023, ch. 12, § 6.

59A-22-39.1. Mastectomies and lymph node dissection; minimum hospital stay coverage required.

A. Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state shall provide coverage for not less than forty-eight hours of inpatient care following a mastectomy and not less than twenty-four hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

B. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician and patient determine that a shorter period of hospital stay is appropriate.

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

D. Coverage for minimum inpatient hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same policy, plan or certificate.

History: 1978 Comp., § 59A-22-39.1, enacted by Laws 1997, ch. 249, § 1.

59A-22-39.2. Prior authorization for gynecological or obstetrical ultrasounds prohibited.

A. An individual or group health insurance policy, health care plan or certificate of insurance that is delivered, issued for delivery or renewed in this state and that provides coverage for gynecological or obstetrical ultrasounds shall not require prior authorization for gynecological or obstetrical ultrasounds.

B. Nothing in this section shall be construed to require payment for a gynecological or obstetrical ultrasound that is not:

(1) medically necessary; or

(2) a covered benefit.

C. As used in this section, "prior authorization" means advance approval that is required by a health insurance policy, health care plan or certificate of insurance as a condition precedent to payment for medical care or related benefits rendered to a covered person, including prospective or utilization review conducted prior to the provision of covered medical care or related benefits.

History: Laws 2019, ch. 182, § 3.

59A-22-39.3. Diagnostic and supplemental breast examinations.

A. An individual or group health insurance policy, health care plan or certificate of insurance that is delivered, issued for delivery or renewed in this state that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental breast examinations.

B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or high deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

History: Laws 2023, ch. 12, § 2.

59A-22-40. Coverage for cytologic and human papillomavirus screening.

A. Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state shall provide coverage for cytologic and human papillomavirus screening for determining the presence of precancerous or cancerous conditions and other health problems. The

coverage shall make available cytologic screening, as determined by the health care provider in accordance with national medical standards, for women who are eighteen years of age or older and for women who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening. The coverage shall make available human papillomavirus screening once every three years for women aged thirty and older.

B. Coverage for cytologic and human papillomavirus screening 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:

(1) "cytologic screening" means a Papanicolaou test and a pelvic exam for asymptomatic as well as symptomatic women;

(2) "health care provider" means any person licensed within the scope of his practice to perform cytologic and human papillomavirus screening, including physicians, physician assistants, certified nurse midwives and certified nurse practitioners; and

(3) "human papillomavirus screening" means a test approved by the federal food and drug administration for detection of the human papillomavirus.

History: 1978 Comp., § 59A-22-40, enacted by Laws 1992, ch. 56, § 2; 2005, ch. 133, § 2.

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.

History: Laws 2007, ch. 278, § 1; 2021, ch. 108, § 19.

59A-22-41. Coverage for individuals with diabetes.

A. Each individual and group health insurance policy, health care plan, certificate of health insurance and managed health care plan delivered or issued for delivery in this state shall provide coverage for individuals with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care benefit and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as otherwise provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given policy. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for individuals with disabilities, including the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following basic health care benefits:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a diagnosis from a health care practitioner that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the federal food and drug administration, all individual or group health insurance policies as described in Subsection A of this section shall:

(1) maintain an adequate formulary to provide those resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. An insurer that requires a covered person to use a specific network provider or to purchase equipment, appliances, supplies or insulin or prescription drugs for the treatment or management of diabetes from a specific durable medical equipment supplier or other supplier as a condition of coverage, payment or reimbursement shall:

(1) maintain an adequate network of durable medical equipment suppliers and other suppliers to provide covered persons with medically necessary diabetes

resources, whether covered under the health policy's prescription drug or medical benefit;

(2) have network contracts in place for the entire policy or plan period and shall not allow contracts with network providers, durable medical equipment suppliers and other suppliers to lapse or terminate without ensuring the availability of a replacement and continuity of care; provided that single-case agreements do not satisfy the requirements of Paragraph (1) of this subsection or this paragraph;

(3) monitor network providers, durable medical equipment suppliers and other network suppliers to ensure that medically necessary equipment, appliances, supplies and insulin or other prescription drugs are being delivered to a covered person in a timely manner and when needed by the covered person;

(4) guarantee reimbursement to a covered person within thirty days following receipt of a written demand from the covered person who pays out of pocket for necessary equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered timely to the covered person, and the portion of payment for which the patient is responsible shall not exceed the amount for the same covered benefit obtained from a contracted supplier;

(5) pay interest at the rate of eighteen percent per year on the amount of reimbursement due to a covered person if not paid within thirty days as required by Paragraph (4) of this subsection;

(6) beginning on April 1, 2024, submit a written report each quarter to the superintendent for the previous quarter on the following metrics:

(a) the number of written demands for reimbursement of out-of-pocket expenses from covered persons received by the health care insurer;

(b) the number of out-of-pocket claims for reimbursement paid and the aggregate amount of claims reimbursed by the health care insurer within the time required by Paragraph (4) of this subsection;

(c) the number of out-of-pocket claims for reimbursement paid more than thirty days following receipt of a written demand and the aggregate amount of these payments, excluding interest; and

(d) the aggregate amount of interest paid by the health care insurer pursuant to Paragraph (5) of this subsection; and

(7) beginning on April 1, 2024, submit a written report each quarter for the previous quarter to the superintendent with the following information for each durable medical equipment supplier or other supplier that was under contract with the health care insurer or its agent during the previous quarter:

(a) the name, address and telephone number of each supplier and, if applicable, the corresponding date upon which the respective supplier's contract expired, lapsed or was terminated during the previous quarter;

(b) the percentage of total deliveries, by description of item, that did not meet the delivery requirements specified in Paragraph (3) of this subsection; and

(c) the number of complaints received by the health care insurer or its agent during the previous quarter related to late deliveries, incomplete orders or incorrect orders, respectively.

G. The superintendent shall annually audit all health insurers offering policies, plans or certificates as described in Subsection A of this section for compliance with the requirements of this section. If the superintendent determines that a health care insurer has not complied with the requirements of this section, the superintendent shall impose corrective action or use any other enforcement mechanism available to the superintendent to obtain the health care insurer's compliance with this section.

H. Absent a change in diagnosis or in a covered person's management or treatment of diabetes or its complications, a health care insurer shall not require more than one prior authorization per policy period for any single drug or category of item enumerated in this section if prescribed as medically necessary by the covered person's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a covered person has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the covered person's health care practitioner. Nothing in this subsection shall be construed to require payment for diabetes resources that are not covered benefits.

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

J. For purposes of this section:

(1) "basic health care benefits":

(a) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(b) does not include services for alcohol or drug abuse, dental or long-term rehabilitation treatment; and

(2) "managed health care plan" means a health benefit plan offered by a health care insurer that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in the plan through its own employed health care providers or by contracting with selected or participating health care providers. A managed health care plan includes only those plans that provide comprehensive basic health care services to enrollees on a prepaid, capitated basis, including the following:

(a) health maintenance organizations;

(b) preferred provider organizations;

(c) individual practice associations;

(d) competitive medical plans;

(e) exclusive provider organizations;

(f) integrated delivery systems;

(g) independent physician-provider organizations;

(h) physician hospital-provider organizations; and

(i) managed care services organizations.

History: 1978 Comp., § 59A-22-41, enacted by Laws 1997, ch. 7, § 1 and by Laws 1997, ch. 255, § 1; 2020, ch. 36, § 2; 2023, ch. 50, § 2.

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.

History: Laws 2003, ch. 192, § 1; 2021, ch. 108, § 20.

59A-22-42. Coverage for prescription contraceptive drugs or devices.

A. Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state that provides a prescription drug benefit shall provide, at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

B. Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) cost sharing for insureds;

(2) utilization review;

(3) prior authorization or step-therapy requirements; or

(4) any other restrictions or delays on the coverage.

C. An insurer may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method of contraception without patient cost sharing; provided that when an insured's health care provider determines that a particular drug or item is medically necessary, the individual or group health insurance policy, health care plan or certificate of insurance shall cover the brand-name pharmacy drug or item without cost sharing. Medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. An insurer shall grant an insured an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an insured, the insured's representative or the insured's health care provider;

(2) defer to the determination of the insured's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

E. An insurer shall not require a prescription for any drug, item or service that is available without a prescription.

F. An insurer shall provide coverage and shall reimburse a health care provider or dispensing entity on a per-unit basis for dispensing a six-month supply of contraceptives at one time; provided that the contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe six months of contraceptives at one time; or

(2) permit an insurer to limit coverage or impose cost sharing for an alternate method of contraception if an insured changes contraceptive methods before exhausting a previously dispensed supply.

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

I. The provisions of this section apply to individual and group health insurance policies, health care plans and certificates of insurance delivered or issued for delivery after January 1, 2020.

J. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) "cost sharing" means a deductible, copayment or coinsurance that an insured is required to pay in accordance with the terms of an individual or group health insurance policy, health care plan or certificate of insurance; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business.

K. A religious entity purchasing individual or group health insurance coverage may elect to exclude prescription contraceptive drugs or devices from the health coverage purchased.

History: Laws 2001, ch. 14, § 1; 2003, ch. 202, § 12; 2019, ch. 263, § 3.

59A-22-43. Required coverage of patient costs incurred in cancer clinical trials.

A. A health plan shall provide coverage for routine patient care costs incurred as a result of the patient's participation in a cancer clinical trial if:

(1) the clinical trial is undertaken for the purposes of the prevention of or the prevention of reoccurrence of cancer or the early detection or treatment of cancer for which no equally or more effective standard cancer treatment exists;

(2) the clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent;

(3) the clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention and is for the prevention, prevention of reoccurrence, early detection, treatment or palliation of cancer in humans and in which the scientific study includes all of the following:

(a) specific goals;

(b) a rationale and background for the study;

(c) criteria for patient selection;

(d) specific direction for administering the therapy or intervention and for monitoring patients;

(e) a definition of quantitative measures for determining treatment response;

(f) methods for documenting and treating adverse reactions; and

(g) a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment;

(4) the clinical trial is being conducted with approval of at least one of the following:

(a) one of the federal national institutes of health;

(b) a federal national institutes of health cooperative group or center;

(c) the federal department of defense;

(d) the federal food and drug administration in the form of an investigational new drug application;

(e) the federal department of veterans affairs; or

(f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility;

(5) the clinical trial is being provided as part of a cancer clinical trial;

(6) the proposed clinical trial or study has been reviewed and approved by an institutional review board that has an active federal-wide assurance of protection for human subjects;

(7) the personnel providing the clinical trial or conducting the study:

(a) are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise;

(b) agree to accept reimbursement as payment in full from the health plan at the rates that are established by that plan and are not more than the level of reimbursement applicable to other similar services provided by health care providers within the plan's provider network; and

(c) agree to provide written notification to the health plan when a patient enters or leaves a clinical trial;

(8) there is no non-investigational treatment equivalent to the clinical trial;

(9) the available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative; and

(10) there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

B. Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a cancer clinical trial.

C. If a patient is denied coverage of a cost and contends that the denial is in violation of this section, the patient may appeal the decision to deny the coverage of a

cost to the superintendent, and that appeal shall be expedited to ensure resolution of the appeal within no more than thirty days after the date of appeal to the superintendent. Programs pursuant to Title 19 or Title 21 of the federal Social Security Act, which have their respective expedited appeal processes, shall be exempt from this subsection.

D. A health plan shall not provide benefits that supplant a portion of a cancer clinical trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.

E. The provisions of this section do not create a private right or cause of action for or on behalf of a patient against the health plan providing coverage. This section provides only an administrative remedy to the superintendent for violation of this section or a related rule promulgated by the superintendent.

F. A health plan may impose deductibles, coinsurance requirements or other standard cost-sharing provisions on benefits provided pursuant to this section.

G. In no event shall the health plan be responsible for out-of-state or out-of-network costs unless the health plan pays for standard treatment out of state or out of network. In no event shall the health plan be responsible for out-of-state costs for any trials undertaken for the purposes of the prevention of or the prevention of reoccurrence of cancer.

H. The provisions of this section do not apply to short-term travel, accident-only or limited or specified disease contracts or policies issued by a health plan.

I. As used in this section:

(1) "clinical trial" means a course of treatment provided to a patient for the purpose of prevention, prevention of reoccurrence, early detection or treatment of cancer;

(2) "cooperative group" means a formal network of facilities that collaborate on research projects and have an established federal national institutes of health-approved peer review program operating within the group;

(3) "health plan":

(a) means: 1) a health insurer; 2) a nonprofit health service provider; 3) a health maintenance organization; 4) a managed care organization; 5) a provider service organization; or 6) the state's medical assistance program, whether providing services on a managed care or fee-for-service basis; and

(b) does not include individual policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income,

specified disease, accident only, hospital indemnity or other limited-benefit health insurance policies;

(4) "institutional review board" means a board, committee or other group that is both:

(a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of the review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and

(b) approved by the federal national institutes of health for protection of the research risks;

(5) "investigational drug or device" means a drug or device that has not been approved by the federal food and drug administration;

(6) "federal-wide assurance of protection for human subjects" means a contract between an institution and the office for human research protections of the federal department of health and human services that defines the relationship of the institution to that department and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects participating in clinical trials;

(7) "patient" means an individual who participates in a cancer clinical trial and who is an insured, a member or a beneficiary of a health plan; and

(8) "routine patient care cost":

(a) means: 1) a medical service or treatment that is a benefit under a health plan that would be covered if the patient were receiving standard cancer treatment; or 2) a drug provided to a patient during a cancer clinical trial if the drug has been approved by the federal food and drug administration, whether or not that organization has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug; and

(b) does not include: 1) the cost of an investigational drug, device or procedure; 2) the cost of a non-health care service that the patient is required to receive as a result of participation in the cancer clinical trial; 3) costs associated with managing the research that is associated with the cancer clinical trial; 4) costs that would not be covered by the patient's health plan if non-investigational treatments were provided; 5) costs of those extra tests that would not be performed except for participation in the cancer clinical trial; and 6) costs paid or not charged for by the cancer clinical trial providers.

History: Laws 2001, ch. 27, § 1; 2002, ch. 30, § 1; 2009, ch. 212, § 2.

59A-22-44. Coverage for smoking cessation treatment.

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state and that offers maternity benefits shall offer coverage for smoking cessation treatment.

B. Coverage for smoking cessation treatment 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.

History: Laws 2003, ch. 337, § 1.

59A-22-45. Coverage of alpha-fetoprotein IV screening test.

An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall provide coverage for an alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks of pregnancy, to screen for certain genetic abnormalities in the fetus.

History: Laws 2004, ch. 122, § 3.

59A-22-46. Coverage of part-time employees.

An insurer that provides group health insurance pursuant to Chapter 59A, Article 22 NMSA 1978 shall make available, upon an employer's request prior to issuance, delivery or renewal, coverage for regular part-time employees who work or are expected to work an average of at least twenty hours per week over a six-month period. Nothing in this section shall be construed to require an employer to offer or provide coverage for regular part-time employees.

History: Laws 2005, ch. 42, § 1.

59A-22-47. Coverage of colorectal cancer screening.

A. An individual or group health insurance policy, health care plan and certificate of health insurance that is delivered, issued for delivery or renewed in this state shall provide coverage for colorectal screening for determining the presence of precancerous or cancerous conditions and other health problems. The coverage shall make available colorectal cancer screening, as determined by the health care provider in accordance

with the evidence-based recommendations established by the United States preventive services task force.

B. Coverage for colorectal screening 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.

History: Laws 2007, ch. 17, § 1.

59A-22-48. General anesthesia and hospitalization for dental surgery.

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 hospitalization and general anesthesia provided in a hospital or ambulatory surgical center for dental surgery for the following:

(1) insureds exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;

(2) insureds for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

(3) insured children or adolescents who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

(4) insureds with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or

(5) other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.

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

C. Coverage for dental surgery may be subject to copayments, deductibles and coinsurance subject to network and prior authorization requirements consistent with those imposed on other benefits under the same policy, plan or certificate.

History: Laws 2007, ch. 218, § 2.

59A-22-49. Coverage for autism spectrum disorder diagnosis and treatment.

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 to an insured for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;

(2) shall not be subject to annual or lifetime dollar limits;

(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. Coverage for treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis shall not be denied to an insured on the basis of the insured's age.

D. The coverage required pursuant to Subsection A of this section shall not be subject to deductibles or coinsurance provisions that are less favorable to an insured than the deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health insurance policy, health care plan or certificate of health insurance, except as otherwise provided in Subsection B of this section.

E. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

F. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include:

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

G. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.

H. The provisions of this section shall not apply to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies.

I. As used in this section:

(1) "autism spectrum disorder" means:

(a) a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American psychiatric association; or

(b) a condition diagnosed as autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder or childhood disintegrative

disorder pursuant to diagnostic criteria published in a previous edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American psychiatric association;

(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and

(3) "high school" means a school providing instruction for any of the grades nine through twelve.

History: Laws 2009, ch. 74, § 1; 2019, ch. 119, § 3.

59A-22-49.1. Coverage for orally administered anticancer medications; limits on patient costs.

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 and that provides coverage for cancer treatment shall provide coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits by the plan.

B. An insurer shall not increase patient cost-sharing for anticancer medications in order to achieve compliance with the provisions of this section.

C. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, copayment, deductible or coinsurance provision that does not apply to intravenously administered or injected anticancer medication used to kill or slow the growth of cancerous cells.

D. As used in this section, "insurer" or "health plan":

(1) means:

(a) a health insurer;

(b) a nonprofit health service provider;

(c) a health maintenance organization;

(d) a managed care organization; or

(e) a provider service organization; and

(2) does not include individual policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies.

History: Laws 2011, ch. 55, § 2.

59A-22-49.2. Coverage of prescription eye drop refills.

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 and that provides coverage for prescription eye drops shall not deny coverage for a renewal of prescription eye drops when:

(1) the renewal is requested by the insured at least twenty-three days for a thirty-day supply of eye drops, forty-five days for a sixty-day supply of eye drops or sixty-eight days for a ninety-day supply of eye drops from the later of the date that the original prescription was dispensed to the insured or the date that the last renewal of the prescription was dispensed to the insured; and

(2) the prescriber indicates on the original prescription that additional quantities are needed and that the renewal requested by the insured does not exceed the number of additional quantities needed.

B. As used in this section, "prescriber" means a person who is authorized pursuant to the New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978] to prescribe prescription eye drops.

History: Laws 2012, ch. 27, § 2.

59A-22-49.3. Coverage for telemedicine services.

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 services provided via telemedicine to the same extent that the health insurance plan, policy or contract covers the same services when those services are provided via in-person consultation or contact. An insurer shall not impose any unique condition for coverage of services provided via telemedicine.

B. An insurer shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by an insurer that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978].

D. The provisions of this section shall not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. An insurer shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the health insurance plan, policy or contract provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent.

G. An insurer may charge a deductible, copayment, or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. An insurer shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the health insurance plan, policy or contract, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any plan, policy or contract year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health insurance plan, policy or contract.

I. An insurer shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the insurer reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to an individual policy, plan or contract intended to supplement major medical group-type coverage, such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) "consulting telemedicine provider" means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) "health care provider" means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of the professional's license;

(3) "in real time" means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(4) "originating site" means a place at which a patient is physically located and receiving health care services via telemedicine;

(5) "store-and-forward technology" means electronic information, imaging and communication, including interactive audio, video and data communication, that is transferred or recorded or otherwise stored for asynchronous use; and

(6) "telemedicine" means the use of telecommunications and information technology to provide clinical health care from a distance. "Telemedicine" allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. "Telemedicine" allows patients in remote locations to access medical expertise without travel.

History: Laws 2013, ch. 105, § 2; 2019, ch. 255, § 2.

59A-22-49.4. Prescription drugs; prohibited formulary changes; notice requirements.

A. As of January 1, 2014, 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 and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall not make any of the following changes to coverage for a prescription drug within one hundred twenty days of any previous change to coverage for that prescription drug, unless a generic version of the prescription drug is available:

(1) reclassify a drug to a higher tier of the formulary;

(2) reclassify a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary;

(3) increase the cost-sharing, copayment, deductible or co-insurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

(6) impose or modify a drug's quantity limit; or

(7) impose a step-therapy restriction.

B. The insurer shall give the affected insured at least sixty days' advance written notice of the impending change when it is determined that one of the following modifications will be made to a formulary:

(1) reclassification of a drug to a higher tier of the formulary;

(2) reclassification of a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary;

(3) an increase in the cost-sharing, copayment, deductible or coinsurance charges for a drug;

(4) removal of a drug from the formulary;

(5) addition of a prior authorization requirement;

(6) imposition or modification of a drug's quantity limit; or

(7) imposition of a step-therapy restriction for a drug.

C. Notwithstanding the provisions of Subsections A and B of this section, the insurer may immediately and without prior notice remove a drug from the formulary if the drug:

(1) is deemed unsafe by the federal food and drug administration; or

(2) has been removed from the market for any reason.

D. The insurer shall provide to each affected insured the following information in plain language regarding prescription drug benefits:

(1) notice that the insurer uses one or more drug formularies;

(2) an explanation of what the drug formulary is;

(3) a statement regarding the method the insurer uses to determine the prescription drugs to be included in or excluded from a drug formulary; and

(4) a statement of how often the insurer reviews the contents of each drug formulary.

E. As used in this section:

(1) "formulary" means the list of prescription drugs covered by a policy, plan or certificate of health insurance; and

(2) "step therapy" means a protocol that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are to be prescribed.

History: Laws 2013, ch. 138, § 2.

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 [Chapter 59A, Article 54 NMSA 1978]; 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 [Chapter 59A NMSA 1978], 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 [7-40-1 to 7-40-10 NMSA 1978] 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.

History: Laws 2010, ch. 94, § 1; 2013, ch. 74, § 26; 2018, ch. 57, § 20; 2019, ch. 235, § 8; 2019, ch. 235, § 9; 2021, ch. 108, § 21.

59A-22-51. Dental insurance plan; dental fees not covered; severability.

A. As used in this section:

(1) "covered services" means dental care services for which a reimbursement is available under an enrollee's plan contract or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments or any other limitation; and

(2) "dental insurance plan" means any policy of insurance that is issued by a health care service contractor that provides for coverage of dental services not in connection with a medical plan.

B. No contract of any health care service contractor that covers any dental services and no contract or participating provider agreement with a dentist shall require, directly or indirectly, that a dentist who is a participating provider provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the health care service contractor unless the dental services are covered services.

C. A health care service contractor or other person providing third party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

D. If any part or application of this section is held invalid, the remainder or its application to other situations or persons shall not be affected.

History: Laws 2011, ch. 128, § 1.

59A-22-52. Prescription drug prior authorization protocols.

A. After January 1, 2014, a health insurer shall accept the uniform prior authorization form developed pursuant to Sections 2 [59A-2-9.8 NMSA 1978] and 3 [61-11-6.2 NMSA 1978] of this 2013 act as sufficient to request prior authorization for prescription drug benefits.

B. No later than twenty-four months after the adoption of national standards for electronic prior authorization, a health insurer shall exchange prior authorization requests with providers who have e-prescribing capability.

C. If a health insurer fails to use or accept the uniform prior authorization form or fails to respond within three business days upon receipt of a uniform prior authorization form, the prior authorization request shall be deemed to have been granted.

D. As used in this section, "health insurer":

(1) means:

(a) a health insurer;

(b) a nonprofit health service provider;

(c) a health maintenance organization;

(d) a managed care organization; or

(e) a provider service organization; and

(2) does not include:

(a) a person that delivers, issues for delivery or renews an individual policy intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policy;

(b) a physician or a physician group to which a health insurer has delegated financial risk for prescription drugs and that does not use a prior authorization process for prescription drugs; or

(c) a health insurer or its affiliated providers if the health insurer owns and operates its pharmacies and does not use a prior authorization process for prescription drugs.

History: Laws 2013, ch. 170 , § 5.

59A-22-53. Pharmacy benefits; prescription synchronization.

A. An individual health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state and that provides a prescription drug benefit shall allow an insured to fill or refill a prescription for less than a thirty-day supply of the prescription drug, and apply a prorated daily copayment or coinsurance for the fill or refill, if:

(1) the prescribing practitioner or the pharmacist determines the fill or refill to be in the best interest of the insured;

(2) the insured requests or agrees to receive less than a thirty-day supply of the prescription drug; and

(3) the reduced fill or refill is made for the purpose of synchronizing the insured's prescription drug fills.

B. An individual health insurance policy, health care plan or certificate of health insurance that offers a prescription drug benefit shall not:

(1) deny coverage for the filling of a chronic medication when the fill is made in accordance with a plan to synchronize multiple prescriptions for the insured pursuant to Subsection A of this section established among the insurer, the prescribing practitioner and a pharmacist. The insurer shall allow a pharmacy to override any denial indicating that a prescription is being refilled too soon for the purposes of medication synchronization; and

(2) prorate a dispensing fee to a pharmacy that fills a prescription with less than a thirty-day supply of prescription drug pursuant to Subsection A of this section. The insurer shall pay in full a dispensing fee for a partially filled or refilled prescription for each prescription dispensed, regardless of any prorated copayment or coinsurance that the insured may pay for prescription synchronization services.

History: Laws 2015, ch. 65, § 3.

59A-22-53.1. Prescription drug coverage; step therapy protocols; clinical review criteria; exceptions.

A. Each individual health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state that provides a prescription drug benefit for which any step therapy protocols are required shall establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with insurers, health maintenance organizations, health care plans, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest; and

(b) using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a health insurance policy, health care plan or certificate of insurance restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy protocol, an insured and the practitioner prescribing the prescription drug shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. An insurer may use its existing medical exceptions process in accordance with the provisions of Subsections D through I of this section to satisfy this requirement. The process shall be made easily accessible for insureds and practitioners on the insurer's publicly accessible website.

D. An insurer shall expeditiously grant an exception to the health insurance policy's, health care plan's or certificate of insurance's step therapy protocol, based on medical necessity and a clinically valid explanation from the patient's prescribing practitioner as to why a drug on the health insurance policy's, health care plan's or certificate of insurance's formulary that is therapeutically equivalent to the prescribed drug should not be substituted for the prescribed drug, if:

(1) the prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

(2) the prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) while under the insured's current health insurance policy, health care plan or certificate of insurance, or under the insured's previous health coverage, the insured has tried the prescription drug that is the subject of the exception request or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or

(4) the prescription drug required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the prescription drug is expected to:

(a) cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;

(b) worsen a comorbid condition of the patient; or

(c) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

E. Upon the granting of an exception to a health insurance policy's, health care plan's or certificate of insurance's step therapy protocol, an insurer shall authorize coverage for the prescription drug that is the subject of the exception request for no less than the duration of the therapeutic effect of the drug. An insurer shall include in its evidence of coverage language describing an insured's rights pursuant to this subsection.

F. An insurer shall respond with its decision on an insured's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, an insurer shall respond within twenty-four hours of receipt of the exception request. In the event the insurer does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. An insurer's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978].

H. After an insured has made an exception request in accordance with the provisions of this section, an insurer shall authorize continued coverage of a prescription drug that is the subject of the exception request pending the determination of the exception request.

I. The provisions of this section shall not be construed to prevent:

(1) a health insurance policy, health care plan or certificate of insurance from requiring a patient to try a biosimilar, interchangeable biologic or generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

J. The superintendent shall promulgate rules as may be necessary to appropriately implement the provisions of this section.

K. Nothing in this section shall be interpreted to interfere with the superintendent's authority to regulate prescription drug coverage benefits under other state and federal law.

L. As used in this section, "medical necessity" or "medically necessary" means health care services determined by a practitioner, in consultation with the insurer, to be appropriate or necessary, according to:

(1) any applicable, generally accepted principles and practices of good medical care;

(2) practice guidelines developed by the federal government or national or professional medical societies, boards or associations; or

(3) any applicable clinical protocols or practice guidelines developed by the insurer consistent with federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

History: Laws 2018, ch. 9, § 3; 2024, ch. 42, § 3.

59A-22-53.2. Pharmacist prescriptive authority services; reimbursement parity.

An insurer shall reimburse a participating provider that is a certified pharmacist clinician or pharmacist certified to provide a prescriptive authority service who provides a service pursuant to a health insurance plan, policy or certificate of health insurance at the standard contracted rate that the health insurance policy, health care plan or

certificate of health insurance reimburses, for the same service pursuant to that policy, plan or certificate, any licensed physician or physician assistant licensed pursuant to the Medical Practice Act [Chapter 41, Article 5 NMSA 1978] or any advanced practice certified nurse practitioner licensed pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978].

History: Laws 2020, ch. 58, § 3; 2021, ch. 54, § 11.

59A-22-53.3. Calculating an insured's cost-sharing obligation for prescription drug coverage.

A. When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to 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, the insurer shall credit the insured for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

History: Laws 2023, ch. 206, § 3.

59A-22-54. Provider credentialing; requirements; deadline.

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The superintendent shall approve no more than two forms of application to be used for the credentialing of providers.

B. An insurer shall not require a provider to submit information not required by a credentialing application established pursuant to Subsection A of this section.

C. The provisions of this section apply equally to initial credentialing applications and applications for recredentialing.

D. The rules that the superintendent adopts and promulgates shall require primary credential verification no more frequently than every three years and allow provisional credentialing for a period of one year.

E. Nothing in this section shall be construed to require an insurer to credential or provisionally credential a provider.

F. The rules that the superintendent adopts and promulgates shall establish that an insurer or an insurer's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within thirty calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration;

(3) within ten working days after receipt of a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the insurer requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be reasonably related to the information in the application; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen days as described in Paragraph (2) of this subsection, load into the insurer's provider payment system all provider information, including all information needed to correctly reimburse a newly approved provider according to the provider's contract. The insurer or insurer's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the insurer's provider payment system.

G. An insurer shall reimburse a provider for covered health care services for any claims from the provider that the insurer receives with a date of service more than thirty calendar days after the date on which the insurer received a complete credentialing application for that provider if:

(1) the provider:

(a) has submitted a complete credentialing application and any supporting documentation that the insurer has requested in writing within the time frame established in Paragraph (3) of Subsection F of this section;

(b) has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and

(c) has professional liability insurance or is covered under the Medical Malpractice Act [Chapter 41, Article 5 NMSA 1978]; and

(2) the insurer:

(a) has approved, or has failed to approve or deny, the applicant's complete credentialing application within the time frame established pursuant to Paragraph (1) or (2) of Subsection F of this section; or

(b) fails to load the approved applicant's information into the insurer's provider payment system in accordance with Paragraph (4) of Subsection F of this section.

H. A provider who, at the time services were rendered, was not employed by a practice or group that has contracted with the insurer to provide services at specified rates of reimbursement shall be paid by the insurer in accordance with the insurer's standard reimbursement rate.

I. A provider who, at the time services were rendered, was employed by a practice or group that has contracted with the insurer to provide services at specified rates of reimbursement shall be paid by the insurer in accordance with the terms of that contract.

J. The superintendent shall adopt and promulgate rules to provide for the resolution of disputes relating to reimbursement and credentialing arising in cases where credentialing is delayed beyond thirty days after application.

K. An insurer shall reimburse a provider pursuant to Subsections G, H and I of this section until the earlier of the following occurs:

(1) the insurer's approval or denial of the provider's complete credentialing application; or

(2) the passage of three years from the date the insurer received the provider's complete credentialing application.

L. As used in this section:

(1) "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider; and

(2) "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in a state.

History: Laws 2015, ch. 111, § 1; 2016, ch. 20, § 2; 2023, ch. 175, § 1.

59A-22-55. Coverage exclusion. (Contingent repeal. *See* note.)

Coverage of vasectomy and male condoms pursuant to Section 3 [59A-22-42 NMSA 1978] of this 2019 act is excluded for high-deductible individual and group health insurance policies, health care plans or certificates of insurance with health savings accounts delivered or issued for delivery in this state until an insured's deductible has been met.

History: Laws 2019, ch. 263, § 4.

59A-22-56. Physical rehabilitation services; limits on cost sharing.

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 not impose a member cost share for physical rehabilitation services that is greater than that for primary care services on a coinsurance percentage basis when coinsurance is applied or on an absolute dollar amount when a copay is applied.

B. As used in this section:

(1) "physical rehabilitation services" means services aimed at maximizing an individual's level of function, returning to a prior level of function or maintaining or slowing the decline of function, which services are provided by or under the direction of a licensed physical therapist, occupational therapist or speech therapist; and

(2) "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.

History: Laws 2019, ch. 188, § 2.

59A-22-57. Behavioral health services; elimination of cost sharing.

A. Until January 1, 2027, 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 that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of this section:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient

and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing method that requires the insured to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same individual or group health insurance policy, health care plan or certificate of health insurance;

(3) "copayment" means a cost-sharing method that requires the insured to pay a fixed dollar amount when health care services are received, with the insurer paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same individual or group health insurance policy, health care plan or certificate of health insurance; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of the insured other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of an individual or group health insurance policy, health care plan or certificate of health insurance.

History: Laws 2021, ch. 136, § 6.

59A-22-58. Anatomical gift nondiscrimination.

A. For purposes of this section:

(1) "covered person" means a policyholder or other person covered by a health benefit plan; and

(2) "organ transplant" includes parts or the whole of organs, eyes or tissue.

B. All individual and group health insurance policies delivered or issued for delivery in this state that provide coverage for organ transplants and associated care shall not:

(1) deny that coverage solely on the basis of a covered person's physical or mental disability;

(2) deny to a covered person with a physical or mental disability eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit policy or plan solely for the purpose of avoiding the requirements of this section;

(3) penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a health care provider to induce that health care provider not to provide an organ transplant or associated care to a covered person with a physical or mental disability; or

(4) reduce or limit coverage benefits to a covered person with a physical or mental disability for the associated care related to organ transplantation as determined in consultation with the physician and patient.

History: Laws 2023, ch. 171, § 3.

59A-22-59. Chiropractic physician services; limits on cost sharing and coinsurance.

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 that offers coverage of the services of a chiropractic physician shall not impose a copayment or coinsurance on those chiropractic physician services that exceeds the copayment or coinsurance imposed for primary care services.

B. As used in this section, "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.

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

History: Laws 2023, ch. 51, § 2.

59A-22-60. Sexually transmitted infection care; cost sharing eliminated.

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 that offers coverage for preventive care or treatment of sexually transmitted infections shall not impose cost sharing on insureds.

B. Pursuant to this section, preventive care or treatment of sexually transmitted infections shall not be conditioned upon the gender identity of the insured.

C. The provisions of Subsection A of this section do not apply to high-deductible health care plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

D. For the purposes of this section:

(1) "cost sharing" means policy deductibles, copayments or coinsurance;

(2) "preventive care" means screening, testing, examination or counseling and the administration, dispensing or prescribing of preventive drugs, devices or supplies incidental to the prevention of a sexually transmitted infection;

(3) "sexually transmitted infection" means chlamydia, syphilis, gonorrhea, HIV and relevant types of hepatitis, as well as any other sexually transmitted infection regardless of mode of transportation, as designated by rule upon making a finding that the particular sexually transmitted infection is contagious; and

(4) "treatment" means medically necessary care for the management of an existing sexually transmitted infection.

History: Laws 2023, ch. 99, § 2.

59A-22-61. Biomarker testing coverage.

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 insureds to receive biomarker testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of an insured's disease or condition when the test is supported by medical and scientific evidence.

B. Coverage provided pursuant to this section shall be for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of an insured's disease or condition when the test is supported by medical and scientific evidence, including:

(1) labeled indications for a United States food and drug administration-approved or -cleared test;

(2) indicated tests for a United States food and drug administration-approved drug;

(3) warnings and precautions on United States food and drug administration labels;

(4) federal centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations; or

(5) nationally recognized clinical practice guidelines.

C. An individual or group health policy, health care plan or certificate of health insurance providing coverage for biomarker testing pursuant to this section shall ensure that:

(1) coverage is provided in a manner that limits disruptions in care, including coverage for multiple biopsies or biospecimen samples; and

(2) a patient and a practitioner who prescribe biomarker testing have clear, accessible and convenient processes to request an appeal of a benefit denial by the insurer and that those processes are accessible on the insurer's website.

D. Coverage for biomarker testing may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

E. The provisions of this section do not apply to short-term travel, accident-only or limited or specified disease policies, plans or certificates of health insurance.

F. As used in this section:

(1) "biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. "Biomarker" includes gene mutations, characteristics of genes or protein expression;

(2) "biomarker testing" means analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker and includes single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing; and

(3) "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that are:

(a) developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy; and

(b) used to establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

History: Laws 2023, ch. 138, § 3.

59A-22-62. Medical necessity and nondiscrimination standards for coverage of prosthetics or orthotics.

A. An individual health plan that is delivered, issued for delivery or renewed in this state that offers coverage for prosthetic and custom orthotic devices shall consider

these benefits habilitative or rehabilitative benefits for purposes of any state or federal requirement for coverage of essential health benefits.

B. When performing a utilization review for a request for coverage of prosthetic or orthotic benefits, an insurer shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Such standards may be named by the superintendent in rule.

C. An insurer shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely on the basis of an insured's actual or perceived disability.

D. An insurer shall not deny a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

E. A health benefits plan that is delivered, issued for delivery or renewed in this state that offers coverage for prosthetics and custom orthotic devices shall include language describing an insured's rights pursuant to Subsections C and D of this section in its evidence of coverage and any benefit denial letters.

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual health plan may impose cost sharing on prosthetic or custom orthotic devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. A health plan that provides coverage for prosthetic or orthotic services shall ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the managed care plan's provider network located in the state. In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the insurer shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

H. If coverage for prosthetic or custom orthotic devices is provided, payment shall be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(1) a change in the physiological condition of the patient;

(2) an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than sixty percent of the cost of a replacement device or of the part being replaced.

I. Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

J. The provisions of this section do not apply to excepted benefits plans subject to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978].

History: Laws 2023, ch. 196, § 3.

ARTICLE 22A
Preferred Provider Arrangements

59A-22A-1. Short title.

Chapter 59A, Article 22A NMSA 1978 shall be known and may be cited as the "Preferred Provider Arrangements Law".

History: 1978 Comp., § 59A-22A-1, enacted by Laws 1993, ch. 320, § 59.

59A-22A-2. Purpose.

The purpose of the Preferred Provider Arrangements Law is to encourage health care cost containment while preserving quality of care by allowing health care insurers to enter into preferred provider arrangements in accordance with minimum standards for preferred provider arrangements and for the health benefit plans associated with those arrangements.

History: 1978 Comp., § 59A-22A-2, enacted by Laws 1993, ch. 320, § 60.

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 [Chapter 59A, Article 23C NMSA 1978], "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.

History: 1978 Comp., § 59A-22A-3, enacted by Laws 1993, ch. 320, § 61; 2021, ch. 108, § 22.

59A-22A-4. Preferred provider arrangements.

Notwithstanding any provisions of law to contrary, any health care insurer may enter into preferred provider arrangements.

A. Such arrangements shall:

(1) establish the amount and manner of payment to the preferred provider. Such amount and manner of payment may include capitation payments for preferred providers;

(2) include mechanisms which are designed to minimize the cost of the health benefit plan; for example:

(a) the review or control of utilization of health care services; or

(b) procedures for determining whether health care services rendered are medically necessary; and

(3) assure reasonable access to covered services available under the preferred provider arrangement and an adequate number of preferred providers to render those services.

B. Such arrangements shall not unfairly deny health benefits for medically necessary covered services.

C. If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities which would require it to be licensed as a health care insurer, such entity shall file with the superintendent information describing its activities, a description of the contract or agreement it has entered into with the health care providers, and such other information as is required by the provisions of the Health Care Benefits Jurisdiction Act [59A-15-14 to 59A-15-19 NMSA 1978] and any regulations promulgated under its authority. Employers who enter into contracts with health care providers for the exclusive benefit of their employees and dependents are subject to the Health Care Benefits Jurisdiction Act and are exempt from this requirement only to the extent required by federal law.

History: 1978 Comp., § 59A-22A-4, enacted by Laws 1993, ch. 320, § 62.

59A-22A-5. Health benefit plans.

A. Health care insurers may issue health benefit plans which provide for incentives for covered persons to use the health care services of preferred providers. Such policies or subscriber agreement shall contain at least the following provisions:

(1) a provision that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider that emergency care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider; and

(2) a provision which clearly identifies the differentials in benefit levels for health care services of preferred providers and benefit levels for health care services of non-preferred providers.

B. If a health benefit plan provides differences in benefit levels payable to preferred providers compared to other providers, such differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

History: 1978 Comp., § 59A-22A-5, enacted by Laws 1993, ch. 320, § 63.

59A-22A-6. Preferred provider participation requirements.

Health care insurers may place reasonable limits on the number or classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there is no discrimination against providers on the basis of religion, race, color, national origin, age, sex or marital status, and further provided that selection of preferred providers is primarily based on, but not limited to, cost and availability of covered services and the quality of services performed by the providers.

History: 1978 Comp., § 59A-22A-6, enacted by Laws 1993, ch. 320, § 64.

59A-22A-7. General requirements.

Health care insurers complying with the Preferred Provider Arrangements Law shall be subject to and are required to comply with all other applicable laws, rules and regulations of this state.

History: 1978 Comp., § 59A-22A-7, enacted by Laws 1993, ch. 320, § 65.

ARTICLE 22B
Prior Authorization

59A-22B-1. Short title.

Sections 3 through 7 [59A-22B-1 to 59A-22B-5 NMSA 1978] of this act may be cited as the "Prior Authorization Act".

History: Laws 2019, ch. 187, § 3.

59A-22B-2. Definitions.

As used in the Prior Authorization Act:

A. "adjudicate" means to approve or deny a request for prior authorization;

B. "auto-adjudicate" means to use technology and automation to make a near-real-time determination to approve, deny or pend a request for prior authorization;

C. "covered person" means an individual who is insured under a health benefits plan;

D. "emergency care" means medical care, pharmaceutical benefits or related benefits 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;

E. "health benefits plan" means a policy, contract, certificate or agreement, entered into, offered or issued by a health insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of medical care, pharmaceutical benefits or related benefits;

F. "health care professional" means an individual who is licensed or otherwise authorized by the state to provide health care services;

G. "health care provider" means a health care professional, corporation, organization, facility or institution licensed or otherwise authorized by the state to provide health care services;

H. "health insurer" means a health maintenance organization, nonprofit health care plan, provider service network, medicaid managed care organization or third-party payer or its agent;

I. "medical care, pharmaceutical benefits or related benefits" means medical, behavioral, hospital, surgical, physical rehabilitation and home health services, and includes pharmaceuticals, durable medical equipment, prosthetics, orthotics and supplies;

J. "medical necessity" means health care services determined by a health care provider, in consultation with the health insurer, to be appropriate or necessary according to:

(1) applicable, generally accepted principles and practices of good medical care;

(2) practice guidelines developed by the federal government or national or professional medical societies, boards or associations; or

(3) applicable clinical protocols or practice guidelines developed by the health insurer consistent with federal, national and professional practice guidelines, which shall apply to the diagnosis, direct care and treatment of a physical or behavioral health condition, illness, injury or disease;

K. "medical peer review" means review by a health care professional from the same or similar practice specialty that typically manages the medical condition, procedure or treatment under review for prior authorization;

L. "office" means the office of superintendent of insurance;

M. "pend" means to hold a prior authorization request for further clinical review;

N. "pharmacy benefits manager" means an agent responsible for handling prescription drug benefits for a health insurer; and

O. "prior authorization" means a pre-service determination that a health insurer makes regarding a covered person's eligibility for health care services, based on medical necessity, the appropriateness of the site of services and the terms of the covered person's health benefits plan.

History: Laws 2019, ch. 187, § 4.

59A-22B-3. Emergency care.

Emergency care provided to a covered person, regardless of where the emergency care is provided, shall not be subject to prior authorization requirements.

History: Laws 2019, ch. 187, § 5.

59A-22B-4. Duties of office; prescribing penalties.

A. The office shall standardize and streamline the prior authorization process across all health insurers.

B. On or before September 1, 2019, the office shall, in collaboration with health insurers and health care providers, promulgate a uniform prior authorization form for medical care, pharmaceutical benefits or related benefits to be used by every health insurer and health care provider after January 1, 2020; provided that the uniform prior authorization form shall conform to the requirements established for medicare and medicaid medical and pharmacy prior authorization requests.

C. The office shall maintain a log of complaints against health insurers for failure to comply with the Prior Authorization Act. After two warnings issued by the superintendent of insurance, the office may levy a fine of not more than five thousand

dollars ($5,000) on a health insurer that fails to comply with the provisions of the Prior Authorization Act.

D. By September 1, 2019, and each September 1 thereafter, the office shall provide an annual written report to the governor and the legislature to include, at a minimum:

(1) prior authorization data for each health insurer individually and for health insurers collectively;

(2) the number and nature of complaints against individual health insurers for failure to follow the Prior Authorization Act; and

(3) actions taken by the office, including the imposition of fines, against individual health insurers to enforce compliance with the Prior Authorization Act.

E. The annual written report shall be posted on the office's website.

History: Laws 2019, ch. 187, § 6.

59A-22B-5. Prior authorization requirements.

A. A health insurer that requires prior authorization shall:

(1) use the uniform prior authorization forms developed by the office for medical care, for pharmaceutical benefits or related benefits pursuant to Section 6 [59A-22B-4 NMSA 1978] of this 2019 act and for prescription drugs pursuant to Section 59A-2-9.8 NMSA 1978;

(2) establish and maintain an electronic portal system for:

(a) the secure electronic transmission of prior authorization requests on a twenty-four-hour, seven-day-a-week basis, for medical care, pharmaceutical benefits or related benefits; and

(b) by January 1, 2021, auto- adjudication of prior authorization requests;

(3) provide an electronic receipt to the health care provider and assign a tracking number to the health care provider for the health care provider's use in tracking the status of the prior authorization request, regardless of whether or not the request is tracked electronically, through a call center or by facsimile;

(4) by January 1, 2021, auto-adjudicate all electronically transmitted prior authorization requests to approve or pend a request for benefits; and

(5) accept requests for medical care, pharmaceutical benefits or related benefits that are not electronically transmitted.

B. Prior authorization shall be deemed granted for determinations not made within seven days; provided that:

(1) an adjudication shall be made within twenty-four hours, or shall be deemed granted if not made within twenty-four hours, when a covered person's health care professional requests an expedited prior authorization and submits to the health insurer a statement that, in the health care professional's opinion that is based on reasonable medical probability, delay in the treatment for which prior authorization is requested could:

(a) seriously jeopardize the covered person's life or overall health;

(b) affect the covered person's ability to regain maximum function; or

(c) subject the covered person to severe and intolerable pain; and

(2) the adjudication time line shall commence only when the health insurer receives all necessary and relevant documentation supporting the prior authorization request.

C. After December 31, 2020, an insurer may automatically deny a covered person's prior authorization request that is electronically submitted and that relates to a prescription drug that is not on the covered person's health benefits plan formulary; provided that the insurer shall accompany the denial with a list of alternative drugs that are on the covered person's health benefits plan formulary.

D. Upon denial of a covered person's prior authorization request based on a finding that a prescription drug is not on the covered person's health benefits plan formulary, a health insurer shall notify the person of the denial and include in a conspicuous manner information regarding the person's right to initiate a drug formulary exception request and the process to file a request for an exception to the denial.

E. An auto-adjudicated prior authorization request based on medical necessity that is pended or denied shall be reviewed by a health care professional who has knowledge or consults with a specialist who has knowledge of the medical condition or disease of the covered person for whom the authorization is requested. The health care professional shall make a final determination of the request. If the request is denied after review by a health care professional, notice of the denial shall be provided to the covered person and covered person's provider with the grounds for the denial and a notice of the right to appeal and describing the process to file an appeal.

F. A health insurer shall establish a process by which a health care provider or covered person may initiate an electronic appeal of a denial of a prior authorization request.

G. A health insurer shall have in place policies and procedures for annual review of its prior authorization practices to validate that the prior authorization requirements advance the principles of lower cost and improved quality, safety and service.

H. The office of superintendent of insurance shall establish by rule protocols and criteria pursuant to which a covered person or a covered person's health care professional may request expedited independent review of an expedited prior authorization request made pursuant to Subsection B of this section following medical peer review of a prior authorization request pursuant to the Prior Authorization Act.

History: Laws 2019, ch. 187, § 7.

59A-22B-6. Prior authorization rescinding or modifying prohibited.

A health insurer shall not rescind or modify an authorization for mental health or substance use disorder services that has been authorized, after the provider renders the services pursuant to a determination of medical necessity, in good faith, except for cases of fraud or violation of the provider's contract with the health insurer.

History: Laws 2023, ch. 114, § 11.

59A-22B-7. Prior authorization or referral requirement for in-network mental health or substance use disorder services coverage prohibited.

A. A health insurer shall not require prior authorization and referral requirements for the following mental health or substance use disorder services:

(1) acute or immediately necessary care;

(2) acute episodes of chronic mental health or substance use disorder conditions; or

(3) initial in-network inpatient or outpatient substance use treatment services.

B. Prior authorization shall be determined in consultation with the insured's mental health or substance use disorder services provider for:

(1) continuation of services in chronic or stable conditions; or

(2) additional services.

C. Except in cases in which the insured terminates a plan, a health insurer shall not terminate coverage of services without consultation with the insured's mental health or substance use disorder services provider.

D. A health insurer shall not limit coverage for mental health or substance use disorder services up to the point of relief of presenting signs and symptoms or to short-term care or acute treatment.

E. The duration of coverage for an insured with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the insured rather than on arbitrary time limits.

F. A health insurer may require a mental health or substance use disorder services provider to provide notification to the health insurer after the initiation of in-network mental health or substance use disorder treatment pursuant to Subsection A of this section.

G. If a provider fails to notify a health insurer pursuant to Subsection F of this section, a health insurer may perform appropriate utilization review.

H. A health insurer may require a mental health or substance use disorder services provider to develop and submit a treatment plan for an insured receiving in-network services in a manner that is compliant with federal law.

History: Laws 2023, ch. 114, § 12.

59A-22B-8. Prior authorization for prescription drugs or step therapy for certain conditions prohibited.

A. Coverage for medication approved by the federal food and drug administration that is prescribed for the treatment of an autoimmune disorder, cancer or a substance use disorder, pursuant to a medical necessity determination, shall not be subject to prior authorization, except in cases in which a biosimilar, interchangeable biologic or generic version is available.

B. A health insurer shall not impose step therapy requirements before authorizing coverage for medication approved by the federal food and drug administration that is prescribed for the treatment of an autoimmune disorder, cancer or a substance use disorder, pursuant to a medical necessity determination, except in cases in which a biosimilar, interchangeable biologic or generic version is available.

History: Laws 2023, ch. 114, § 13; 2024, ch. 42, § 4.

ARTICLE 23
Group and Blanket Health Insurance Contracts

59A-23-1. Scope of article.

This article [Chapter 59A, Article 23 NMSA 1978] shall apply only as to group health insurance contracts and blanket health insurance contracts as hereinafter defined.

History: Laws 1984, ch. 127, § 460.

59A-23-2. Blanket health insurance.

A. Blanket health insurance is declared to be that form of health insurance covering special groups of not fewer than ten persons as enumerated in one of the following paragraphs:

(1) under a policy or contract issued to a common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on the common carrier;

(2) under a policy or contract issued to an employer that shall be deemed the policyholder, covering a group of employees defined by reference to exceptional hazards incident to employment;

(3) under a policy or contract issued to a college, school or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students and teachers;

(4) under a policy or contract issued in the name of a volunteer fire department or first aid or other such volunteer group, which shall be deemed the policyholder, covering all of the members of the department or group; or

(5) under a policy or contract issued to any other substantially similar group that, in the discretion of the superintendent, may be subject to the issuance of a blanket health policy or contract.

B. An individual application shall not be required from a person covered under a blanket sickness or accident policy or contract.

C. All benefits under any blanket sickness and accident policy shall be payable to the person insured or the person's agent, or to the person's designated beneficiary or beneficiaries, or to the person's estate, except that if the person insured is a minor, such benefits may be made payable to the minor's parent, guardian or other person actually supporting the minor.

D. A blanket sickness or accident policy or contract issued to a college, school or other institution of learning or to the head or principal thereof shall not be identified or sold as a student health plan.

History: Laws 1984, ch. 127, § 461; 2017, ch. 130, § 15.

59A-23-3. Group health insurance.

A. Group health insurance is that form of health insurance covering groups of persons, with or without their dependents, and issued upon the following basis:

(1) under a policy issued to an employer, who shall be deemed the policyholder, insuring at least one employee of such employer for the benefit of persons other than the employer. The term "employees", as used in this section, includes the officers, managers and employees of the employer, leased workers if the employer is registered as an employee leasing contractor pursuant to the Employee Leasing Act [60-13A-1 to 60-13A-14 NMSA 1978], the partners, if the employer is a partnership, the officers, managers and employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners and employees of individuals and firms the business of which is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer", as used in this section, includes any municipal or governmental corporation, unit, agency or department thereof and the proper officers, as such, or any unincorporated municipality or department thereof, as well as private individuals, partnerships and corporations. A small employer shall also be subject to the Small Group Rate and Renewability Act [Chapter 59A, Article 23C NMSA 1978]. A "small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during the preceding year, employed no more than fifty eligible employees. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer;

(2) under a policy issued to an association, including a labor union and an agricultural association, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least twenty-five members of the association for the benefit of persons other than the association or its officers or trustees, as such;

(3) under a policy issued to a cooperative; or

(4) under a policy issued to any other substantially similar group that, in the discretion of the superintendent, may be subject to the issuance of a group sickness and accident policy or contract.

B. Each policy, as provided by this section, shall contain in substance the following provisions:

(1) a provision that the policy, the application of the policyholder, if such application or copy thereof is attached to such policy, and the individual applications, if any, submitted in connection with such policy by the employees or members, shall constitute the entire contract between the parties, and that all statements, in the absence of fraud, made by any applicant or applicants shall be deemed representations

and not warranties, and that no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application for such insurance;

(2) a provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit; and

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

C. For purposes of this section only, the directors of a corporation shall be deemed to be employees of the corporation.

D. For the purposes of this section, "cooperative" means a private health insurance cooperative established pursuant to Section 59A-23-11 NMSA 1978.

History: Laws 1984, ch. 127, § 462; 1991, ch. 153, § 10; 1993, ch. 126, § 5; 1994, ch. 75, § 28; 2011, ch. 34, § 1; 2023, ch. 68, § 2.

59A-23-3.1. Group insurance reports required.

A. At least quarterly, upon request by the employer, each insurer who has delivered or issued for delivery a policy of group insurance covering twenty-six or more employees, all or a portion of the premiums for which is paid by the employer of the insureds, shall submit to the employer a financial summary report by coverage of expenses incurred by or on behalf of the employees of that employer since the last report. The report shall include the number and amount of monthly paid claims, monthly covered lives and an accounting of reserves and retention costs.

B. Upon request by the employer, each insurer shall provide to the employer claims information that provides sufficient detail, subject to state and federal privacy laws, to enable the employer to obtain and compare group health insurance rates from multiple insurers or establish a plan of self-insurance.

C. The report and claims information required by this section shall be provided within thirty days from the date of request.

History: 1978 Comp., § 59A-23-3.1, enacted by Laws 1985, ch. 167, § 1; 1987, ch. 281, § 2; 1993, ch. 164, § 1; 2007, ch. 53, § 1.

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.

History: Laws 1984, ch. 127, § 463; 1988, ch. 89, § 3; 1990, ch. 5, § 3; 1992, ch. 56, § 3; 1997, ch. 7, § 2; 1997, ch. 249, § 2; 1997, ch. 250, § 2; 1997, ch. 255, § 2; 2001, ch. 14, § 2; 2003, ch. 337, § 2; 2007, ch. 278, § 2; 2009, ch. 212, § 3; 2021, ch. 108, § 23.

59A-23-5. Extended disability benefit.

Any group health insurance policy may provide for payment not exceeding one thousand dollars ($1,000) as an extended disability benefit upon the insured's death from any cause, which benefit shall not be construed as life insurance.

History: Laws 1984, ch. 127, § 464.

59A-23-6. Alcohol dependency coverage.

A. Each insurer that delivers or issues for delivery in this state a group health insurance policy shall offer and make available benefits for the necessary care and treatment of alcohol dependency. Such benefits shall:

(1) be subject to annual deductibles and coinsurance consistent with those imposed on other benefits within the same policy;

(2) provide no less than thirty days necessary care and treatment in an alcohol dependency treatment center and thirty outpatient visits for alcohol dependency treatment; and

(3) be offered for benefit periods of no more than one year and may be limited to a lifetime maximum of no less than two benefit periods. Such offer of benefits shall be subject to the rights of the group health insurance holder to reject the coverage or to select any alternative level of benefits if that right is offered by or negotiated with that insurer.

B. For purposes of this section, "alcohol dependency treatment center" means a facility that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a physician or meeting the quality standards of the behavioral health services division of the human services department [health care authority department] and which facility also:

(1) is affiliated with a hospital under a contractual agreement with an established system for patient referral;

(2) is accredited as such a facility by the joint commission; or

(3) meets at least the minimum standards adopted by the behavioral health services division for treatment of alcoholism in regional treatment centers.

C. This section applies to policies delivered or issued for delivery or renewed, extended or amended in this state on or after July 1, 1983 or upon expiration of a collective bargaining agreement applicable to a particular policyholder, whichever is later; provided that this section does not apply to blanket, short-term travel, accident-only, limited or specified disease, individual conversion policies or policies designed for issuance to persons eligible for coverage under Title 18 of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental

plans. With respect to any policy forms approved by the office of superintendent of insurance prior to the effective date of this section, an insurer is authorized to comply with this section by the use of endorsements or riders; provided that such endorsements or riders are approved by the office of superintendent of insurance as being in compliance with this section and applicable provisions of the Insurance Code.

D. If an organization offering group health benefits to its members makes more than one health insurance policy or nonprofit health care plan available to its members on a member option basis, the organization shall not require alcohol dependency coverage from one health insurer or health care plan without requiring the same level of alcohol dependency coverage for all other health insurance policies or health care plans that the organization makes available to its members.

History: 1978 Comp., § 59-18-24, enacted by Laws 1983, ch. 64, § 1; 1978 Comp., § 59-18-24, recompiled as 59A-23-6 by Laws 1987, ch. 259, § 32; 2007, ch. 325, § 12; 2013, ch. 74, § 27.

59A-23-6.1. Coverage of alpha-fetoprotein IV screening test.

A blanket or group health policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall provide coverage for an alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks of pregnancy, to screen for certain genetic abnormalities in the fetus.

History: Laws 2004, ch. 122, § 5.

59A-23-6.2. Prior authorization for gynecological or obstetrical ultrasounds prohibited.

A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in this state and that provides coverage for gynecological or obstetrical ultrasounds shall not require prior authorization for gynecological or obstetrical ultrasounds.

B. Nothing in this section shall be construed to require payment for a gynecological or obstetrical ultrasound that is not:

(1) medically necessary; or

(2) a covered benefit.

C. As used in this section, "prior authorization" means advance approval that is required by blanket or group health insurance policy or contract as a condition precedent to payment for medical care or related benefits rendered to a covered person, including prospective or utilization review conducted prior to the provision of covered medical care or related benefits.

History: Laws 2019, ch. 182, § 4.

59A-23-7. Blanket or group health policy or certificate; provisions relating to individuals who are eligible for medical benefits under the medicaid program.

A. Each blanket or group health policy or certificate of insurance that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy or certificate to be paid to the human services department [health care authority department] when:

(1) the human services department [health care authority department] has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;

(2) payment for the services in question has been made by the human services department [health care authority department] to the medicaid provider; and

(3) the insurer is notified that the insured individual receives benefits under the medicaid program and that benefits must be paid directly to the human services department [health care authority department].

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the human services department [health care authority department] for insurance benefits when the claim is first submitted by the human services department [health care authority department] to the insurer.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any blanket or group health insurance policy or certificate for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy or certificate shall be made payable to the provider. The insurer may be notified that the insured individual is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the insurer.

D. No blanket or group health insurance policy or certificate delivered, issued for delivery or renewed in this state on or after the effective date of this section shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in

any case where the insurer has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by an insurer for those health care items or services.

History: 1978 Comp., § 59A-23-7, enacted by Laws 1989, ch. 183, § 3; 1994, ch. 64, § 4.

59A-23-7.1. Reserved.

59A-23-7.2. Coverage of children.

A. An insurer shall not deny enrollment of a child under the health plan of the child's parent on the grounds that the child:

(1) was born out of wedlock;

(2) is not claimed as a dependent on the parent's federal tax return; or

(3) does not reside with the parent or in the insurer's service area.

B. When a child has health coverage through an insurer of a noncustodial parent, the insurer shall:

(1) provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(3) make payments on claims submitted in accordance with Paragraph (2) of this subsection directly to the custodial parent, the provider or the state medicaid agency.

C. When a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage, the insurer shall be required:

(1) to permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) if the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

(3) not to disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(a) the court or administrative order is no longer in effect; or

(b) the child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.

D. An insurer shall not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the medicaid program and covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

E. An insurer shall provide coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the early childhood education and care department, provided eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars ($3,500) annually for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel who are working in early intervention programs approved by the early childhood education and care department. No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.

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.

History: Laws 2003, ch. 391, § 3; 2021, ch. 108, § 24.

59A-23-7.4. Coverage of circumcision for newborn males.

A blanket or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall provide coverage for circumcision for newborn males.

History: Laws 2004, ch. 122, § 6.

59A-23-7.5. Coverage of part-time employees.

An insurer that provides group health insurance pursuant to Chapter 59A, Article 23 NMSA 1978 shall make available, upon an employer's request prior to issuance, delivery or renewal, coverage for regular part-time employees who work or are expected

to work an average of at least twenty hours per week over a six-month period. Nothing in this section shall be construed to require an employer to offer or provide coverage for regular part-time employees.

History: Laws 2005, ch. 42, § 2.

59A-23-7.6. Coverage of colorectal cancer screening.

A. A blanket or group health policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall provide coverage for colorectal screening for determining the presence of precancerous or cancerous conditions and other health problems. The coverage shall make available colorectal cancer screening, as determined by the health care provider in accordance with the evidence-based recommendations established by the United States preventive services task force.

B. Coverage for colorectal screening 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.

History: Laws 2007, ch. 17, § 2.

59A-23-7.7. General anesthesia and hospitalization for dental surgery.

A. A blanket 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 hospitalization and general anesthesia provided in a hospital or ambulatory surgical center for dental surgery for the following:

(1) insureds exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;

(2) insureds for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

(3) insured children or adolescents who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result

in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

(4) insureds with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or

(5) other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.

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

C. Coverage for dental surgery may be subject to copayments, deductibles and coinsurance subject to network and prior authorization requirements consistent with those imposed on other benefits under the same policy, plan or certificate.

History: Laws 2007, ch. 218, § 3.

59A-23-7.8. Hearing aid coverage for children required.

A. A blanket 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 a hearing aid and any related service for the full cost of one hearing aid per hearing-impaired ear up to two thousand two hundred dollars ($2,200) every thirty-six months for hearing aids for insured children under eighteen years of age or under twenty-one years of age if still attending high school. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two-thousand-two-hundred-dollar ($2,200) limit as provided in this subsection without financial or contractual penalty to the insured or to the provider of the hearing aid.

B. An insurer that delivers, issues for delivery or renews in this state a blanket or group health insurance policy, health care plan or certificate of health insurance may make available to the policyholder the option of purchasing additional hearing aid coverage that exceeds the services described in this section.

C. Hearing aid coverage offered shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a physician, licensed in New Mexico.

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

E. Coverage for hearing aids may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

F. For the purposes of this section, "hearing aid" means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

History: Laws 2007, ch. 356, § 3.

59A-23-7.9. Coverage for autism spectrum disorder diagnosis and treatment.

A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in this state shall provide coverage to an insured for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;

(2) shall not be subject to annual or lifetime dollar limits;

(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. Coverage for treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis shall not be denied to an insured on the basis of the insured's age.

D. The coverage required pursuant to Subsection A of this section shall not be subject to deductibles or coinsurance provisions that are less favorable to an insured

than the deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the blanket or group health insurance policy or contract, except as otherwise provided in Subsection B of this section.

E. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

F. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include:

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

G. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.

H. The provisions of this section shall not apply to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies.

I. As used in this section:

(1) "autism spectrum disorder" means:

(a) a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American psychiatric association; or

(b) a condition diagnosed as autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder or childhood disintegrative disorder pursuant to diagnostic criteria published in a previous edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American psychiatric association;

(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and

(3) "high school" means a school providing instruction for any of the grades nine through twelve.

History: Laws 2009, ch. 74, § 2; 2019, ch. 119, § 4.

59A-23-7.10. Coverage for orally administered anticancer medications; limits on patient costs.

A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in this state and that provides coverage for cancer treatment shall provide coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits by the plan.

B. An insurer shall not increase patient cost-sharing for anticancer medications in order to achieve compliance with the provisions of this section.

C. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, copayment, deductible or coinsurance provision that does not apply to intravenously administered or injected anticancer medication used to kill or slow the growth of cancerous cells.

D. As used in this section, "insurer" or "blanket or group health insurance plan":

(1) means:

(a) a health insurer;

(b) a nonprofit health service provider;

(c) a health maintenance organization;

(d) a managed care organization; or

(e) a provider service organization; and

(2) does not include blanket or large group policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies.

History: Laws 2011, ch. 55, § 3.

59A-23-7.11. Coverage of prescription eye drop refills.

A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in this state and that provides coverage for prescription eye drops shall not deny coverage for a renewal of prescription eye drops when:

(1) the renewal is requested by the insured at least twenty-three days for a thirty-day supply of eye drops, forty-five days for a sixty-day supply of eye drops or sixty-eight days for a ninety-day supply of eye drops from the later of the date that the original prescription was dispensed to the insured or the date that the last renewal of the prescription was dispensed to the insured; and

(2) the prescriber indicates on the original prescription that additional quantities are needed and that the renewal requested by the insured does not exceed the number of additional quantities needed.

B. As used in this section, "prescriber" means a person who is authorized pursuant to the New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978] to prescribe prescription eye drops.

History: Laws 2012, ch. 27, § 3.

59A-23-7.12. Coverage for telemedicine services.

A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in this state shall provide coverage for services provided via telemedicine to the same extent that the health insurance plan, policy or contract covers the same services when those services are provided via in-person consultation or contact. An insurer shall not impose any unique condition for coverage of services provided via telemedicine.

B. An insurer shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by an insurer that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978].

D. The provisions of this section shall not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. An insurer shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the health insurance plan, policy or contract provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent.

G. An insurer may charge a deductible, copayment or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. An insurer shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the health insurance plan, policy or contract, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any plan, policy or contract year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health insurance plan, policy or contract.

I. An insurer shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the insurer reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to a group or blanket policy, plan or contract intended to supplement major medical group-type coverage, such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) "consulting telemedicine provider" means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) "health care provider" means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of the professional's license;

(3) "in real time" means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(4) "originating site" means a place at which a patient is physically located and receiving health care services via telemedicine;

(5) "store-and-forward technology" means electronic information, imaging and communication, including interactive audio, video and data communication, that is transferred or recorded or otherwise stored for asynchronous use; and

(6) "telemedicine" means the use of telecommunications and information technology to provide clinical health care from a distance. "Telemedicine" allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. "Telemedicine" allows patients in remote locations to access medical expertise without travel.

History: Laws 2013, ch. 105, § 3; 2019, ch. 255, § 3.

59A-23-7.13. Prescription drugs; prohibited formulary changes; notice requirements.

A. As of January 1, 2014, 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 and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall not make any of the following changes to coverage for a prescription drug within one hundred twenty days of any previous change to coverage for that prescription drug, unless a generic version of the prescription drug is available:

(1) reclassify a drug to a higher tier of the formulary;

(2) reclassify a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary;

(3) increase the cost-sharing, copayment, deductible or co-insurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

(6) impose or modify a drug's quantity limit; or

(7) impose a step-therapy restriction.

B. The insurer shall give the affected insured at least sixty days' advance written notice of the impending change when it is determined that one of the following modifications will be made to a formulary:

(1) reclassification of a drug to a higher tier of the formulary;

(2) reclassification of a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary;

(3) an increase in the cost-sharing, copayment, deductible or coinsurance charges for a drug;

(4) removal of a drug from the formulary;

(5) addition of a prior authorization requirement;

(6) imposition or modification of a drug's quantity limit; or

(7) imposition of a step-therapy restriction for a drug.

C. Notwithstanding the provisions of Subsections A and B of this section, the insurer may immediately and without prior notice remove a drug from the formulary if the drug:

(1) is deemed unsafe by the federal food and drug administration; or

(2) has been removed from the market for any reason.

D. The insurer shall provide to each affected insured the following information in plain language regarding prescription drug benefits:

(1) notice that the insurer uses one or more drug formularies;

(2) an explanation of what the drug formulary is;

(3) a statement regarding the method the insurer uses to determine the prescription drugs to be included in or excluded from a drug formulary; and

(4) a statement of how often the insurer reviews the contents of each drug formulary.

E. As used in this section:

(1) "formulary" means the list of prescription drugs covered by a policy, plan or certificate of health insurance; and

(2) "step therapy" means a protocol that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are to be prescribed.

History: Laws 2013, ch. 138, § 3.

59A-23-7.14. Coverage for contraception.

A. Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state that provides a prescription drug benefit shall provide, at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

B. Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) cost sharing for insureds;

(2) utilization review;

(3) prior authorization or step-therapy requirements; or

(4) any restrictions or delays on the coverage.

C. An insurer may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method category of contraception without cost sharing by the insured; provided that when an insured's health care provider determines that a particular drug or item is medically necessary, the individual or group health insurance policy, health care plan or certificate of health insurance shall cover the brand-name pharmacy drug or item without cost sharing. A determination of medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. An insurer shall grant an insured an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an insured, the insured's representative or the insured's health care provider;

(2) defer to the determination of the insured's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

E. An insurer shall not require a prescription for any drug, item or service that is available without a prescription.

F. An individual or group health insurance policy, health care plan or certificate of health insurance shall provide coverage and shall reimburse a health care provider or dispensing entity on a per unit basis for dispensing a six-month supply of contraceptives; provided that the contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe six months of contraceptives at one time; or

(2) permit an insurer to limit coverage or impose cost sharing for an alternate method of contraception if an insured changes contraceptive methods before exhausting a previously dispensed supply.

H. The provisions of this section shall not apply to short-term travel, accident-only, hospital-indemnity-only, limited-benefit or specified-disease health benefits plans.

I. The provisions of this section apply to individual or group health insurance policies, health care plans or certificates of insurance delivered or issued for delivery after January 1, 2020.

J. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives;

progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) cost sharing" means a deductible, copayment or coinsurance that an insured is required to pay in accordance with the terms of an individual or group health insurance policy, health care plan or certificate of insurance; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business.

K. A religious entity purchasing individual or group health insurance coverage may elect to exclude prescription contraceptive drugs or items from the health insurance coverage purchased.

59A-23-7.15. Coverage exclusion. (Contingent repeal. *See* note.)

Coverage of vasectomy and male condoms pursuant to Section 5 [59A-23-7.14 NMSA 1978] of this 2019 act is excluded for high-deductible individual or group health insurance policies, health care plans or certificates of insurance with health savings accounts delivered or issued for delivery in this state until an insured's deductible has been met.

59A-23-7.16. Heart artery calcium scan coverage.

A. A group health plan, other than a small group health plan or a blanket health insurance policy or contract that is delivered, issued for delivery or renewed in this state shall provide coverage for eligible insureds to receive a heart artery calcium scan.

B. Coverage provided pursuant to this section shall:

(1) be limited to the provision of a heart artery calcium scan to an eligible insured to be used as a clinical management tool;

(2) be provided every five years if an eligible insured has previously received a heart artery calcium score of zero; and

(3) not be required for future heart artery calcium scans if an eligible insured receives a heart artery calcium score greater than zero.

C. At its discretion or as required by law, an insurer may offer or refuse coverage for further cardiac testing or procedures for eligible insureds based upon the results of a heart artery calcium scan.

D. The provisions of this section do not apply to short-term travel, accident-only or limited or specified-disease policies, plans or certificates of health insurance.

E. As used in this section:

(1) "eligible insured" means an insured who:

(a) is a person between the ages of forty-five and sixty-five; and

(b) has an intermediate risk of developing coronary heart disease as determined by a health care provider based upon a score calculated from an evidence-based algorithm widely used in the medical community to assess a person's ten-year cardiovascular disease risk, including a score calculated using a pooled cohort equation;

(2) "health care provider" means a physician, physician assistant, nurse practitioner or other health care professional authorized to furnish health care services within the scope of the professional's license; and

(3) "heart artery calcium scan" means a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function.

59A-23-7.17. Coverage for individuals with diabetes.

A. Each group health insurance contract and blanket health insurance contract delivered or issued for delivery in this state shall provide coverage for individuals with diabetes who use insulin, individuals with diabetes who do not use insulin and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care benefit and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as otherwise provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given policy. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for persons with disabilities, including the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of persons with disabilities, including the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following basic health care benefits:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a diagnosis from a health care practitioner that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the federal food and drug administration, all individual or group health insurance policies as described in Subsection A of this section shall:

(1) maintain an adequate formulary to provide those resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drugs, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. An insurer that requires a covered person to use a specific network provider or to purchase equipment, appliances, supplies or insulin or prescription drugs for the treatment or management of diabetes from a specific durable medical equipment supplier or other supplier as a condition of coverage, payment or reimbursement shall:

(1) maintain an adequate network of durable medical equipment suppliers and other suppliers to provide covered persons with medically necessary diabetes resources whether covered under the health policy's prescription drug or medical benefit;

(2) have network contracts in place for the entire policy or plan period and shall not allow contracts with network providers, durable medical equipment suppliers and other suppliers to lapse or terminate without ensuring the availability of a replacement and continuity of care; provided that single-case agreements do not satisfy the requirements of Paragraph (1) of this subsection or this paragraph;

(3) monitor network providers, durable medical equipment suppliers and other network suppliers to ensure that medically necessary equipment, appliances, supplies and insulin or other prescription drugs are being delivered to a covered person in a timely manner and when needed by the covered person;

(4) guarantee reimbursement to a covered person within thirty days following receipt of a written demand from the covered person who pays out of pocket for necessary equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered in a timely manner to the covered person and the portion of payment for which the patient is responsible shall not exceed the amount for the same covered benefit obtained from a contracted supplier;

(5) pay interest at the rate of eighteen percent per year on the amount of reimbursement due to a covered person if not paid within thirty days as required by Paragraph (4) of this subsection;

(6) beginning on April 1, 2024, submit a written report each quarter to the superintendent for the previous quarter on the following metrics:

(a) the number of written demands for reimbursement of out-of-pocket expenses from covered persons received by the health care insurer;

(b) the number of out-of-pocket claims for reimbursement paid and the aggregate amount of claims reimbursed by the health care insurer within the time required by Paragraph (4) of this subsection;

(c) the number of out-of-pocket claims for reimbursement paid more than thirty days following receipt of a written demand and the aggregate amount of these payments, excluding interest; and

(d) the aggregate amount of interest paid by the health care insurer pursuant to Paragraph (5) of this subsection; and

(7) beginning on April 1, 2024, submit a written report each quarter for the previous quarter to the superintendent with the following information for each durable medical equipment supplier or other supplier that was under contract with the health care insurer or its agent during the previous quarter:

(a) the name, address and telephone number of each supplier and, if applicable, the corresponding date upon which the respective supplier's contract expired, lapsed or was terminated during the previous quarter;

(b) the percentage of total deliveries, by description of item, that did not meet the delivery requirements specified in Paragraph (3) of this subsection; and

(c) the number of complaints received by the health care insurer or its agent during the previous quarter related to late deliveries, incomplete orders or incorrect orders, respectively.

G. The superintendent shall annually audit all health insurers offering policies, plans or certificates as described in Subsection A of this section for compliance with the requirements of this section. If the superintendent determines that a health care insurer has not complied with the requirements of this section, the superintendent shall impose corrective action or use any other enforcement mechanism available to the superintendent to obtain the health care insurer's compliance with this section.

H. Absent a change in diagnosis or in a covered person's management or treatment of diabetes or its complications, a health care insurer shall not require more than one

prior authorization per policy period for any single drug or category of item enumerated in this section if prescribed as medically necessary by the covered person's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a covered person has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the covered person's health care practitioner. Nothing in this subsection shall be construed to require payment for diabetes resources that are not covered benefits.

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

J. For purposes of this section, "basic health care benefits":

(1) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(2) does not include services for alcohol or drug abuse, dental or long-term rehabilitation treatment.

History: Laws 2023, ch. 50, § 3.

59A-23-7.18. Biomarker testing coverage.

A. A blanket 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 insureds to receive biomarker testing.

B. Coverage provided pursuant to this section shall be for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of an insured's disease or condition when the test is supported by medical and scientific evidence, including:

(1) labeled indications for a United States food and drug administration-approved or -cleared test;

(2) indicated tests for a United States food and drug administration-approved drug;

(3) warnings and precautions on United States food and drug administration labels;

(4) federal centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations; or

(5) nationally recognized clinical practice guidelines.

C. A blanket or group health policy, health care plan or certificate of health insurance providing coverage for biomarker testing pursuant to this section shall ensure that:

(1) coverage is provided in a manner that limits disruptions in care, including coverage for multiple biopsies or biospecimen samples; and

(2) a patient and a practitioner who prescribes biomarker testing have clear, accessible and convenient processes to request an appeal of a benefit denial by the insurer and that those processes are accessible on the insurer's website.

D. Coverage for biomarker testing may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

E. The provisions of this section do not apply to accident-only or limited or specified disease policies, plans or certificates of health insurance.

F. As used in this section:

(1) "biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. "Biomarker" includes gene mutations, characteristics of genes or protein expression;

(2) "biomarker testing" means analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker and includes single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing; and

(3) "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that are:

(a) developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy; and

(b) used to establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

History: Laws 2023, ch. 138, § 4.

59A-23-8. Group formed to purchase health insurance; limitations.

A. No policy or certificate of group health insurance may be renewed, delivered or issued for delivery in this state to a group formed for the purpose of purchasing one or more policies of group health insurance unless the superintendent has approved the issuance. The superintendent shall not grant his approval unless he finds that:

(1) the benefits of the policy are reasonable in relation to the premium charged; and

(2) the group to which the policy is issued is organized and operated in a fiscally sound manner.

B. An insurer may exclude or limit the coverage in a policy issued pursuant to this section for any person as to whom evidence of insurability is not satisfactory to the insurer.

C. The provisions of this section apply to the offering in this state of a policy issued in another state or its certificates.

History: Laws 1991, ch. 125, § 28.

59A-23-9. Repealed.

History: Laws 1997, ch. 243, § 20; repealed by Laws 2021, ch. 108, § 37.

59A-23-10. Employer utilization and loss data availability.

Claims information, including utilization and loss experience under health insurance provided under Chapter 59A, Article 23 NMSA 1978 shall be made available only upon the request of and to employers of employees with such coverage within sixty days of an employer's written request for such information, provided the employer's coverage extends to no less than twenty-five individual employees, regardless of whether family coverage is included. In providing such utilization data, carriers shall not reveal information that allows identification of an individual employee or the employee's family or the specific conditions for which coverage was provided.

History: Laws 2003, ch. 252, § 1.

59A-23-11. Private health insurance cooperatives; incorporation.

A. A person may form a cooperative to purchase employer health benefit plans. A cooperative shall be organized as a nonprofit corporation and has the rights and duties provided by the Nonprofit Corporation Act [Chapter 53, Article 8 NMSA 1978].

B. Two or more large employers or small employers or any combination of large employers and small employers with an aggregate of fifty or more full-time-equivalent employees may purchase group health benefit plans pursuant to Chapter 59A, Article 23 NMSA 1978.

C. A carrier shall not form, or be a member of, a cooperative. A carrier may associate with a sponsoring entity, such as a business association, chamber of commerce or other organization representing employers or serving an analogous function, to assist the sponsoring entity in forming a cooperative.

D. A cooperative shall:

(1) arrange for group health benefit plan coverage for employer groups that participate in the cooperative by contracting with carriers pursuant to Chapter 59A, Article 23 NMSA 1978;

(2) collect premiums to cover the cost of:

(a) group health benefit plan coverage purchased through the cooperative; and

(b) the cooperative's administrative expenses;

(3) establish administrative and accounting procedures for the operation of the cooperative;

(4) establish procedures under which an applicant for or participant in group health benefit plan coverage issued through the cooperative may have a grievance reviewed by an impartial person;

(5) contract with carriers to provide services to employers covered through the cooperative; and

(6) develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in, group health benefit plan coverage through the cooperative.

E. A cooperative may negotiate the premiums paid by its members.

F. Notwithstanding the provisions of Subsections B and C of this section, a cooperative may restrict membership to employers within a single industry grouping as defined by the most recent edition of the United States census bureau's North American Industry Classification System.

G. A carrier shall issue health benefit plan coverage for the cooperative through a licensed agent marketing the coverage in accordance with the provisions of Chapter 59A, Article 23 NMSA 1978.

H. The members of a cooperative shall be considered a single risk pool.

I. A cooperative may make available to its members more than one group health benefit plan, but each plan shall be made available to all employees covered by the cooperative.

J. The provisions of this section do not limit or restrict a small or large employer's access to health benefit plans pursuant to the Insurance Code [Chapter 59A NMSA 1978].

K. A group health benefit plan provided through a cooperative shall provide coverage for diabetes equipment, supplies and services.

L. A carrier may elect not to participate in a cooperative. The carrier may elect to participate in one or more cooperatives and may select the cooperatives in which the carrier will participate.

M. A cooperative shall not self-insure or self-fund any health benefit plan or portion of a plan.

N. A cooperative may contract only with a carrier that demonstrates that the carrier:

(1) is in good standing with the division;

(2) has the capacity to administer health benefit plans;

(3) is able to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;

(4) is able to conduct utilization management and establish applicable procedures and policies;

(5) is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers;

(6) has a satisfactory grievance procedure and is able to respond to enrollees' calls, questions and complaints; and

(7) has financial capacity, either through satisfying financial solvency standards that the superintendent shall set or through appropriate reinsurance or other risk-sharing mechanisms.

O. A cooperative is not a carrier or an insurer, and an employee of the cooperative shall not be required to be licensed as an agent or broker pursuant to the provisions of the Insurance Code. This exemption from licensure includes a cooperative that acts to provide information about and to solicit membership in the cooperative.

P. A cooperative shall register as a cooperative with the insurance division in accordance with division rules.

Q. For the purposes of this section:

(1) "carrier" means a person that is subject to licensure by the superintendent or subject to the provisions of the Insurance Code and that provides one or more health benefit or insurance plans in the state;

(2) "large employer" means a person, firm, corporation, partnership or association actively engaged in business that, on at least fifty percent of its working days during either of the two preceding years, employed no fewer than fifty-one employees eligible for employer-sponsored coverage; provided that:

(a) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(b) companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state income taxation shall be considered one employer;

(c) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year; and

(d) the employer does not self-insure; and

(3) "small employer" means a person, firm, corporation, partnership or association actively engaged in business that, on at least fifty percent of its working days during either of the two preceding years, employed no less than two and no more than fifty employees eligible for employer-sponsored coverage; provided that:

(a) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(b) companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state income taxation shall be considered one employer;

(c) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year; and

(d) the employer does not self-insure.

History: Laws 2011, ch. 34, § 2.

59A-23-12. Prescription drug prior authorization protocols.

A. After January 1, 2014, an insurer shall accept the uniform prior authorization form developed pursuant to Sections 2 [59A-2-9.8 NMSA 1978] and 3 [61-11-6.2 NMSA 1978] of this 2013 act as sufficient to request prior authorization for prescription drug benefits.

B. No later than twenty-four months after the adoption of national standards for electronic prior authorization, a health insurer shall exchange prior authorization requests with providers who have e-prescribing capability.

C. If an insurer fails to use or accept the uniform prior authorization form or fails to respond within three business days upon receipt of a uniform prior authorization form, the prior authorization request shall be deemed to have been granted.

D. As used in this section, "insurer":

(1) means:

(a) an insurer;

(b) a nonprofit health service provider;

(c) a health maintenance organization;

(d) a managed care organization; or

(e) a provider service organization; and

(2) does not include:

(a) a person that delivers, issues for delivery or renews an individual policy intended to supplement major medical group-type coverages such as medicare

supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policy;

(b) a physician or a physician group to which a health insurer has delegated financial risk for prescription drugs and that does not use a prior authorization process for prescription drugs; or

(c) an insurer or its affiliated providers, if the insurer owns and operates its pharmacies and does not use a prior authorization process for prescription drugs.

History: Laws 2013, ch. 170, § 6.

59A-23-12.1. Prescription drug coverage; step therapy protocols; clinical review criteria; exceptions.

A. Each group or blanket health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state that provides a prescription drug benefit for which any step therapy protocols are required shall establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with insurers, health maintenance organizations, health care plans, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest; and

(b) using analytical and methodological experts to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a health insurance policy, health care plan or certificate of insurance restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy protocol, an insured and the practitioner prescribing the prescription drug shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. An insurer may use its existing medical exceptions process in accordance with the provisions of Subsections D through I of this section to satisfy this requirement. The process shall be made easily accessible for insureds and practitioners on the insurer's publicly accessible website.

D. An insurer shall expeditiously grant an exception to the health insurance policy's, health care plan's or certificate of insurance's step therapy protocol, based on medical necessity and a clinically valid explanation from the patient's prescribing practitioner as to why a drug on the health insurance policy's, health care plan's or certificate of insurance's formulary that is therapeutically equivalent to the prescribed drug should not be substituted for the prescribed drug, if:

(1) the prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

(2) the prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) while under the insured's current health insurance policy, health care plan or certificate of insurance, or under the insured's previous health coverage, the insured has tried the prescription drug that is the subject of the exception request or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or

(4) the prescription drug required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the prescription drug is expected to:

(a) cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;

(b) worsen a comorbid condition of the patient; or

(c) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

E. Upon the granting of an exception to a health insurance policy's, health care plan's or certificate of insurance's step therapy protocol, an insurer shall authorize coverage for the prescription drug that is the subject of the exception request.

F. An insurer shall respond with its decision on an insured's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, an insurer shall respond within twenty-four hours of receipt of the exception request. In the event the insurer does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. An insurer's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978].

H. After an insured has made an exception request in accordance with the provisions of this section, an insurer shall authorize continued coverage of a prescription drug that is the subject of the exception request pending the determination of the exception request.

I. The provisions of this section shall not be construed to prevent:

(1) a health insurance policy, health care plan or certificate of insurance from requiring a patient to try a generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

J. The provisions of this section shall apply only to a health insurance policy, health care plan or certificate of insurance delivered, issued for delivery or renewed on or after January 1, 2019.

K. The superintendent shall promulgate rules as may be necessary to appropriately implement the provisions of this section.

L. Nothing in this section shall be interpreted to interfere with the superintendent's authority to regulate prescription drug coverage benefits under other state and federal law.

M. As used in this section, "medical necessity" or "medically necessary" means health care services determined by a practitioner, in consultation with the insurer, to be appropriate or necessary, according to:

(1) any applicable, generally accepted principles and practices of good medical care;

(2) practice guidelines developed by the federal government or national or professional medical societies, boards or associations; or

(3) any applicable clinical protocols or practice guidelines developed by the insurer consistent with federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

History: Laws 2018, ch. 9, § 4.

59A-23-12.2. Pharmacist prescriptive authority services; reimbursement parity.

An insurer shall reimburse a participating provider that is a certified pharmacist clinician or pharmacist certified to provide a prescriptive authority service who provides a service pursuant to a health insurance plan, policy or certificate of health insurance at the standard contracted rate that the health insurance policy, health care plan or certificate of health insurance reimburses, for the same service pursuant to that policy, plan or certificate, any licensed physician or physician assistant licensed pursuant to the Medical Practice Act [Chapter 41, Article 5 NMSA 1978] or any advanced practice certified nurse practitioner licensed pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978].

History: Laws 2020, ch. 58, § 4; 2021, ch. 54, § 12.

59A-23-12.3. Calculating an insured's cost-sharing obligation for prescription drug coverage.

A. When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to a group health plan other than a small group health plan or a blanket health insurance policy or contract that is delivered, issued for delivery or renewed in this state, the insurer shall credit the insured for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans, tax-favored plans or high-deductible health plans

with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

History: Laws 2023, ch. 206, § 4.

59A-23-13. Pharmacy benefits; prescription synchronization.

A. A group or blanket health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state and that provides a prescription drug or device benefit shall allow an insured to fill or refill a prescription for less than a thirty-day supply of the prescription drug, and apply a prorated daily copayment or coinsurance for the fill or refill, if:

(1) the prescribing practitioner or the pharmacist determines the fill or refill to be in the best interest of the insured;

(2) the insured requests or agrees to receive less than a thirty-day supply of the prescription drug; and

(3) the reduced fill or refill is made for the purpose of synchronizing the insured's prescription drug fills.

B. A group or blanket health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state and that provides a prescription drug or device benefit shall not:

(1) deny coverage for the filling of a chronic medication when the fill is made in accordance with a plan to synchronize multiple prescriptions for the insured pursuant to Subsection A of this section established among the insurer, the prescribing practitioner and a pharmacist. The insurer shall allow a pharmacy to override any denial indicating that a prescription is being refilled too soon for the purposes of medication synchronization; and

(2) prorate a dispensing fee to a pharmacy that fills a prescription with less than a thirty-day supply of prescription drug pursuant to Subsection A of this section. The insurer shall pay in full a dispensing fee for a partially filled or refilled prescription for each prescription dispensed, regardless of any pro-rated copayment or coinsurance that the insured may pay for prescription synchronization services.

History: Laws 2015, ch. 65, § 4.

59A-23-14. Provider credentialing; requirements; deadline.

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The superintendent shall approve no more than two forms of application to be used for the credentialing of providers.

B. An insurer shall not require a provider to submit information not required by a credentialing application established pursuant to Subsection A of this section.

C. The provisions of this section apply equally to initial credentialing applications and applications for recredentialing.

D. The rules that the superintendent adopts and promulgates shall require primary credential verification no more frequently than every three years and allow provisional credentialing for a period of one year.

E. Nothing in this section shall be construed to require an insurer to credential or provisionally credential a provider.

F. The rules that the superintendent adopts and promulgates shall establish that an insurer or an insurer's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within thirty calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration;

(3) within ten working days after receipt of a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the insurer requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be reasonably related to the information in the application; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen days as described in Paragraph (2) of this subsection, load into the insurer's provider payment system all provider information, including all information needed to correctly reimburse a newly approved provider according to the provider's contract. The insurer or insurer's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the insurer's provider payment system.

G. An insurer shall reimburse a provider for covered health care services for any claims from the provider that the insurer receives with a date of service more than thirty calendar days after the date on which the insurer received a complete credentialing application for that provider if:

(1) the provider:

(a) has submitted a complete credentialing application and any supporting documentation that the insurer has requested in writing within the time frame established in Paragraph (3) of Subsection F of this section;

(b) has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and

(c) has professional liability insurance or is covered under the Medical Malpractice Act [Chapter 41, Article 5 NMSA 1978]; and

(2) the insurer:

(a) has approved, or has failed to approve or deny, the applicant's complete credentialing application within the time frame established pursuant to Paragraph (1) or (2) of Subsection F of this section; or

(b) fails to load the approved applicant's information into the insurer's provider payment system in accordance with Paragraph (4) of Subsection F of this section.

H. A provider who, at the time services were rendered, was not employed by a practice or group that has contracted with the insurer to provide services at specified rates of reimbursement shall be paid by the insurer in accordance with the insurer's standard reimbursement rate.

I. A provider who, at the time services were rendered, was employed by a practice or group that has contracted with the insurer to provide services at specified rates of reimbursement shall be paid by the insurer in accordance with the terms of that contract.

J. The superintendent shall adopt and promulgate rules to provide for the resolution of disputes relating to reimbursement and credentialing arising in cases where credentialing is delayed beyond thirty days after application.

K. An insurer shall reimburse a provider pursuant to Subsections G, H and I of this section until the earlier of the following occurs:

(1) the insurer's approval or denial of the provider's complete credentialing application; or

(2) the passage of three years from the date the insurer received the provider's complete credentialing application.

L. As used in this section:

(1) "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider; and

(2) "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in the state.

History: Laws 2015, ch. 111, § 2; 2016, ch. 20, § 3; 2023, ch. 175, § 2.

59A-23-15. Physical rehabilitation services; limits on cost sharing.

A. A group or blanket health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall not impose a member cost share for physical rehabilitation services that is greater than that for primary care services on a coinsurance percentage basis when coinsurance is applied or on an absolute dollar amount when a copay is applied.

B. As used in this section:

(1) "physical rehabilitation services" means services aimed at maximizing an individual's level of function, returning to a prior level of function or maintaining or slowing the decline of function, which services are provided by or under the direction of a licensed physical therapist, occupational therapist or speech therapist; and

(2) "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.

History: Laws 2019, ch. 188, § 3.

59A-23-16. Behavioral health services; elimination of cost sharing.

A. Until January 1, 2027, a group or blanket health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of this section:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing method that requires a covered person to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same group or blanket health insurance policy, health care plan or certificate of health insurance;

(3) "copayment" means a cost-sharing method that requires a covered person to pay a fixed dollar amount when health care services are received, with the insurer paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same group or blanket health insurance policy, health care plan or certificate of health insurance; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of a covered person other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of a group or blanket health insurance policy, health care plan or certificate of health insurance.

History: Laws 2021, ch. 136, § 7.

59A-23-17. Anatomical gift nondiscrimination.

A. For purposes of this section:

(1) "covered person" means a policyholder or other person covered by a health benefit plan; and

(2) "organ transplant" includes parts or the whole of organs, eyes or tissue.

B. All individual and group health insurance policies delivered or issued for delivery in this state that provide coverage for organ transplants or associated care shall not:

(1) deny that coverage solely on the basis of a covered person's physical or mental disability;

(2) deny to a covered person with a physical or mental disability eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit policy or plan solely for the purpose of avoiding the requirements of this section;

(3) penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a health care provider to induce that health care provider not to provide an organ transplant or associated care to a covered person with a physical or mental disability; or

(4) reduce or limit coverage benefits to a covered person with a physical or mental disability for the associated care related to organ transplantation as determined in consultation with the physician and patient.

History: Laws 2023, ch. 171, § 4.

59A-23-18. Diagnostic and supplemental breast examinations.

A. A blanket or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental breast examinations.

B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or high deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

History: Laws 2023, ch. 12, § 3.

59A-23-19. Chiropractic physician services; limits on cost sharing and coinsurance.

A. A group or blanket health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state that offers coverage of the services of a chiropractic physician shall not impose a copayment or coinsurance on those chiropractic physician services that exceeds the copayment or coinsurance imposed for primary care services.

B. As used in this section, "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.

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

History: Laws 2023, ch. 51, § 3.

59A-23-20. Employee leasing contractor group health plan requirements.

A. A group health plan sponsored by an employee leasing contractor shall be treated as a multiple employer welfare arrangement for purposes of the Insurance Code.

B. A group health plan sponsored by an employee leasing contractor shall be a fully insured plan.

C. For the purposes of determining whether an employee leasing contractor is a small or large employer, the employee leasing contractor's leased workers shall be counted as employees in addition to the employee leasing contractor's employees, and when an employee leasing contractor has:

(1) at least two but not more than fifty employees, the employee leasing contractor shall be treated as a small employer pursuant to the Health Insurance Portability Act, and the group health plan that it sponsors shall be subject to the rules of

the small group market, including rules applicable to the small group market by reason of the federal Patient Protection and Affordable Care Act; and

(2) fifty-one or more employees, the employee leasing contractor shall be treated as a large employer pursuant to the Health Insurance Portability Act, and the group health plan that it sponsors shall be subject to the rules of the large group market, including rules applicable to the large group market by reason of the federal Patient Protection and Affordable Care Act.

D. With respect to a group health plan described in this section that is subject to large group market rules, the rules shall apply to the group health plan as a whole and any rules applicable solely to other markets, such as the small group market or individual market, shall not apply to the group health plan or to any of the coverage provided by the group health plan.

E. For the purposes of this section:

(1) "employee leasing contractor" means any person who is registered as an employee leasing contractor pursuant to the Employee Leasing Act [60-13A-1 to 60-13A-14 NMSA 1978];

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

(3) "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;

(4) "leased worker" means a worker provided by an employee leasing contractor who is treated as a leased worker for the purposes of the Employee Leasing Act;

(5) "multiple employer welfare arrangement" means a plan for providing welfare benefits for employees of more than one employer as defined by 29 U.S.C. Section 1002; and

(6) "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.

History: Laws 2023, ch. 68, § 1.

59A-23-21. Sexually transmitted infection care; cost sharing eliminated.

A. A blanket or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state that offers coverage for preventive care or treatment of sexually transmitted infections shall not impose cost sharing on eligible insureds.

B. Pursuant to this section, preventive care or treatment of sexually transmitted infections shall not be conditioned upon the gender identity of the insured.

C. The provisions of Subsection A of this section do not apply to high-deductible health care plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

D. For the purposes of this section:

(1) "cost sharing" means policy deductibles, copayments or coinsurance;

(2) "preventive care" means screening, testing, examination or counseling and the administration, dispensing or prescribing of preventive drugs, devices or supplies incidental to the prevention of a sexually transmitted infection;

(3) "sexually transmitted infection" means chlamydia, syphilis, gonorrhea, HIV and relevant types of hepatitis, as well as any other sexually transmitted infection regardless of mode of transportation, as designated by rule upon making a finding that the particular sexually transmitted infection is contagious; and

(4) "treatment" means medically necessary care for the management of an existing sexually transmitted infection.

History: Laws 2023, ch. 99, § 3.

59A-23-22. Definitions.

As used in Sections 14 through 22 [59A-23-22 to 59A-23-30 NMSA 1978] of this 2023 act:

A. "generally recognized standards" means standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

(1) psychiatry;

(2) psychology;

(3) social work;

(4) clinical counseling;

(5) addiction medicine and counseling; or

(6) family and marriage counseling; and

B. "mental health or substance use disorder services" means:

(1) professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder; or

(2) professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act [Chapter 61, Article 9A NMSA 1978].

History: Laws 2023, ch. 114, § 14.

59A-23-23. Benefits required.

A group health plan, other than a small group health plan or a blanket health insurance policy or contract that is delivered, issued for delivery or renewed in this state shall provide coverage for all mental health or substance use disorder services required by generally recognized standards of care.

History: Laws 2023, ch. 114, § 15.

59A-23-24. Parity for coverage of mental health or substance use disorder services.

A. The office of superintendent of insurance shall ensure that an insurer complies with federal and state laws, rules and regulations applicable to coverage for mental health or substance use disorder services.

B. An insurer shall not impose quantitative treatment limitations, financial restrictions, limitations or requirements on the provision of mental health or substance use disorder services that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on substantially all of the coverage of benefits for other conditions.

C. An insurer shall not impose non-quantitative treatment limitations for the treatment of mental health or substance use disorders or conditions unless factors,

including the processes, strategies or evidentiary standards used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to and are applied no more restrictively than the factors used in applying the limitation with respect to medical or surgical benefits in the classification.

History: Laws 2023, ch. 114, § 16.

59A-23-25. Provider network adequacy.

A. An insurer shall maintain an adequate provider network to provide mental health or substance use disorder services.

B. The superintendent shall ensure access to mental health or substance use disorder services providers, including parity with medical and surgical services provider access, through regulation and review of claims processing, provider reimbursement procedures, network adequacy and provider reimbursement rate adequacy.

C. An insurer shall ensure that the process by which reimbursement rates for mental health and substance use disorder services are determined is comparable to and no more stringent than the process for reimbursement of medical or surgical benefits. In developing provider reimbursement rates, an insurer shall demonstrate that it has performed a comparability analysis of provider:

(1) reimbursement rates in surrounding states;

(2) reimbursement rates between mental health and substance use disorder providers and medical or surgical providers; and

(3) credentialing processes for mental health and substance use disorder providers and medical or surgical providers.

D. An insurer shall undertake all efforts, including increasing provider reimbursement rates through the processes and strategies described in Subsection C of this section, to ensure state-mandated network adequacy for the provision of mental health or substance use disorder services.

E. When in-network access to mental health or substance use disorder services is not reasonably available, an insurer shall provide access to out-of-network services with the same cost-sharing obligations to the insured as those required for in-network services.

History: Laws 2023, ch. 114, § 17.

59A-23-26. Utilization review of mental health or substance use disorder services.

A. An insurer shall, at least monthly, review and update the insurer's utilization review process to reflect the most recent evidence and generally recognized standards of care.

B. When performing a utilization review of mental health or substance use disorder services, including level of care placement, continued stay, transfer and discharge, an insurer shall apply criteria in accordance with generally recognized standards of care.

C. An insurer shall provide utilization review training to staff and contractors undertaking activities related to utilization review.

D. An insurer shall:

(1) develop utilization review policies regarding quantitative and non-quantitative limitations for mental health or substance use disorder services coverage that are no more restrictive than the utilization review policies regarding quantitative and non-quantitative limitations for medical and surgical care; and

(2) make utilization review policies available to providers or plan members.

History: Laws 2023, ch. 114, § 18.

59A-23-27. Prohibited exclusions of coverage for mental health or substance use disorder services.

An insurer shall not exclude provider prescribed coverage for mental health or substance use disorder services otherwise included in its coverage when:

A. it is available pursuant to federal or state law for individuals with disabilities;

B. it is otherwise ordered by a court or administrative agency;

C. it is available to an insured through a public benefit program; or

D. an insured has a concurrent diagnosis.

History: Laws 2023, ch. 114, § 19.

59A-23-28. Level of care determinations for the provision of mental health or substance use disorder services.

A. An insurer shall provide coverage for all in-network mental health or substance use disorder services, consistent with generally recognized standards of care, including placing an insured into a medically necessary level of care.

B. Changes in level and duration of care shall be determined by the insured's provider in consultation with the insurer.

C. Level of care determinations shall include placement of an insured into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility or an outpatient treatment program.

D. Level of care services for an insured with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the insured rather than arbitrary time limits.

History: Laws 2023, ch. 114, § 20.

59A-23-29. Coordination of care.

At the request of an insured, an insurer may facilitate communication between mental health or substance use disorder services providers and the insured's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the insured.

History: Laws 2023, ch. 114, § 21.

59A-23-30. Confidentiality provisions.

An insurer shall protect the confidentiality of an insured receiving mental health or substance use disorder services.

History: Laws 2023, ch. 114, § 22.

59A-23-31. Exceptions.

The provisions of Sections 14 through 22 [59A-23-22 to 59A-23-30 NMSA 1978] of this 2023 act do not apply to short-term plans subject to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978].

History: Laws 2023, ch. 114, § 23.

59A-23-32. Medical necessity and nondiscrimination standards for coverage of prosthetics and orthotics.

A. A group health plan that is delivered, issued for delivery or renewed in this state that covers essential health benefits or covers prosthetic and custom orthotic devices shall consider these benefits habilitative or rehabilitative benefits for purposes of state or federal requirements on essential health benefits coverage.

B. When performing a utilization review for a request for coverage of prosthetic or orthotic benefits, an insurer shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Such standards may be named by the superintendent in rule.

C. An insurer shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely based on an insured's actual or perceived disability.

D. An insurer shall not deny a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

E. A health benefits plan that is delivered, issued for delivery or renewed in this state that offers coverage for prosthetics and custom orthotic devices shall include language describing an insured's rights pursuant to Subsections C and D of this section in its evidence of coverage and any benefit denial letters.

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. A group health plan may impose cost sharing on prosthetic or custom orthotic devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. A group health plan that provides coverage for prosthetic or orthotic services shall ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the managed care plan's provider network located in the state. In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the insurer shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

H. If coverage for prosthetic or custom orthotic devices is provided, payment shall be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(1) a change in the physiological condition of the patient;

(2) an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than sixty percent of the cost of a replacement device or of the part being replaced.

I. Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

J. The provisions of this section do not apply to excepted benefits plans subject to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978].

History: Laws 2023, ch. 196, § 4.

ARTICLE 23A
Long-Term Care Insurance

59A-23A-1. Short title.

Chapter 59A, Article 23A NMSA 1978 may be cited as the "Long-Term Care Insurance Law".

History: Laws 1989, ch. 136, § 1; 1993, ch. 126, § 6.

59A-23A-2. Purpose.

The purpose of the Long-Term Care Insurance Law is to promote the public interest in and the availability of long-term care insurance policies, protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, establish standards for long-term care insurance, facilitate public understanding and comparison of long-term care insurance policies and facilitate flexibility and innovation in the development of long-term care insurance coverage.

History: Laws 1989, ch. 136, § 2; 1993, ch. 126, § 7.

59A-23A-3. Scope.

The provisions of the Long-Term Care Insurance Law shall apply to policies, certificates or riders delivered or issued for delivery in this state on or after July 1, 1989. The Long-Term Care Insurance Law is not intended to supersede any obligations of any entity to comply with the substance of any other provision of law, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance.

History: Laws 1989, ch. 136, § 3; 1993, ch. 126, § 8.

59A-23A-4. Definitions.

As used in the Long-Term Care Insurance Law:

A. "applicant" means:

(1) in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(2) in the case of a group long-term care insurance policy, the proposed certificate holder;

B. "certificate" means any certificate issued under a group long-term care insurance policy;

C. "group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(1) one or more employers or labor organizations established by one or more employers or labor organizations or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof of the labor organizations;

(2) any professional, trade or occupational association for its members or former or retired members, or a combination thereof, if the association:

(a) is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) has been maintained in good faith for purposes other than obtaining insurance;

(3) an association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the superintendent that the association or associations have at the outset a minimum of twenty-five persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provided that:

(a) the association or associations hold regular meetings not less than annually to further purposes of the members;

(b) except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c) the members have voting privileges and representation on the governing board and committees.

Sixty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the superintendent finds that the association or associations do not satisfy those organizational requirements; or

(4) a group other than as described in Paragraph (1), (2) or (3) of this subsection, subject to a finding by the superintendent that:

(a) the issuance of the group policy is not contrary to the best interest of the public;

(b) the issuance of the group policy would result in economies of acquisition or administration; and

(c) the benefits are reasonable in relation to the premiums charged;

D. "long-term care insurance" means any insurance coverage advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, including group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance, and policies or riders which provide for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health insurers; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this article;

E. "long-term care insurance policy" means an individual or group policy or an individual or group certificate of health insurance issued pursuant to the provisions of Chapter 59A, Articles 22, 23, 44, 46 and 47 NMSA 1978; and

F. "rider" means any additional long-term care coverage provision added to any type of policy by issuance of an amending document.

History: Laws 1989, ch. 136, § 4; 1993, ch. 126, § 9.

59A-23A-5. Extraterritorial jurisdiction; group long-term care insurance.

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Paragraph (4) of Subsection C of Section 59A-23A-4 NMSA 1978, unless the superintendent has determined prior to the offer that:

A. the coverage meets the requirements of Chapter 59A, Article 23A NMSA 1978 and any regulations pertaining thereto, or the insurance commissioner of another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in New Mexico has determined that such requirements have been met; and

B. the requirements of Section 59A-23-8 NMSA 1978 have been met.

History: 1978 Comp., § 59A-23A-5, enacted by Laws 1993, ch. 126, § 10.

59A-23A-6. Long-term care insurance; standards; requirements.

A. The superintendent may promulgate regulations in accordance with the provisions of Section 59A-2-9 NMSA 1978 that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, certificates and riders, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, levels of care, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

B. Long-term care insurance policies and certificates shall contain the standard provisions set forth in Sections 59A-22-2, 59A-22-4, 59A-22-8 through 59A-22-15, 59A-22-18, 59A-22-20, 59A-22-21, 59A-22-23, 59A-22-25, 59A-23-3, 59A-44-19, 59A-46-8 and 59A-47-24 NMSA 1978 and provisions concerning preexisting conditions in accordance with Section 59A-23A-7 NMSA 1978.

C. No long-term care insurance policy, certificate or rider shall:

(1) be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(3) provide coverage for skilled nursing care only;

(4) provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

(5) condition eligibility for any benefits on a prior hospitalization or institutionalization requirement or limit or restrict eligibility for any benefits based on such prior requirement or condition eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement;

(6) provide post-confinement, post-acute care or recuperative benefits unless such benefits are clearly labeled in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement; or

(7) condition eligibility of non-institutional benefits on the prior receipt of institutional care involving a stay of more than thirty days.

D. The superintendent may promulgate regulations in accordance with the provisions of Section 59A-2-9 NMSA 1978 establishing loss ratio standards, minimum reserve standards, nonforfeiture standards and rate stabilization standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the regulations.

E. A long-term care insurance policy, certificate or rider, except an employer group policy, certificate or rider, shall have a notice prominently printed on the first page of the policy, certificate or rider, or attached thereto, stating in substance that the policyholder or certificate holder has the right to return the policy, certificate or rider within thirty days of its delivery and to have the premium refunded within thirty days of the return of the policy, certificate or rider if, after examination of the policy, certificate or rider, the policyholder or certificate holder is not satisfied for any reason.

F. A certificate delivered or issued for delivery in this state shall include:

(1) a description of the principal benefits and coverage provided in the policy; and

(2) a statement of the principal exclusions, reductions and limitations contained in the policy.

G. No long-term care insurance policy, certificate or rider shall be advertised, marketed or offered as long-term care or nursing home insurance unless it complies with the provisions of the Long-Term Care Insurance Law.

H. Long-term care insurance policies, certificates and riders shall be filed in accordance with the provisions of Chapter 59A, Articles 18, 22, 23, 44, 46 and 47 NMSA 1978.

I. An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

J. The superintendent shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

K. In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

L. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

M. The outline of coverage shall include:

(1) a description of the principal benefits and coverage provided in the policy;

(2) a statement of the principal exclusions, reductions and limitations contained in the policy;

(3) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium; continuation or conversion provisions of group coverage shall be specifically described;

(4) a statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(5) a description of the terms under which the policy or certificate may be returned and premium refunded;

(6) a brief description of the relationship of cost of care and benefits; and

(7) a statement that the coverage afforded is not medicare supplement coverage.

N. A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

(1) a description of the principal benefits and coverage provided in the policy;

(2) a statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) a statement that the group master policy determines governing contractual provisions.

O. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount of benefits, the length of benefit and the guaranteed lifetime benefits if any, for each covered person;

(3) any exclusions, reductions and limitations on benefits of long-term care; and

(4) if applicable to the policy type, the summary shall also include:

(a) a disclosure of the effects of exercising other rights under the policy;

(b) a disclosure of guarantees related to long-term care costs of insurance charges; and

(c) current and projected maximum lifetime benefits.

P. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

(1) any long-term care benefits paid out during the month;

(2) an explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

(3) the amount of long-term care benefits existing or remaining.

History: Laws 1989, ch. 136, § 6; 1993, ch. 126, § 11.

59A-23A-7. Preexisting condition; definition; coverage.

A. No long-term care insurance policy, certificate or rider, including a group long-term care policy or certificate shall use a definition of preexisting condition that is more restrictive than the following: "preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

B. No long-term care insurance policy, certificate or rider, including a group long-term care policy, certificate or rider, shall exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

C. The definition of preexisting condition as provided in Subsection A of this section does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

D. In the policy, certificate or rider, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered within six months following the effective date of coverage of the insured person. No long-term care insurance policy, certificate or rider may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond six months following the effective date of coverage of the insured person.

History: Laws 1989, ch. 136, § 7.

59A-23A-8. Incontestability period.

A. For a policy or certificate that has been in force for less than six months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six months but less than two years an insurer may rescind a long-term care insurance policy or certificate or

deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

C. After a policy or certificate has been in force for two years it is not contestable upon the grounds of misrepresentation alone. Such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

D. No long-term care insurance policy or certificate may be field issued based on medical or health status. For purposes of this subsection, "field issued" means a policy or certificate issued by an agent or a third party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

History: 1978 Comp., § 59A-23A-8, enacted by Laws 1993, ch. 126, § 12.

59A-23A-9. Authority to promulgate regulations.

The superintendent shall promulgate regulations in accordance with the provisions of Section 59A-2-9 NMSA 1978 that include minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long-term care insurance.

History: 1978 Comp., § 59A-23A-9, enacted by Laws 1993, ch. 126, § 13.

59A-23A-10. Penalties.

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars ($10,000), whichever is greater.

History: 1978 Comp., § 59A-23A-10, enacted by Laws 1993, ch. 126, § 14.

59A-23A-11. Filing requirements for advertising.

A. Every issuer of long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state, whether through written, radio or television media, to the superintendent for review and approval. The advertisement shall comply with all applicable laws of this state and shall

be retained by the insurer for at least three years from the date the advertisement was first used.

B. Persons who market long-term care insurance policies, certificates or riders in this state shall not advertise any policies or certificates unless:

(1) the issuer of the policy certificate or rider has provided the superintendent with a copy of the advertisement; and

(2) the superintendent has reviewed and approved the advertisement.

History: 1978 Comp., § 59A-23A-11, enacted by Laws 1993, ch. 126, § 15.

59A-23A-12. Medicaid long-term care partnership program; certification of policies; rulemaking.

A. The superintendent shall certify an individual or group insurance policy, insurance plan or certificate of insurance to be qualified state long-term care insurance partnership program insurance when the policy, plan or certificate of insurance:

(1) covers an insured who was a resident of the state when coverage first became effective under the policy, plan or certificate;

(2) meets the definition of a qualified state long-term care insurance contract pursuant to Section 7702B(b) of the federal Internal Revenue Code of 1986;

(3) was not issued earlier than the effective date of the state plan amendment required pursuant to Section 2 [27-2-12.17 NMSA 1978] of this 2013 act;

(4) as of the date of purchase:

(a) is sold to an individual who is sixty years of age or younger and provides some level of inflation protection;

(b) is sold to an individual who is between sixty-one and seventy-five years of age and provides some level of inflation protection; or

(c) is sold to an individual who is over seventy-five years of age; and

(5) meets all other applicable federal and state laws relating to qualified state long-term care insurance partnership programs.

B. The superintendent shall adopt and promulgate rules establishing the procedures pursuant to which the superintendent shall certify an individual or group insurance policy, insurance plan, certificate of insurance or rider that is delivered, issued for

delivery or renewed in this state as qualified state long-term care insurance partnership program insurance.

C. The superintendent shall consult with the secretary of human services regarding the adoption of rules regarding reciprocity with respect to individuals who have purchased qualified state long-term care insurance partnership program insurance in another state participating in a qualified state long-term care insurance partnership program.

D. The superintendent shall ensure that any licensed producer that sells a policy, plan, certificate or rider pursuant to the Long-Term Care Insurance Law demonstrates an understanding of qualified state long-term care partnership program insurance and how it relates to other public and private coverage of long-term care expenses.

E. The superintendent shall establish by rule the disclosure requirements pursuant to Section 5 [59-23A-13 NMSA 1978] of this 2013 act regarding the qualified state long-term care partnership program for licensed producers that sell or offer for sale an insurance plan, insurance policy or certificate of insurance that is intended to qualify as long-term care partnership program insurance.

F. As used in this section:

(1) "licensed producer" means an agent, broker or reinsurance intermediary licensed pursuant to the applicable provisions of the Insurance Code; and

(2) "rider" means a long-term care coverage provision added to any type of insurance plan, insurance policy or certificate of insurance.

History: Laws 2013, ch. 139, § 4.

59A-23A-13. Licensed producers; qualified state long-term care partnership program; disclosures

A. A licensed producer that sells or offers for sale an insurance plan, insurance policy, certificate of insurance or rider that is intended to qualify as qualified state long-term care partnership program insurance shall disclose the availability of qualified state long-term care insurance partnership program insurance and outline the requirements and benefits of participation in the qualified state long-term care insurance partnership program.

B. As used in this section:

(1) "licensed producer" means an agent, broker or reinsurance intermediary licensed pursuant to the applicable provisions of the Insurance Code; and

(2) "rider" means a long-term care coverage provision added to any type of insurance plan, insurance policy or certificate of insurance.

History: Laws 2013, ch. 139, § 5.

ARTICLE 23B
Minimum Healthcare Protection (Repealed.)

59A-23B-1. Repealed.

History: Laws 1991, ch. 111, § 1; 2010, ch. 95, § 2; repealed by Laws 2019, ch. 259, § 22.

59A-23B-2. Repealed.

History: Laws 1991, ch. 111, § 2; repealed by Laws 2019, ch. 259, § 22.

59A-23B-3. Repealed.

History: Laws 1991, ch. 111, § 3; 1994, ch. 60, § 1; 1997, ch. 249, § 3; 1997, ch. 250, § 3; 2003, ch. 337, § 3; 2008, ch. 87, § 2; repealed by Laws 2019, ch. 259, § 22.

59A-23B-4. Repealed.

History: Laws 1991, ch. 111, § 4; 1994, ch. 60, § 2; repealed by Laws 2019, ch. 259, § 22.

59A-23B-5. Repealed.

History: Laws 1991, ch. 111, § 5; 2017, ch. 130, § 16; repealed by Laws 2019, ch. 259, § 22.

59A-23B-6. Repealed.

History: Laws 1991, ch. 111, § 6; 1994, ch. 60, § 3; 1997, ch. 22, § 2; 1997, ch. 243, § 21; 1998, ch. 41, § 3; 2010, ch. 95, § 3; repealed by Laws 2019, ch. 259, § 22.

59A-23B-7. Repealed.

History: Laws 1991, ch. 111, § 7; repealed by Laws 2019, ch. 259, § 22.

59A-23B-8. Repealed.

History: Laws 1991, ch. 111, § 8; repealed by Laws 2019, ch. 259, § 22.

59A-23B-9. Repealed.

History: Laws 1991, ch. 111, § 9; repealed by Laws 2019, ch. 259, § 22.

59A-23B-10. Repealed.

History: Laws 1991, ch. 111, § 10; 1994, ch. 64, § 6; repealed by Laws 2019, ch. 259, § 22.

59A-23B-10.1. Reserved.

59A-23B-10.2. Repealed.

History: 1978 Comp., § 59A-23B-10.2, enacted by Laws 1994, ch. 64, § 7; repealed by Laws 2019, ch. 259, § 22.

59A-23B-11. Repealed.

History: Laws 1991, ch. 111, § 11; repealed by Laws 2019, ch. 259, § 22.

59A-23B-12. Repealed.

History: Laws 2003, ch. 252, § 2; repealed by Laws 2019, ch. 259, § 22.

ARTICLE 23C
Small Group Rate and Renewability

59A-23C-1. Short title.

Chapter 59A, Article 23C NMSA 1978 may be cited as the "Small Group Rate and Renewability Act".

History: Laws 1991, ch. 153, § 1; 1994, ch. 75, § 29.

59A-23C-2. Purpose of act.

The purpose of the Small Group Rate and Renewability Act is to promote the continuing availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals and to improve the efficiency and fairness of the small group health insurance marketplace.

History: Laws 1991, ch. 153, § 2.

59A-23C-3. Definitions.

As used in the Small Group Rate and Renewability Act:

A. "actuarial certification" means a written statement by a member of the American academy of actuaries or another individual acceptable to the superintendent that a small employer carrier is in compliance with the provisions of Section 59A-23C-5 NMSA 1978, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans;

B. "base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

C. "carrier" 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;

D. "case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, that are considered by the carrier in the determination of premium rates for the small employer, but "case characteristics" does not include claim experience, health status and duration of coverage since issue;

E. "class of business" means all small employers as shown on the records of the small employer carrier. A separate class of business may be established by the small employer carrier on the basis that the applicable health benefit plans have been acquired from another small employer carrier as a distinct grouping of plans;

F. "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;

(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 Insurance Pool Act [Medical Insurance Pool Act] [Chapter 59A, Article 54 NMSA 1978];

(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;

G. "department" means the department of insurance;

H. "group health plan" means an employee welfare benefit plan as defined Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and including 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;

I. "health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract or health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental or disability income insurance, medicare supplement coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance or automobile medical-payment insurance;

J. "index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

K. "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 8 and 9 [59A-23A-8 and 59A-23A-9 NMSA 1978] of the Health Insurance Portability Act;

L. "new business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

M. "rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier;

N. "small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during either of the two preceding years, employed no less than two and no more than fifty eligible employees; provided that:

(1) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(2) companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state income taxation shall be considered one employer; and

(3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year;

O. "small employer carrier" means any insurer that offers health benefit plans covering the employees of a small employer; and

P. "superintendent" means the superintendent of insurance.

History: Laws 1991, ch. 153, § 3; 1994, ch. 75, § 30; 1997, ch. 243, § 22.

59A-23C-4. Health insurance plans subject to the Small Group Rate and Renewability Act.

A. Except as provided in Subsections B and C of this section, the provisions of the Small Group Rate and Renewability Act apply to any health benefit plan that provides coverage to one or more employees of a small employer.

B. The provisions of the Small Group Rate and Renewability Act shall not apply to individual health insurance policies that are subject to policy form and premium rate approval as provided in Section 59A-18-12, 59A-18-13, 59A-44-16, 59A-46-8, 59A-47-25 or 59A-47-26 NMSA 1978.

C. Any policies or certificates of a master policy that because of solicitation by agents or through the mail or mass media advertising are treated as individual policies and subject to the approvals stated in Subsection B of this section.

History: Laws 1991, ch. 153, § 4.

59A-23C-5. Repealed.

History: Laws 1991, ch. 153, § 5; 1994, ch. 75, § 31; 1997, ch. 243, § 23; repealed by Laws 2019, ch. 259, § 22.

59A-23C-5.1. Adjusted community rating.

A. A health benefit plan that is offered by a carrier to a small employer shall be offered without regard to the health status of any individual in the group, except as provided in the Small Group Rate and Renewability Act. The only rating factors that may be used to determine the initial year's premium charged a group, subject to the maximum rate variation provided in this section for all rating factors, are the group members':

(1) ages;

(2) geographic areas of the place of employment; or

(3) smoking practices.

B. Separately for an insurer's individual and group policies, no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under nineteen years of age or children nineteen to twenty-five years of age who are full-time students may have rates that are lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, multiple employer welfare arrangement, fraternal benefit society, health maintenance organization or nonprofit health care plan from offering rates that differ depending upon family composition. For the purposes of this subsection, "family composition" refers only to whether coverage covers an individual or a family.

C. The superintendent shall adopt and promulgate rules to implement the provisions of this section.

History: Laws 1994, ch. 75, § 33; 1997, ch. 22, § 3; 1997, ch. 243, § 24; 1998, ch. 41, § 4; 2010, ch. 95, § 4; 2019, ch. 259, § 5.

59A-23C-6. Provisions on renewability of coverage.

A. Except as provided in Subsection B of this section, a health benefit plan subject to the Small Group Rate and Renewability Act shall be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons:

(1) nonpayment of required premiums;

(2) fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or that individual's representative;

(3) noncompliance with plan provisions;

(4) the number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; or

(5) the small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

Eligibility classifications may not be changed if any individual is eliminated, due to the change, who was insured immediately prior to the change without first receiving the approval of the superintendent.

B. A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the superintendent in each state in which an affected insured individual is known to reside at least ninety days prior to termination of coverage. A carrier which exercises its right to cease to renew all plans in a class of business shall not:

(1) establish a new class of business for a period of five years after the nonrenewal of the plans without prior approval of the superintendent; or

(2) transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the insurer offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

C. A small employer carrier may not change eligibility classifications upon renewal or replacement within twelve months of its termination of its own coverage if the change in classification eliminates from coverage any individual who was insured previous to the change and would have continued to be insured if the change in eligibility had not occurred.

History: Laws 1991, ch. 153, § 6.

59A-23C-7. Disclosure of rating practices and renewability provisions.

Each small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following:

A. the provisions concerning the carriers' right to change premium rates and the factors that affect changes in premium rates; and

B. the provisions relating to renewability of coverage.

History: Laws 1991, ch. 153, § 7; 2019, ch. 259, § 6.

59A-23C-7.1. Repealed.

History: Laws 1994, ch. 75, § 32; 1997, ch. 243, § 25; repealed by Laws 2019, ch. 259, § 22.

59A-23C-8. Maintenance of records.

A. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

B. Each small employer carrier shall file each March 1 with the superintendent an actuarial certification that the carrier is in compliance with this section and that the rating methods of the insurer are actuarially sound. The certification shall include the index rate for all classes of business as of January 1. A copy of the certification shall be retained by the insurer at its principal place of business.

C. A small employer carrier shall make the information and documentation described in Subsection A of this section available to the superintendent upon request. The information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the superintendent to persons outside of the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

D. Each small employer carrier shall maintain at its principal place of business a complete copy of the disclosure of rating practices and renewability provided to the small employer for a period of three years during which time it shall be available to the superintendent upon request.

History: Laws 1991, ch. 153, § 8.

59A-23C-8.1. Employer utilization and loss data availability.

Employer claims information, including utilization and loss experience under health insurance under a group health plan, a health benefit plan or a plan provided under Chapter 59A, Article 23C NMSA 1978 shall be made available only upon the request of and to employers of employees with such coverage within sixty days of an employer's written request to the carrier for such information, provided the employer's coverage

extends to no less than twenty-five individual employees, regardless of whether family coverage is included. In providing such utilization data, carriers shall not reveal information that permits identification of an individual insured or the insured's family or the specific conditions for which coverage was provided.

History: Laws 2003, ch. 252, § 3.

59A-23C-9. Discretion of the superintendent.

The superintendent may suspend all or any part of Section 5 [59A-23C-5 NMSA 1978] of the Small Group Rate and Renewability Act as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the superintendent that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health benefits.

History: Laws 1991, ch. 153, § 9.

59A-23C-10. Health insurers; direct services.

A. A health insurer shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines 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. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

B. An insurer that fails to comply with the eighty-five percent reimbursement requirement in Subsection A of this section shall issue a dividend or credit against future premiums to all policyholders in an amount sufficient to assure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits equal eighty-five percent of the premiums collected in 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 the requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

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

D. 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 [Chapter 59A, Article 54 NMSA 1978]; 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 but does not include a person that only issues a limited-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; and

(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 [7-40-1 to 7-40-10 NMSA 1978] and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance.

History: Laws 2010, ch. 94, § 2; 2013, ch. 74, § 28; 2018, ch. 57, § 21.

ARTICLE 23D
Medical Care Savings Accounts

59A-23D-1. Short title.

Chapter 59A, Article 23D NMSA 1978 may be cited as the "Medical Care Savings Account Act".

History: Laws 1995, ch. 93, § 1; 1997, ch. 243, § 26; 1997, ch. 254, § 1.

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 [Chapter 59A NMSA 1978]; 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.

History: Laws 1995, ch. 93, § 2; 1997, ch. 243, § 27; 1997, ch. 254, § 2; 2003, ch. 391, § 4; 2013, ch. 74, § 29; 2021, ch. 108, § 25.

59A-23D-3. Account administrator; registration with department; department powers and duties.

A. An account administrator shall register annually with the department and pay an annual registration fee of twenty-five dollars ($25.00). The registration fee shall be deposited in the general fund. Registration as an account administrator does not affect the regulation of a bank, savings and loan association, credit union, trust company or insurance company as otherwise provided by law.

B. An account administrator shall provide to the department annually a list of the employers for whom it provides account administration and the number of employees and dependents for whom it administers accounts. The information shall be provided in the form requested by the department. The department may request other information it deems appropriate from the account administrator; provided, however, that the department shall not request any information about an individual employee or dependent unless a complaint has been filed with the department by that employee or dependent and the information is required to investigate the complaint.

C. The department may receive, investigate and settle complaints about medical care savings accounts and account administrators or it may refer complaints to other appropriate agencies.

D. The department, beginning January 1, 1998, shall adjust annually the deductible for qualified higher deductible health plans to reflect the adjustment allowed by the Internal Revenue Code of 1986 for medical savings accounts.

History: Laws 1995, ch. 93, § 3; 1997, ch. 243, § 28; 1997, ch. 254, § 3.

59A-23D-4. Medical care savings account program.

A. Except as otherwise provided by statute, contract or collective bargaining agreement, an employer may establish a medical care savings account program for his employees.

B. In establishing the program, the employer shall:

(1) provide a qualified higher deductible health plan for the benefit of his employees;

(2) contribute to medical care savings accounts for the employees; and

(3) appoint an account administrator to administer the savings accounts.

C. Principal contributed to and interest earned on a medical care savings account and money paid for eligible medical expenses are exempt from taxation under the Income Tax Act [Chapter 7, Article 2 NMSA 1978].

D. Before establishing a program, the employer shall notify all employees in writing of the federal tax status of the program and how federal income taxation affects New Mexico income taxes.

E. Any compensation required by the account administrator to administer the program shall be paid by the employer, and the employer shall not require the employee to contribute to such compensation while the employee participates in the program. If the employee ceases to participate in the program, he shall be responsible for costs associated with his account.

F. Nothing in the Medical Care Savings Account Act prohibits the employer from requiring the employee to contribute to the qualified higher deductible health plan or the medical care savings account.

G. Nothing in the Medical Care Savings Account Act requires an employee to participate in a program. The employer shall offer the program to all employees on a nondiscriminatory basis.

History: Laws 1995, ch. 93, § 4; 2001, ch. 194, § 1.

59A-23D-5. Account administrator; employer and employee responsibilities.

A. An employer, in conjunction with an account administrator, shall provide a current written statement to employees that details how money in their medical care savings

accounts is or will be invested and the rate of return employees may reasonably anticipate on the investment of the savings accounts. The account administrator shall file the statement with the department.

B. Except as provided in Section 59A-23D-6 NMSA 1978, money in a savings account shall be used solely for the purpose of paying the eligible medical expenses of an employee and his dependents.

C. Payments may be made by the employee directly to a health care provider through the use of a debit card or check that accesses the employee's medical savings account. If the account administrator determines that the employee paid for goods or services that do not qualify as eligible medical expenses, the employee shall be required to reimburse his medical savings account, and he shall be liable for any federal and state taxes and penalties. If the employee chooses to be reimbursed for eligible medical expenses, the account administrator shall reimburse the employee from the employee's medical care savings account. When seeking reimbursement, the employee shall submit documentation of eligible medical expenses paid by the employee.

D. If an employer makes contributions to a program on a periodic installment basis, the employer may advance to an employee, interest free, an amount necessary to cover eligible medical expenses incurred that exceed the amount in the employee's savings account if the employee agrees to repay the advance from future installments or when he ceases to be an employee of the employer or a participant in the program. Such advances shall be exempt from taxation under the Income Tax Act [Chapter 7, Article 2 NMSA 1978].

History: Laws 1995, ch. 93, § 5; 1997, ch. 243, § 29; 1997, ch. 254, § 4; 2001, ch. 194, § 2.

59A-23D-6. Withdrawals.

A. An employee may withdraw money without penalty from his medical care savings account for a purpose other than payment of eligible medical expenses when the employee attains the age specified in Section 1811 of the Social Security Act. An employee may also withdraw money without penalty for payment of coverage for:

(1) a health plan during any period of continuation coverage required under any federal law;

(2) a qualified long-term care insurance contract as defined by Section 7702B(6) of the Internal Revenue Code of 1986; or

(3) a health plan during a period in which the person is receiving unemployment compensation under any federal or state law.

B. Except as provided in Subsection A of this section, if an employee withdraws money from the employee's medical care savings account that is not used exclusively to pay eligible medical expenses of the employee or a dependent, it shall be included in the gross income of the employee for taxation purposes.

C. Except as provided in Subsection A of this section, if an employee withdraws money from the employee's medical care savings account for a purpose other than a rollover to a new account administrator:

(1) the amount of the withdrawal shall be considered gross income to the employee and subject to taxation; and

(2) the administrator shall also consider as a withdrawal on behalf of the employee a penalty equal to fifteen percent of the amount of the withdrawal and shall consider this as gross income to the employee for taxation purposes.

D. If a person is no longer employed by an employer that participates in a program or if an employee chooses to cease participating in the program, the person or employee shall, within sixty days of his final day of employment or participation:

(1) request, in writing, the rollover of his savings account to a new account administrator;

(2) request, in writing, that the former employer's account administrator continue to administer the savings account, including in the request an agreement to pay the cost, if any, of account administration on that savings account; or

(3) withdraw the money from the savings account subject to the provisions of Subsection C of this section, if the withdrawal is not for the purpose of a rollover when within sixty days of the receipt of the funds they are placed with a new account administrator.

E. No more than sixty days after the date of notification by the employee pursuant to Subsection D of this section, the account administrator shall:

(1) transfer the savings account to a new account administrator as requested;

(2) agree, in writing, to continue to act as the account administrator for the savings account; or

(3) mail a check to the person or employee at his last known address for the amount in the account as of the day the check was issued.

F. Upon the death of an employee, the account administrator shall distribute the principal and accumulated interest of the savings account to the estate of the employee.

History: Laws 1995, ch. 93, § 6; 1997, ch. 243, § 30; 1997, ch. 254, § 5; 2001, ch. 194, § 3.

59A-23D-7. Report.

A. The superintendent shall report to the legislature on or before December 1, 1999 on the availability of health care coverage pursuant to the Medical Care Savings Account Act and the market share of programs in comparison with traditional employer-provided health insurance programs; the results of a survey of employer and employee satisfaction with programs; and the results of a loss ratio study relative to programs.

B. The superintendent shall adopt and promulgate regulations for enforcing and administering the provisions of the Medical Care Savings Account Act.

History: Laws 1995, ch. 93, § 7; 1997, ch. 243, § 31; 1997, ch. 254, § 6.

ARTICLE 23E
Health Insurance Portability

59A-23E-1. Short title.

Chapter 59A, Article 23E NMSA 1978 may be cited as the "Health Insurance Portability Act".

History: Laws 1997, ch. 243, § 1; 1998, ch. 41, § 5.

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 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;

(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 Medical Insurance Pool Act [Chapter 59A, Article 54 NMSA 1978];

(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;

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 benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care or any 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 insurance coverage offered in connection with a group health plan or any other health insurance subject to the provisions of Chapter 59A, Article 23 NMSA 1978;

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 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 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 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 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.

History: Laws 1997, ch. 243, § 2; 1998, ch. 41, § 6; 2019, ch. 259, § 7.

59A-23E-3. Limitation on preexisting condition exclusion period.

A health insurance issuer or health benefits plan offering group health insurance, blanket health insurance or individual health insurance shall not impose any preexisting condition exclusion with respect to that health insurance plan or coverage. A health insurance issuer or health insurance plan offering group health insurance, blanket health insurance or individual health insurance shall not impose a waiting period in excess of ninety days with respect to a health insurance plan or coverage.

History: Laws 1997, ch. 243, § 3; 1998, ch. 41, § 7; 2019, ch. 259, § 8.

59A-23E-4. Repealed.

History: Laws 1997, ch. 243, § 4; 1998, ch. 41, § 8; repealed by Laws 2019, ch. 259, § 22.

59A-23E-5. Repealed.

History: Laws 1997, ch. 243, § 5; 1998, ch. 41, § 9; 2008, ch. 87, § 3; repealed by Laws 2019, ch. 259, § 22.

59A-23E-6. Repealed.

History: Laws 1997, ch. 243, § 6; 1998, ch. 41, § 10; repealed by Laws 2019, ch. 259, § 22.

59A-23E-7. Repealed.

History: Laws 1997, ch. 243, § 7; 1998, ch. 41, § 11; repealed by Laws 2019, ch. 259, § 22.

59A-23E-8. Group health plan; group health insurance; special enrollment periods for individuals losing other coverage.

A. group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee who is eligible but not enrolled for coverage under the terms of the plan, or a dependent of the employee if the dependent is eligible but not enrolled for coverage, to enroll for coverage under the terms of the plan if:

(1) the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

(2) the employee stated in writing at the time coverage was offered that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement at the time and provided the employee with notice of that requirement and the consequences of the requirement at the time;

(3) the employee's or dependent's coverage described in Paragraph (1) of this subsection was:

(a) under a COBRA continuation provision and the coverage under that provision was exhausted; or

(b) not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated; and

(4) under the terms of the plan, the employee requested enrollment not later than thirty days after the date of exhaustion of coverage described in Subparagraph (a) of Paragraph (3) of this subsection or termination of coverage or employer contribution described in Subparagraph (b) of Paragraph (3) of this subsection.

B. A group health plan or a health insurance issuer offering group health insurance plan coverage shall permit an eligible enrollee to enroll for coverage under the terms of the plan if either of the following conditions is met:

(1) the eligible enrollee's medical assistance provided pursuant to the Public Assistance Act is terminated; or

(2) the eligible enrollee becomes eligible for medical assistance, with respect to coverage under the group health plan or health insurance plan, under such medicaid plan or state child health plan, including under any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the group health plan or health insurance plan not later than sixty days after the date the employee or dependent is determined to be eligible for such assistance.

C. As used in this section, "eligible enrollee" means an employee or dependent of an employee who is eligible, but not enrolled, for coverage under the terms of an employer's group health plan.

History: Laws 1997, ch. 243, § 8; 1998, ch. 41, § 12; 2019, ch. 259, § 9.

59A-23E-9. Group health plan; special enrollment periods for dependent beneficiaries.

A. A group health plan shall provide for a dependent special enrollment period described in Subsection B of this section during which a person may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage, if:

(1) the plan makes coverage available to a dependent of an individual;

(2) the individual is a participant under the plan or has met any waiting period applicable to becoming a participant and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

(3) the person has become the dependent of the individual through marriage, birth, adoption or placement for adoption.

B. A dependent special enrollment period pursuant to this subsection shall be for a period of not less than thirty days and shall begin on the later of:

(1) the date dependent coverage is made available; or

(2) the date of the marriage, birth, adoption or placement for adoption described in Subsection A of this section.

C. If an individual seeks to enroll a person as a dependent during the first thirty days of a dependent special enrollment period, the coverage of the dependent becomes effective:

(1) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(2) in the case of birth, as of the date of the birth; or

(3) in the case of adoption or placement for adoption, the date of the adoption or placement.

History: Laws 1997, ch. 243, § 9; 1998, ch. 41, § 13.

59A-23E-10. Group health plan; group health insurance; use of affiliation period by health maintenance organizations as alternative to preexisting condition exclusion.

A. A health maintenance organization that offers health insurance coverage in connection with a group health plan and does not impose any preexisting condition exclusion allowed pursuant to Section 59A-23E-3 NMSA 1978 with respect to any particular coverage option may impose an affiliation period for the coverage option if that period:

(1) is applied uniformly without regard to any health status related factors; and

(2) does not exceed two months, or three months in the case of a late enrollee.

B. During an affiliation period, a health maintenance organization is not required to provide health care services or benefits to a participant or beneficiary, and it shall not charge a premium to a participant or beneficiary for any coverage.

C. An affiliation period begins to run on the enrollment date and shall run concurrently with any waiting period under the plan.

D. A health maintenance organization described in Subsection A of this section may use alternative methods different from those described in that subsection to address adverse selection as approved by the superintendent.

History: Laws 1997, ch. 243, § 10; 1998, ch. 41, § 14.

59A-23E-11. Prohibiting discrimination based on health status against individual participants and beneficiaries.

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not establish rules for eligibility or continued eligibility of any individual to enroll or continue to participate in a health plan, or eligibility or continued

eligibility for benefits, based on any of the following factors in relation to the individual or a dependent of the individual:

A. health status;

B. medical condition, including both physical and mental illnesses;

C. claims experience;

D. receipt of health care;

E. medical history;

F. genetic information;

G. evidence of insurability, including conditions arising out of acts of domestic violence;

H. disability;

I. gender;

J. national origin;

K. sexual orientation; or

L. any other health status-related factor that the superintendent specifies in rules of the office of superintendent of insurance.

History: Laws 1997, ch. 243, § 11; 1998, ch. 41, § 15; 2019, ch. 259, § 10.

59A-23E-12. Prohibiting discrimination based on health status against individual participants and beneficiaries in premium contributions.

A. A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not require an individual as a condition of enrollment or continued enrollment under the plan to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of the health status related factor in relation to the individual or a person enrolled under the plan as a dependent of the individual.

B. The provisions of Subsection A of this section shall not be construed to:

(1) restrict the amount that an employer or an individual may be charged for coverage under a group health plan or individual health coverage; or

(2) prevent a group health plan or a health insurance issuer offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

C. A group health benefits plan or a health insurance issuer that offers group health insurance coverage in connection with a group health benefits plan shall not adjust premiums or contribution amounts for the group covered under the plan on the basis of genetic information.

History: Laws 1997, ch. 243, § 12; 1998, ch. 41, § 16; 2019, ch. 259, § 11.

59A-23E-13. Health insurance issuers; guaranteed availability of coverage; exceptions for network plans, insufficient financial capacity and bona fide associations; employer contribution rules.

A. Except as provided in Subsections C through E of this section, a health insurance issuer that offers health insurance coverage in the individual or small group markets shall:

(1) accept every individual or employer that applies for coverage;

(2) accept for enrollment under the offered coverage an eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan or during an open or special enrollment period as specified in rules of the office of superintendent of insurance; and

(3) not place a restriction on an eligible individual being a participant or a beneficiary that is inconsistent with Sections 59A-23E-11 and 59A-23E-12 NMSA 1978.

B. The superintendent shall adopt and promulgate rules relating to enrollment periods.

C. A health insurance issuer that offers health insurance coverage in the group or individual markets through a network plan may:

(1) limit the employers or individuals that may apply for the coverage to those with eligible individuals who live, work or reside in the service area for the network plan; and

(2) within the service area of the network plan, deny coverage to individuals or employers within the service area for the network plan if the issuer has demonstrated to the superintendent that it:

(a) will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing individuals, group contract holders and enrollees; and

(b) is applying this exception uniformly to all employers and individuals without regard to the claims experience of those individuals or those employers, their employees and their dependents or any health status related factor relating to those individuals, employees and dependents.

D. A health insurance issuer, upon denying insurance coverage in any service area pursuant to the provisions of Subsection C of this section, shall not offer coverage in the group market or individual market within the service area for a period of one hundred eighty days after the date coverage is denied.

E. A health insurance issuer may deny health insurance coverage in the individual and group markets if the issuer has demonstrated to the superintendent that it:

(1) does not have the financial reserves necessary to underwrite additional coverage; and

(2) is applying this exception uniformly to all individuals, employers and their employees in the individual and group markets in the state consistent with state law and without regard to the claims experience of those individuals, employers, their employees and their dependents or any health status related factor relating to those individuals, employees and dependents.

F. A health insurance issuer, upon denying health insurance coverage in accordance with Paragraphs (1) and (2) of Subsection E of this section, shall not offer coverage in the group or individual markets in the state for a period of one hundred eighty days after the date the coverage is denied or until the issuer has demonstrated to the superintendent that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later. The superintendent may provide for the application of this subsection on a service-area-specific basis.

G. As used in this section, "eligible individual" means, with respect to a health insurance issuer offering an individual or group health plan, an individual whose eligibility shall be determined:

(1) in accordance with the terms of the plan;

(2) as provided by the issuer under the rules of the issuer that are uniformly applicable in the state to the individual and group markets; and

(3) in accordance with New Mexico Insurance Code provisions governing the issuer and the small group market.

History: Laws 1997, ch. 243, § 13; 1998, ch. 41, § 17; 2019, ch. 259, § 12.

59A-23E-14. Health insurance issuers; guaranteed availability of coverage.

A. Except as provided in Subsections B through F of this section, a health insurance issuer that offers health insurance coverage in the individual or group markets shall renew or continue that coverage in force at the option of the plan sponsor or the individual.

B. A health insurance issuer may refuse to renew or may discontinue health insurance coverage offered pursuant to Subsection A of this section if:

(1) the plan sponsor or individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) the plan sponsor or individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the coverage;

(3) the issuer is ceasing to offer coverage in the market in accordance with Subsection C of this section; or

(4) in the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with that plan who lives, resides or works in the service area of the issuer or the area for which the issuer is authorized to do business and the issuer would deny enrollment with respect to the network plan pursuant to Paragraph (1) of Subsection C of Section 59A-23E-13 NMSA 1978.

C. A health insurance issuer may discontinue offering a particular type of individual or group health insurance coverage offered in the group or individual markets only if:

(1) the issuer provides notice to each plan sponsor or individual provided coverage of this type in the market and to the participants and beneficiaries covered under the coverage of the discontinuation at least ninety days prior to the date of the discontinuation;

(2) the issuer offers to a plan sponsor or individual provided coverage of this type in the market the option to purchase any other health insurance plan coverage currently being offered by the issuer in that market; and

(3) in exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to Paragraph (2) of this subsection, the issuer acts uniformly without regard to the claims experience of those sponsors or individuals or

any health status related factors relating to any participants or beneficiaries who may become eligible for that coverage.

D. If a health insurance issuer elects to discontinue offering all health insurance coverage in the individual or group markets, coverage may be discontinued only if:

(1) the issuer provides notice to the superintendent and to each plan sponsor or to the individual and participants and beneficiaries covered under that coverage of the discontinuation at least one hundred eighty days prior to the date of discontinuation; and

(2) all health insurance issued or delivered for issuance in the state in the market is discontinued and coverage is not renewed.

E. After discontinuation pursuant to Subsection D of this section, the health insurance issuer shall not provide for the issuance of any health insurance coverage in the market involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

F. At the time of coverage renewal pursuant to Subsection A of this section, a health insurance issuer may modify the coverage for a policy form offered to a group or individual if the modification is effective on a uniform basis among all groups or individuals, as applicable, with that policy form.

History: Laws 1997, ch. 243, § 14; 1998, ch. 41, § 18; 2019, ch. 259, § 13.

59A-23E-15. Disclosure of information by health insurance issuers.

A. A health insurance issuer when offering health insurance coverage to an employer or individual shall:

(1) make a reasonable disclosure to the small employer or individual as part of its solicitation and sales materials, of the availability of information described in Subsection B of this section; and

(2) upon request of the employer or individual provide the information described.

B. Except as provided in Subsection D of this section, a health insurance issuer offering a health plan to an employer or individual shall provide information pursuant to Subsection A of this section concerning:

(1) the provisions of coverage concerning the issuer's right to change premium rates and the factors that may affect changes in premium rates;

(2) the provisions of coverage relating to renewability of coverage; and

(3) the benefits and premiums available under all health insurance coverage for which the small employer is qualified.

C. Information furnished pursuant to this section shall be provided to employers or individuals in a manner determined to be understandable by the average employer or individual and shall be sufficient to reasonably inform employers or individuals of their rights and obligations under the health insurance coverage.

D. A health insurance issuer is not required by this section to disclose information that is proprietary and trade secret information.

History: Laws 1997, ch. 243, § 15; 1998, ch. 41, § 19; 2019, ch. 259, § 14.

59A-23E-16. Exclusions, limitations and exceptions for certain group health plans and group health insurance.

A. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to any group retiree health plan and health insurance coverage offered in connection with a group retiree health plan if, on the first day of the plan year, the plan has fewer than two employees who are current employees.

B. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 shall not apply with respect to a group health plan or group retiree health plan that is a nonfederal governmental plan if the plan sponsor makes an election under the provisions of this subsection in conformity with regulations of the federal secretary of health and human services. The period of an election for exclusion made pursuant to this subsection is for a single specified plan year or, in the case of a plan provided pursuant to a collective bargaining agreement, for the term of the agreement. The plan for which an election is made shall provide under the terms of the election for:

(1) notice to enrollees on an annual basis and at the time of enrollment of the facts and consequences of the election; and

(2) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with Section 59A-23E-7 NMSA 1978 [repealed].

C. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to a group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (9) of Subsection L of Section 59A-23E-2 NMSA 1978 if the benefits are:

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

(2) otherwise not an integral part of the plan.

D. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to any group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (10) of Subsection L of Section 59A-23E-2 NMSA 1978 if:

(1) the benefits are provided under a separate policy, certificate or contract of insurance;

(2) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(3) the benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health plan maintained by the same plan sponsor.

E. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to any group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (11) of Subsection L of Section 59A-23E-2 NMSA 1978 if the benefits are provided under a separate policy, certificate or contract of insurance.

History: Laws 1997, ch. 243, § 16; 1998, ch. 41, § 20; 2019, ch. 259, § 15.

59A-23E-17. Treatment of partners and self-employed individuals in connection with group health plans.

A. Any plan, fund or program that would not be an employee welfare benefit plan, except for the provisions of this section, that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care to current or former partners in the partnership or to their dependents directly or through insurance, reimbursement or otherwise, shall be treated as an employee welfare benefit plan that is a group health plan.

B. As used in this section:

(1) "employer" includes a partnership in relation to a partner; and

(2) "participant" includes:

(a) in connection with a group health plan maintained by a partnership, an individual who is a partner in relationship to the partnership; and

(b) in connection with a group health plan maintained by a self-employed individual under which one or more employees are participants, the self-employed individual, if he or his beneficiaries are or may become eligible to receive a benefit under the plan.

History: Laws 1997, ch. 243, § 17; 1998, ch. 41, § 21.

59A-23E-18. Requirement for mental health benefits in an individual or group health plan, or group health insurance offered in connection with the plan, for a plan year of an employer.

A. A group health plan or group or individual health insurance shall not impose treatment limitations or financial restrictions, limitations or requirements on the provision of mental health benefits that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on coverage of benefits for other conditions.

B. As used in this section, "mental health benefits" means mental health benefits as described in the group health plan or group health insurance offered in connection with the plan.

History: 1978 Comp., § 59A-23E-18, enacted by Laws 2000, ch. 6, § 1; 2019, ch. 259, § 16; 2023, ch. 114, § 24.

59A-23E-19. Individual health insurance coverage; guaranteed renewability; exceptions.

A. Except as otherwise provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue that coverage in force at the option of the individual.

B. A health insurance issuer may refuse to renew or discontinue health insurance coverage of an individual in the individual market if:

(1) the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) the individual has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage;

(3) the issuer is ceasing to offer coverage in the individual market in accordance with Subsection C of this section;

(4) in the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer lives, resides or works in the service area of the issuer or the area for which the issuer is authorized to do business but only if the coverage is terminated pursuant to this paragraph uniformly without regard to any health status related factor of covered individuals; and

(5) in the case of health insurance coverage that is made available to the individual market only through one or more bona fide associations, the membership of the individual in the association on the basis of which the coverage is provided ceases, but only if the coverage is terminated pursuant to this paragraph uniformly without regard to any health status related factor of covered individuals.

C. A health insurance issuer may discontinue offering a particular type of group health insurance coverage offered in the individual market only if:

(1) the issuer provides notice to each covered individual provided coverage of this type in the market of the discontinuation at least ninety days prior to the date of the discontinuation;

(2) the issuer offers to each individual in the individual market provided coverage of this type the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in that market; and

(3) in exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to Paragraph (2) of this subsection, the issuer acts uniformly without regard to any health status related factor of enrolled individuals or individuals who may become eligible for that coverage.

D. If a health insurance issuer elects to discontinue offering all health insurance coverage, the individual coverage may be discontinued only if:

(1) the issuer provides notice to the superintendent and to each individual of the discontinuation at least one hundred eighty days prior to the date of the expiration of the coverage; and

(2) all health insurance issued or delivered for issuance in the state in the market is discontinued and coverage is not renewed.

E. After discontinuation pursuant to Subsection D of this section, the health insurance issuer shall not provide for the issuance of any health insurance coverage in the market involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

F. At the time of coverage renewal pursuant to Subsection A of this section, a health insurance issuer may modify the coverage for a policy form offered to individuals

in the individual market if the modification is consistent with law and effective on a uniform basis among all individuals with that policy form.

G. If health insurance coverage is made available by a health insurance issuer in the individual market to an individual only through one or more associations, a reference to an "individual" is deemed to include a reference to that association.

History: 1978 Comp., § 59A-23E-19, enacted by Laws 1998, ch. 41, § 23.

59A-23E-20. Certification of coverage by issuers in the individual market.

The provisions of Section 59A-23E-7 NMSA 1978 [repealed] apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

History: 1978 Comp., § 59A-23E-20, enacted by Laws 1998, ch. 41, § 24.

ARTICLE 23F
New Mexico Health Insurance Exchange

59A-23F-1. Short title.

Chapter 59A, Article 23F NMSA 1978 may be cited as the "New Mexico Health Insurance Exchange Act".

History: Laws 2013, ch. 54, § 1; 2020, ch. 35, § 1.

59A-23F-2. Definitions.

As used in the New Mexico Health Insurance Exchange Act:

A. "board" means the board of directors of the exchange;

B. "bronze plan" means a level of coverage that is designed to provide benefits that are actuarially equivalent to sixty percent of the full actuarial value of the benefits provided under a health benefit plan or the allowable value for a bronze plan as defined by federal regulation;

C. "enrollee" means:

(1) a qualified individual or qualified employee enrolled in a qualified health plan;

(2) the dependent of a qualified employee enrolled in a qualified health plan through the small business health options program;

(3) a person who is enrolled in a qualified health plan through the small business health options program, consistent with applicable law and the terms of the group health plan; or

(4) a business owner enrolled in a qualified health plan through the small business health options program, provided that at least one employee of the business owner enrolls in a qualified health plan through the small business health options program, or the dependent of a business owner enrolled in a qualified health plan through the small business health options program;

D. "exchange" means the New Mexico health insurance exchange, composed of an exchange for the individual market and a small business health options program or "SHOP" exchange under a single governance and administrative structure;

E. "gold plan" means a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under a health benefit plan or the allowable value for a gold plan as defined by federal regulation;

F. "health benefit plan" means an individual or group policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

G. "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;

H. "insurance producer" means a person required to be licensed in this state to sell, solicit or negotiate insurance;

I. "Native American" means:

(1) an individual who is a member of any federally recognized Indian nation, tribe or pueblo or who is an Alaska native; or

(2) an individual who has been deemed eligible for services and programs provided to Native Americans by the United States public health service or the bureau of Indian affairs;

J. "navigator" means a person that, in a manner culturally and linguistically appropriate to the state's diverse populations, conducts public education, distributes tax credit and qualified health plan enrollment information, facilitates enrollment in qualified health plans or provides referrals to consumer assistance or ombudsman services.

"Navigator" does not mean a health insurance issuer or a person that receives any consideration, directly or indirectly, from any health insurance issuer in connection with the enrollment of a qualified individual in a qualified health plan; provided that an insurance producer may be a navigator if the insurance producer receives no consideration, directly or indirectly, from any health insurance issuer in connection with the enrollment of a qualified individual or qualified employer in a qualified health plan, an approved health plan or any other health coverage;

K. "qualified employee" means an employee or former employee of a qualified employer who has been offered health insurance coverage by that qualified employer through the small business health options program for the employee or former employee and, if the qualified employer offers dependent coverage through the small business health options program, for the employee or former employee's dependents;

L. "qualified employer" means a small employer that elects to make, at a minimum, all of the employer's full-time employees eligible for one or more qualified health plans in the small group market offered through a small business health options program;

M. "qualified health plan" means a health plan that has in effect a certification from the superintendent that it meets the standards set forth in applicable federal and state law and regulations and rules as well as any additional requirements established by the board;

N. "qualified individual" means an individual who has been determined eligible to enroll through the exchange in a qualified health plan in the individual market;

O. "silver plan" means a level of coverage that is designed to provide benefits that are actuarially equivalent to seventy percent of the full actuarial value of the benefits provided under a health benefit plan or the allowable value for a silver plan as defined by federal regulation;

P. "small business health options program" means a program operated by the exchange through which a qualified employer can provide its employees and their dependents with access to one or more qualified health plans; and

Q. "superintendent" means the superintendent of insurance.

History: Laws 2013, ch. 54, § 2; 2020, ch. 35, § 2.

59A-23F-3. New Mexico health insurance exchange created; board created.

A. The "New Mexico health insurance exchange" is created as a nonprofit public corporation to provide qualified individuals and qualified employers with increased access to health insurance in the state and shall be governed by a board of directors constituted pursuant to the provisions of the New Mexico Health Insurance Exchange

Act. The exchange is a governmental entity for purposes of the Governmental Conduct Act [Chapter 10, Article 16 NMSA 1978], the Gift Act [Chapter 10, Article 16B NMSA 1978], the Sunshine Portal Transparency Act [Chapter 10, Article 16D NMSA 1978], the Whistleblower Protection Act [10-16C-1 to 10-16C-4 NMSA 1978], the Procurement Code [13-1-28 to 13-1-199 NMSA 1978] and the Tort Claims Act [41-4-1 to 41-4-27 NMSA 1978], and neither the exchange nor the board shall be considered a governmental entity for any other purpose.

B. The exchange shall not duplicate, impair, enhance, supplant, infringe upon or replace, in whole or in any part, the powers, duties or authority of the superintendent, including the superintendent's authority to review and approve premium rates pursuant to the provisions of the Insurance Code.

C. All health insurance issuers and health maintenance organizations authorized to conduct business in this state and meeting the requirements of the rules promulgated by the superintendent pursuant to Section 59A-23F-7 NMSA 1978, the regulations under federal law and the requirements established by the board shall be eligible to participate in the exchange.

D. The "board of directors of the New Mexico health insurance exchange" is created. The board consists of thirteen voting directors as follows:

(1) one voting director is the superintendent or the superintendent's designee;

(2) six voting directors appointed by the governor, including the secretary of health care authority or the secretary's designee, a health insurance issuer and a consumer advocate; and

(3) six voting directors, three appointed by the president pro tempore of the senate, including one health care provider, and three appointed by the speaker of the house of representatives, including one health insurance issuer. One of the directors appointed by the president pro tempore of the senate and one of the directors appointed by the speaker of the house of representatives shall be from a list of at least two candidates provided, respectively, by the minority floor leader of the senate and by the minority floor leader of the house of representatives.

E. Except as provided in Subsection F of this section, managerial and full-time staff of the exchange shall be subject to applicable provisions of the Governmental Conduct Act and shall not have any direct or indirect affiliation with any health care provider, health insurance issuer or health care service provider.

F. Each director shall comply with the conflict-of-interest provisions of Subsection E of this section, except as follows:

(1) directors who may be appointed from the board of directors of the New Mexico medical insurance pool shall not be considered to have a conflict of interest with respect to their association with that entity;

(2) the secretary of health care authority, or the secretary's designee, shall not be considered to have a conflict of interest with respect to the secretary's performance of the secretary's duties as secretary of health care authority;

(3) the director who is a health care provider shall not be considered to have a conflict of interest arising from that director's receipt of payment for services as a health care provider; and

(4) directors who are representatives of health insurance issuers shall not be considered to have a conflict of interest with respect to those directors' association with their respective health insurance issuers.

G. Each director and employee of the exchange shall have a fiduciary duty to the exchange, to the state and to those persons who purchase or enroll in qualified health plan coverage or medical assistance coverage through the exchange.

H. The board shall be composed, as a whole, to assure representation of the state's Native American population, ethnic diversity, cultural diversity and geographic diversity.

I. Directors shall have demonstrated knowledge or experience in at least one of the following areas:

(1) purchasing coverage in the individual market;

(2) purchasing coverage in the small employer market;

(3) health care finance;

(4) health care economics or health care actuarial science;

(5) health care policy;

(6) the enrollment of underserved residents in health care coverage;

(7) administration of a private or public health care delivery system;

(8) information technology;

(9) starting a small business with fifty or fewer employees; or

(10) provision of health care services.

J. The governor shall appoint no more than four directors from the same political party.

K. Except for the secretary of health care authority, the non-health insurance issuer directors appointed by the governor shall be appointed for initial terms of three years or less, staggered so that the term of at least one director expires on June 30 of each year. The non-health insurance insurer directors appointed by the legislature shall be appointed for initial terms of three years or less, staggered so that the term of at least one director expires on June 30 of each year. The health insurance issuers appointed to the board shall, upon appointment, select one of them by lot to have an initial term ending on June 30 following one year of service and one to have an initial term ending on June 30 following two years of service. Following the initial terms, health insurance issuer directors shall be appointed for terms of two years. A director whose term has expired shall continue to serve until a successor is appointed by the respective appointing authority. Health insurance issuer directors shall not serve two consecutive terms.

L. The exchange, members of the board and employees of the exchange shall operate consistent with provisions of the Governmental Conduct Act, the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978], the Financial Disclosure Act [Chapter 10, Article 16A NMSA 1978], the Gift Act, the Whistleblower Protection Act, the Open Meetings Act [Chapter 10, Article 15 NMSA 1978] and the Procurement Code and shall not be subject to the Personnel Act [Chapter 10, Article 9 NMSA 1978].

M. The board and the exchange shall implement performance-based budgeting and submit annual budgets for the exchange to the secretary of finance and administration and the legislative finance committee.

N. The exchange shall cover its directors and employees under a surety bond, in an amount that the director of the risk management division of the general services department shall prescribe.

O. A majority of directors constitutes a quorum. The board may allow members to attend meetings by telephone or other electronic media. A decision by the board requires a quorum and a majority of directors in attendance voting in favor of the decision.

P. Within thirty days of the effective date of the New Mexico Health Insurance Exchange Act, the board shall be fully appointed and the superintendent shall convene an organizational meeting of the board, during which the board shall elect a chair and vice chair from among the directors. Thereafter, every three years, the board shall elect in open meeting a chair and vice chair from among the directors. The chair and vice chair shall serve no more than two consecutive three-year terms as chair and vice chair.

Q. A vacancy on the board shall be filled by appointment by the original appointing authority for the remainder of the director's unexpired term.

R. A director may be removed from the board by a two-thirds' majority vote of the directors. The board shall set standards for attendance and may remove a director for lack of attendance, neglect of duty or malfeasance in office. A director shall not be removed without proceedings consisting of at least one ten-day notice of hearing and an opportunity to be heard. Removal proceedings shall be before the board and in accordance with procedures adopted by the board.

S. Appointed directors may receive per diem and mileage in accordance with the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978], subject to the travel policy set by the board. Appointed directors shall receive no other compensation, perquisite or allowance.

T. The board shall:

(1) meet at the call of the chair and no less often than once per calendar quarter. There shall be at least seven days' notice given to directors prior to any meeting. There shall be sufficient notice provided to the public prior to meetings pursuant to the Open Meetings Act;

(2) create, make appointments to and duly consider recommendations of an advisory committee or committees made up of stakeholders, including health insurance issuers, health care consumers, health care providers, health care practitioners, insurance producers, qualified employer representatives and advocates for low-income or underserved residents;

(3) create an advisory committee made up of members insured through the New Mexico medical insurance pool to make recommendations to the board regarding the transition of each organization's insured members into the exchange. The advisory committee shall only exist until a transition plan has been adopted by the board;

(4) create an advisory committee made up of Native Americans, some of whom live on a reservation and some of whom do not live on a reservation, to guide the implementation of the Native American-specific provisions of the federal Patient Protection and Affordable Care Act and the federal Indian Health Care Improvement Act;

(5) designate a Native American liaison, who shall assist the board in developing and ensuring implementation of communication and collaboration between the exchange and Native Americans in the state. The Native American liaison shall serve as a contact person between the exchange and New Mexico Indian nations, tribes and pueblos and shall ensure that training is provided to the staff of the exchange, which may include training in:

(a) cultural competency;

(b) state and federal law relating to Indian health; and

(c) other matters relating to the functions of the exchange with respect to Native Americans in the state; and

(6) establish at least one walk-in customer service center where persons may, if eligible, enroll in qualified health plans or public coverage programs.

History: Laws 2013, ch. 54, § 3; 2019, ch. 266, § 1; 2020, ch. 35, § 3; 2024, ch. 39, § 125.

59A-23F-4. Board of directors; powers.

The board may:

A. seek and receive grant funding from federal, state or local governments or private philanthropic organizations to defray the costs of operating the exchange;

B. generate funding, including charging assessments or fees, to support its operations in accordance with provisions of the New Mexico Health Insurance Exchange Act solely for the reasonable administrative costs of the exchange; provided that no assessment or user fee shall be imposed upon a carrier that exclusively offers policies, plans or contracts outside the exchange intended to supplement major medical coverage, including medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policy;

C. establish a Native American service center to ensure that the exchange:

(1) is accessible to Native Americans;

(2) complies with the provisions of the federal Indian Health Care Improvement Act and Indian-specific provisions of the federal Patient Protection and Affordable Care Act; and

(3) facilitates meaningful, ongoing consultation with Native Americans;

D. create ad hoc advisory councils;

E. request assistance from other boards, commissions, departments, agencies and organizations as necessary to provide appropriate expertise to accomplish the exchange's duties;

F. enter into contracts with persons or other organizations as necessary or proper to carry out the provisions and purposes of the New Mexico Health Insurance Exchange Act, including the authority to contract or employ staff for the performance of administrative, legal, actuarial, accounting and other functions; provided that no contractor shall be a health insurance issuer or a producer;

G. enter into contracts with similar exchanges of other states for the joint performance of common administrative functions;

H. enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities; provided that these agreements include adequate protections of the confidentiality of the information to be shared and comply with all state and federal laws and regulations;

I. sue or be sued or otherwise take any necessary or proper legal action in the execution of its duties and powers;

J. appoint board committees, which may include non-board members, to provide technical assistance in the operation of the exchange and any other function within the authority of the exchange; and

K. conduct periodic audits to assure the general accuracy of the financial data submitted to the exchange.

History: Laws 2013, ch. 54, § 4.

59A-23F-5. Plan of operation.

A. No later than September 1, 2020, the board, in coordination with insurance producers appointed and compensated by the insurance industry, shall review its plan of operation and approve amendments to it as appropriate to ensure that the exchange is operated using best practices for state-based exchanges in business administration, consumer engagement and public outreach and marketing.

B. The board shall provide for public notice and hearing prior to approving amendments to the plan of operation.

C. The plan of operation shall contain:

(1) procedures to implement the provisions of the New Mexico Health Insurance Exchange Act, consistent with state and federal law;

(2) procedures for handling and accounting for the exchange's assets and money;

(3) regular times and meeting places for meetings of the board;

(4) a statewide consumer assistance program, including a navigator program;

(5) procedures for consumer complaints and grievances for issues relating to the exchange;

(6) procedures for alternative dispute resolution between the exchange and contractors or health insurance issuers;

(7) policies that:

(a) promote effective communication and collaboration between the exchange and Indian nations, tribes and pueblos, including communicating and collaborating on those nations', tribes' and pueblos' plans for creating or participating in health insurance exchanges; and

(b) promote cultural competency in providing effective services to Native Americans;

(8) conflict-of-interest policies and procedures;

(9) details on the contents of the reports required pursuant to the New Mexico Health Insurance Exchange Act; and

(10) provisions necessary and proper for the execution of the powers and duties of the board and exchange.

History: Laws 2013, ch. 54, § 5; 2019, ch. 266, § 2; 2020, ch. 35, § 4.

59A-23F-6. Board duties; reporting.

The board shall:

A. between July 1, 2013 and January 1, 2015, provide quarterly reports to the legislature, the governor and the superintendent on the implementation of the exchange and report annually and upon request thereafter;

B. keep an accurate accounting of all of the activities, receipts and expenditures of the exchange and submit this information annually to the superintendent and as required by federal law to the federal secretary of health and human services;

C. beginning with the first year of operation in which access to health insurance coverage is provided, obtain an annual audit of the exchange's operations from an independent certified public accountant;

D. publish the administrative costs of the exchange as required by state or federal law; and

E. discharge those duties required to implement and operate the exchange in accordance with the provisions of the New Mexico Health Insurance Exchange Act consistent with state and federal law.

History: Laws 2013, ch. 54, § 6.

59A-23F-6.1. Board; additional duties and powers.

In addition to other duties and powers in the New Mexico Health Insurance Exchange Act, the board shall:

A. in consultation with the superintendent:

(1) establish policies and procedures for the review and recommendation of health benefits plans to be offered on the exchange;

(2) determine additional minimum requirements for a health insurance issuer to be considered for participation in the exchange; and

(3) determine standards and criteria for health benefits plans to be offered through the exchange that offer an optimal level of choice, value, quality and service and that are in the best interests of qualified individuals and qualified small employers;

B. establish policies and procedures that allow city, county and state governments, Indian nations, tribes and pueblos, tribal organizations, urban Native American organizations, private foundations and other entities to pay premiums and cost-sharing on behalf of qualified individuals consistent with federal requirements;

C. provide for the operation of a toll-free hotline to respond to requests for assistance, using staff that is trained to provide assistance in a culturally and linguistically appropriate manner;

D. provide for an annual regular enrollment period and special enrollment periods in the best interest of qualified individuals and qualified small employers;

E. maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans;

F. use a standardized format for presenting health benefit plan options in the exchange;

G. determine the criteria and process for eligibility, enrollment and disenrollment of enrollees and potential enrollees in the exchange and coordinate that process with the human services department [health care authority department] in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverages;

H. inform individuals of eligibility requirements for medicaid, the children's health insurance program or other applicable state or local public programs. If the exchange

assesses that an individual may be eligible for a program, the board shall share information with that program to facilitate the eligibility determination and enrollment of the individual;

I. establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credits and cost-sharing reductions under applicable federal or state law;

J. perform duties required of, or delegated to, the exchange by the secretary of the United States department of health and human services or the United States secretary of the treasury related to determining eligibility for premium tax credits or reduced cost sharing;

K. maintain a statewide consumer assistance program, including a navigator program; and

L. maintain a small business health options program exchange through which qualified employers may access coverage for their employees, providing as appropriate premium aggregation and other related services to minimize the administrative burdens for qualified employers and to:

(1) enable a qualified employer to specify a level of coverage so that its employees may enroll in a qualified health plan offered through the small business health options program exchange at the specified level of coverage; or

(2) enable a qualified employer to provide a specific amount or other payment formulated in accordance with federal law to be used as part of an employee's choice of plan.

History: Laws 2020, ch. 35, § 6.

59A-23F-7. Superintendent of insurance; rulemaking.

The superintendent shall coordinate with the board to promulgate rules necessary to implement and carry out the provisions of the New Mexico Health Insurance Exchange Act, including rules to establish the criteria for certification of qualified health plans.

History: Laws 2013, ch. 54, § 7; 2020, ch. 35, § 5.

59A-23F-8. Funding.

A. To fund the planning, implementation and operation of the exchange, the board shall contract with the human services department [health care authority department] or any other state agency that receives federal funds allocated, appropriated or granted to the state for purposes of funding the planning, implementation or operation of a health insurance exchange.

B. The human services department [health care authority department] or any other state agency that receives federal funds allocated, appropriated or granted to the state for purposes of funding the planning, implementation or operation of a health insurance exchange shall contract with the board to provide those funds to the exchange in consideration for its planning, implementation or operation.

History: Laws 2013, ch. 54, § 8.

59A-23F-9. Standardized health plans.

A. The board may establish no more than three standardized health plans for each of three levels of coverage with increasing benefits, designated bronze, silver and gold plans.

B. In establishing standardized health plans, the board may design those plans to:

(1) limit increases in health plan premium rates;

(2) reduce the deductible portion of a benefit an insured individual is required to pay;

(3) make more services available before a deductible amount is applied to a benefit;

(4) provide predictable cost sharing;

(5) maximize available subsidies;

(6) limit adverse premium impacts;

(7) reduce barriers to maintaining and improving health; and

(8) encourage choice based on value.

C. The board may update the standardized health plans annually.

D. The board shall provide for notice and public comment before finalizing each year's standardized health plans.

E. The board shall establish a procedure and time line for providing written notice of the standardized health plans to health insurance issuers before the year in which the health plans are to be offered on the exchange.

F. Beginning on January 1, 2022, the board may require a health insurance issuer offering a qualified health plan through the exchange to offer one silver standardized health plan and one gold standardized health plan on the exchange. If a health

insurance issuer offers a bronze health plan through the exchange, the exchange may also require the issuer to offer one bronze standardized health plan through the exchange.

G. A health insurance issuer offering standardized health plans through the exchange may also offer nonstandardized health plans through the exchange.

H. The actuarial value of nonstandardized silver health plans offered through the exchange shall not be less than the actuarial value of the standardized silver health plan with the lowest actuarial value.

History: Laws 2020, ch. 35, § 7.

59A-23F-10. Reporting.

The board shall make reports publicly available as follows:

A. during all exchange open enrollment periods beginning on or after October 1, 2021, the board shall produce weekly reports that include information on:

(1) applications;

(2) plan selections;

(3) new enrollees;

(4) enrollees renewing coverage;

(5) call center volume; and

(6) website traffic;

B. within sixty days following the last day of each open enrollment period beginning on or after October 1, 2021, the board shall produce a report with the number of effectuated enrollments from the most recent open enrollment period; and

C. beginning on September 1, 2022, and on each succeeding September 1, the board, in consultation with the superintendent, shall issue a report that includes analysis of:

(1) the individual health insurance market;

(2) on- and off-exchange enrollment and demographics;

(3) small business enrollment;

(4) qualified health plan pricing;

(5) outreach and enrollment assistance activities;

(6) the impact of offering standardized health plans; and

(7) the remaining uninsured in New Mexico and strategies to reach them.

History: Laws 2020, ch. 35, § 8.

59A-23F-11. Health care affordability fund.

A. The "health care affordability fund" is created in the state treasury. The fund consists of distributions, appropriations, gifts, grants and donations. Money in the fund at the end of a fiscal year shall not revert to any other fund. The health care authority shall administer the fund, and money in the fund is subject to appropriation by the legislature for purposes provided by this section. Disbursements from the fund shall be made by warrant of the secretary of finance and administration pursuant to vouchers signed by the secretary of health care authority or the secretary's authorized representative.

B. The purpose of the fund is to:

(1) reduce health care premiums and cost sharing for New Mexico residents who purchase health care coverage on the New Mexico health insurance exchange;

(2) reduce premiums for small businesses and their employees purchasing health care coverage in the fully insured small group market;

(3) provide resources for planning, design and implementation of health care coverage initiatives for uninsured New Mexico residents; and

(4) provide resources for administration of state health care coverage initiatives for uninsured New Mexico residents.

C. If the federal Patient Protection and Affordable Care Act is repealed in full or in part by an act of congress or invalidated by the United States supreme court and eliminates or reduces comprehensive health care coverage for New Mexico residents through medicaid or the New Mexico health insurance exchange, the fund may be used to maintain coverage through the New Mexico health insurance exchange or through medical assistance programs administered by the health care authority; provided that coverage is prioritized for New Mexico residents with incomes below two hundred percent of the federal poverty level.

D. Prior to July 1, 2025, the staff of the legislative finance committee shall conduct a program evaluation to measure the impact of changes to the health insurance premium

surtax and the creation of the health care affordability fund as it relates to the purpose of the fund.

E. Prior to July 1 of each year, the health care authority shall provide actuarial data from the health care affordability fund to the legislative finance committee.

F. Prior to July 1 of each year, the secretary of health care authority, in consultation with the superintendent, the secretary of taxation and revenue and the chief executive officer of the New Mexico health insurance exchange, shall work with the legislative finance committee and the department of finance and administration to develop and report on performance measures relating to the health care affordability fund and any programs or initiatives funded by the fund.

History: Laws 2021, ch. 136, § 4; 2024, ch. 39, § 126.

59A-23F-12. Health care affordability plan; rulemaking; reporting requirements.

A. After the effective date of this 2024 act, rules covering the following provisions may be amended as the health care authority determines:

(1) providing enhanced premium and cost-sharing assistance to individuals and families for the purchase of qualified health plans on the New Mexico health insurance exchange. In providing this assistance, the health care authority shall develop health care affordability criteria designed to reduce the amount that individuals pay in premiums and out-of-pocket medical expenses for qualified health plans offered on the New Mexico health insurance exchange; and

(2) establishing income eligibility parameters for the health care affordability criteria for plan year 2023 and each subsequent calendar year based on available funds. New Mexico residents who qualify shall have an income that is eligible for advanced premium tax credits under the federal Patient Protection and Affordable Care Act.

B. After the effective date of this 2024 act, the health care authority, in consultation with the superintendent, the New Mexico medical insurance pool, the department of health and stakeholder groups, including health care providers that serve uninsured residents, health insurance carriers and consumer advocacy groups, may update the plan for extending health care coverage access to uninsured New Mexico residents who do not qualify for federal premium assistance or, except by reason of incarceration, qualified health plans, through the New Mexico health insurance exchange. The plan shall include:

(1) details about health care benefits;

(2) health care affordability criteria designed to reduce the amount that individuals pay in premiums and out-of-pocket medical expenses under the plan and that result in, to the greatest extent possible, health care costs comparable to costs for New Mexico residents for whom assistance is provided under Subsection A of this section; and

(3) income eligibility parameters that prioritize eligibility for New Mexico residents with incomes under two hundred percent of the federal poverty level.

C. On or before October 31, 2024 and each October 31 thereafter, the health care authority shall submit a report to the legislative finance committee and the legislative health and human services committee, which includes:

(1) a summary of the affordability criteria implemented pursuant to Subsections A and B of this section;

(2) the estimated number of uninsured New Mexico residents who enrolled in coverage following implementation of the affordability criteria pursuant to Subsections A and B of this section; and

(3) the amount in reduced costs and coverage assistance the initiatives provided in the current and previous calendar years by income level, county and coverage source.

History: Laws 2021, ch. 136, § 5; 2024, ch. 39, § 127.

ARTICLE 23G
Short-Term Health Plan and Excepted Benefit

59A-23G-1. Short title.

Chapter 59A, Article 23G NMSA 1978 may be cited as the "Short-Term Health Plan and Excepted Benefit Act".

History: Laws 2019, ch. 235, § 1; 2023, ch. 169, § 6.

59A-23G-2. Definitions.

As used in the Short-Term Health Plan and Excepted Benefit Act:

A. "bona fide association" means an association that has been in existence for not less than five years and that exists for purposes other than the business of insurance;

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

(1) coverage-only for 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 benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care or any combination of those benefits; and

(c) other similar excepted benefits specified in rule;

(10) the following benefits, offered as independent, non-coordinated benefits:

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

(b) hospital indemnity or other fixed indemnity insurance;

(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 federal 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; and

(12) other similar individual or group insurance coverage or arrangement designated by the superintendent pursuant to rule under which benefits are secondary or incidental to health events, services or medical care;

C. "excepted benefits plan" means a health benefits plan that offers only excepted benefits;

D. "health benefits plan" means an individual or group policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

E. "health insurance carrier" means an entity subject to the insurance laws of the state, including a health insurance company, a health maintenance organization, a hospital and health services corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefits plans or managed health care plans in the state;

F. "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 carrier;

G. "major medical coverage" means a health benefits plan that provides benefits other than excepted benefits;

H. "permitted health insurance coverage" means a health benefits plan, excepted benefits plan, short-term plan and other categories or types of health insurance coverage designated by the superintendent; and

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

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

(2) 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

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

History: Laws 2019, ch. 235, § 2.

59A-23G-3. Short-term plans; excepted benefits; standards for policy provisions.

A. The superintendent shall adopt and promulgate rules to establish specific standards:

(1) that set the manner, content and required disclosure for the sale of short-term plans and excepted benefits plans, including standards for full and fair disclosure; and

(2) for the sale of short-term plans and excepted benefits plans, which standards shall include standards relating to:

(a) terms of renewability or extension of coverage;

(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage provisions;

(d) coverage of dependents;

(e) preexisting conditions;

(f) termination of insurance;

(g) probationary periods;

(h) limitations;

(i) exceptions;

(j) reductions and exclusions;

(k) elimination periods;

(l) requirements for replacement by the health insurance carrier;

(m) recurrent conditions;

(n) the definition of terms to describe the specific types of coverage sold pursuant to the Short-Term Health Plan and Excepted Benefit Act and specific standards and policy provisions required of these plans;

(o) benefit duration;

(p) scope of coverage;

(q) advertising and marketing;

(r) sales practices;

(s) mandatory disclosures;

(t) coverage suitability; and

(u) policy and certificate approval.

B. All advertisements, marketing materials and application and policy forms relating to short-term plans shall prominently display a notice that the coverage is unavailable to any potential insured who has been covered under a short-term plan in the previous twelve-month period.

History: Laws 2019, ch. 235, § 3.

59A-23G-4. Benefits; minimum standards.

A. The superintendent shall adopt and promulgate rules to establish minimum standards for benefits provided by short-term plans and excepted benefits plans that are subject to the Short-Term Health Plan and Excepted Benefit Act.

B. Rules of the superintendent shall require short-term plans to cover state-mandated benefits in addition to each of the following categories of benefits:

(1) diagnostic;

(2) rehabilitative;

(3) maternity;

(4) neonatal;

(5) behavioral health services;

(6) emergency services;

(7) hospitalization;

(8) ambulatory services; and

(9) prescription drugs.

History: Laws 2019, ch. 235, § 4.

59A-23G-5. Rates; medical loss ratios.

The superintendent shall adopt and promulgate rules to establish standards for rates, including medical loss ratios, of short-term plans and excepted benefits plans. Rules relating to rates shall be based on generally recognized and current actuarial standards.

History: Laws 2019, ch. 235, § 5.

59A-23G-6. Prohibition; association, trust or multiple employer welfare arrangement plans.

No insurer shall issue, and no association, trust or multiple employer welfare arrangement shall offer, a short-term or excepted benefits plan to a resident of the state unless through a bona fide association.

History: Laws 2019, ch. 235, § 6.

59A-23G-7. Exclusion prohibition not applicable to excepted benefit plans or policies.

A. Notwithstanding any other provisions of law, an excepted benefits policy or plan shall not exclude coverage for losses incurred for a preexisting condition more than twelve months from the effective date of coverage. The policy or plan shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within twelve months before the effective date of coverage.

B. As used in this section, "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 office of superintendent of insurance rules, 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 benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care or any combination of those benefits; and

(c) other similar limited benefits specified in office of superintendent of insurance rules;

(10) the following benefits, offered as independent, non-coordinated 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 federal 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.

History: Laws 2019, ch. 259, § 21.

59A-23G-8. Dental plan; prior authorization.

A. For purposes of this section, "prior authorization" means a written communication indicating whether a specific service is covered or multiple services are covered and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a provider using a format prescribed by a dental plan.

B. A dental plan shall provide a prior authorization upon the submission of a properly formatted request from a covered person.

C. A dental plan shall not deny any claim subsequently submitted for services included in a prior authorization unless one of the following circumstances applies for each service denied:

(1) benefit limitations, including annual maximums or frequency limitations, not applicable at the time of the prior authorization, are reached due to the covered person's utilization subsequent to issuance of the prior authorization;

(2) the documentation submitted for the claim clearly fails to support the claim as originally authorized;

(3) subsequent to the issuance of a prior authorization, new services are provided to the covered person or a change in the covered person's condition occurs that would cause prior-authorized services to no longer be medically necessary, based on prevailing standards of care;

(4) subsequent to the issuance of a prior authorization, new services are provided to the covered person or a change in the covered person's condition occurs such that the prior-authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the covered person's plan in effect at the time the request for prior authorization was made; or

(5) denial of the claim was due to one of the following reasons:

(a) another entity is responsible for payment;

(b) the provider has already been paid for the services identified on the claim;

(c) the claim submitted was fraudulent;

(d) the prior authorization was based on erroneous information provided to the dental plan by the provider, the covered person or other person; or

(e) the covered person was not eligible for the service on the date it was provided and the provider did not know, or with the exercise of reasonable care, could not have known the covered person's eligibility status.

History: Laws 2023, ch. 169, § 7.

59A-23G-9. Dental plan; designation of payment.

A. A dental plan shall provide for the direct payment of covered benefits to a provider, specified by a covered person, regardless of the provider's network or contractual status with the dental plan.

B. A dental plan shall provide for the direct payment of covered benefits to a provider, specified by a covered person, by including on its claim forms an:

(1) option for the designation of payment from the covered person to the provider; and

(2) an attestation to be completed by the covered person.

History: Laws 2023, ch. 169, § 8.

59A-23G-10. Dental plan; erroneously paid claims; restrictions on recovery.

A. A dental plan shall establish policies and procedures for payment recovery, including providing:

(1) notice to the provider that identifies the error made in the processing or payment of the claim;

(2) an explanation of the recovery being sought; and

(3) an opportunity for the provider to appeal the recovery being sought as set forth in Subsection C of this section.

B. A dental plan shall not initiate payment recovery procedures more than twenty-four months after the original payment for a claim was made unless the claim was fraudulent or intentionally misrepresented.

C. A dental plan shall not attempt to recover an erroneously paid claim by withholding or reducing payment for a different claim unless the plan:

(1) notifies the provider, in writing, within twelve months of the erroneously paid claim; and

(2) advises the provider that an automatic deduction shall occur within forty-five days of receiving notification unless the provider submits a written appeal to the plan pursuant to the grievance rules prescribed by the superintendent of insurance.

D. The provisions of this section shall not apply to duplicate payments.

History: Laws 2023, ch. 169, § 9.

59A-23G-11. Dental plan; methods of payment.

A. For purposes of this section, "credit card payment" means a type of electronic funds transfer whereby:

(1) a health insurance carrier issues a single-use series of numbers associated with the payment of services rendered by the provider and chargeable to a predetermined amount; and

(2) the provider is responsible for processing the payment by using a credit card terminal or internet portal.

B. A health insurance carrier shall not place restrictions on a provider regarding acceptable methods of payment, including designating credit card payments as the only acceptable form of payment.

C. When transmitting a payment to a provider using an electronic funds transfer, other than one made through the automated clearinghouse network, a health insurance carrier:

(1) shall not charge a fee to the provider solely to transmit a payment without the provider's consent;

(2) shall notify the provider of any other fees associated with transmitting a payment; and

(3) shall provide a provider with a fee-free method of transmitting a payment and provide instructions for utilizing the method.

History: Laws 2023, ch. 169, § 10.

59A-23G-12. Dental plan; provider network leasing.

A. For purposes of this section:

(1) "contracting entity" means any person or entity that enters into direct contracts with a provider for the delivery of services in the ordinary course of business;

(2) "provider" means a person acting within the scope of licensure to provide dental services or supplies;

(3) "provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and providing for the delivery of and payment for services to covered persons; and

(4) "third party" means a person or entity that enters into a contract with a contracting entity or with another third party to gain access to the services or contractual discounts of a provider network contract.

B. At a time when a contract relevant to granting access to a provider network to a third party is entered into or renewed, or when there are material modifications made, a contracting entity shall not require a provider to participate in third-party access to the provider network contract or contract directly with a third party that acquired the provider network. If a provider opts out, the contracting entity shall not cancel or otherwise end a contractual relationship with the provider. When initially contracting with a provider, a

contracting entity must accept a qualified provider even if the provider rejects a network lease provision.

C. A contracting entity shall not grant a third party access to a provider network contract, a provider's services or discounts provided pursuant to a provider network contract unless:

(1) the provider network contract states that the contracting entity may enter into an agreement with a third party, allowing the third party to obtain the health insurance carrier's rights and responsibilities as though the third party were the contracting entity;

(2) the third party accessing the provider network contract agrees to comply with all of the terms of the provider network contract; and

(3) the contracting entity:

(a) identifies all third parties with which it contracts in a list on its website that is updated every ninety days;

(b) notifies a provider that a new third party is planning to lease or purchase the provider network contract at least thirty business days before the lease or purchase takes effect;

(c) requires the third party to identify the source of the discount on all remittances or explanation of benefits under which the discount is taken; and

(d) makes available a copy of the provider network contract relied upon in the adjudication of a claim to a provider within thirty days of the provider's request.

D. A third party's right to a provider's discounted rate shall cease upon the termination date of the provider network contract.

E. The provisions of this section shall not apply if access to a provider network contract is granted to a dental carrier of an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates shall be made available to a provider on the contracting entity's website.

History: Laws 2023, ch. 169, § 11.

ARTICLE 23H
Easy Enrollment

59A-23H-1. Short title.

Chapter 59A, Article 23H NMSA 1978 may be cited as the "Easy Enrollment Act".

History: Laws 2022, ch. 33, § 1; 2024, ch. 39, § 128.

59A-23H-2. Definitions.

As used in the Easy Enrollment Act:

A. "authority" or "department" means the health care authority;

B. "exchange" means the New Mexico health insurance exchange;

C. "health coverage program" means medicaid, health care coverage available through the federal children's health insurance program, a qualified health plan available through the exchange pursuant to the New Mexico Health Insurance Exchange Act [Chapter 59A, Article 23F NMSA 1978] or a health plan available through the New Mexico medical insurance pool pursuant to the Medical Insurance Pool Act [Chapter 59A, Article 54 NMSA 1978];

D. "insurance-relevant information" means information pertaining to the insurance enrollment status of a taxpayer or members of a taxpayer's household and that is derived or obtained from the taxpayer's state income tax return; provided that information is limited to that information necessary to assess the eligibility of the taxpayer or members of the taxpayer's household for health coverage programs and includes:

(1) adjusted gross income and other types of reported income used to assess eligibility for health coverage programs;

(2) household size;

(3) claimed dependents; and

(4) contact information and identifying information necessary to assess health coverage program eligibility and used to match against relevant third-party data sources;

E. "medicaid" means the joint federal-state health coverage program pursuant to Title 19 or Title 21 of the federal Social Security Act, as amended, and the rules promulgated pursuant to that act;

F. "qualified health plan" means a health plan that has in effect a certification from the superintendent of insurance that meets the standards set forth in applicable federal and state law and rules as well as any additional requirements established by the board of directors of the exchange pursuant to the New Mexico Health Insurance Exchange Act; and

G. "taxpayer" means an individual subject to the tax imposed pursuant to the Income Tax Act [Chapter 7, Article 2 NMSA 1978].

History: Laws 2022, ch. 33, § 2; 2024, ch. 39, § 129.

59A-23H-3. Easy enrollment program; establishment; purpose.

The "easy enrollment program" is established to, in accordance with the provisions of the Easy Enrollment Act:

A. facilitate identification of taxpayers and members of the taxpayers' households who are uninsured;

B. provide taxpayers with a method to consent to the taxation and revenue department's provision of insurance-relevant information to the department and the exchange for the purpose of assessing eligibility for health coverage programs;

C. provide for notification to taxpayers regarding their eligibility or eligibility of their household members for health coverage programs; and

D. facilitate enrollment in health coverage programs.

History: Laws 2022, ch. 33, § 3.

59A-23H-4. Taxation and revenue department duties; income tax form revision; taxpayer consent.

A. The state income tax form shall allow a taxpayer to:

(1) identify whether the taxpayer or members of the taxpayer's household are uninsured;

(2) provide the taxpayer's consent to provide to the department and the exchange:

(a) the taxpayer's insurance-relevant information; and

(b) information on any consent provided by the taxpayer pursuant to this subsection;

(3) provide the taxpayer's consent to enroll:

(a) the taxpayer in medicaid; or

(b) members of the taxpayer's household in medicaid if: 1) coverage by medicaid is available to those household members; and 2) the taxpayer has legal authority to consent to enroll those household members; and

(4) provide information on any consent provided by the taxpayer pursuant to this subsection.

B. The taxation and revenue department shall forward to the department:

(1) the taxpayer's insurance-relevant information if, on the taxpayer's state income tax form, the taxpayer elects to provide the taxpayer's insurance-relevant information to the department and the exchange pursuant to Subsection A of this section; and

(2) information on any consent by a taxpayer provided pursuant to this section if the taxpayer agrees to provide information on that consent to the department and the exchange in accordance with this section.

History: Laws 2022, ch. 33, § 4.

59A-23H-5. Health care authority duties.

A. Upon receipt of a taxpayer's insurance-relevant information from the taxation and revenue department, the authority shall assess the taxpayer's eligibility or the eligibility of members of the taxpayer's household for health coverage programs. If the required insurance-relevant information is insufficient to assess the eligibility of the taxpayer or of the members of the taxpayer's household for those health coverage programs, the authority may request additional information from the taxpayer.

B. If the authority assesses that a taxpayer or a member of the taxpayer's household is eligible for medicaid, the authority shall contact the taxpayer and provide the taxpayer with information on:

(1) health coverage programs available to the taxpayer or member of the taxpayer's household; and

(2) specific enrollment instructions and information on enrollment assistance.

C. If the information transferred to the authority is sufficient to complete an eligibility determination and the taxpayer has consented to being enrolled in medicaid, the authority may enroll the taxpayer in medicaid.

D. The authority shall refer taxpayers or members of the taxpayer's household to the exchange if the authority assesses that a taxpayer or a member of the taxpayer's household may be eligible for a qualified health plan available through the exchange pursuant to the New Mexico Health Insurance Exchange Act [Chapter 59A, Article 23F

NMSA 1978]. The authority may share insurance-relevant information provided by the taxation and revenue department with the exchange for the purpose of assisting a taxpayer with enrollment in a qualified health plan.

History: Laws 2022, ch. 33, § 5; 2024, ch. 39, § 130.

59A-23H-6. New Mexico health insurance exchange duties.

A. Upon receipt of a taxpayer's insurance-relevant information from the department, the exchange shall assess the taxpayer's eligibility or the eligibility of members of the taxpayer's household for qualified health plans and financial assistance. If the required insurance-relevant information is insufficient to assess the eligibility of the taxpayer or the eligibility of the members of the taxpayer's household for those health coverage programs, the exchange may request additional information from the taxpayer.

B. If the exchange assesses that a taxpayer or a member of the taxpayer's household is eligible for a qualified health plan available through the exchange pursuant to the New Mexico Health Insurance Exchange Act [Chapter 59A, Article 23F NMSA 1978], the exchange shall provide the taxpayer with information on:

(1) qualified health plans available to the taxpayer or members of the taxpayer's household through the exchange;

(2) specific enrollment instructions for each of those qualified health plans available to the taxpayer or members of the taxpayer's household; and

(3) the federal premium assistance credit provided pursuant to 26 U.S.C. 36B.

C. If a taxpayer informs the exchange that the taxpayer is interested in enrolling in a qualified health plan for which the taxpayer or a member of the taxpayer's household is eligible, the exchange shall provide the taxpayer with a special enrollment period pursuant to the provisions of Section 59A-23F-6.1 NMSA 1978.

D. The exchange may enroll a taxpayer or a member of the taxpayer's household in a qualified health plan for which that person is eligible and for which that person would not be charged a premium; provided that the required consent under the required legal authority is made pursuant to Section 4 [59A-23H-4 NMSA 1978] of the Easy Enrollment Act.

E. When, pursuant to this section, a taxpayer enrolls or is enrolled in a qualified health plan available through the exchange, the exchange shall:

(1) ensure that coverage begins within the time period required by law; and

(2) provide the taxpayer with at least an annual reminder of the need for the taxpayer to notify the exchange of any change in household circumstances applicable to health care coverage of the taxpayer or the taxpayer's household member.

F. If the exchange assesses that a taxpayer or a member of the taxpayer's household may be eligible for a health plan available through the New Mexico medical insurance pool pursuant to the Medical Insurance Pool Act [Chapter 59A, Article 54 NMSA 1978], the exchange shall inform the taxpayer of that potential eligibility and refer the taxpayer to the New Mexico medical insurance pool for enrollment purposes.

History: Laws 2022, ch. 33, § 6.

ARTICLE 24
Health Insurance for Seniors (Repealed, Recompiled.)

59A-24-1 to 59A-24-7. Repealed.

59A-24-8. Recompiled.

ARTICLE 24A
Medicare Supplements

59A-24A-1. Short title.

Chapter 59A, Article 24A NMSA 1978 may be cited as the "Medicare Supplement Act".

History: Laws 1989, ch. 28, § 1; 1992, ch. 3, § 1.

59A-24A-2. Applicability and scope.

A. Except as otherwise specifically provided, the Medicare Supplement Act shall apply to:

(1) all medicare supplement policies delivered or issued for delivery in this state on or after the effective date of that act;

(2) all certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state; and

(3) insurers issuing policies or certificates under Chapter 59A, Articles 44, 46 and 47 NMSA 1978.

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

C. The provisions of the Medicare Supplement Act are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to medicare eligible persons, which policies are not marketed or held to be medicare supplement policies or benefit plans, except that policies designed to reimburse or pay as the result of hospitalization for hospital, medical and surgical expenses of persons eligible for medicare are subject to Sections 59A-24A-6 and 59A-24A-8 NMSA 1978.

History: Laws 1989, ch. 28, § 2; 1992, ch. 3, § 2.

59A-24A-3. Definitions.

As used in the Medicare Supplement Act:

A. "applicant" means:

(1) in the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) in the case of a group medicare supplement policy, the proposed certificate holder;

B. "certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy;

C. "certificate form" means the document on which a certificate is delivered or issued for delivery;

D. "issuer" means insurance companies, fraternal benefit societies, nonprofit health care plans, health maintenance organizations and any other entities that deliver or issue for delivery in this state medicare supplement policies or certificates;

E. "medicare" means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

F. "medicare supplement policy" means:

(1) a group policy as defined in Chapter 59A, Article 23 NMSA 1978;

(2) an individual policy as defined in Chapter 59A, Article 22 NMSA 1978; or

(3) a group or individual certificate issued pursuant to the Nonprofit Health Care Plan Law [Chapter 59A, Article 47 NMSA 1978] or the Health Maintenance Organization Act [Chapter 59A, Article 46 NMSA 1978] that is advertised, marketed or designed as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare;

G. "policy form" means the document on which a policy is delivered or issued for delivery by the issuer; and

H. "superintendent" means the superintendent of insurance.

History: Laws 1989, ch. 28, § 3; 1992, ch. 3, § 3.

59A-24A-4. Standards for policy provisions; authority to promulgate regulations.

A. No medicare supplement policy or certificate, in force in this state, shall contain benefits that duplicate benefits provided by medicare.

B. Notwithstanding any other provisions of law of this state, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

C. The superintendent shall adopt reasonable regulations to establish specific standards for policy provisions contained in medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state, except as those laws are modified by the provisions of the Medicare Supplement Act. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in the Medicare Supplement Act, shall apply to medicare supplement policies and certificates. The standards may cover, but are not limited to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions and reductions;

(6) elimination periods;

(7) requirements for replacement;

(8) recurrent conditions; and

(9) definitions of terms.

D. The superintendent shall adopt reasonable regulations to establish minimum standards for benefits and claims payment, marketing practices, compensation arrangements and reporting practices for medicare supplement policies and certificates.

E. The superintendent may adopt reasonable regulations necessary to conform medicare supplement policies and certificates to the requirements of federal law. The regulations may, but are not limited to:

(1) require refunds or credits if policies or certificates do not meet loss ratio requirements;

(2) establish a uniform methodology for calculating and reporting loss ratios;

(3) assure public access to information in the possession of issuers concerning policies, premiums and loss ratios;

(4) establish an approval process for policy forms, certificate forms and proposed premium increases;

(5) establish procedures for conducting public hearings prior to granting approval to proposed premium increases; and

(6) establish standards for medicare select policies and certificates if the state is authorized to operate as a medicare select state.

F. The superintendent may adopt reasonable regulations that specify prohibited policy or certificate provisions not otherwise specifically authorized by statute that, in the opinion of the superintendent, are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

History: Laws 1989, ch. 28, § 4; 1990, ch. 110, § 4; 1992, ch. 3, § 4.

59A-24A-5. Repealed.

59A-24A-6. Loss ratio standards.

Medicare supplement policies and other policies designed to reimburse or pay as the result of hospitalization for the hospital, medical and surgical expenses of persons eligible for medicare shall return to policyholders benefits that are reasonable in relation to the premium charged. The superintendent shall issue reasonable regulations to

establish minimum standards for loss ratios of medicare supplement policies and other policies designed to reimburse or pay as the result of hospitalization for the hospital, medical and surgical expenses of persons eligible for medicare on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

History: Laws 1989, ch. 28, § 6; 1990, ch. 110, § 6; 1992, ch. 3, § 5.

59A-24A-7. Repealed.

59A-24A-8. Filing of health insurance for seniors; rates and forms.

A. The superintendent shall adopt regulations for the review and approval or disapproval of all rate filings or forms made pursuant to Chapter 59A, Articles 15, 18, 44, 46 and 47 NMSA 1978. During the initial review periods provided under Chapter 59A, Articles 15, 18, 44, 46 and 47 NMSA 1978, the superintendent may disapprove any form filed with him.

B. The superintendent may, in addition to any disapproval authority granted in Chapter 59A, Articles 15, 18, 44, 46 and 47 NMSA 1978, disapprove rate filings if the earned premium in the most recent calendar year is less than forty percent of the highest calendar year's earned premium for the form and, in the superintendent's judgment, those rates would result in a dropping of coverage that is not beneficial to the citizens of New Mexico. Alternately, the superintendent may:

(1) require that the experience be combined with the experience of any other form with similar benefits; or

(2) adjust the requested rate.

History: Laws 1989, ch. 28, § 8; 1990, ch. 110, § 7; 1992, ch. 3, § 6.

59A-24A-9. Disclosure standards.

A. In order to provide for full and fair disclosure in the sale of medicare supplement policies or certificates, no medicare supplement policy or certificate shall be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time application is made.

B. The superintendent shall prescribe the format and content of the outline of coverage required by Subsection A of this section. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(1) a description of the principal benefits and coverage provided in the policy or certificate;

(2) a statement that provides disclosure of any provision concerning automatic renewal premium increases based on the age of a policyholder;

(3) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and

(4) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing contractual provisions.

C. The superintendent may prescribe by regulation a standard form and content of an informational brochure for persons eligible for medicare that is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies or certificates, the superintendent may require by regulation that the informational brochure be provided to any prospective insured eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies or certificates, the superintendent may require by regulation that the prescribed brochure be provided upon request to any prospective insured eligible for medicare, but the brochure shall be provided no later than the time the policy or certificate is delivered.

D. The superintendent may adopt regulations for captions or notice requirements determined to be in the public interest and designed to inform a prospective insured that particular insurance coverages are not medicare supplement coverages for all health insurance policies sold to persons eligible for medicare by reason of age. The regulations shall not apply to the following policies:

(1) medicare supplement;

(2) disability income;

(3) basic, catastrophic or major medical expense; or

(4) single, premium or nonrenewable.

E. The superintendent may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of health policies or certificates by persons eligible for medicare.

History: Laws 1989, ch. 28, § 9; 1992, ch. 3, § 7.

59A-24A-10. Notice of free examination.

Medicare supplement policies and certificates shall have a notice printed prominently on the first page of the policy or certificate or attached to the policy stating that the applicant shall have the right to return the policy or certificate within thirty days of delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid in a timely manner directly to the applicant by the issuer.

History: Laws 1989, ch. 28, § 10; 1992, ch. 3, § 8.

59A-24A-11. Limitation of sales of medicare supplement policies and other policies designed to reimburse or pay as the result of hospitalization for hospital, medical or surgical expenses.

The superintendent may establish reasonable rules and regulations to restrict the sale of medicare supplement policies and other policies designed to reimburse or pay as the result of hospitalization for hospital, medical or surgical expenses that result in over-insurance to an insured.

History: Laws 1989, ch. 28, § 11; 1992, ch. 3, § 9.

59A-24A-12. Filing requirements for advertising.

A. Every issuer of medicare supplement insurance policies or certificates in this state shall provide a copy of any medicare supplement advertisement intended for use in this state, whether through written, radio or television medium, to the superintendent for review and approval. The advertisement shall comply with all applicable laws of this state.

B. Persons who market medicare supplement insurance policies or certificates in this state shall not advertise any policies or certificates unless:

(1) the issuer of the policy or certificate has provided the superintendent with a copy of the advertisement; and

(2) the superintendent has reviewed and approved the advertisement.

History: Laws 1989, ch. 28, § 12; 1992, ch. 3, § 10.

59A-24A-13. Administrative procedures.

Regulations adopted pursuant to the Medicare Supplement Act shall be subject to the provisions of 59A-2-9 NMSA 1978.

History: Laws 1989, ch. 28, § 13.

59A-24A-14. Penalties.

In addition to any other applicable penalties for violations of the Insurance Code, the superintendent may impose penalties pursuant to the provisions of Section 59A-1-18 NMSA 1978, for a violation of the Medicare Supplement Act. The superintendent may require issuers violating any provision of the Medicare Supplement Act or regulations adopted pursuant to that act to cease marketing any medicare supplement policy or certificate in this state that is related directly or indirectly to a violation or may require the issuer to take actions that are necessary to comply with the provisions of that act, or both.

History: Laws 1989, ch. 28, § 14; 1992, ch. 3, § 11.

59A-24A-15. Medicare supplement policy; provisions relating to individuals who are eligible for medical benefits under the medicaid program.

A. Each medicare supplement policy that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy to be paid to the human services department [health care authority department] when:

(1) the human services department [health care authority department] has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;

(2) payment for the services in question has been made by the human services department [health care authority department] to the medicaid provider; and

(3) the issuer is notified that the insured individual receives benefits under the medicaid program and that benefits must be paid directly to the human services department [health care authority department].

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the human services department [health care authority department] for insurance benefits when the claim is first submitted by the human services department [health care authority department] to the issuer.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any medicare supplement policy for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy shall be made payable to the provider. The issuer may be notified that the insured individual is eligible for medicaid

benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the issuer.

D. No medicare supplement policy delivered, issued for delivery or renewed in this state or after the effective date of this section shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state, unless:

(1) the medicare supplement policy or certificate has been suspended at the request of a policy or certificate holder for a period not to exceed twenty-four months; and

(2) during the period of suspension, the policy or certificate holder is entitled to medical assistance pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.

History: 1978 Comp., § 59A-24-8, enacted by Laws 1989, ch. 183, § 4, recompiled as § 59A-24A-15 by Laws 1990, ch. 110, § 8; 1992, ch. 3, § 12.

59A-24A-16. Rules and regulations; procedures.

Rules and regulations adopted pursuant to the provisions of the Medicare Supplement Act shall be subject to the provisions of Section 59A-2-9 NMSA 1978.

History: 1978 Comp., § 59A-24A-16, enacted by Laws 1992, ch. 3, § 13.

ARTICLE 25
Credit Life and Credit Health Insurance

59A-25-1. Scope and short title.

A. All life insurance and all health insurance in connection with loans or other credit transactions shall be subject to the provisions of this article, except such insurance in connection with a loan or other credit transaction of more than ten (10) years' duration; nor shall insurance be subject to this article where issuance of the insurance is an isolated transaction on part of the insurer not related to an agreement or plan for insuring debtors of the creditor.

B. This article [Chapter 59A, Article 25 NMSA 1978] may be cited as the "Law for Regulation of Credit Life Insurance and Credit Health Insurance."

History: Laws 1984, ch. 127, § 473.

59A-25-2. Purpose.

The purpose of this article is to promote the public welfare by regulating credit life insurance and credit health insurance. Nothing in this article is intended to prohibit or discourage reasonable competition. The provisions of this article shall be liberally construed.

History: Laws 1984, ch. 127, § 472.

59A-25-3. Definitions.

For the purposes of this article:

A. "credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction;

B. "credit accident and health insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

C. "creditor" means the lender of money or vendor or lessor of goods, services or property, rights or privileges for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender, vendor or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them;

D. "credit transaction" includes loans, purchases and leases in which the debtor or his successor in interest become liable for the payment of the indebtedness in one or more payments to the creditor;

E. "debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction; and

F. "indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

History: Laws 1984, ch. 127, § 474.

59A-25-4. Forms of credit life, credit health insurances.

Credit life insurance and credit health insurance shall be issued only in the following forms:

A. individual policies of life insurance issued to debtors on the term plan;

B. individual policies of health insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

C. group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan; and

D. group policies of health insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

History: Laws 1984, ch. 127, § 475.

59A-25-5. Amount of insurance.

A. The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness and, where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

B. Notwithstanding the provisions of Subsection A, above, insurance on agricultural credit transactions and other credit transactions not providing for amortization of the indebtedness and not exceeding two (2) years in duration may be written up to the amount of the loan commitment on a nondecreasing or level term plan.

C. Notwithstanding the provisions of Subsection A, above, or any other provision of this article, insurance on educational credit transaction commitments may be written for the amount of the portion of such commitment that has not already been advanced by the creditor.

D. The total amount of periodic indemnity payable by credit health insurance in event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness, and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

History: Laws 1984, ch. 127, § 476.

59A-25-6. Term of insurance.

The term of any credit life or credit health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, or the date when the debtor applies for such insurance, whichever is later, except that where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty (30) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for

insurance. The term of such insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in Section 480 [59A-25-9 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 477.

59A-25-7. Provisions of policies and certificates; disclosure to debtors.

A. All credit life insurance and credit health insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

B. Each such individual policy or group certificate shall, in addition to other requirements of law, set forth the name and home office address of the insurer, the name or names of the debtor or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor, the premium or amount of payment, if any, by the debtor separately for credit life insurance and credit health insurance, a description of the coverage including the amount and term thereof and any exceptions, limitations and restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate, and provide for refund of premiums as required by Section 480 [59A-25-9 NMSA 1978] of this article.

C. The individual policy or group certificate shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter in this section provided.

D. If the individual policy or group certificate is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit health insurance, the amount, term and a brief description of the coverage provided, shall be delivered to the debtor at the time such indebtedness is incurred. The copy of the application or such notice of proposed insurance shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty (30) days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate to be delivered to the

debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in Section 477 [59A-25-6 NMSA 1978] of this article.

E. If the named insurer does not accept the risk, then the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made.

History: Laws 1984, ch. 127, § 478.

59A-25-8. Filing, approval and withdrawal of forms.

A. All policies, certificates of insurance, notice of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this state and the schedules of premium rates pertaining to them shall be filed by the insurer with the superintendent.

B. The superintendent shall, within sixty days after the filing of any such policies, certificates of insurance, notice of proposed insurance, applications for insurance, endorsements and riders, disapprove any form if the benefits provided therein are not reasonable in relation to the premium charge or if it contains provisions that are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage or that are contrary to a provision of the Insurance Code or of a rule or regulation promulgated thereunder.

C. If the superintendent notifies the insurer that the form is disapproved, it is unlawful thereafter for the insurer to issue or use the form. In the notice, the superintendent shall specify the reason for disapproval and state that a hearing will be granted within twenty days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued or used until the expiration of thirty days after it has been filed, unless the superintendent gives prior written approval thereto.

D. The superintendent may, at any time after a hearing held not less than twenty days after written notice to the insurer, withdraw approval of a form on any ground set forth in Subsection B of this section. The written notice of hearing shall state the reason for the proposed withdrawal.

E. The insurer shall not issue the forms or use them after the effective date of withdrawal.

F. If a group policy of credit life insurance or credit health insurance has been or is delivered in another state, the insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this state as

specified in Subsections B and D of Section 59A-25-7 NMSA 1978, and the forms shall be approved by the superintendent if they conform with the requirements specified in such subsections and if the schedules of premium rates applicable to the insurance evidenced by the certificate or notice are not in excess of the insurer's schedules of premium rates filed with the superintendent.

History: Laws 1984, ch. 127, § 479; 2017, ch. 130, § 17.

59A-25-9. Premiums and refunds.

A. Any insurer may revise its schedules of premium rates from time to time and shall file such revised schedules with the superintendent. No insurer shall issue any credit life insurance policy or credit health insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the superintendent.

B. Each individual policy or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided, however, that the superintendent shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the superintendent.

C. If a creditor requires a debtor to make any payment for credit life insurance or credit health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

D. The amount charged to a debtor for any credit life or credit health insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

E. Nothing in this article shall be construed to authorize any payments for insurance now prohibited under any statute, or rule thereunder, governing credit transaction.

History: Laws 1984, ch. 127, § 480.

59A-25-10. Authorized insurer, licensed agent required.

A credit life or credit health insurance policy shall be delivered or issued for delivery in this state only by an insurer holding a certificate of authority to transact such insurance in this state, and shall be issued only through a duly appointed and licensed agent of the insurer in this state.

History: Laws 1984, ch. 127, § 481.

59A-25-11. Claims administration.

A. All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

B. All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

C. No plan or arrangement shall be used whereby any person other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

History: Laws 1984, ch. 127, § 482.

59A-25-12. Existing insurance; choice of insurer.

When credit life or credit health insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact such an insurance business in this state. The creditor shall timely inform the debtor in writing of the debtor's rights under this section, in form prescribed or approved by the superintendent.

History: Laws 1984, ch. 127, § 483.

59A-25-13. Director of financial institutions division to report violations.

The director of the financial institutions division of this state, in connection with his examination of lending institutions under his supervision, regulation or control, shall investigate and examine the procedures and policies of such lending agencies regarding issue and sale of insurance in connection with loans, and to report immediately to the superintendent any questionable procedures or violations of this article by any such lending agency.

History: Laws 1984, ch. 127, § 484.

59A-25-14. Penalties.

In addition to any other penalty provided by law, any person violating the superintendent's order under this article after the order has become final and while the order is in effect, shall upon conviction thereof forfeit and pay to the state of New Mexico not to exceed five hundred dollars ($500), except that if the violation is found to be wilful the penalty shall be in [a] sum not over two thousand dollars ($2,000).

History: Laws 1984, ch. 127, § 485.

ARTICLE 26
Casualty Insurance Contracts

59A-26-1. Scope of article.

This article [Chapter 59A, Article 26 NMSA 1978] applies as to certain contracts of casualty insurance, as identified in the respective sections of this article, other than mortgage guaranty insurance contracts, motor vehicle insurance contracts and employer's liability or workmen's compensation insurance contracts, which such excepted contracts are respectively covered under a separate subsequent article of the Insurance Code. All such casualty contracts shall also be subject to applicable provisions of Article 18 [Chapter 59A, Article 18 NMSA 1978] (the insurance contract) of the Insurance Code.

History: Laws 1984, ch. 127, § 486.

ARTICLE 27
Marine and Transportation Insurance Contracts

59A-27-1. Scope of article.

This article [Chapter 59A, Article 27 NMSA 1978] applies only as to contracts of marine and transportation insurance, as such insurance is defined in Section 111 [59A-7-5 NMSA 1978][repealed] of the Insurance Code. All such insurance contracts shall be subject to the provisions, as applicable, of Article 18 [Chapter 59A, Article 18 NMSA 1978] (the insurance contract) of the Insurance Code.

History: Laws 1984, ch. 127, § 487.

ARTICLE 28
Mortgage Guaranty Insurance Contracts

59A-28-1. Scope of article.

This article [Chapter 59A, Article 28 NMSA 1978] shall apply only with respect to contracts of mortgage guaranty insurance as defined in Section 112 [59A-7-6 NMSA 1978] of the Insurance Code. Such contracts are also subject to the applicable provisions of Article 18 [Chapter 59A, Article 18 NMSA 1978] (the insurance contract) of the Insurance Code.

History: Laws 1984, ch. 127, § 488.

ARTICLE 29
Property Insurance Contracts; Fair Plan Act

59A-29-1. Short title.

This article [Chapter 59A, Article 29 NMSA 1978] may be cited as the "FAIR Plan Act" (fair access to insurance requirements).

History: 1978 Comp., § 59A-29-1, enacted by Laws 1985, ch. 61, § 1.

59A-29-2. Organization of FAIR plan and underwriting association.

All insurers licensed to write and writing essential property insurance, as defined by the superintendent of insurance, in New Mexico on a direct basis are authorized, subject to approval and regulation by the superintendent of insurance, to establish and maintain a FAIR plan and to establish and maintain an underwriting association and to formulate and from time to time amend the plan and articles of association and rules and regulations in connection therewith and to assess and share on a fair and equitable basis all expenses, income and losses incident to such FAIR plan and underwriting association in a manner consistent with the provisions of the FAIR Plan Act. Such underwriting association shall be known as the "New Mexico Property Insurance Program."

History: 1978 Comp., § 59A-29-2, enacted by Laws 1985, ch. 61, § 2.

59A-29-3. Participation.

Each insurer authorized to write and writing essential property insurance in New Mexico shall be required to become and remain a member of the FAIR plan and the underwriting association and comply with the requirements thereof as a condition of its authority to transact property insurance business. As a prerequisite to such authority to transact property insurance business each insurer shall automatically subscribe to the articles of agreement on file in the superintendent's office.

History: 1978 Comp., § 59A-29-3, enacted by Laws 1985, ch. 61, § 3.

59A-29-4. Requirements of plan and authority of association.

The FAIR plan and articles of association shall make provision for an underwriting association having authority on behalf of its members to cause to be issued property insurance policies, to reinsure in whole or in part any such policies and to cede any such reinsurance. The plan and articles of association shall provide, among other things, for the perils to be covered, geographical area of coverage, compensation and commission, assessments of members, the sharing of expenses, income and losses on an equitable basis, cumulative weighted voting for the governing committee of the association, the administration of the plan and association and any other matter necessary or convenient for the purpose of assuring fair access to insurance requirements.

History: 1978 Comp., § 59A-29-4, enacted by Laws 1985, ch. 61, § 4.

59A-29-5. Changes in plan or articles.

The governing committee of the New Mexico property insurance program may, on its own initiative or at the request of the superintendent of insurance, amend the plan and articles, subject to approval by the superintendent.

History: 1978 Comp., § 59A-29-5, enacted by Laws 1985, ch. 61, § 5.

59A-29-6. Appeals; judicial review.

A. A person aggrieved by an action or decision of the administrators of the FAIR plan or the underwriting association or of any insurer as a result of its participation may appeal to the superintendent within thirty days from the date of the action or the decision. The superintendent shall, after hearing held upon thirty days' written notice, issue an order approving the action or decision or disapproving the action or decision with respect to the matter that is the subject of appeal.

B. All final orders and decisions of the superintendent shall be subject to judicial review in the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: 1978 Comp., § 59A-29-6, enacted by Laws 1985, ch. 61, § 6; 1998, ch. 55, § 64; 1999, ch. 265, § 68.

59A-29-7. Immunity.

There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, the association or its agents or employees, the governing committee or the superintendent or his representative for any action taken by them in the performance of their powers and duties under the FAIR Plan Act. The meetings, activities, recommendations and decisions of the governing committee of the

association as required or permitted in that act shall not be open to public inspection, nor be considered public documents, nor be subject to Sections 10-15-1 through 10-15-4 NMSA 1978.

History: 1978 Comp., § 59A-29-7, enacted by Laws 1985, ch. 61, § 7.

59A-29-8. Repealed.

59A-29-9. Retroactive application.

The FAIR Plan Act shall be effective and shall apply retroactively to April 30, 1981, to validate action taken under the New Mexico interim uniform basic property insurance and placement program promulgated by the superintendent of insurance.

History: 1978 Comp., § 59A-29-9, enacted by Laws 1985, ch. 61, § 9.

59A-29-10 to 59A-29-12. Repealed.

ARTICLE 30
Title Insurance

59A-30-1. Short title.

Chapter 59A, Article 30 NMSA 1978 may be cited as the "New Mexico Title Insurance Law".

History: 1978 Comp., § 59A-30-1, enacted by Laws 1985, ch. 28, § 1; 2009, ch. 80, § 3.

59A-30-2. Purpose and legislative intent of article.

A. The purpose of the New Mexico Title Insurance Law is to provide a comprehensive body of law for the effective regulation and active supervision of the business of title insurance transacted within this state in accordance with the McCarran-Ferguson Act (P.L. 79-15, 15 U.S.C. Sections 1011-1015).

B. The legislature intends that the business of title insurance be regulated by the state to provide for the protection of consumers and purchasers of title insurance policies and the financial stability of the title insurance industry.

C. The legislature intends that the title insurance market be competitive for all title insurance agents, that regulation of the title insurance industry does not disproportionately impact independent title agencies and that regulation of the industry

does not place independent title insurance agents at a competitive disadvantage with underwriter-owned title companies.

History: 1978 Comp., § 59A-30-2, enacted by Laws 1985, ch. 28, § 2; 2009, ch. 80, § 4.

59A-30-3. Definitions.

As used in the New Mexico Title Insurance Law:

A. "agency agreement" means a document executed by a title insurer and title insurance agent that defines the compensation of the title insurance agent and the scope of the title insurance agent's authority;

B. "basic premium rate" means the premium rate for an original owner's policy of title insurance;

C. "business of title insurance" means:

(1) issuing as title insurer or offering to issue as title insurer a title insurance policy; or

(2) transacting or proposing to transact by a title insurer or title insurance agent any of the following activities when conducted or performed in contemplation of the issuance of a title insurance policy:

(a) soliciting or negotiating the issuance of a title insurance policy;

(b) guaranteeing, warranting or otherwise insuring the correctness of title searches;

(c) executing title insurance policies;

(d) effecting contracts of reinsurance;

(e) abstracting, searching or examining titles; or

(f) doing or proposing to do any business in substance equivalent to the business of title insurance in a manner designed to evade the provisions of the New Mexico Title Insurance Law or other laws applicable to the business of title insurance;

D. "charge" means any consideration, other than premiums billed by a title insurance agent or title insurer or both, for the performance of services, including but not necessarily limited to:

(1) consideration for the supervising or handling of escrows, settlements, closings, preparation of abstracts, delivery or recording of transfer and lien documents and disbursing funds;

(2) consideration for services commenced but not completed; and

(3) consideration for title searches conducted for a purpose other than issuance of a title insurance policy.

"Charge" does not include consideration collected by a title insurer or title insurance agent when the consideration is limited to the amount billed for services rendered by a third party;

E. "premium" means the consideration for issuing a title insurance policy and includes the consideration for searching and examining a title when conducted or performed for the purpose of the issuance of a title insurance policy;

F. "available funds" means funds subject to immediate withdrawal by cash or check in a depository account with a financial institution, held in the name of and subject to the control of a title insurance agent, title insurer or third party fiduciary, not including a person or entity that is a party to the transaction, cooperating in the closing of a transaction with a title insurance agent or title insurer;

G. "title insurance agent" means a person licensed as an agent under the Insurance Code [Chapter 59A NMSA 1978] and appointed by a title insurer;

H. "title insurance policy" or "policy" means a contract indemnifying against loss or damage arising from any of the following that exist on or before the effective date of the policy:

(1) defects in the insured title;

(2) liens or encumbrances on the insured title;

(3) unmarketability of the insured title;

(4) invalidity or unenforceability of liens or encumbrances on the property that is the subject of the policy; or

(5) lack of legal right of access to and from the property.

"Title insurance policy" or "policy" does not include an abstract; and

I. "title insurer" means any person authorized under the laws of this state to transact as insurer the business of title insurance.

History: 1978 Comp., § 59A-30-3, enacted by Laws 1985, ch. 28, § 3; 1989, ch. 95, § 1; 2009, ch. 80, § 5.

59A-30-4. Control and supervision by superintendent.

A. Title insurers and title insurance producers shall operate in New Mexico under the control and supervision of the superintendent. The superintendent shall promulgate such rules and regulations as are necessary to carry out the provisions of the New Mexico Title Insurance Law. The superintendent may adopt uniform rules and regulations to address underwriting standards and practices, including but not limited to rules and regulations that prohibit title insurers from insuring specified risks that the superintendent determines may pose an unreasonable risk to the financial stability of title insurers.

B. No title insurer or title insurance producer shall collect any premium, issue any title insurance policy or agency agreement, or reinsure any portion of the risk assumed under any title insurance policy, other than in conformance with the New Mexico Title Insurance Law and rules and regulations adopted by the superintendent as authorized by the New Mexico Title Insurance Law.

History: 1978 Comp., § 59A-30-4, enacted by Laws 1985, ch. 28, § 4; 2009, ch. 80, § 6; 2016, ch. 89, § 61.

59A-30-4.1. Reporting by superintendent.

The superintendent shall compile a report for the legislature no later than October 1 each year beginning in 2013 detailing title insurance statistics, including a report on the status of price competition within the title insurance industry in New Mexico. Annual reports shall be made available to interested parties and the general public.

History: Laws 2009, ch. 80, § 13; 2013, ch. 74, § 30.

59A-30-5. Policy forms.

No title insurer or title insurance agent shall use any form of title insurance policy other than the uniform forms promulgated by the superintendent under the New Mexico Title Insurance Law. The superintendent shall not promulgate any uniform form under which the coverage offered is excessive or inadequate in relation to the premium charged for the coverage.

History: 1978 Comp., § 59A-30-5, enacted by Laws 1985, ch. 28, § 5.

59A-30-5.1. Available funds required to issue policy.

Unless the consideration necessary to create the estate to be insured has been previously delivered, no title insurance agent or title insurer shall issue a title insurance policy until the title insurance agent, title insurer or a third party fiduciary holds available funds, as defined under Subsection E of Section 59A-30-3 NMSA 1978, in an amount sufficient to create the estate being insured and to pay in accordance with the instructions of the parties to the transaction, all sums required to be paid through and at the time of the closing.

History: 1978 Comp., § 59A-30-5.1, enacted by Laws 1989, ch. 95, § 2.

59A-30-6. Premiums; agency agreements; duty to promulgate reasonable rates; exception.

A. The superintendent shall promulgate the premium rates of title insurers and title insurance producers for title insurance policies and the percentage of premium to be retained by title insurers under agency agreements, except that premium rates for reinsurance as between title insurers shall not be promulgated by the superintendent. No premium that has not been promulgated or approved by the superintendent shall be charged for any title insurance policy. The superintendent shall not promulgate charges of title insurers and title insurance producers other than premium rates for title insurance policies and the percentage of premium to be retained by title insurers under agency agreements.

B. The superintendent shall promulgate additional premium rates for searches or examinations of title conducted or performed for the purpose of issuance of a title insurance policy when the search or examination involves more than one chain of title or other unusual complexity.

C. Premium rates promulgated by the superintendent shall not be excessive, inadequate or unfairly discriminatory and shall contain an allowance permitting a profit that is not unreasonable in relation to the risks incurred in the business of title insurance. Premium rates may include an allowance for recoupment of assessments made pursuant to the Title Insurance Guaranty Act [Chapter 59A, Article 30A NMSA 1978].

D. Title insurance producers shall retain not less than eighty percent of the gross premiums collected on commitments, policies and endorsements issued for one to four family residential property transactions with a liability amount of not more than two million dollars ($2,000,000); provided, however, that from July 1, 2009 until otherwise ordered by the superintendent, title insurance producers shall retain not less than eighty-one percent of the gross premiums collected on commitments, policies and endorsements issued for one to four family residential property transactions with a liability amount of not more than two million dollars ($2,000,000). The portion of the premium to be retained by the title insurance producers for policies with a liability amount greater than two million dollars ($2,000,000) shall be set by rule.

E. A title insurer may file with the superintendent proposed title insurance rates for a specific county or counties lower than the premium rate promulgated by the superintendent. The superintendent shall provide notice of the filed title insurance rates to all insurance producers and underwriters doing business in that county or counties and may conduct a hearing. In determining whether to approve filed title insurance rates, the superintendent shall consider the interests and protection of consumers and independent title insurance producers and the potential impact on competition within the title insurance industry. Upon approval of the filed title insurance rates, the title insurer and its insurance producers shall use the filed and approved title insurance rates.

F. The superintendent shall adopt rules to establish standards and procedures by which a title insurance rate lower than the promulgated rate shall be filed and may be approved.

History: 1978 Comp., § 59A-30-6, enacted by Laws 1985, ch. 28, § 6; 1999, ch. 60, § 19; 2009, ch. 80, § 7; 2016, ch. 89, § 62.

59A-30-6.1. Premiums; refinanced property.

The premium rates for title insurance policies issued in connection with the refinance of an existing mortgage or deed of trust, where a prior loan policy has been issued and a copy of the policy or a closing statement evidencing the issuance of the policy is furnished to the insurer or title insurance agent showing title vested in the same borrower and covering the same property, shall not exceed the percentage of the basic premium rate promulgated or approved by the superintendent as follows:

A. forty percent of the current basic premium rate applied to any amount up to the amount of the previous policy insuring the mortgage or deed of trust being refinanced, if the new policy is issued within three years from the date of the prior policy;

B. fifty percent of the current basic premium rate applied to any amount up to the amount of the previous policy insuring the mortgage or deed of trust being refinanced, if the new policy is issued more than three years but less than five years from the date of the prior policy;

C. sixty percent of the current basic premium rate applied to any amount up to the amount of the previous policy insuring the mortgage or deed of trust being refinanced, if the new policy is issued more than five years but less than ten years from the date of the prior policy;

D. eighty percent of the current basic premium rate applied to any amount up to the amount of the previous policy insuring the mortgage or deed of trust being refinanced, if the new policy is issued more than ten years but less than twenty years from the date of the prior policy; or

E. the premium for insurance coverage above the amount of the previous policy shall be ninety percent of the current basic premium rate as set by rule. In no event shall the premium collected be less than the minimum premium based on the promulgated or approved rate for a loan policy.

History: 1978 Comp., § 59A-30-6.1, as enacted by Laws 2009, ch. 80, § 8.

59A-30-6.2. Premiums; Indian nation, tribe or pueblo trust property.

Title insurance policies purchased in association with the acquisition of title to property by the United States in trust for a federally recognized Indian nation, tribe or pueblo located wholly or partially in New Mexico where no monetary consideration is paid, shall be issued subject to the promulgated or filed and approved premium rates for the original issuance of a title insurance policy on the same property for an amount equal to the reduced liability limit for the acquisition provided for by the United States department of justice, unless a higher liability amount is required by the United States.

History: 1978 Comp., § 59A-30-6.2, as enacted by Laws 2009, ch. 80, § 9.

59A-30-7. Reporting of experience.

The superintendent shall promulgate reasonable rules, including rules providing statistical plans, for use thereafter by all title insurers and title insurance agents in the recording and reporting of revenue, loss and expense experience so that the experience of title insurers and title insurance agents may be made available to the superintendent at least annually in such form and detail as may be necessary to aid the superintendent in promulgating or approving premium rates.

History: 1978 Comp., § 59A-30-7, enacted by Laws 1985, ch. 28, § 7; 2009, ch. 80, § 10.

59A-30-8. Hearings; notice.

A. The superintendent shall commence a hearing no earlier than November 1 of every third calendar year to consider promulgation of premium rates and any other matters related to the regulation of the business of title insurance deemed necessary by the superintendent.

B. The superintendent may, in the superintendent's discretion, hold a public hearing at any time to consider promulgation of premium rates and such other matters and subjects related to the regulation of the business of title insurance as the superintendent shall determine necessary or proper.

C. Notice of the public hearings provided for in Subsections A and B of this section shall be as provided in Subsection A of Section 59A-4-16 NMSA 1978.

D. The superintendent may promulgate premium rates and forms of title insurance policies only after a public hearing as provided in Subsections A and B of this section.

E. After the collection of all evidence relevant to the hearing, the superintendent shall file a notice of closure of the administrative record. The superintendent shall issue a decision within sixty days following the filing of the notice of closure of the administrative record for the public hearing provided for in Subsections A and B of this section. However, if the superintendent determines that the data and information presented to the superintendent pursuant to Section 59A-30-7 NMSA 1978 are incomplete, inaccurate or otherwise insufficient to determine whether a change in rates is warranted, the superintendent shall require a party, intervenor or participant at the public hearing to furnish the additional necessary data and information, and, in such event, the period of time allowed for the superintendent to issue a decision shall commence from the date such additional data and information are furnished.

History: 1978 Comp., § 59A-30-8, enacted by Laws 1985, ch. 28, § 8; 1990, ch. 62, § 1; 2009, ch. 80, § 11; 2023, ch. 140, § 1.

59A-30-9. Review; appeals.

A person aggrieved by an order of the superintendent promulgating, approving or disapproving rates under the New Mexico Title Insurance Law shall have the rights to review and appeal provided for in Sections 59A-17-34 and 59A-17-35 NMSA 1978. The request for review shall be filed no later than thirty days after the superintendent's issuance of the order that promulgated, approved or disapproved the rates.

History: 1978 Comp., § 59A-30-9, enacted by Laws 1985, ch. 28, § 9; 1998, ch. 55, § 65; 2009, ch. 80, § 12.

59A-30-10. Reserve for losses and loss expenses.

A. All title insurers operating under the provisions of the New Mexico Title Insurance Law shall at all times establish and maintain, in addition to other reserves, a reserve against unpaid losses and a reserve against loss expense. Such reserves shall be calculated by making a careful estimate in each case of the loss and loss expense likely to be incurred by reason of every claim presented pursuant to notice, from or on behalf of the insured of a title defect in or lien or adverse claim against the title insured, that may result in a loss or cause expense to be incurred for the proper disposition of the claim.

B. The amounts so estimated may be revised from time to time as circumstances warrant, but shall be redetermined at least once each year.

C. The amounts set aside in such reserve in any year shall be deducted in determining the net profits for such year of any title insurer.

History: 1978 Comp., § 59A-30-10, enacted by Laws 1985, ch. 28, § 10.

59A-30-11. Underwriting standards and record retention.

A. No title insurance policy may be written unless the title insurer or its title insurance agent has caused to be conducted a reasonable search and examination of the title using an abstract plant meeting the requirements of Section 59A-12-13 NMSA 1978 and has caused to be made a determination of insurability of title in accordance with sound underwriting practices. The duty to search and examine imposed by this section is solely for the purpose of enhancing the financial stability of title insurers for the benefit of insureds under title insurance policies. The New Mexico Title Insurance Law is not intended and should not be construed to create any duty to search and examine that runs to the benefit of, or to create any right or cause of action in favor of, any person other than a title insurer.

B. Evidence of the examination of title and determination of insurability shall be preserved and retained in the files of the title insurer or its title insurance agent for a period of not less than fifteen years after the title insurance policy has been issued. Instead of retaining the original evidence, the title insurer or title insurance agent may in the regular course of business establish a system whereby all or part of the evidence is recorded, copied or reproduced by any process that accurately and legibly reproduces or forms a durable medium for reproducing the contents of the original. This subsection shall not apply to:

(1) a title insurer assuming liability through a contract of reinsurance; or

(2) a title insurer acting as coinsurer if one of the other coinsuring title insurers has complied with this section.

History: 1978 Comp., § 59A-30-11, enacted by Laws 1985, ch. 28, § 11; 1999, ch. 60, § 20.

59A-30-12. Maintenance assessment.

The superintendent shall determine a rate of assessment and collect a maintenance fee in an amount not to exceed one percent of the correctly reported gross title insurance premiums on policies written in New Mexico of all authorized title insurers. The fee required by this section is in addition to all other taxes and fees now imposed or that may be subsequently imposed and that are not in conflict with this article. The superintendent, after taking into account the unexpended funds produced by this fee, if any, shall adjust the rate of assessment each year to produce the amount of funds that he estimates will be necessary to pay all the expenses of regulating the business of title insurance during the succeeding year. The superintendent in promulgating premium rates shall take into account assessments made under this section.

History: 1978 Comp., § 59A-30-12, enacted by Laws 1985, ch. 28, § 12.

59A-30-13. Title insurance maintenance assessment fund created; appropriation.

There is created a "title insurance maintenance assessment fund" in the state treasury. All receipts of the department of insurance collected under Section 59A-30-12 NMSA 1978 shall be deposited in the title insurance maintenance assessment fund and are appropriated to the superintendent for use in paying the expenses of the insurance department incurred in administering the New Mexico Title Insurance Law, including compensation and expenses of salaried personnel and consultants employed by the superintendent in administering the New Mexico Title Insurance Law.

History: 1978 Comp., § 59A-30-13, enacted by Laws 1985, ch. 28, § 13.

59A-30-14. Other provisions applicable.

To the extent not in conflict with the New Mexico Title Insurance Law, the following articles and provisions of the Insurance Code [Chapter 59A NMSA 1978] shall also apply to title insurers, title insurance agents and the business of title insurance:

A. Chapter 59A, Article 1 NMSA 1978;

B. Chapter 59A, Article 2 NMSA 1978;

C. Chapter 59A, Article 4 NMSA 1978;

D. Chapter 59A, Article 5 NMSA 1978;

E. Chapter 59A, Article 6 NMSA 1978;

F. Chapter 59A, Article 7 NMSA 1978;

G. Chapter 59A, Article 8 NMSA 1978;

H. Chapter 59A, Article 9 NMSA 1978;

I. Chapter 59A, Article 10 NMSA 1978;

J. Chapter 59A, Article 11 NMSA 1978;

K. Chapter 59A, Article 12 NMSA 1978;

L. the Unauthorized Insurers Law [Chapter 59A, Article 13 NMSA 1978];

M. Chapter 59A, Article 16 NMSA 1978;

N. the Insurance Fraud Act [Chapter 59A, Article 16C NMSA 1978];

O. Chapter 59A, Article 34 NMSA 1978; and

P. The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978].

History: 1978 Comp., § 59A-30-14, enacted by Laws 1985, ch. 28, § 14; 1999, ch. 60, § 21; 1999, ch. 289, § 27; 2001, ch. 297, § 3.

59A-30-15. Repealed.

History: Laws 1985, ch. 28, § 16; repealed by Laws 2009, ch. 80, § 14.

ARTICLE 30A
Title Insurance Guaranty

59A-30A-1. Short title.

Sections 1 through 18 [59A-30A-1 to 59A-30A-18 NMSA 1978] of this act may be cited as the "Title Insurance Guaranty Act".

History: Laws 1999, ch. 60, § 1.

59A-30A-2. Purpose.

The purpose of the Title Insurance Guaranty Act is to provide a mechanism for continuation of coverage and payment of covered claims under certain title insurance policies, to avoid excessive delay in payment and avoid financial loss to policyholders because of insolvency of a title insurer, to assist in detection and prevention of title insurer insolvencies and to provide an association to assess the cost of such protection among title insurers.

History: Laws 1999, ch. 60, § 2.

59A-30A-3. Scope.

The Title Insurance Guaranty Act applies to all insurers authorized to transact title insurance business in New Mexico.

History: Laws 1999, ch. 60, § 3.

59A-30A-4. Definitions.

As used in the Title Insurance Guaranty Act:

A. "account" means an account created by Section 5 of the Title Insurance Guaranty Act;

B. "association" means the title insurance guaranty association;

C. "covered claim" means an unpaid claim of an insured in excess of one thousand dollars ($1,000) covered under and not in excess of the applicable limits of a title insurance policy insuring land located in New Mexico issued by an insolvent insurer, if the insurer is found insolvent pursuant to Paragraph (2) of Subsection D of this section after the effective date of the Title Insurance Guaranty Act. Subject to applicable policy limits, the association's liability for covered claims shall not exceed two hundred fifty thousand dollars ($250,000) per claim and does not include any amount in excess of two hundred fifty thousand dollars ($250,000) per claim. The total amount that may be recovered from the association by a claimant for all covered claims shall not exceed five hundred thousand dollars ($500,000). "Covered claim" does not include an amount due by or for the benefit of a reinsurer, insurer, insurance pool or underwriting association, as subrogation recoveries or otherwise; provided, that a claim asserted against a person insured by an insolvent insurer that, if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool or underwriting association, would be a covered claim, may be filed directly with the receiver of the insolvent insurer. In no event may any such claim be asserted in a legal or administrative action against the insolvent insurer's insured unless that claim is based on the insured's fraud. "Covered claim" does not include the amount of a claim that an insured recovers from any person, including an agent, regardless of whether an assignment is taken. "Covered claim" does not include supplementary payment obligations, including but not limited to adjustment fees and expenses, attorney fees and expenses and court costs, nor does it include punitive, exemplary, extracontractual or bad-faith damages awarded by a court judgment against an insurer;

D. "insolvent insurer" means an insurer:

(1) authorized to transact title insurance business in New Mexico at the time the title insurance policy was issued; and

(2) against which an order of liquidation with a finding of insolvency has been entered after the effective date of the Title Insurance Guaranty Act by a court of competent jurisdiction in the insurer's state of domicile, or in this state, which has not been stayed or been the subject of a writ of supersedeas or other comparable order;

E. "member insurer" means any insurer authorized to transact title insurance business in New Mexico;

F. "net written premiums" means gross premiums written in this state on title insurance policies. "Net written premiums" does not include premiums on contracts between insurers or reinsurers;

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

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

I. "title insurance policy" or "policy" means those terms as defined in Section 59A-30-3 NMSA 1978 with respect to policies issued on land located in New Mexico.

History: Laws 1999, ch. 60, § 4.

59A-30A-5. Organization of association.

All member insurers shall remain members of the association as a condition of their authority to transact insurance in this state. The association may take the form of any appropriate legal entity under New Mexico law, including a corporation, partnership or unincorporated association, as approved by the superintendent. For purposes of administration and assessment, the association shall have two separate accounts:

A. the administrative account; and

B. the title guaranty account.

History: Laws 1999, ch. 60, § 5.

59A-30A-6. Board of directors.

A. The association's board of directors shall consist of not less than five nor more than eleven appointed members serving terms as provided in the association's plan of operation, and the superintendent or his designated representative as an ex-officio member. Appointed board members shall be selected by member insurers, subject to the superintendent's approval. A majority of the appointed members shall be employed by member insurers. Vacancies shall be filled for the remaining term by majority vote of the remaining board members, subject to the superintendent's approval.

B. Board members may be reimbursed from the administrative account for any reasonable and necessary expenses incurred in their capacities as board members, but the amount of such reimbursement shall not exceed guidelines provided by the approved plan of operation.

History: Laws 1999, ch. 60, § 6.

59A-30A-7. Duties and powers of the association.

A. The association shall:

(1) be obligated to the extent of covered claims arising from policies of an insolvent insurer issued prior to the finding of insolvency, except that the association

shall not be obligated as to policies replaced by another title insurance policy that covers the claim. In no event shall the association be obligated to a policyholder in an amount in excess of the obligation of the insolvent insurer under the policy;

(2) be deemed the insolvent insurer to the extent of the insurer's obligation on covered claims and to such extent shall have all rights, duties and obligations of the insurer as if the insurer had not become insolvent; provided that the association shall have no liability for any past claims based on negligence of the insurer or its agents in searching and reporting the condition of a title, on bad faith of the insolvent insurer, on the closing of any transaction or for exemplary or punitive damages;

(3) pay for the administration and operation of the association from the administrative account, through proceeds received from an annual guaranty fee to be collected in the amounts and manner established by rule of the superintendent;

(4) allocate claims payments, loss and adjustment expense and administrative expense to the appropriate accounts and assess member insurers, separately for each account, amounts necessary to pay the association's obligations subsequent to an insolvency. Assessments shall not be made in a year in which guaranty fee proceeds, together with unencumbered account balances and other assets, will be sufficient to satisfy the association's obligations. Assessments shall be made against each member insurer in the proportion that the member insurer's net written premiums for the last full calendar year bears to net written premiums of all member insurers for that calendar year. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in a year an amount greater than two percent of that member insurer's net written premiums for the preceding calendar year. If it appears that the maximum assessment available, together with unencumbered account balances and other assets, will be insufficient in a year to make all necessary payments, the association's obligations shall be paid pro rata and the unpaid portion shall be paid as soon as additional assessment proceeds or other funds become available. The association may pay claims in an order that it deems reasonable, including payments as claims are received or by groups or categories of claims. The association may exempt or defer, in whole or in part, the assessment of a member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority in any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer acting as a servicing facility may set off against an assessment any authorized payments made on covered claims and expenses incurred in the payment of the claims by such member insurer if they are chargeable to the account for which the assessment is made;

(5) investigate claims and adjust, compromise, settle and pay covered claims to the extent of the association's obligations, and deny all other claims. The association may review settlements, releases and judgments to which the insolvent insurer or its

insureds are parties to determine the extent to which such settlements, releases and judgments may be properly contested;

(6) notify such persons as the superintendent may direct pursuant to Section 9 [59A-30A-9 NMSA 1978] of the Title Insurance Guaranty Act;

(7) receive, handle, adjust and pay claims through its employees or through one or more insurers or other persons designated as servicing facilities, subject to the superintendent's approval; provided that a member insurer may decline any such designation;

(8) reimburse each servicing facility for obligations of the association paid by the facility and for reasonable expenses incurred by the facility for handling claims on behalf of the association, and pay other expenses of the association authorized by the Title Insurance Guaranty Act; and

(9) refund excess funds in an account to member insurers in proportion to the contribution of each member insurer to that account, when the board of directors estimates that the assets in the account will exceed the liabilities for the coming year.

B. The association may:

(1) employ persons or contract with servicing facilities necessary to handle claims and to perform other association duties;

(2) borrow funds necessary to effectuate the purposes of the Title Insurance Guaranty Act in accordance with the plan of operation, subject to the superintendent's approval;

(3) sue or be sued, and intervene in any court or other forum having jurisdiction over an insolvent insurer or its insureds;

(4) negotiate and enter into contracts necessary to carry out the purposes of the Title Insurance Guaranty Act; and

(5) perform all other acts necessary or proper to effectuate the purposes of the Title Insurance Guaranty Act.

History: Laws 1999, ch. 60, § 7.

59A-30A-8. Plan of operation.

A. The association shall submit to the superintendent a plan of operation and amendments to the plan necessary or suitable to ensure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon the superintendent's written approval. If, at any time, the

association fails to submit the plan or suitable amendments to the superintendent, he shall, after notice and hearing, adopt necessary or advisable rules to effectuate the provisions of the Title Insurance Guaranty Act. The rules shall continue in force until the superintendent modifies them or they are superseded by a plan or amendments submitted by the association and approved by the superintendent.

B. All member insurers shall comply with the association's plan of operation.

C. The association's plan of operation, among other things, shall establish all procedures for conducting the association's business, for handling its assets, for receiving, handling, adjusting and paying claims, for keeping records and for the conduct of other activities necessary to carry out the association's powers and duties.

D. The association's plan of operation may provide that any of the association's powers and duties, except those specified in Paragraph (3) of Subsection A and Paragraph (2) of Subsection B of Section 7 [59A-30A-7 NMSA 1978] of the Title Insurance Guaranty Act, be delegated to a corporation, association or other organization that performs or will perform functions similar to those of the association in two or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility and paid for performing any other function.

History: Laws 1999, ch. 60, § 8.

59A-30A-9. Duties and powers of superintendent.

A. The superintendent shall:

(1) promptly forward to the association a copy of any complaint or petition seeking an order of liquidation with a finding of insolvency against a title insurer;

(2) notify the association that a title insurer has been found to be an insolvent insurer not later than three days after he receives notice of the finding; and

(3) upon request of the board of directors, provide the association with a statement of the net written premiums of each member insurer.

B. The superintendent may:

(1) require that the association or an insolvent insurer's licensed New Mexico agents notify the insurer's New Mexico insureds and other interested parties of the finding of insolvency and of their rights under the Title Insurance Guaranty Act. Notification shall be made by mail at the last known address; provided that if sufficient information for notification by mail is not available, notice by publication in one or more newspapers of general circulation in the state shall be sufficient;

(2) suspend or revoke, after notice and hearing, a member insurer's certificate of authority if the insurer fails to pay any assessment within thirty days after it was due or fails to comply with the association's plan of operation. In the alternative, the superintendent may impose a civil penalty not to exceed five percent of the unpaid assessment per month; provided that no civil penalty shall be less than one hundred dollars ($100) per month; and

(3) revoke the designation of any servicing facility if he finds that claims are not being handled satisfactorily.

History: Laws 1999, ch. 60, § 9.

59A-30A-10. Effect of paid claims.

A. A person recovering under the Title Insurance Guaranty Act shall be deemed to have assigned his rights and claims under the insolvent insurer's policy to the association to the extent of his recovery from the association. Every insured seeking the protection of the Title Insurance Guaranty Act shall cooperate with the association to the same extent as required to cooperate with the insurer. The association shall have no cause of action against an insured for sums it has paid out except such causes of action as the insurer would have had. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims by the association do not operate to reduce the liability of the insured to the receiver, liquidator or statutory successor for unpaid assessments.

B. The court having jurisdiction shall grant claims assigned pursuant to Subsection A of this section and the claims expenses of the association or similar organization in another state the same priority as the claims had before assignment. The association may make application to the court for reimbursement of such claims and expenses and, upon proper application, the court shall order appropriate disbursement to be made.

C. The association shall, within the time set by the receivership court, file with the receiver or liquidator of the insolvent insurer, statements of paid claims and claims expense and reserves for unpaid claims and claims expense.

History: Laws 1999, ch. 60, § 10.

59A-30A-11. Nonduplication of recovery.

A person having a claim under any other title insurance policy that is not an insolvent insurer's policy, which is also a covered claim, shall first exhaust his rights under such other title insurance policy. An amount payable for a covered claim shall be reduced by the amount of any recovery under such other title insurance policy.

History: Laws 1999, ch. 60, § 11.

59A-30A-12. Prevention of insolvencies.

A. To aid in the detection and prevention of title insurer insolvencies, the association's board of directors may, upon majority vote:

(1) make recommendations to the superintendent for the detection and prevention of insolvencies; and

(2) respond to requests by the superintendent to discuss and make recommendations regarding the status of a member insurer whose financial condition may be hazardous to policyholders or the public. Recommendations pursuant to this paragraph shall not be available for public inspection.

B. The superintendent shall report to the association's board of directors when he has reasonable cause to believe that a title insurer may be insolvent or in a financial condition hazardous to its policyholders or the public. The report, and subsequent meetings, activities, recommendations and decisions of the board of directors as required or permitted in this subsection, shall not be open to the public or available for public inspection.

C. At the conclusion of a domestic title insurer insolvency for which the association was obligated to pay covered claims, the association's board of directors may prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit the report to the superintendent. The report, and subsequent meetings, activities, recommendations and decisions of the board of directors as required or permitted in this section, shall not be open to the public or available for public inspection.

History: Laws 1999, ch. 60, § 12.

59A-30A-13. Examination of association; financial reports.

The association is subject to the superintendent's examination and regulation pursuant to Chapter 59A, Article 4 NMSA 1978. The board of directors shall submit, not later than June 30 each year, a financial report for the preceding calendar year prepared by an independent certified public accountant acceptable to the superintendent. The financial report shall be in a form approved by the superintendent.

History: Laws 1999, ch. 60, § 13.

59A-30A-14. Appeals.

A. An insured whose claim is denied in whole or in part by the association may request the receivership court, or the ancillary receivership court in this state, to review the association's decision. The request for review shall be filed within thirty days after the date of denial. The receivership court and ancillary receivership court in this state

shall have exclusive jurisdiction of all such claims. The decision of the court shall be binding on both the claimant and the association.

B. A member insurer may appeal to the superintendent from any action of the association's board of directors by filing a notice of appeal within thirty days after the date of the action appealed from.

C. A final order of the superintendent pursuant to Subsection B of this section is subject to judicial review by an action in the district court of Santa Fe county to set aside the order as unlawful or not supported by substantial evidence. If judicial review is not sought within thirty days after the date of the superintendent's order, the order shall be final and not subject to appeal.

History: Laws 1999, ch. 60, § 14.

59A-30A-15. Recognition of assessment in rates.

The title insurance rates and premiums promulgated by the superintendent shall include amounts sufficient to recoup within three years after assessment a sum equal to the amounts paid to the association by the member insurers, less amounts returned to the member insurers by the association. Rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurers. The entire amount of any such recoupment shall be passed through to insurers.

History: Laws 1999, ch. 60, § 15.

59A-30A-16. Immunity; confidentiality.

A. There shall be no liability on the part of, and no cause of action of any nature shall exist against, a member insurer, the association or its agents or employees, the board of directors, an individual director or the superintendent or his representative for an action taken by them in connection with carrying out their powers and duties under the Title Insurance Guaranty Act or failure to prevent any insolvency. The association shall defend all actions alleging such liability except that the attorney general shall defend any such actions against the superintendent or his representatives.

B. The meetings, activities, recommendations and decisions of the board of directors pursuant to the Title Insurance Guaranty Act shall not be open to the public or available for public inspection; provided that no representative of a member insurer shall be excluded from a meeting of the board of directors, with the exception of a representative of an insolvent insurer.

History: Laws 1999, ch. 60, § 16.

59A-30A-17. Stay of proceedings; reopening of default judgments.

All proceedings in which the insolvent insurer is a party or is obligated to represent a party in a court in New Mexico shall be stayed for not to exceed six months from the date of a finding of insolvency to permit proper representation by the association of all pending causes of action. As to covered claims arising from a judgment under a decision, verdict or finding resulting from the default of the insolvent insurer or its failure to defend an insured, the association, either on its own behalf or on behalf of the insured, may apply to have the judgment, order, decision, verdict or finding set aside by the same court, administrator or arbitrator that made it and may defend against the claim on its merits.

History: Laws 1999, ch. 60, § 17.

59A-30A-18. Termination; distribution of funds.

A. The superintendent shall by order terminate the operation of the association if he finds, after hearing, that there is in effect a statutory or voluntary plan that:

(1) is a permanent plan that is adequately funded or for which an adequate means of funding is provided; and

(2) extends or will extend, to New Mexico title insurance policyholders and residents, protection and benefits with respect to insolvent insurers not less favorable than the protection provided under the Title Insurance Guaranty Act.

B. If the association's operation is terminated, the association, as soon as possible, shall distribute the balance of money and assets remaining, after discharge of the functions of the association with respect to prior insurer insolvencies not covered by another plan, to member insurers that are then writing title insurance policies in this state, pro rata upon the basis of the aggregate of payments and assessments made by the respective insurers during the five years next preceding the date of the order.

History: Laws 1999, ch. 60, § 18.

ARTICLE 31
Surety Insurance Contracts

59A-31-1. Scope of article.

Chapter 59A, Article 31 NMSA 1978 shall apply only as to contracts of surety insurance, as defined in Section 59A-7-8 NMSA 1978 [repealed]. Such contracts are also subject to the applicable provisions of Chapter 59A, Articles 5 and 18 NMSA 1978.

History: Laws 1984, ch. 127, § 508; 2013, ch. 63, § 1.

ARTICLE 32
Motor Vehicle Insurance

59A-32-1. Assigned risk plan, short title.

Sections 520 through 532 [59A-32-1, 59A-32-3 to 59A-32-13 NMSA 1978] of this article comprise and may be cited as the "Motor Vehicle Assigned Risks Law".

History: Laws 1984, ch. 127, § 520.

59A-32-2. Scope of article.

This article shall apply only as to contracts of vehicle insurance, as defined in Section 113 [59A-7-7 NMSA 1978] of the Insurance Code. Such contracts shall also be subject to the applicable provisions of Article 18 [Chapter 59A, Article 18 NMSA 1978] (the insurance contract) of the Insurance Code.

History: Laws 1984, ch. 127, § 509.

59A-32-3. Purpose of assigned risk plan.

The purpose of the assigned risk plan is to provide for the equitable distribution and apportionment among insurers authorized to transact in this state the business of automobile and motor vehicle bodily injury, property damage liability and physical damage insurance, of insurance afforded applicants who are in good faith entitled to, but who are unable to procure, such insurance through ordinary methods.

History: Laws 1984, ch. 127, § 521.

59A-32-4. Assigned risk plan.

Every insurer referred to in Section 521 [59A-32-3 NMSA 1978] of this article shall cooperate in the formulation of a plan or plans for the equitable apportionment among such insurers of insurance afforded applicants who are in good faith entitled to, but who are unable to procure, such insurance through ordinary methods.

History: Laws 1984, ch. 127, § 522.

59A-32-5. Requirements of assigned risk plans.

Any such agreement or plan for the assignment of risks involving automobile and motor vehicle bodily injury and property damage liability insurance shall include provision for: reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise, and by the assignment of risks to insurers

participating in the plan; rates and reasonable rate modifications which shall be applicable to such risks and which shall not be excessive, inadequate or unfairly discriminatory; the limits of liability which any insurer to whom a risk is assigned shall be required to assume; and a method whereby applicants for insurance, persons insured and insurers under the plan may have a hearing on grievances and the right to appeal from the decision on any such grievance to the superintendent.

History: Laws 1984, ch. 127, § 523.

59A-32-6. Review of proposed assigned risk plans.

Every such plan for the assignment of risks involving automobile and motor vehicle bodily injury and property damage liability insurance shall be filed in writing with the superintendent. The superintendent shall review the plan as soon as reasonably possible after filing, to determine whether or not it meets the requirements of Section 523 [59A-32-5 NMSA 1978] of this article. Each plan shall be on file with the superintendent for a waiting period of thirty (30) days before it becomes effective, unless sooner approved in writing. Unless disapproved in writing by the superintendent within the thirty (30) day waiting period, a plan shall be deemed approved and shall become effective upon the expiration of that period.

History: Laws 1984, ch. 127, § 524.

59A-32-7. Disapproval of effective assigned risk plans.

When any assigned risk plan has become effective as above provided, the superintendent may thereafter disapprove such plan or any portion thereof on the ground that it does not meet the requirements of Section 523 [59A-32-5 NMSA 1978] of this article, but only after a full hearing held upon not less than ten (10) days' written notice to every insurer affected, specifying the matters to be considered at such hearing, and only by an order specifying the respects in which the superintendent finds that such plan fails to meet the requirements imposed, and stating the date, within a reasonable period thereafter, when such plan, or portion thereof, shall be deemed to cease to be effective. No such order shall affect any assignment made or policy issued or made prior to the expiration of the period specified in the order. Amendments to any such plan or plans shall be prepared, filed and reviewed in the same manner as provided with respect to the original plan or plans.

History: Laws 1984, ch. 127, § 525.

59A-32-8. Failure to file plan; assigned risk plan prescribed.

If no plan which meets the requirements of Section 523 [59A-32-5 NMSA 1978] of this article above has been filed with the superintendent within ninety (90) days after June 30, 1959, or within the period stated in any order which disapproves an existing plan, the superintendent may formulate and prescribe a plan which does meet such

requirements, after hearing or consultation with insurers authorized to transact in this state the business of automobile and motor vehicle bodily injury and property damage liability insurance. When any plan or plans or amendment thereto has or have been approved or prescribed, no insurer to which such plan is applicable shall thereafter issue any policy of such insurance, or undertake to transact such business in this state, unless the insurer participates in such plan.

History: Laws 1984, ch. 127, § 526.

59A-32-9. Appeal to governing committee.

Any person affected by the action or inaction of any insurer pursuant to the assigned risks plan may appeal to the governing committee of the assigned risk plan or plan may appeal to the governing committee of the assigned risk plan or plans to which such insurer is a subscriber.

History: Laws 1984, ch. 127, § 527.

59A-32-10. Appeal to superintendent.

Any person or subscribing insurer to the plan or plans affected by any ruling or decision of the governing committee of any assigned risk plan or decision of the governing committee of any assigned risk plan or plans pursuant to the Motor Vehicle Assigned Risks Law [59A-32-1, 59A-32-3 to 59A-32-13 NMSA 1978] may appeal to the superintendent from such ruling or decision.

History: Laws 1984, ch. 127, § 528.

59A-32-11. Action by superintendent.

The superintendent, whenever any matter is referred to him under the Motor Vehicle Assigned Risks Law [59A-32-1, 59A-32-3 to 59A-32-13 NMSA 1978], shall review all information available to him and relating to the matter, including information available to him and relating to the matter, including information available to him from his records, the records of the motor vehicle division of the transportation department and other sources, and based upon his consideration of such information and the record of any hearing which he may in his discretion call and conduct informally, the superintendent, in his reasonable discretion, may: refuse to approve any application for assignment of risk; approve the rejection of any application by any insurer concerned; refuse to approve the renewal to reassignment of an existing policy; or take such other action as he shall determine to be fair and reasonable under all the circumstances. All testimony and other evidence on which the superintendent bases any action under the Motor Vehicle Assigned Risks Law shall be filed of record in the insurance department. Any such action by the superintendent shall be by order in writing, directed to the parties affected and filed of record in the insurance department.

History: Laws 1984, ch. 127, § 529.

59A-32-12. Action by superintendent; review.

Any action by the superintendent pursuant to the Motor Vehicle Assigned Risks Law [59A-32-1, 59A-32-3 to 59A-32-13 NMSA 1978] shall be subject to review and appeal as provided in Article 4 [Chapter 59A, Article 4 NMSA 1978] (examinations, hearings and appeals) of the Insurance Code.

History: Laws 1984, ch. 127, § 530.

59A-32-13. Rules and regulations.

The superintendent may prescribe, amend, supplement and revoke from time to time regulations as he may deem warranted for the administration of the Motor Vehicle Assigned Risks Law [59A-32-1, 59A-32-3 to 59A-32-13 NMSA 1978].

History: Laws 1984, ch. 127, § 531.

59A-32-14. Insurance policies; appropriate reduction in premiums.

A. Any rates, rating schedules or rating manuals for the liability, personal injury protection and collision coverages of a motor vehicle insurance policy submitted to or filed with the superintendent of insurance shall provide for an appropriate reduction in premium charges for a three-year consecutive period for such coverages when the principal operator of the covered vehicle:

(1) is an insured driver fifty-five years or older; and

(2) has successfully completed a motor vehicle accident prevention course approved by the traffic safety bureau of the state highway and transportation department.

B. Any discount used by the insurer pursuant to this section shall be presumed appropriate unless credible data demonstrates otherwise.

History: Laws 1987, ch. 18, § 1; 1989, ch. 131, § 1.

59A-32-15. Conditions for maintaining the discount.

The premium reduction required by this section shall be effective for an insured for a three-year period after successful completion of the approved course, except that the insurer may require, as a condition of maintaining the discount, that the insured:

A. not be involved in an accident for which the insured is at fault; and

B. not be convicted or plead guilty or nolo contendere to a moving traffic violation.

History: Laws 1987, ch. 18, § 2.

59A-32-16. Certificate of course completion.

Upon successfully completing the approved course, each person shall be issued a certificate by the organization offering the course which shall be used to qualify for the premium discount required by Section 1 [59A-32-14 NMSA 1978] of this act.

History: Laws 1987, ch. 18, § 3.

59A-32-17. Exceptions.

The provisions of this act [59A-32-14 to 59A-32-19 NMSA 1978] do not apply in the event the approved course is ordered by a court or other governmental entity resulting from a moving traffic violation or made a condition of the dismissal of a moving traffic violation.

History: Laws 1987, ch. 18, § 4.

59A-32-18. Continued eligibility.

Each participant shall take an approved course every three years in order to continue to be eligible for the reduction in premiums.

History: Laws 1987, ch. 18, § 5.

59A-32-19. Discounts or reductions in premiums.

Nothing in Sections 59A-32-14 through 59A-32-18 NMSA 1978 shall prohibit an insurer offering private passenger motor vehicle insurance to New Mexico residents from providing a minimum twenty percent premium discount for bodily injury liability, property damage liability and collision coverages.

History: Laws 1987, ch. 18, § 6; 1991, ch. 135, § 1; 1993, ch. 194, § 1.

59A-32-20. Rental car companies; insurance coverage.

Any rental car company offering for sale insurance coverage or collision damage waivers shall state clearly on the front page of the rental contract that the purchaser of the insurance coverage or collision damage waiver offered may be covered for such claims on his personal motor vehicle insurance policy and that if such insurance coverage exists under the renter's personal insurance policy, and the coverage is confirmed, the renter may require that the rental car company must submit any claims to

the renter's personal insurance carrier as the renter's agent. The rental car company shall not make any written or oral representations that it will not present claims or negotiate with the renter's insurance carrier. For purposes of this section, confirmation of coverage includes telephone confirmation from an insurance company representative.

History: Laws 1987, ch. 303, § 1.

59A-32-21. Discounts for comprehensive coverage.

A. Any insurance company authorized to write private passenger automobile insurance within the state shall provide a minimum premium discount of ten percent for motor vehicles with passive anti-theft devices. These discounts shall apply to comprehensive coverage and shall be approved by the superintendent pursuant to Section 59A-17-13 NMSA 1978 as part of the insurer's rate filing. Some or all of the premium discounts required by this section may be omitted upon demonstration to the superintendent in an insurer's rate filing that the discounts are duplicative of other discounts provided by the insurer.

B. As used in this section, "passive anti-theft device" means any item or system installed in an automobile that is activated automatically when the operator turns the ignition key to the off position and that is designed to prevent unauthorized use, as prescribed by regulations of the superintendent. The "passive anti-theft device" does not include an ignition interlock provided as a standard anti-theft device by the original automobile manufacturer.

History: Laws 1993, ch. 137, § 1.

59A-32-22. Freedom of choice; doctor of oriental medicine.

A. Within the area and limits of coverage offered an insured and selected by him in the application for insurance, for vehicle insurance medical payments as defined in Subsection D of Section 59A-7-7 NMSA 1978, the right of any person to exercise full freedom of choice in the selection of any licensed doctor of oriental medicine for treatment within his scope of practice shall not be restricted under any new policy of vehicle insurance issued after July 1, 1997 in this state or in the processing of any claim made pursuant to that policy. Any person insured or claiming benefits under the medical payments portion of such vehicle insurance policy providing within its coverage for payment of benefits or indemnity for any condition or circumstance described in Subsection D of Section 59A-7-7 NMSA 1978 shall be deemed to have complied with the requirements of the policy as to submission of proof of loss upon submitting written proof supported by any doctor of oriental medicine.

B. As used in this section, "doctor of oriental medicine" means a person licensed as a doctor of oriental medicine pursuant to the Acupuncture and Oriental Medicine Practice Act [Chapter 61, Article 14A NMSA 1978].

History: Laws 1997, ch. 84, § 1.

59A-32-23. Vehicle insurance; primary liability; assignment; notice.

A. When a vehicle owned by a licensed automobile dealer is loaned without a fee to a person for demonstration purposes, as a temporary substitute for that person's vehicle while it is being serviced or repaired, as a promotional courtesy vehicle or as a courtesy vehicle, primary insurance or self-insurance coverage shall be provided by the motor vehicle insurer providing coverage to the person using the demonstration vehicle, temporary substitute vehicle, promotional courtesy vehicle or a courtesy vehicle, and coverage provided by the dealer or the dealer's insurer applies only as excess coverage.

B. A person proposing to operate a motor vehicle for the purposes identified in Subsection A of this section may assume primary responsibility for the operator's vehicle insurance by signing the following statement:

"PRIMARY LIABILITY ASSIGNMENT

In consideration of the vehicle owner entrusting the motor vehicle elsewhere described to me, I agree that my vehicle insurance or self-insurance coverage shall be primarily responsible for any loss or damage caused by or to the motor vehicle.".

C. The agreement set forth in Subsection B of this section shall be binding on all insurers and self-insurers transacting insurance in the state as a condition of doing the business of transacting insurance.

History: Laws 2001, ch. 88, § 1; 2002, ch. 86, § 1.

ARTICLE 32A
Rental Car Insurance Limited Producer License

59A-32A-1. Short title.

This act [59A-32A-1 to 59A-32A-9 NMSA 1978] may be cited as the "Rental Car Insurance Limited Producer License Act".

History: Laws 2001, ch. 94, § 1.

59A-32A-2. Definitions.

As used in the Rental Car Insurance Limited Producer License Act:

A. "rental agreement" means a written master, corporate, group or individual agreement setting forth the terms and conditions governing the use of a rental car rented or leased by a rental car company;

B. "rental car" means a motor vehicle that is intended to be rented or leased for a period of ninety consecutive days or less by a driver who is not required to possess a commercial driver's license to operate the motor vehicle and the motor vehicle is one of the following:

(1) a private passenger motor vehicle, including a passenger van, minivan or sports utility vehicle; or

(2) a cargo vehicle, including a cargo van, pickup truck or truck with a gross vehicle weight of less than twenty-six thousand pounds;

C. "rental car agent" means a rental car company that is licensed to offer, sell, bind, effect, solicit or negotiate rental car insurance;

D. "rental car company" means a person or entity in the business of renting rental cars to the public, including a franchisee;

E. "rental car insurance" means insurance sold in connection with and incidental to the rental of vehicles, whether at the rental office or by a preselection of coverage in master, corporate, group or individual agreements, that is nontransferable, does not apply to any vehicle other than the rental car that is the subject of the rental agreement and is limited to the following kinds of insurance:

(1) personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs with the rental car during the rental period;

(2) liability insurance that, at the exclusive option of the rental car company, may include uninsured and underinsured motorist coverage, whether offered separately or in combination with other liability insurance, and that provides protection to renters and other authorized drivers of rental cars for liability arising from the operation of the rental car during the rental period;

(3) personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period;

(4) roadside assistance and emergency sickness insurance; and

(5) any other travel or vehicle-related insurance coverage that a rental car company may offer in connection with and incidental to the rental of a rental car, as may be approved by the superintendent of insurance;

F. "rental car endorsee" means a rental car agent employee who offers, sells, binds, effects, solicits or negotiates rental car insurance; and

G. "renter" means a person who obtains the use of a vehicle from a rental car company under the terms of a rental agreement.

History: Laws 2001, ch. 94, § 2.

59A-32A-3. General rules.

A. No rental car company and no officer, director, employee or agent of a rental car company shall offer, sell, bind, effect, solicit or negotiate the purchase of rental car insurance unless that company is licensed as an insurance producer pursuant to the New Mexico Insurance Code [Chapter 59A NMSA 1978] or has complied with the requirements of the Rental Car Insurance Limited Producer License Act.

B. The superintendent of insurance may issue to a rental car company that has complied with the requirements of the Rental Car Insurance Limited Producer License Act, a license that authorizes the rental car company to act as a rental car agent in accordance with the provisions of that act, in connection with and incidental to rental agreements, on behalf of any insurer authorized to write such insurance in this state.

History: Laws 2001, ch. 94, § 3.

59A-32A-4. Licensing rental car companies as rental car agents.

A rental car company may apply to be licensed as a rental car agent under the terms of the Rental Car Insurance Limited Producer License Act if it satisfies all of the requirements of that act and if it files the following documents with the superintendent of insurance:

A. a written application for licensure, signed by the applicant or by an officer of the applicant, in the form prescribed by the superintendent of insurance that includes a listing of all locations at which the rental car company intends to offer, sell, bind, effect, solicit or negotiate rental car insurance; and

B. a certificate filed by the insurer for the applicant stating that the insurer has satisfied itself that the applicant is trustworthy and competent to act as its insurance producer limited to this purpose; that the insurer has reviewed the employee training program required by Subsection D of Section 59A-32A-5 NMSA 1978 and believes that it satisfies the statutory requirements; and that the insurer will appoint the applicant to act as its insurance producer to transact the kinds of insurance that are permitted by the Rental Car Insurance Limited Producer License Act if the license for which the applicant is applying is issued by the superintendent of insurance. The certification shall be subscribed by an officer or managing agent of the insurer on a form prescribed by the superintendent of insurance.

History: Laws 2001, ch. 94, § 4; 2016, ch. 89, § 63.

59A-32A-5. Rental car endorsees.

A. An employee of a rental car agent may be a rental car endorsee authorized to offer, sell, bind, effect, solicit or negotiate rental car insurance under the authority of the rental car agent licensee if all of the following conditions have been satisfied:

(1) the employee is eighteen years of age or older;

(2) the employee has completed the training described in Subsection D of Section 5 [59A-32A-5 NMSA 1978] of the Rental Car Insurance Limited Producer License Act; and

(3) the rental car agent, at the time it submits its rental car agent license application pursuant to Section 3 [59A-32A-3 NMSA 1978] of the Rental Car Insurance Limited Producer License Act, also establishes a list of the names of all of its rental car endorsees. The list shall be maintained by the rental car agent in a form prescribed by the superintendent of insurance and updated quarterly. Each list shall be retained by the rental car agent for three years and shall be made available to the superintendent of insurance for review and inspection upon request.

B. A rental car endorsee shall act on behalf of its rental car agent in the offering, sale, binding, effectuation, solicitation or negotiation of rental car insurance. A rental car agent is responsible for, and must supervise, all actions of its endorsees related to the offering, sale, binding, effectuation, solicitation or negotiation of rental car insurance. The conduct of a rental car endorsee acting within the scope of his employment or agency shall be deemed the conduct of the rental car agent for purposes of the Rental Car Insurance Limited Producer License Act.

C. The manager at each location of a rental car agent or the direct supervisor of the rental car agent's endorsees at each location shall be responsible for the supervision of each rental car endorsee at the location. A rental car agent shall identify the manager or direct supervisor at each location in the list that it maintains in compliance with Paragraph (3) of Subsection A of this section.

D. A rental car agent shall provide training for each rental car endorsee prior to allowing him to offer, sell, bind, effect, solicit or negotiate rental car insurance. The training program shall be submitted to the superintendent of insurance for approval prior to use and shall meet the following minimum standards:

(1) instruction about the kinds of insurance specified in the Rental Car Insurance Limited Producer License Act that are offered for sale to prospective renters; and

(2) disclosures to be given to prospective renters that are required under the Rental Car Insurance Limited Producer License Act, including:

(a) that the purchase of the rental car insurance is not required in order for the renter to rent a rental car; and

(b) that the renter may have insurance policies in place that already provide the coverage being offered by the rental car company.

E. A rental car endorsee's authorization to offer, sell, bind, effect, solicit or negotiate rental car insurance shall expire when the endorsee's employment with the rental car agent has terminated.

History: Laws 2001, ch. 94, § 5.

59A-32A-6. Rental car agent and endorsee restrictions.

No insurance may be issued, offered, sold, solicited or negotiated pursuant to this section unless:

A. the rental period of the rental agreement is ninety consecutive days or less;

B. at every location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(1) summarize, clearly and correctly, the material terms and conditions of coverage offered to renters, including the identify of the insurer;

(2) describe the process for filing a claim in the event the renter elects to purchase coverage, including a toll-free telephone number to report a claim;

(3) provide the rental car agent's name, address, telephone number and license number, as well as the consumer hotline number for the superintendent of insurance;

(4) state that the rental car insurance offered by the rental car agent or endorsee may provide a duplication of coverage already provided by a renter's personal automobile policy or by another source of coverage;

(5) state that the purchase by the renter of the rental car insurance is not required in order to rent a rental car;

(6) state that neither the rental car agent nor its endorsees are qualified to evaluate the adequacy of the renter's existing insurance coverages;

(7) set forth the costs for the rental car insurance in the rental agreement; and

(8) contain any additional information as the superintendent of insurance may prescribe; and

C. evidence of the rental car insurance purchased is disclosed on the face of the rental agreement.

History: Laws 2001, ch. 94, § 6.

59A-32A-7. Rental car agent and endorsee prohibitions.

A rental car agent or endorsee shall not:

A. offer, sell, bind, effect, solicit or negotiate the purchase of rental car insurance except in conjunction with and incidental to rental agreements;

B. advertise, represent or otherwise portray itself or any of its employees or agents as licensed insurers or insurance producers; or

C. pay any person, including a rental car endorsee, any compensation, fee or commission that is dependent solely on the placement of insurance under the license issued pursuant to the Rental Car Insurance Limited Producer License Act. Nothing in this section shall prohibit production payments or incentive payments to a person that are not dependent solely upon the sale of insurance.

History: Laws 2001, ch. 94, § 7; 2016, ch. 89, § 64.

59A-32A-8. Enforcement.

A. In the event a provision of the Rental Car Insurance Limited Producer License Act is violated by a rental car agent or endorsee, the superintendent of insurance may:

(1) after notice and hearing, revoke or suspend the license issued under the Rental Car Insurance Limited Producer License Act; or

(2) after notice and hearing, impose other penalties, including suspending the transaction of insurance at specific rental locations where violations of the Rental Car Insurance Limited Producer License Act have occurred.

B. If a person offers or sells insurance in connection with, or incidental to, rental agreements or holds himself or a company out as a rental car agent without satisfying the requirements of the Rental Car Insurance Limited Producer License Act, the superintendent of insurance shall be authorized to issue a cease and desist order.

History: Laws 2001, ch. 94, § 8.

59A-32A-9. Trust accounts.

Notwithstanding any provision of the Rental Car Insurance Limited Producer License Act or any other rule or statute, a licensee pursuant to that act shall not be required to treat money collected from renters purchasing rental car insurance when renting rental cars as funds received in a fiduciary capacity or to hold the funds in separate trust accounts.

History: Laws 2001, ch. 94, § 9.

ARTICLE 33
Workers' Compensation Insurance Contracts and Assigned Risks

59A-33-1. Assigned risk pool, short title.

Chapter 59A, Article 33 NMSA 1978 may be cited as the "Workers' Compensation Assigned Risk Pool Law".

History: Laws 1984, ch. 127, § 534; 1989, ch. 42, § 1.

59A-33-2. Scope of article.

The Workers' Compensation Assigned Risk Pool Law shall apply only as to contracts of workers' compensation insurance. Such contracts shall also be subject to the applicable provisions of Chapter 59A, Article 18 NMSA 1978.

History: Laws 1984, ch. 127, § 533; 1989, ch. 42, § 2.

59A-33-3. Purpose.

It is the purpose of the Workers' Compensation Assigned Risk Pool Law to provide for the insurance of workers' compensation insurance risks that have, in good faith but without success, sought insurance in the usual manner from any two or more insurers authorized to transact in New Mexico the business of workers' compensation insurance and to provide for the equitable distribution of risks among commercial line insurers.

History: Laws 1984, ch. 127, § 535; 1989, ch. 42, § 3; 1990 (2nd S.S.), ch. 2, § 94; 1993, ch. 201, § 1.

59A-33-4. Definitions.

As used in the Workers' Compensation Assigned Risk Pool Law:

A. "board" means the governing board of the pool;

B. "commercial line insurer" means any foreign, alien or domestic stock or mutual insurer, or reciprocal or interinsurance exchange, or association or other corporation or organization authorized to transact workers' compensation insurance, commercial multiple peril insurance or commercial general liability insurance in this state. The superintendent may adopt rules and regulations to define commercial multiple peril insurance or commercial general liability insurance. For policy years beginning on or after January 1, 1994, "commercial line insurer" shall apply to workers' compensation only and shall not include commercial multiple peril insurance or commercial general liability insurance;

C. "person" means an individual, firm, association, corporation or a public or private agency or institution;

D. "policyholder" means a person or entity insured through or by the pool;

E. "pool" means the New Mexico workers' compensation assigned risk pool established pursuant to Section 59A-33-5 NMSA 1978;

F. "rejected risk" means an employer who is in good faith entitled to insurance but is unable to procure or retain insurance through ordinary methods in the voluntary market as evidenced by at least two written rejections. The term includes any legal entities that may be combined for experience-rating purposes according to the rules of the superintendent; and

G. "servicing carrier" means a person designated by the superintendent to issue a policy that evidences the insurance coverages provided to a rejected risk and to service the policyholder as provided in the Workers' Compensation Assigned Risk Pool Law.

History: Laws 1984, ch. 127, § 536; 1989, ch. 42, § 4; 1990 (2nd S.S.), ch. 2, § 95; 1993, ch. 201, § 2.

59A-33-5. Organization of assigned risk pool.

A. To carry into effect the provisions of the Workers' Compensation Assigned Risk Pool Law, there shall be maintained a nonprofit unincorporated association of commercial line insurers to be known as the "New Mexico workers' compensation assigned risk pool", and every commercial line insurer shall be a member of the pool.

B. The pool shall be governed by a board constituted of seven persons, appointed by the superintendent as follows:

(1) at least four members shall be knowledgeable and have experience in the field of workers' compensation insurance and be employed by or represent private, voluntary licensed insurance companies;

(2) all members shall be appointed for two-year terms; and

(3) all members shall be appointed and subject to removal by the superintendent.

C. The board shall adopt, amend and repeal bylaws, subject to the approval of the superintendent, to govern the board's and the pool's operation and administration and to provide for the self-sufficient, economic, fair and nondiscriminatory administration of the pool.

D. The pool shall pay all costs and expenses of operating and maintaining the pool, including any allowances for servicing policies issued through or reinsured by the pool. State funds shall not be appropriated or expended for payment of any costs or expenses incurred in the operation or maintenance of the pool.

E. There shall be no liability on the part of and no cause of action shall arise against the board, the pool, its executive director or any of its staff, agents, servants or employees or against any member of the pool or any of its officers, directors, agents, servants or employees, arising out of or in connection with any judgment or decision made in connection with the performance of the powers and duties under the Workers' Compensation Assigned Risk Pool Law. This shall include any inspections, safety engineering investigations performed, or recommendations made in good faith in any reports or in communications concerning employers due to their applying for or being provided insurance coverage by the pool, or at any administrative hearing or inquiry conducted in connection with insurance coverage provided by the pool pursuant to the purposes and objectives of the Workers' Compensation Assigned Risk Pool Law.

History: Laws 1984, ch. 127, § 537; 1989, ch. 42, § 5; 1990 (2nd S.S.), ch. 2, § 96.

59A-33-5.1. Operation of pool.

The pool shall operate towards being self-sufficient and shall be self-sufficient no later than July 1, 1995. The rates charged the policyholders shall be set so that the amount received in premiums, together with reasonable investment income earned on those premiums, is reasonably expected to be sufficient to pay claims and losses incurred and reasonable operating expenses of the servicing carriers.

History: 1978 Comp., § 59A-33-5.1, enacted by Laws 1990 (2nd S.S.), ch. 2, § 97.

59A-33-5.2. Pool deficit review.

A. The pool's efficient and self-sufficient operation is essential to the successful operation of the workers' compensation system in New Mexico. The effect of the pool's operation upon small employers is a particularly critical concern that merits continuing and close supervision by the state. The state should make all reasonable efforts to ensure that employers who are good risks, and particularly small employers who have established good safety records, are not penalized in the pool with higher than warranted workers' compensation premium charges.

B. For the reasons set forth in this section, the superintendent shall continuously and closely monitor the performance of the pool, paying special attention to small employers. The superintendent shall report quarterly to the legislative finance committee on the status of the assigned risk pool.

History: Laws 1990 (2nd S.S.), ch. 3, § 5.

59A-33-6. Powers of the pool; duty of member companies; servicing carriers.

A. The pool shall provide workers' compensation insurance, pursuant to the terms of the Workers' Compensation Assigned Risk Pool Law, for any risk, under the laws of the state providing for workers' compensation, which risk in good faith has been tendered to and rejected by two or more insurers writing workers' compensation insurance. The pool may purchase reinsurance, either on a single occurrence or aggregate coverage basis.

B. In accordance with the bylaws of the pool, the board shall designate servicing carriers, that are willing to serve as such, the total number of which shall be determined by the board. Contracts with and compensation of servicing carriers shall be subject to the superintendent's approval. Contracts shall be for a term determined by the board subject to the superintendent's approval.

C. Following the adoption by the pool and approval by the superintendent of rules and regulations of the pool as provided for in Section 59A-33-9 NMSA 1978, the procedures and remedies established under the Workers' Compensation Assigned Risk Pool Law shall be the sole and exclusive procedures and remedies of any applicant for workers' compensation insurance in this state whose application for such insurance has in good faith been rejected in writing by two or more insurers writing workers' compensation insurance.

History: Laws 1984, ch. 127, § 538; 1989, ch. 42, § 6; 1990 (2nd S.S.), ch. 2, § 98.

59A-33-7. Assignment of risks by the pool.

When any person makes application to two or more insurers writing workers' compensation insurance for workers' compensation insurance and the insurers in good faith reject in writing the application, that person may file with the pool an application for assignment of the risk to a servicing carrier. If it appears to the pool that the risk is, in good faith, entitled to insurance, the pool shall assign such risk to a servicing carrier.

History: Laws 1984, ch. 127, § 539; 1989, ch. 42, § 7; 1990 (2nd S.S.), ch. 2, § 99.

59A-33-8. Issuance of policy; annual report.

A. The servicing carriers to which the pool assigns a workers' compensation insurance risk shall issue a policy, upon the payment of the premiums, in a form and for those limits of liability that are approved by the superintendent in accordance with the Workers' Compensation Assigned Risk Pool Law; but the undertakings of any issued policy shall be fully reinsured by all of the members of the pool, and the liability of the member issuing the policy shall be limited to its liability as a reinsurer. On any workers' compensation policy so issued, all members of the pool shall be reinsurers, as among themselves, in proportion to the amount that the net direct commercial line premiums on the insurance written in this state during the corresponding calendar year by the issuing member bears to the total of commercial line premiums written in this state during the corresponding calendar year by all members of the agency, and each policy may be endorsed to reflect the plan of reinsurance described in this section.

B. The superintendent may by regulation establish an incentive program for commercial line insurers to voluntarily write small employers outside of the assigned risk pool. In establishing the program, the superintendent may provide for credits or adjustments to the net direct commercial line premium for the purposes of determining the reinsurance share described in Subsection A of this section.

History: Laws 1984, ch. 127, § 540; 1989, ch. 42, § 8; 1990 (2nd S.S.), ch. 2, § 100; 1993, ch. 201, § 3.

59A-33-9. Rules and regulations.

The pool shall adopt regulations to assure the fair, reasonable, equitable and nondiscriminatory assignment of workers' compensation insurance risks, the applicable rates and rate modifications and other matters necessary or advisable to carry into effect the provisions of the Workers' Compensation Assigned Risk Pool Law. Regulations shall have the prior approval of the superintendent before they become effective. If the pool for any reason has failed to adopt regulations as provided in this section, the superintendent may adopt and issue reasonable regulations assuring the fair, reasonable, equitable and nondiscriminatory assignment of workers' compensation insurance risks, the applicable rates and rate modifications and other matters necessary or advisable to carry into effect the provisions of the Workers' Compensation Assigned Risk Pool Law. Regulations adopted and issued by the superintendent shall continue in force until modified by the superintendent or superseded by regulations adopted by the pool and approved by the superintendent.

History: Laws 1984, ch. 127, § 541; 1989, ch. 42, § 9; 1990 (2nd S.S.), ch. 2, § 101.

59A-33-9.1. Policyholders' duty to disclose; ratings experience.

A. Failure or refusal by any rejected risk to make full disclosure to the pool, servicing carrier or insurer writing a policy of information concerning the policyholder's true ownership, change of ownership, operations or payroll or any other failure to disclose fully any records pertaining to workers' compensation insurance, shall be

sufficient grounds for the pool to terminate the insurance of the policyholder as one not in good faith.

B. Incurred experience shall be used in future ratings regardless of a change in ownership, control, management or operations, and leasing companies shall adopt the incurred experience of the insured, so that no employer shall evade the burdens imposed by an unfavorable or high-cost experience.

History: 1978 Comp., § 59A-33-9.1, enacted by Laws 1990 (2nd S.S.), ch. 2, § 102.

59A-33-10. Authority of superintendent.

A. The superintendent may approve amendments to policy forms, endorsements, rates, rating plans or minimum premiums different from those normally applicable to a risk in order to apply to each risk assigned by the pool the policy forms, endorsements, rates, rating plans and minimum premiums as are commensurate with the greater hazard of the risk, and expenses involved in insuring the risk, considering in that connection the experience and the physical and other conditions of the risk.

B. Rates for any risk assigned by the pool shall be subject to approval by the superintendent in accordance with the applicable procedures provided in Chapter 59A, Article 17 NMSA 1978 so far as applicable. The superintendent may establish separate rates for any industry or workers' compensation classifications in the pool when the public interest so requires; provided that the rates established are fair, equitable and adequate.

C. If the pool or its governing board fails to act within a reasonable time or acts in a manner inconsistent with its rules, regulations, bylaws or articles of agreement or with statutory or case law, regulations of the superintendent or the public interest, the superintendent shall assume the power and duties of the pool and board and cause the pool to act in a manner conformable to law and the public interest.

D. The superintendent may direct the pool to release and make public any information he determines to be nonconfidential contained in applications for insurance from the pool and premium and loss information relating to individual risks.

E. The superintendent shall develop a marketing assistance plan to seek underwriters for risks assigned to the pool.

F. Members of the pool shall report all premium and loss information in a form and at the intervals required by the pool's regulations.

G. The superintendent shall adopt a surcharge program for any risks insured by the pool for the purpose of encouraging safety and fully funding any deficit caused by excessive losses. The surcharge program shall include a minimum surcharge of ten

percent of the premium for all risks insured by the pool and shall include higher surcharges for risks with adverse loss experience.

H. The superintendent may adopt a retrospective rating plan for any risk insured by the pool that has an annual premium greater than twenty-five thousand dollars ($25,000). The superintendent may establish the criteria that determine when the retrospective rating plan applies to a particular risk. Any risk not eligible for such a plan within the pool shall be eligible for a surcharge based on its individual risk.

I. The superintendent shall adopt a schedule debit plan for any risks insured by the pool that do not comply with loss-control recommendations, have frequency or severity problems, employ underaged or temporary employees or have any exposure that is greater than average for the class.

J. The superintendent shall adopt a schedule credit plan for any risks insured by the pool that have a good loss record, as determined in regulations adopted by the superintendent, and that have made a special good-faith effort but have not been able to purchase insurance in the private voluntary market at any reasonable cost. For the purposes of this section, "special good-faith effort" means, in addition to securing at least two written rejections from insurers in the voluntary market, contacting at least one independent insurance agent who states in writing that the agent has made an independent good-faith effort to locate insurance for the rejected risk in the private voluntary market.

History: Laws 1984, ch. 127, § 542; 1989, ch. 42, § 10; 1990 (2nd S.S.), ch. 2, § 103.

59A-33-11. Safety rules prescribed by the pool.

Any servicing carrier shall administer and enforce reasonable regulations adopted by the board, subject to the superintendent's approval, for the prevention of injuries to employees of its assigned policyholders or any applicant for assignment for workers' compensation insurance. For this purpose, the representatives of any servicing carrier shall have free access to the premises of any assigned policyholder or applicant for assignment during regular working hours. The failure or refusal by any policyholder or applicant to comply with the safety regulations or to permit such access shall be sufficient grounds for determining whether the policyholder or applicant is, in good faith, entitled to workers' compensation insurance or to a surcharge or restrospective [retrospective] rate for continued coverage.

History: Laws 1984, ch. 127, § 543; 1989, ch. 42, § 11; 1990 (2nd S.S.), ch. 2, § 104.

59A-33-12. Appeal to superintendent.

Any person aggrieved by any ruling or decision of the pool with respect to any assigned risk policy of workers' compensation insurance may file a written appeal to the superintendent, within thirty days following the ruling or decision. Upon receipt of an

appeal, the superintendent shall schedule and hold a full hearing, on at least ten days' written notice to the parties affected, of the subject matter of the appeal, and after consideration of all matters presented at the hearing, as well as information available to him from the records of the insurance department, the superintendent may affirm, annul or modify the appealed ruling or decision, or take any other action with respect thereto determined by him to be fair, reasonable and nondiscriminatory, under all the circumstances. All testimony and other evidence on which the superintendent bases any decision under the Workers' Compensation Assigned Risk Pool Law shall be in writing, directed to the parties affected and filed of record in the insurance department.

History: Laws 1984, ch. 127, § 544; 1989, ch. 42, § 12; 1990 (2nd S.S.), ch. 2, § 105.

59A-33-13. Action by superintendent; review.

Any action by the superintendent pursuant to the Workers' Compensation Assigned Risk Pool Law shall be subject to the review and appeal as provided in Chapter 59A, Article 4 NMSA 1978.

History: Laws 1984, ch. 127, § 545; 1989, ch. 42, § 13.

59A-33-14. Workers' compensation policies to provide for deductible provision at option of insured.

Any workers' compensation insurance policy issued to cover a risk in this state shall include provisions giving the insured employer the option of choosing a deductible based upon the employer's financial ability to repay the insurer any amounts expended by the insurer on behalf of the employer.

The deductible may be an amount ranging from five hundred dollars ($500) to two thousand five hundred dollars ($2,500), in increments of five hundred dollars ($500), or the amount of five thousand dollars ($5,000) or ten thousand dollars ($10,000). In exercising his authority to approve the form of the policy to be issued, the superintendent of insurance shall not approve any policy form that permits, directly or indirectly, any part of the deductible to be charged to or passed on to the worker.

History: Laws 1989, ch. 257, § 1; 1990 (2nd S.S.), ch. 2, § 106.

59A-33-15. Pool policyholder liability.

No policyholder in the assigned risk pool shall be liable for any deficit incurred by the pool for the calendar year 1991 unless that policyholder's policy is issued or renewed in 1991. A policyholder in the pool as of January 1, 1991, shall not, therefore, be liable for any deficit incurred by the pool for 1991 unless that policyholder's policy is renewed with the pool in calendar year 1991.

History: Laws 1990 (2nd S.S.), ch. 2, § 107.

ARTICLE 34
Domestic Stock and Mutual Insurers

59A-34-1. Scope of article.

This article [Chapter 59A, Article 34 NMSA 1978] applies as to domestic stock insurers and domestic mutual insurers as defined in Sections 71, 74, and 76 [59A-5-4, 59A-5-7, and 59A-5-9 NMSA 1978] of the Insurance Code.

History: Laws 1984, ch. 127, § 547.

59A-34-2. Application of general corporation statutes.

The applicable statutes of this state relating to the powers and procedures of domestic private corporations formed for profit shall also apply to domestic stock insurers and to domestic mutual insurers except where in conflict with the express provisions of the Insurance Code and the reasonable implications of such provisions.

History: Laws 1984, ch. 127, § 548.

59A-34-3. Insurance business exclusive; exceptions.

A. Except as provided in this section, no domestic insurer shall engage in any business other than the insurance business and in business activities reasonably and necessarily incidental to such insurance business.

B. A title insurer may also engage in business as an escrow agent.

C. Any insurer may also engage in business activities reasonably related to the management, supervision, servicing of and protection of its interests as to its lawful investments, and to full utilization of its facilities.

D. An insurer may own subsidiaries which may engage in such businesses as are provided for in Section 145 [59A-9-12 NMSA 1978] of the Insurance Code.

History: Laws 1984, ch. 127, § 549.

59A-34-4. Incorporation.

A. Seven (7) or more individuals who have reached the age of majority may incorporate a stock insurer; ten (10) or more such individuals may incorporate a mutual insurer. Not less than two-thirds of the incorporators shall be citizens of the United

States and residents of New Mexico. The articles of incorporation shall be signed by all incorporators and acknowledged by not less than three (3) of the incorporators as deeds are required to be acknowledged.

B. The articles of incorporation shall state:

(1) the name of the corporation; if a mutual, the word "mutual" shall be part of the name;

(2) the duration of its existence, which may be perpetual;

(3) if a stock corporation, the number of shares of authorized capital stock and the par value of each such share;

authorized capital stock shall consist solely of one class of common stock with par value of not less that five dollars ($5) per share, and shares without par value shall not be authorized; the extent, if any, to which each share shall be liable to assessment;

(4) if a mutual corporation, the maximum contingent liability of each member for payment of losses and expenses incurred, which liability shall be prominently stated in the articles of incorporation, and such conditions applicable to nonassessable policies as may be consistent with law;

(5) the limitations, if any, on the corporation's indebtedness;

(6) designation of the superintendent as an agent of the corporation upon whom may be served all process in any action or proceeding against the corporation;

(7) the kinds of insurance the corporation is formed to transact, according to the definitions set forth in Article 7 [Chapter 59A, Article 7 NMSA 1978] of the Insurance Code;

(8) the number of directors, not less than five (5), who shall conduct the corporation's affairs, and the names and addresses of the corporation's first directors and officers for a stated term of office of not less than six (6) months or more than one year's duration from date of incorporation;

(9) the date and time of the annual meeting of stockholders or members;

(10) the city or town in New Mexico in which is to be located the corporation's principal place of business;

(11) such other provisions, not inconsistent with law, as deemed appropriate by the incorporators; and

(12) the names and addresses of the incorporators.

History: Laws 1984, ch. 127, § 550.

59A-34-5. Filing, recording of articles; authority to raise capital or transact insurance required.

A. When executed and acknowledged by the incorporators, the articles of incorporation shall be filed with the secretary of state, and copies thereof certified by the secretary of state shall be filed with the superintendent and recorded in the office of the county clerk in the county of New Mexico wherein the corporation proposes to have its principal place of business.

B. Upon completion of such filings and recording, the secretary of state shall issue to the corporation a certificate of incorporation, and incorporation shall be deemed effective as of date of issuance of such certificate.

C. The corporation shall not raise any capital through sale of shares or otherwise except in compliance with Chapter 59A, Article 35 NMSA 1978, and shall not transact business as an insurer until it has applied for and received from the superintendent a certificate of authority as provided for under Chapter 59A, Article 5 NMSA 1978.

History: Laws 1984, ch. 127, § 551; 2013, ch. 75, § 20.

59A-34-6. Amendment of articles of incorporation.

A. The articles of incorporation of a stock insurer may be amended in accordance with the general statutes of New Mexico applying to corporations formed for profit. A copy of the amendment, certified by the secretary of state, shall be filed with the superintendent, and a copy likewise certified shall be recorded in the county clerk's office of the county of the corporation's principal place of business. No amendment shall reduce authorized capital below the amount of paid-in capital stock required under Section 59A-5-16 NMSA 1978 for the certificate of authority covering the kinds of insurance immediately thereafter to be transacted by the insurer.

B. The articles of incorporation of a mutual insurer may be amended by the affirmative vote of two-thirds of its members present in person or by proxy at a regular or special meeting of its members of which notice in writing of the proposed amendment was mailed to all members at least thirty days in advance, unless notice shall otherwise be provided for as approved by the superintendent. A certificate of the amendment, signed and acknowledged by the president and attested by the secretary of the corporation, shall be filed and recorded as required of original articles of incorporation.

History: Laws 1984, ch. 127, § 552; 2013, ch. 75, § 21.

59A-34-7. Nonuser of corporate charter.

A. Any domestic insurer which within one year from date of incorporation has not completed its organization and obtained a certificate of authority from the superintendent to transact insurance, shall unless granted an extension as hereinafter provided, forfeit its corporate charter, and the superintendent shall thereupon commence a proceeding for liquidation and dissolution of the corporation pursuant to the applicable provisions of Article 41 [Chapter 59A, Article 41 NMSA 1978] (conservation, rehabilitation, liquidation) of the Insurance Code. Upon written request by the corporation filed with him prior to the expiration of one year from its date of incorporation and for good cause shown, the superintendent may extend for an additional year the period within which the corporation shall qualify for and secure its certificate of authority as an insurer.

B. Any insurer which ceases to write and issue new insurance business for a continuous period of two years shall forfeit its right to resume the writing of new business except with the prior written approval of the superintendent granted upon reasonable grounds. Unless such approval is granted, the superintendent shall commence a proceeding pursuant to Article 41 (conservation, rehabilitation, liquidation) of the Insurance Code to liquidate and dissolve the insurer.

History: Laws 1984, ch. 127, § 553.

59A-34-8. Prohibited interest of officers, directors and employees in certain transactions.

A. No officer or director of an insurer, or any employee of the insurer shall accept, except for the insurer, or be beneficiary of, any fee, brokerage, gift or other emolument in addition to fixed salary or compensation, because of any investment, loan, deposit, purchase, sale, exchange, reinsurance or other similar transaction made by or for the insurer, or be pecuniarily interested therein in any capacity except on behalf of the insurer.

B. No insurer shall guarantee the financial obligation of any of its officers, directors, or employees.

C. This section shall not prohibit such a director, officer, or employee from:

(1) being a policyholder of the insurer and enjoying the rights customarily provided for holders of such policies;

(2) participating as beneficiary in any pension or deferred compensation plan, profit-sharing plan, stock option plan or similar plan authorized by the insurer and to which he may be eligible;

(3) receiving a fee in reasonable amount, if a director and not a salaried officer or employee, for special services rendered to the insurer in the usual

independent practice of the profession of the director as attorney, accountant or physician; or

(4) owning shares in a mutual fund or similar pooled investment through which he possesses an indirect interest in other corporations with which the insurer may directly or indirectly transact business, so long as such investment is in kind or amount not material to such transactions of the insurer.

History: Laws 1984, ch. 127, § 554.

59A-34-9. Salaries of officers, directors.

No insurer shall pay any salary, compensation or emolument to any officer or director thereof unless such payment has been duly authorized by the insurer's board of directors.

History: Laws 1984, ch. 127, § 555.

59A-34-10. Records and accounts.

A. Every domestic insurer shall keep at its principal place of business in this state its original books, records, documents, accounts and vouchers in such manner that its financial condition can be ascertained, its financial statements filed with the superintendent readily verified, and its compliance with law determined. A domestic insurer the records of which on January 1, 1983 and on the effective date of the Insurance Code were being lawfully maintained outside this state shall for good cause shown be allowed by the superintendent a reasonable period, not to exceed one (1) year after such effective date, to return such records to its principal place of business in this state.

B. The insurer may destroy records which have become obsolete in accordance with such classifications and schedule for destruction as may be adopted by the insurer and approved in writing by the superintendent.

C. This section shall not be deemed to prohibit safekeeping arrangements for computerized and other records of the insurer outside such principal place of business and in the same general locality of this state so long as readily available to the insurer, and, for purposes of examination, to the superintendent.

History: Laws 1984, ch. 127, § 556.

59A-34-11. Vouchers for expenditures.

No insurer shall make any disbursement of one hundred dollars ($100) or more unless evidenced by a voucher or other document correctly describing the consideration for the payment and supported by a check or receipt endorsed or signed by or on behalf

of the recipient. If the disbursement is for services and reimbursement the voucher or document or other writing referred to therein shall describe the services and itemize the expenditures. If the disbursement is in connection with any matter pending before any legislature or public body or public officer, the voucher or other document shall also correctly describe the nature of the matter and of the insurer's interest therein.

History: Laws 1984, ch. 127, § 557.

59A-34-12. Assets to be kept in state; exceptions.

A. Every domestic insurer shall keep its assets within this state except as requisite for normal transaction of business.

B. An insurer may maintain in or in connection with its branch office located outside this state furniture, fixtures, supplies and funds normally required for operation of the branch office.

C. An insurer may maintain on deposit with or through the insurance supervisory officer of another state, province or country securities as required for authority to transact insurance therein.

D. An insurer may have on deposit temporarily with established securities brokerage firms outside this state securities as required for purchase or sale of securities on the insurer's account, and shall have in its records adequate written receipt evidencing such deposit.

E. An insurer may be owner of book-entry securities of the Federal Reserve Bank.

History: Laws 1984, ch. 127, § 558.

59A-34-13. Removal, concealment of records, assets.

A. No person shall remove all or any material part of the records or assets of a domestic insurer from this state except pursuant to a plan of merger, consolidation or bulk reinsurance approved by the superintendent under this article, or for such other reasonable purposes and periods of time as may be permissible under Section 558 [59A-34-12 NMSA 1978] of this article, or as may have been approved by the superintendent in writing in advance of such removal.

B. No person shall conceal any such records or assets from the superintendent.

C. Any person who unlawfully removes or attempts to remove such records or assets or such material part thereof from its lawful location, or who unlawfully conceals or attempts to conceal the same from the insurer or superintendent, is upon conviction thereof guilty of a felony.

D. Upon any unlawful removal or attempted removal of such records or assets, or upon retention of such record [records] or assets or material part thereof outside this state in violation of this section, or upon any unlawful concealment of or attempt to conceal records or assets the superintendent may, in his discretion, institute delinquency proceedings against the insurer pursuant to Article 41 [Chapter 59A, Article 41 NMSA 1978] (conservation, rehabilitation, liquidation) of the Insurance Code.

History: Laws 1984, ch. 127, § 559.

59A-34-14. Information to stockholders and proxy regulations.

A. This section and Sections 561 and 562 [59A-34-15 and 59A-34-16 NMSA] of this article apply to all domestic stock insurers except:

(1) a domestic stock insurer having of record less than one hundred (100) holders of any class of equities securities; but if ninety-five percent or more of the insurer's equity securities are owned or controlled by a parent or an affiliated insurer, this section and the sections referred to in Subsection A, above, do not apply to the insurer unless its remaining securities are held of record by five hundred (500) or more persons; and

(2) domestic stock insurers which, relative to voting or other securities involved, file with the Securities and Exchange Commission forms of proxies, consents and authorizations pursuant to the Securities Exchange Act of 1934, as amended.

B. The superintendent may promulgate reasonable rules and regulations for effectuation of this section and the sections referred to in Subsection A, above.

History: Laws 1984, ch. 127, § 560.

59A-34-15. Information in advance of stockholder meetings.

Every insurer to which Section 560 [59A-34-14 NMSA 1978] applies shall timely furnish to its stockholders, in advance of stockholder meetings, information in writing reasonably adequate to inform them relative to all matters to be presented by the insurer's management for consideration of stockholders at the meeting.

History: Laws 1984, ch. 127, § 561.

59A-34-16. Solicitation of proxies.

A. No person shall solicit a proxy, consent or authorization in respect of any stock or other voting security of such an insurer unless he furnishes the person so solicited with written information reasonably adequate as to:

(1) the material matters in regard to which the powers so solicited are proposed to be used; and

(2) the person or persons on whose behalf the solicitation is made and the interest of such person or persons in relation to such matters.

B. No person shall so furnish information which the informer knows or has reason to believe in [is] false or misleading as to any material fact, or which fails to state any material fact reasonably necessary to prevent any other statement made from being misleading.

C. The form of all such proxies shall:

(1) conspicuously state on whose behalf the proxy is solicited;

(2) provide for dating the proxy;

(3) impartially identify each matter or group of related matters intended to be acted upon;

(4) provide means for the principal to instruct the vote of his shares as to approval or disapproval of each matter of [or] group, other than election to office; and

(5) be legibly printed, with context suitably organized;

but a proxy may confer discretionary authority as to matters as to which a choice is not specified pursuant to Paragraph (4), above, if the form conspicuously states how it is intended to vote the proxy or authorization in each such case, and may confer discretionary authority as to other matters which may come before the meeting but [were] unknown for a reasonable time prior to the solicitation by the persons on whose behalf the solicitation is made.

D. No proxy shall confer authority to:

(1) vote for election of any person to any office for which a bona fide nominee is not named in the proxy statement; or

(2) vote in any annual meeting (or adjournments thereof) other than the annual meeting next following the date on which the proxy statement and form were furnished stockholders.

E. Any proxy, consent or authorization obtained in violation of, or which violates, this section or the lawful rules and regulations of the superintendent relating thereto, is void.

History: Laws 1984, ch. 127, § 562.

59A-34-17. Management, compensation and agency contracts.

A. No domestic insurer shall make, amend or renew any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the material exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer, or, if an officer, director or otherwise part of the insurer's management, is to receive any commission, bonus or compensation based upon the volume of the insurer's business or transactions, unless the contract is filed with and not disapproved by the superintendent. The contract amendment or renewal shall become effective in accordance with its terms unless disapproved by the superintendent within thirty days after date of filing, subject to such reasonable extension of time as the superintendent may require by written notice given within such thirty days. Any disapproval shall be delivered to the insurer in writing stating the grounds therefor.

B. Any such contract when made, amended, or renewed shall provide that any such manager, producer of its business or contract holder shall within ninety days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, with specification of the emoluments received therefrom by the respective directors, officers, and other principal management personnel of the manager, producer, contract holder or insurer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.

C. The superintendent shall disapprove any such contract, amendment or renewal thereof if he finds that the contract:

(1) subjects the insurer to excessive charges;

(2) is to extend for an unreasonable length of time;

(3) does not contain fair and adequate standards of performance; or

(4) contains other inequitable provisions or provisions which impair the reasonable and proper interests of the insurer's stockholders, policyholders or members.

D. The superintendent may, after a hearing held thereon, disapprove or withdraw his approval of any such contract theretofore permitted to become effective or amended or renewed, if he finds that the contract should be disapproved on any of the grounds specified in Subsection C of this section.

E. Any contract or relationship with and any person who is a managing general agent as defined in the Managing General Agents Law [Chapter 59A, Article 12B NMSA 1978], shall be subject to the provisions of that law.

History: Laws 1984, ch. 127, § 563; 1993, ch. 320, § 66.

59A-34-18. Dividends to stockholders.

A. A domestic stock insurer shall not pay any cash dividend to stockholders except out of that part of its available and accumulated surplus funds otherwise unrestricted and derived from realized net operation profits and realized capital gains.

B. A cash dividend otherwise lawful may be so paid out of the insurer's earned surplus which is in excess of the amount of surplus required to be maintained by it under the Insurance Code.

C. A stock dividend may be paid out of any available surplus. Upon payment of a stock dividend the insurer shall transfer to its paid-in capital stock account funds equal to the aggregate of the par value of shares so distributed.

D. No dividend shall be declared or paid which would reduce the insurer's surplus funds below an amount reasonably required to sustain the insurer's normal operations currently and for the reasonably foreseeable future.

E. This section is subject to the provisions of Section 59A-37-22 NMSA 1978 relative to dividends by insurers which are subject to The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978].

History: Laws 1984, ch. 127, § 564; 1993, ch. 320, § 67.

59A-34-19. Participating policies.

A. If provided for in its articles of incorporation a stock or mutual insurer may issue any or all of its policies with or without participation in profits, savings or unabsorbed portions of premiums, may classify policies issued on a participating or nonparticipating basis and may determine the right to participate and the extent of participation of any class or classes of policies. Any such classification or determination shall be reasonable, and shall not unfairly discriminate as between policyholders within the same classification.

B. A life insurer may issue both participating and nonparticipating policies only if the right or absence of right to participate is reasonably related to the premium charged.

C. After the first policy year no dividend, otherwise earned, shall be made contingent upon payment of the renewal premium on any policy or contract; but a participating life or health insurance policy providing for participation at the end of the first or second policy year or the first and second policy year may provide that such dividend or dividends will be paid subject to payment of the premium for the year next ensuing such first or second policy year.

D. As to life insurance policies, this section is subject to Section 393 [59A-20-28 NMSA 1978] (special requirements as to participating policies) of the Insurance Code.

History: Laws 1984, ch. 127, § 565.

59A-34-20. Dividends to policyholders.

A. The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its surplus funds which represents net realized savings, net realized earnings and net realized capital gains, all in excess of the surplus required by law to be maintained by the insurer.

B. Subject to Section 393 [59A-20-28 NMSA 1978] (special requirements as to participating policies) of the Insurance Code, a domestic stock insurer may pay dividends to holders of its participating policies out of its available surplus.

C. No such dividend shall be paid which is inequitable or which unfairly discriminates between classifications or policies within the same classification.

History: Laws 1984, ch. 127, § 566.

59A-34-21. Illegal dividends; penalty.

A. Any director of a domestic stock or mutual insurer who wilfully votes for or concurs in declaration or payment of an illegal dividend to stockholders or members shall upon conviction thereof be guilty of a misdemeanor punishable by a fine not to exceed five hundred dollars ($500) and shall be jointly and severally liable, together with other such directors, for any loss thereby sustained by the insurer.

B. The stockholders or members receiving such an illegal dividend shall be liable in the amount thereof to the insurer.

C. The superintendent may revoke or suspend the certificate of authority of an insurer which has declared or paid an illegal dividend.

History: Laws 1984, ch. 127, § 567.

59A-34-22. Purchase of own shares by stock insurer.

A. A domestic stock insurer shall have the right to purchase or acquire shares of its own stock only as follows:

(1) for elimination of fractional shares;

(2) incidental to enforcement of rights of the insurer as to lawful transactions previously entered into in good faith for purposes other than acquisition of such shares;

(3) for purposes of a general savings and investment plan for the insurer's personnel;

(4) for mutualization of the insurer as provided in Section 580 [59A-34-34 NMSA 1978] of this article;

(5) for purposes of cancellation in connection with plan of recapitalization or reduction or reclassification of outstanding shares, or under other plan submitted to and approved in writing by the superintendent. The superintendent shall not approve a plan unless found by him to be for reasonable purposes, to be equitable as to the remaining stockholders of the insurer and not materially adverse to protection of policyholders; or

(6) as result of gift or bequest of the shares to the insurer.

B. Its own shares held by the insurer shall be part of paid-in capital stock, but shall not be voted or constitute an asset for financial statement purposes.

History: Laws 1984, ch. 127, § 568.

59A-34-23. Borrowed capital funds.

A. A domestic insurer may without pledge of assets borrow money to defray expense of organization, provide surplus funds or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest on unpaid balance of principal at a reasonable rate approved by the superintendent, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan, except that if a public offering and sale is made of the loan securities the insurer may pay the reasonable costs thereof approved by the superintendent.

B. Money so borrowed, together with the interest thereon if so provided in the agreement, shall not be part of the insurer's legal liabilities except as to its surplus in excess of the amount of surplus stipulated in the agreement, or be basis of any setoff; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount of the loan then unpaid together with any interest thereon accrued but unpaid.

C. Any such loan shall be subject to the superintendent's approval. The insurer, in advance of the loan, shall file with the superintendent a statement of the amount proposed to be so borrowed and the purposes thereof together with a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within thirty (30) days after date of such filing the insurer is notified of the superintendent's disapproval and reasons therefor. The superintendent shall disapprove any proposed loan or agreement if he finds the loan unnecessary or excessive for

purposes intended or that the terms of the agreement are not fair and equitable to the parties and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate.

D. Any such loan or substantial portion thereof shall be repaid by the insurer when no longer reasonably necessary for the purposes intended. No such repayment shall be made unless approved in advance by the superintendent upon his finding that repayment would not deprive the insurer of funds reasonably required for its operations or protection of its policyholders.

E. Such loan agreements when offered for purchase by the public shall for purposes of Article 35 [Chapter 59A, Article 35 NMSA 1978] (sale of insurance securities) of the Insurance Code be deemed to be securities.

F. This section does not apply to other kinds of loans obtained by the insurer in ordinary course of business, or to loans secured by pledge or mortgage of assets.

History: Laws 1984, ch. 127, § 569.

59A-34-24. Mutual membership.

A. Each holder of one or more insurance policies of a domestic mutual insurer, other than holder of a reinsurance contract, is a member of the insurer with all the rights and obligations of such membership, and each such policy so issued shall so specify.

B. Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, firm, estate, trustee or fiduciary may be a member of a mutual insurer.

History: Laws 1984, ch. 127, § 570.

59A-34-25. Mutual members, corporate rights.

A. As to management, records and affairs of the insurer a member of a domestic mutual insurer shall have the same character of rights and relationship as a stockholder has toward a domestic stock insurer.

B. Subsection A above shall not be deemed to:

(1) subject the mutual insurer to requirements of Sections 560 [59A-34-14 NMSA 1978] (information to stockholders and proxy regulations), 561 [59A-34-15 NMSA 1978] (information in advance of stockholder meetings) or 562 [59A-34-16 NMSA 1978] (solicitation of proxies) of this article; or

(2) give mutual members the right of dissent and appraisal on any merger, consolidation, bulk reinsurance, or sale of assets of the insurer.

History: Laws 1984, ch. 127, § 571.

59A-34-26. Mutual insurer bylaws.

A. The initial board of directors of a domestic mutual insurer shall adopt original bylaws for government of the corporation and conduct of its business. Such bylaws shall be subject to approval of the insurer's members at the next annual meeting of members and no bylaw provision shall thereafter be effective which is not so approved. Bylaws shall be revoked or modified only by vote of the insurer's members at a meeting of which notice was given as provided in the bylaws.

B. The bylaws shall provide that each of the insurer's members is entitled to one vote in election of corporate directors and on each matter voted on at membership meetings, and that such right to vote may be exercised in person or pursuant to written proxy.

C. The insurer shall promptly file with the superintendent a copy, certified by the insurer's secretary, of such bylaws and of every modification thereof or addition thereto.

D. The bylaws and modifications thereof or additions thereto shall be subject to the superintendent's approval. The superintendent shall not disapprove any such bylaw, modification or addition unless found by him, after a hearing thereon, to be unlawful, unreasonable, inadequate, unfair or injurious to the proper interests or protection of the insurer's members or any class thereof. The insurer shall not, after receiving written notice of disapproval and during the existence thereof, effectuate any bylaw provision so disapproved.

History: Laws 1984, ch. 127, § 572.

59A-34-27. Mutual members, quorum.

A domestic mutual insurer may in its bylaws adopt a reasonable provision for determining a quorum of members at any meeting thereof, but no provision recognizing a quorum of fewer than a simple majority in person or proxy of all the insurer's members shall be effective unless approved as reasonable by the superintendent. This section shall not affect any other provision of law requiring vote of a different percentage of members for a specified purpose.

History: Laws 1984, ch. 127, § 573.

59A-34-28. Mutual members, contingent liability.

A. Except as to nonassessable policies as provided for in Section 577 [59A-34-31 NMSA 1978] of this article, each member of a domestic mutual insurer shall have contingent liability, pro rata and not one for another, for discharge of the insurer's obligation incurred while the member was a policyholder, which liability shall be in such

maximum amount, not less than one nor more than six (6) times the premium for the member's policy at the annual premium rate, as specified in the insurer's articles of incorporation.

B. Every policy issued by the insurer shall contain a statement of the contingent liability.

C. Termination of the policy shall not relieve the member of contingent liability as to liabilities of the insurer incurred while the policy was in force.

D. Unrealized contingent liability of members does not constitute an asset of the insurer in any determination of financial condition.

History: Laws 1984, ch. 127, § 574.

59A-34-29. Mutual members, levy of contingent liability.

A. If at any time the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of surplus required of it under the Insurance Code for authority to transact the kinds of insurance being transacted, and the deficiency is not otherwise cured, its directors may, if approved by the superintendent as being reasonable and in the best interests of the insurer and its members, levy an assessment only on its members who held policies providing for contingent liability at any time within the twelve (12) months next preceding the date the levy was authorized by the board of directors, and such members shall be liable to the insurer for the amount so assessed.

B. The assessment shall be for the amount required to cure the deficiency and to provide working funds in reasonable amount above such minimum surplus.

C. As to the respective policies subject to the levy, the assessment shall be computed upon the basis of premium earned by the insurer thereon during such twelve (12) month period.

D. No member shall have an offset against any assessment on account of any claim for unearned premiums or loss payable.

E. As to life insurance, any part of the assessment upon a member which remains unpaid following notice of assessment, demand for payment and lapse of a reasonable waiting period as specified in the notice may, if approved by the superintendent as being in the best interest of the insurer and its members, be secured by placing a lien upon the cash surrender values and accumulated dividends held or to be held by the insurer to the credit of the member's policy.

History: Laws 1984, ch. 127, § 575.

59A-34-30. Mutual members, enforcement of contingent liability.

A. Upon levy of an assessment upon its members the mutual insurer shall notify each member of the amount of the assessment as to such member by written notice mailed to the member at his address last of record with the insurer. Failure of the member to receive the notice so mailed, within the time specified therein for payment of the assessment or at all, shall be no defense in any action to collect the assessment.

B. If a member fails to pay the assessment within the period specified in the notice, which period shall not be less than thirty (30) days after the mailing, the insurer may institute suit to collect the same.

History: Laws 1984, ch. 127, § 576.

59A-34-31. Mutual insurers; nonassessable policies.

A. A domestic mutual insurer while maintaining unimpaired surplus funds not less in amount than the minimum paid-in capital stock and surplus required to be maintained by a domestic stock insurer for authority to transact the same kind or kinds of insurance, may, upon receipt of the superintendent's order so authorizing, extinguish the contingent liability of members to assessment under all its policies then in force and, so long as such surplus is maintained, may omit provisions imposing contingent liability in all policies currently issued or renewed. Each such policy so issued or renewed shall contain a statement of nonassessability on its face or by endorsement attached.

B. The superintendent shall not authorize a domestic insurer to extinguish such contingent liability unless the extinction applies to all of the policies of the insurer.

C. The superintendent shall revoke the authority of a domestic mutual insurer to issued policies without contingent liability if:

(1) the insurer's surplus is less than that required under Subsection A, above, or

(2) the insurer, by resolution of its board of directors approved by a majority of the insurer's members at a meeting of the members of which the notice contained notice of the proposed change, requests that the authority to issue nonassessable policies be revoked.

D. During absence of such authority the insurer shall not issue any policy without providing therein for contingent liability of the policyholder, or renew or accept premium on any policy which is then in force without endorsing the same to provide for contingent liability.

History: Laws 1984, ch. 127, § 577.

59A-34-32. Prohibited transactions.

A. No domestic insurer shall participate in any underwriting of the purchase or sale of securities in advance of their issuance or enter into any transaction for such purchase or sale on account of the insurer jointly with any other person.

B. No domestic insurer shall enter into any agreement to withhold from sale any of its property. Except as to statutory deposits required to be made by the insurer, disposition of the insurer's property shall at all times be within control of its board of directors, in accordance with its charter and bylaws.

C. Except as otherwise specifically provided by law, no domestic insurer shall pledge or transfer any of its securities as collateral for a loan if such loan with all other outstanding loans secured by pledge or deposit of its securities aggregates, or will aggregate if such a loan is made, more than five percent of its admitted assets as shown by its last sworn financial statement filed with the superintendent, unless the superintendent first gives his written permission for such loan as necessary in conduct of the business of the insurer; but in no event shall any pledge or transfer of securities for a loan be made by the insurer if the insurer does not receive the proceeds of the loan, or if such proceeds are to be used, directly or indirectly, for investment in other securities. Nothing in this subsection shall prohibit a domestic insurer:

(1) from depositing or maintaining a deposit of any of its securities with the authorities of any other state in accordance with the laws thereof, for authority to transact insurance in such state; or

(2) from depositing securities as collateral for any surety or fidelity bond required for the insurer's business; or

(3) from entering into an agreement with a securityholder's protective committee or from depositing any of its securities with a depository under such agreement or under a plan of reorganization, for the purpose of protecting the insurer's interests.

D. No domestic insurer shall purchase its own stock, except as provided in Section 568 [59A-34-22 NMSA 1978] of this article.

E. No domestic insurer shall in connection with sale of any property agree to repurchase such property or any part thereof.

F. Subsections D and E of this section shall not apply as to purchase or sale of directors' qualifying shares.

G. No domestic insurer shall make any loan or other advance of funds if the insurer knows or reasonably should have known that the proceeds of such loan or advance in whole or part are to be used directly or indirectly for purchase of any stock or other securities of the insurer.

H. No domestic insurer shall dispose or attempt to dispose of more than ten percent of its assets out of regular course of business without advance written approval of the superintendent.

History: Laws 1984, ch. 127, § 578.

59A-34-33. Unauthorized business in other states.

A. No domestic insurer shall transact insurance in any other state without first being legally authorized to do so under the laws of such state.

B. Subsection A above shall not apply to:

(1) contracts entered into where the prospective insured when he signs the application for the insurance is personally present in a state in which the insurer is then authorized to transact the kind of insurance involved;

(2) issuance of certificates under a lawfully transacted group life or group health insurance policy where the master policy or contract was entered into in a state in which the insurer was then authorized to transact the insurance involved and in which the policyholder was then domiciled or otherwise had a bona fide situs; or

(3) renewal or continuance in force, with or without modification, of policies and insurance contracts otherwise lawful and not originally issued in violation of Subsection A above.

C. The superintendent may revoke the certificate of authority of an insurer which violates this section, and may require the insurer to pay to the state in which the business was so unlawfully written the premium taxes otherwise applicable as provided by the laws of such state.

History: Laws 1984, ch. 127, § 579.

59A-34-34. Mutualization of stock insurer.

A. A stock insurer other than title insurer may become a mutual insurer under such plan and procedure as may be approved by the superintendent after a hearing thereon.

B. The superintendent shall not approve any such plan, procedure or mutualization unless he finds that:

(1) it is equitable to stockholders and policyholders;

(2) it is subject to approval by holders of not less than two-thirds of the insurer's outstanding capital stock having voting rights, and by not less than two-thirds of those of the insurer's policyholders who vote on such plan in person or by proxy or by

mail pursuant to such notice, information and procedure as approved by the superintendent;

(3) if a life insurer, right to vote thereon is limited to holders of policies other than term or group policies, and whose policies have been in force for more than one (1) year;

(4) the plan provides for purchase of the shares of any nonconsenting stockholders in the same manner and subject to the same applicable conditions as provided by the general business corporation laws of this state as to rights of nonconsenting stockholders with respect to merger or consolidation of business corporations;

(5) mutualization will result in retirement of the insurer's outstanding capital stock at a price not in excess of the fair market value thereof as determined by competent disinterested appraiser;

(6) the plan provides for definite conditions to be fulfilled by a designated reasonable date upon which such mutualization shall become effective; and

(7) mutualization would leave the insurer with competent and trustworthy management and surplus funds reasonably adequate for the security of its policyholders and to enable the insurer, in the states in which it is then authorized to transact insurance, to continue in business for the same kinds of insurance included in its certificates of authority in such states.

C. No director, officer, agent or employee of the insurer, nor any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than customary salary or other regular compensation, for in any manner aiding, promoting or assisting in the mutualization, except as set forth in the plan of mutualization as approved by the superintendent.

D. This section does not apply to mutualization under order of court pursuant to Article 41 [Chapter 59A, Article 41 NMSA 1978] (conservation, rehabilitation, liquidation) of the Insurance Code.

History: Laws 1984, ch. 127, § 580.

59A-34-35. Conversion to ordinary business corporation.

A. A domestic stock insurer may convert to and become a New Mexico ordinary business corporation through the following procedures:

(1) the insurer must give the superintendent written notice of its intent to convert to an ordinary business corporation;

(2) the insurer must bulk reinsure all its insurance in force, if any, with another insurer authorized to transact such insurance in this state, under a bulk reinsurance agreement approved by the superintendent as provided in Section 586 [59A-34-40 NMSA 1978] of this article. The approval of bulk reinsurance may be made contingent upon approval of the stockholders as provided in Paragraph (4) below;

(3) the insurer must set aside in a special reserve fund in such amount and subject to such administration as may be found by the superintendent to be adequate and reasonable for the purpose, for payment of all obligations, if any, of the insurer incurred under its insurance contracts prior to the effective date of such bulk reinsurance and remaining unpaid, or make other reasonable arrangement for payment of such obligations as may be approved by the superintendent;

(4) the proposed conversion must be approved by affirmative vote of not less than two-thirds of each class of outstanding securities of the insurer having voting rights, at a special meeting of the holders of such securities called and held for the purpose; and at such meeting and by a like vote the articles of incorporation of the corporation must be amended to remove therefrom the power to transact insurance business as an insurer and to provide for such new powers and purposes as may be consistent with the purposes for which the corporation is thereafter to exist;

(5) security holders of the corporation who dissent from the proposed conversion shall have the same applicable rights as exist under the general corporation laws of this state as to dissent from proposed merger of business corporations; and

(6) upon compliance with the requirements of this section and filing of the amended articles of incorporation as required of ordinary business corporations, together with a copy of such amendment filed with the superintendent, the conversion shall thereupon become effective.

B. An insurer which has once converted to an ordinary business corporation shall not have power thereafter to convert to an insurer.

History: Laws 1984, ch. 127, § 581.

59A-34-36. Merger, consolidation of stock insurers.

A. Subject to the provisions of this section a domestic stock insurer may merge or consolidate with one or more domestic or foreign stock insurers by complying with the applicable provisions of the statutes of this state governing merger or consolidation of stock corporations formed for profit. A domestic stock insurer may, as the surviving corporation resulting therefrom, so merge with a domestic general business corporation formed for profit under the general corporation laws of this state if the assets of such general business corporation are in major part such as the insurer could invest its funds in under Article 9 [Chapter 59A, Article 9 NMSA 1978] (investments) of the Insurance Code.

B. No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the superintendent and approved in writing by him after a hearing thereon after notice to the stockholders of each corporation involved. Prior to or at time of filing the plan, a foreign insurer party to the proposed merger or consolidation if not then an authorized insurer shall file with the superintendent the documents and information required as for application for certificate of authority under Paragraphs (1), (3), (4), (5) and (7) of Subsection A, and under Subsection B, of Section 88 [59A-5-21 NMSA 1978] of the Insurance Code. The superintendent shall give his approval within a reasonable time after such filing unless he finds such plan or aggreement [agreement]:

(1) contrary to law; or

(2) unfair or inequitable to the stockholders of any corporation involved; or

(3) would substantially reduce the security of and service to policyholders of the domestic insurer, or result in a surviving insurer which does not meet paid-in capital stock requirements for certificate of authority of a like insurer under Section 83 [59A-5-16 NMSA 1978] of the Insurance Code or is otherwise inadequately financed for reasonable continuing conduct of its business; or

(4) would materially tend to lessen competition in the insurance business in this state or elsewhere as to the kinds of insurance involved, or would materially tend to create a monopoly as to such business; or

(5) is subject to other material and reasonable objections.

C. No director, officer, agent or employee of any corporation party to such merger or consolidation or any other person shall receive any fee, commission, special compensation or other valuable consideration whatsoever for in any manner aiding, promoting, or assisting therein except as set forth in such plan or agreement.

D. Nothing in the Insurance Code shall be deemed to prohibit merger or consolidation between insurers theretofore transacting different kinds of insurance, if the certificate of authority of the surviving and continuing corporation as originally issued or amended covers all the kinds of insurance to be transacted after effectuation of merger or consolidation.

History: Laws 1984, ch. 127, § 582.

59A-34-37. Preservation of old charter in merger, consolidation.

A. In any merger or consolidation of a foreign stock or mutual insurer into or with a domestic insurer under Chapter 59A, Article 34 NMSA 1978, the continuing New Mexico corporation shall for all purposes be deemed to be continuation of the corporate existence of the foreign corporation, with New Mexico as the adoptive state of domicile

and with date of corporate origin the same as the original date of incorporation of the foreign insurer in its original domiciliary state or country, subject to the following conditions:

(1) the plan and agreement of merger or consolidation shall provide for such continuation of corporate existence, with designation of New Mexico as the state of domicile of the foreign corporation by adoption, and shall specify the original date of incorporation of the foreign corporation in its original domiciliary state or country as being the date of incorporation of the New Mexico corporation pursuant to this section;

(2) the articles of corporation of the New Mexico corporation shall provide, or be amended to provide, that the corporation is a continuance of the corporate existence, through adoption of New Mexico as the corporate domicile, of the foreign corporation, and shall specify the original date of incorporation of the foreign corporation in its original domiciliary state or country as being the date of incorporation of the New Mexico corporation pursuant to this section; and

(3) the continuing New Mexico corporation shall as of merger or consolidation effective date have paid-in capital stock and additional surplus in amount not less than as required of a newly-authorized foreign stock insurer under Section 59A-5-16 NMSA 1978 to transact the same kinds of insurance, and shall have all the rights and obligations of, and be given recognition in all respects as, a corporation formed under the laws of this state as of the date of incorporation of the foreign corporation in its original domiciliary state or country. This provision shall not be deemed to impose upon the continuing New Mexico corporation any liability or obligation as to filings, fees, taxes or otherwise that might have accrued prior to effective date of the merger or consolidation.

B. This section shall not be deemed in any manner to preserve, after effective date of merger or consolidation, the corporate existence of the foreign corporation as a corporation of its original domiciliary state or country.

History: Laws 1984, ch. 127, § 583; 2007, ch. 282, § 11.

59A-34-38. Merger, consolidation of mutual insurers.

A. A domestic mutual insurer shall not merge or consolidate with a stock insurer.

B. A domestic mutual insurer may merge or consolidate with another domestic or foreign mutual insurer under applicable procedures prescribed by the laws of this state governing private business corporations as modified by this section.

C. If the insurer is then unimpaired, the plan and agreement for merger or consolidation shall be submitted to and approved by at least two-thirds of the members of each mutual insurer voting thereon at meetings called for the purpose pursuant to reasonable notice and procedure. The plan and agreement may provide for giving such

notice to members by publishing the same once a week for two (2) consecutive weeks in newspapers of general circulation in two (2) out of the four (4) cities of greatest population according to the last preceding national census by an agency of the United States government, in each of the states in which the insurer in [is] authorized to transact insurance; or notice may be given by depositing the same in the United States mail, postage prepaid, addressed to the member at his address last of record with the insurer, or by personal delivery. As to a life insurer, the right to vote may be limited to members whose policies are other than term or group and have been in effect for more than one year.

D. No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the superintendent and approved by him in writing. Prior to or at time of filing the plan a foreign insurer party to the plan if not then an authorized insurer shall file with the superintendent the documents and information required as for application for certificate of authority under Paragraphs (1), (3), (4), (5) and (7) of Subsection A, and under Subsection B, of Section 88 [59A-5-21 NMSA 1978] of the Insurance Code. The superintendent shall not act upon the plan and agreement until after a hearing thereon. The superintendent shall give such approval unless he finds such plan or agreement:

(1) inequitable to policyholders of any insurer involved; or

(2) would substantially reduce the security of and service to policyholders of the insurers, or result in a surviving insurer which does not meet the basic surplus requirements for certificate of authority of a like insurer under Section 83 [59A-5-16 NMSA 1978] of the Insurance Code or is otherwise inadequately financed for reasonable continuing conduct of its business; or

(3) would materially tend to lessen competition in the insurance business in this state or elsewhere as to the kinds of insurance involved or would materially tend to create a monopoly as to such business; or

(4) is unlawful or subject to other material and reasonable objections.

E. No director, officer, agent or employee of any insurer party to such merger or consolidation, or any other person, shall receive any fee, commission or other special valuable consideration whatsoever for in any manner aiding, promoting or assisting therein except as set forth in the plan and agreement as approved by the superintendent.

F. Subsection D of Section 582 [59A-34-36 NMSA 1978] (merger, consolidation of domestic stock insurers) of this article shall also apply as to merger or consolidation under this section.

History: Laws 1984, ch. 127, § 584.

59A-34-39. Conversion of mutual to stock insurer.

A. A domestic mutual insurer may become a stock insurer under such reasonable plan and procedure as may be approved by the superintendent after a hearing thereon of which notice was given to the insurer, its directors or trustees, its officers, employees and its members, all of whom shall have right to appear and be heard at the hearing.

B. The superintendent shall not approve any such plan or procedure unless:

(1) it is lawful, fair and equitable, and free of reasonable objections; and

(2) it is subject to approval by vote of not less than two-thirds of those of the insurer's current members who are entitled to vote and vote thereon in person, by proxy, or by mail at a meeting of members called for the purpose pursuant to reasonable notice and procedure approved by the superintendent. As to a life insurer the right to vote may be limited to members who hold policies other than group policies or term policies for terms of less than twenty (20) years, and whose policies have been in force for not less than one (1) year; and

(3) the equity of each member in the insurer's surplus is determinable under a fair and reasonable formula approved by the superintendent, which formula may exclude any member whose equity would in amount fall below a reasonable sum stated therein; and

(4) the plan gives to each member of the insurer preemptive right to acquire his proportionate part of all of the proposed capital stock of the insurer within a designated reasonable period, as such part is determinable under the plan of conversion, and to apply upon the purchase price thereof his equity in the insurer as determined under Paragraph (3) above; and

(5) the members entitled to participate in purchase of stock shall include not less than all current policyholders of the insurer and each existing person who had been a policyholder of the insurer within three (3) years prior to the date the plan was submitted to the superintendent; and

(6) shares are to be offered to members at a price not greater than to be thereafter offered under the plan to others; and

(7) the plan provides for payment of cash to each member not electing to purchase the shares to which preemptively entitled, in an amount found by the superintendent to be reasonable but not in excess of fifty percent (50%) of the amount of his equity, and which cash payment shall constitute payment and discharge in full of the member's equity or property interest in the mutual insurer. A member shall not have preemptive right to purchase less than all of the shares to which preemptively entitled; and

(8) the plan, when completed, would provide for the converted insurer paid-in capital stock and surplus in amount not less than minimum paid-in capital stock and surplus required of a new domestic stock insurer upon initial authorization to transact like kinds of insurance; and

(9) the superintendent finds that the insurer's management has not, through reduction in volume of new business written, or cancellations or other means sought to reduce, limit or affect the number or identity of the insurer's members to be entitled to participate in such plan or to secure for individuals comprising management any unfair advantage through such plan.

C. Subsection B above shall not be deemed to prohibit inclusion in the plan of provisions under which individuals comprising the insurer's management, employee and agency personnel may be entitled to purchase for cash at the same price as offered to the insurer's members, shares of stock not purchased by members on the preemptive offering to members, in accordance with such reasonable classification of such individuals as may be included in the plan and approved by the superintendent.

D. No director, officer, agent or employee of the insurer, or any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than usual and regular salaries and compensaion [compensation], for in any manner aiding, promoting or assisting in such conversion except as set forth in the plan approved by the superintendent. This provision shall not be deemed to prohibit payment of reasonable fees and compensation to attorneys, accountants, actuaries and other specialists whose services are reasonably required under the plan and performed in the independent practice of their professions even though also directors of the insurer.

History: Laws 1984, ch. 127, § 585.

59A-34-40. Bulk reinsurance.

A. A domestic insurer shall not reinsure with another insurer all or substantially all of its insurance business in force, or of a major class thereof, except under an agreement of bulk reinsurance and in compliance with this section. No such agreement shall become effective unless filed with the superintendent and approved by him in writing.

B. The superintendent shall approve such agreement within a reasonable time after filing if he finds that:

(1) the plan and agreement of bulk reinsurance are fair and equitable to each insurer and to the policyholders involved; and

(2) the reinsurance if effectuated would not materially reduce the protection or service to policyholders of the insurers; and

(3) the agreement embodies adequte [adequate] provisions by which the assuming reinsurer becomes liable to the original insureds for protection and benefits under policies reinsured in accordance with the terms of such policies; and

(4) the assuming reinsurer is authorized to transact such insurance in this state, or is qualified as for such authorization and will appoint the superintendent and his successors as its irrevocable attorney for service of process so long as any policy so reinsured or liability thereunder remains in force or outstanding; and

(5) the reinsurance would not materially tend to lessen competition in the insurance business in this state or elsewhere as to the kinds of insurance involved and would not materially tend to create any monopoly as to such business; and

(6) the proposed bulk reinsurance is free of other reasonable objections.

C. If the superintendent does not so approve he shall forthwith notify each insurer involved in writing specifying the reasons therefor.

D. If for reinsurance of all or substantially all of the business in force of a mutual insurer at a time when the insurer's surplus is not impaired, the plan and agreement for reinsurance must be approved by vote of not less than two-thirds of the mutual insurer's members who vote thereon in person or by proxy at a meeting of members called for the purpose pursuant to such reasonable notice by mail or publication as may be provided for in the plan. For a life insurer, the right to vote may be limited to members whose policies are other than term policies for term of less the [than] twenty (20) years or group policies, and have been in effect for more than one year.

History: Laws 1984, ch. 127, § 586.

59A-34-41. Bulk reinsurance; fees and commissions.

No director, officer, employee, agent or other representative of an insurer party to a bulk reinsurance plan or agreement, nor any other person, shall be paid or receive any fee, commission or other special or valuable consideration for in any manner aiding, promoting or assisting in negotiation or effectuation of such bulk reinsurance, except as stated in the plan and agreement of such reinsurance as approved by the superintendent. This section does not apply as to regular salaries or other regular compensation received or to be received by directors, officers, employees or agents for services rendered in ordinary and regular course of business.

History: Laws 1984, ch. 127, § 587.

59A-34-42. Expense to be borne by parties.

Costs of mailing or otherwise giving notice of any public hearing required in connection with merger, consolidation, or bulk reinsurance of an insurer, and of

furnishing to stockholders or members information relative thereto, shall be borne by the insurers parties to the proposed merger, consolidation or bulk reinsurance. As security for payment of such expenses the superintendent may require such insurers to file with him an acceptable surety bond or other deposit in reasonable amount determined by him.

History: Laws 1984, ch. 127, § 588.

59A-34-43. Mutual member's share of assets on liquidation.

A. Upon any liquidation of a domestic mutual insurer its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, and expense of administration shall be distributed to currently existing persons who had been members of the insurer for at least one year and who were its members at any time within thirty-six (36) months next preceding the date such liquidation was authorized or ordered, or the date of the last termination of the insurer's certificate of authority in this state, whichever date is the earlier; except that if the superintendent believes that the insurer's management has caused or encouraged reduction of the number or changed the identity of members of the insurer in anticipation of liquidation he may enlarge the thirty-six (36) month qualification period as he may deem reasonable.

B. The insurer shall make a reasonable classification of its policies held by such members and a formula based upon such classification and premiums earned for determination of the distributive share of each member participating in the distribution of assets. The classification and formula shall be subject to the superintendent's approval.

History: Laws 1984, ch. 127, § 589.

59A-34-44. Material transactions; report.

A. Every domestic insurer, including health maintenance organizations, nonprofit health care plans and fraternal benefit societies, shall file a report with the superintendent disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance programs unless such transactions have been submitted to the superintendent for review, approval or information purposes pursuant to other provisions of the Insurance Code, laws, regulations or other requirements.

B. The report required in Subsection A of this section is due within fifteen days after the end of the calendar month in which any of the foregoing transactions occur.

C. One complete copy of the report, including any exhibits or other attachments filed as part thereof, shall be filed with the national association of insurance commissioners.

History: 1978 Comp., § 59A-34-44, enacted by Laws 1993, ch. 320, § 68.

59A-34-45. Acquisition and disposition of assets; materiality; scope; reporting requirements.

A. No acquisition or disposition of assets need be reported pursuant to Section 59A-34-44 NMSA 1978 if the acquisition or disposition is not material. For purposes of this section and Section 59A-34-44 NMSA 1978, a material acquisition, or aggregate of any series of acquisitions during any thirty-day period, or disposition, or aggregate of any series of dispositions during any thirty-day period, is one that involves more than five percent of the reporting insurer's total admitted assets as reported in its most recent financial statement filed with the superintendent.

B. Asset acquisitions subject to the provisions of Section 59A-34-44 NMSA 1978 include every purchase, lease, exchange, merger, consolidation, succession or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose. Asset dispositions subject to Section 59A-34-44 NMSA 1978 include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction or other disposition.

C. The following information is required to be disclosed in the report of a material acquisition or disposition of assets:

(1) the date of the transaction;

(2) the manner of acquisition or disposition;

(3) a description of the assets involved;

(4) the nature and amount of the consideration given or received;

(5) the purpose of, or reason for, the transaction;

(6) the manner by which the amount of consideration was determined;

(7) the amount of any gain or loss recognized or realized as a result of the transaction; and

(8) the names of the persons from whom the assets were acquired or to whom they were disposed.

D. Such insurers are required to report acquisitions and dispositions on a non-consolidated basis unless the insurer is part of a consolidated group of insurers which utilizes an intercompany pooling agreement or arrangement or a one hundred percent reinsurance agreement under which the ceding company has ceded substantially all of its direct and assumed business to a pool, and the group reports in accordance with Section 59A-34-44 NMSA 1978 on behalf of the members of the group on a

consolidated basis. For purposes of this section, an insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars ($1,000,000) of total direct plus assumed written premiums during a calendar year that are not subject to the pooling agreement or arrangement and the net income of the business not subject to the pooling agreement or arrangement represents less than five percent of the insurer's capital and surplus. If a group of insurers reports on a consolidated basis as allowed by this subsection, the report shall identify every insurer that is a member of the group.

History: 1978 Comp., § 59A-34-45, enacted by Laws 1993, ch. 320, § 69.

59A-34-46. Nonrenewals, cancellations or revisions of ceded reinsurance programs; materiality; scope; reporting requirements.

A. No nonrenewal, cancellation or revision of a ceded reinsurance program need be reported pursuant to Section 59A-34-44 NMSA 1978 if the nonrenewal, cancellation or revision is not material. For purposes of this section and Section 59A-34-44 NMSA 1978, a material nonrenewal, cancellation or revision is one that, on an annualized basis as indicated in the insurer's most recently filed financial statement, affects more than fifty percent of an insurer's ceded written premium for property or casualty business, including accident and health business when written by a casualty insurer, or affects more than fifty percent of the total reserve credit taken for business ceded for life, annuity, or accident and health business written by an insurer other than a casualty insurer; but the transaction is not material if the insurer's ceded written premium or the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of direct plus assumed written premium or ten percent of the statutory reserve requirement prior to any cession, respectively.

B. Notwithstanding the provisions of Subsection A of this section, and without regard to which part has initiated the nonrenewal, cancellation or revision of ceded reinsurance, a report is to be filed whenever:

(1) the entire cession has been canceled, nonrenewed or revised, and ceded indemnity and loss adjustment expense reserves after any nonrenewal, cancellation or revision represent less than fifty percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation or revision not occurred;

(2) an authorized or accredited reinsurer has been replaced on an existing cession by an unauthorized or nonaccredited reinsurer; or

(3) previously established collateral requirements for unauthorized or nonaccredited reinsurers have been reduced or waived, either as to an existing reinsurer or reinsurers or to one or more reinsurers newly participating in an existing cession.

C. The following information is required to be disclosed in the report of a material nonrenewal, cancellation or revision of a ceded reinsurance program:

(1) the effective date of the nonrenewal, cancellation or revision;

(2) a description of the transaction with an identification of the initiator thereof;

(3) the purpose of, or reason for, the transaction; and

(4) if applicable, the identity of the replacement reinsurers.

D. Insurers are required to report all material nonrenewals, cancellations or revisions of ceded reinsurance programs on a non-consolidated basis unless the insurer is part of a consolidated group of insurers which utilizes an intercompany pooling agreement or arrangement or a one hundred percent reinsurance agreement under which the ceding company has ceded substantially all of its direct and assumed business to a pool, and the group reports in accordance with Section 59A-34-44 NMSA 1978 on behalf of the members of the group on a consolidated basis. For purposes of this subsection an insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars ($1,000,000) of total direct plus assumed written premiums during a calendar year that are not subject to the pooling agreement or arrangement and the net income of the business not subject to the pooling agreement or arrangement represents less than five percent of the insurer's capital and surplus. If a group of insurers reports on a consolidated basis as allowed by this subsection, the report shall identify every insurer that is a member of the group.

History: 1978 Comp., § 59A-34-46, enacted by Laws 1993, ch. 320, § 70.

ARTICLE 35
Sale of Insurance Securities

59A-35-1. Short title.

This article [Chapter 59A, Article 35 NMSA 1978] constitutes and may be cited as the "Sale of Insurance Securities Law".

History: Laws 1984, ch. 127, § 591.

59A-35-2. Scope of article.

This article shall apply as to sale or offer of sale in this state of any insurance security issued or proposed to be issued by any corporation or person whether or not organized under the laws of this state or authorized to transact business in this state.

History: Laws 1984, ch. 127, § 590.

59A-35-3. "Security" defined.

For the purposes of this article and except as context requires otherwise, "security" means any note, stock, treasury stock, share, bond, debenture, evidence of indebtedness, surplus note, contribution certificate, certificate of deposit for a security, certificate of interest or participation, voting trust certificate, reorganization certificate, investment contract (whether or not included as a provision in an insurance policy), or other similar instrument of an insurer or other person for financing formation or operations or management or acquisition of an insurer or interest therein, whether stock, mutual, reciprocal, Lloyds plan or other type of insurer.

History: Laws 1984, ch. 127, § 592.

59A-35-4. "Affiliate" defined.

For the purposes of this article an "affiliate" is a person controlling or controlled by or under common control with an insurer or issuer of securities.

History: Laws 1984, ch. 127, § 593.

59A-35-5. "Promoter" defined.

For the purposes of this article a "promoter" is any person who, acting alone or with others, initiates or participates in founding an insurer or organization to acquire financial interest in or to finance, manage or control an insurer, other than as policyholder.

History: Laws 1984, ch. 127, § 594.

59A-35-6. Registration of security; permit required.

No person shall sell or offer for sale in this state any security not exempt under Section 596 [59A-35-7 NMSA 1978] of this article, unless registered with the superintendent, covered by a subsisting securities permit issued by the superintendent and otherwise in compliance with requirements of this article.

History: Laws 1984, ch. 127, § 595.

59A-35-7. Exemptions.

No such registration or permit shall be required as to:

A. isolated sales of securities in private transactions, whether or not effected through a broker-dealer;

B. non-issuer distribution of an outstanding security by a registered broker-dealer;

C. transactions in due and regular discharge of responsibilities and duties by an executor, administrator, sheriff, marshal, receiver, trustee in bankruptcy, guardian or conservator;

D. securities distributed to existing holders of securities of the distributing entity as a dividend, stock split or reverse stock split, paid in whole or in part in such distributed securities;

E. securities distributed to existing holders of securities of the distributing entity without payment of additional consideration pursuant to a right of conversion, or exchange, or pursuant to reclassification, recapitalization, reorganization, sale of assets, or liquidation of the distributing entity;

F. offer and sale of securities by a newly-formed domestic corporation not involving a public offering and so offered and sold to not over twenty-five (25) persons if:

(1) upon completion of such offering and sale the domestic corporation has not in excess of twenty-five (25) security holders;

(2) all purchasers of the securities do so for investment purposes only and not with a view to further distribution, and so declare in writing to the domestic corporation;

(3) no commission or other compensation is paid or to be paid in connection with any such sale; and

(4) prior to any such offer and sale the domestic corporation files with the superintendent in writing the plan, purposes, and manner of conduct of the proposed offer and sale, uses to be made of proceeds thereof, and information in writing proposed to be given offerees, and such filing is not disapproved by the superintendent within twenty (20) days after filing. The superintendent may disapprove the filing upon reasonable grounds. Failure of the superintendent so to disapprove shall not be deemed, inferred, or represented to be an approval of the proposal;

G. sales of securities by an insurance holding corporation for purposes which do not include the financing, directly or indirectly, of an insurer;

H. securities issued or proposed to be issued pursuant to any merger, consolidation, bulk reinsurance, conversion, or mutualization approved by the superintendent under Article 34 [Chapter 59A, Article 34 NMSA 1978] (domestic stock and mutual insurers) of the Insurance Code; or

I. fractional share interests in stock of the issuer offered and sold for purpose of rounding out to whole shares in connection with any stock dividend or other distribution of shares to existing security holders of the issuer.

History: Laws 1984, ch. 127, § 596.

59A-35-8. Registration procedure.

A. The person desiring to register a security under this article shall file with the superintendent a registration statement in form as prescribed and furnished by the superintendent appropriate to the proposed offering. In prescribing the registration statement form the superintendent shall give due consideration to the circumstances of the offering, whether by a newly-formed domestic corporation or entity, whether covered by registration or other appropriate filing with the Securities and Exchange Commission under which an offering may be made of the securities, and to practices of administrators of state laws governing offer and sale of corporate securities relative to registration by coordination, or qualification, or upon notification.

B. As to registrants in general the registration statement and documents required to be filed therewith may, and as to newly-formed proposed insurers or newly-formed entities shall, require disclosure of:

(1) name and address of proposed issuer, business in which engaged or to engage, business history and financial condition;

(2) name and residence address of each promoter, director, officer and other management personnel and ultimate controlling stockholder or owner of the issuer, insurer or registrant, together with business experience, biographical information and proof of identity;

(3) affiliates, if any, of registrant or issuer, business in which engaged, financial condition, and material arrangements and transactions between such affiliates and registrant or issuer;

(4) use to be made of proceeds of proposed sale of securities;

(5) underwriting arrangements, if any, of the securities, or plan under which securities are proposed to be offered and sold, together with copies of contracts made or proposed to be made relating thereto;

(6) information proposed to be furnished offerees as shown by copy of any proposed prospectus or other printed information to be given offerees;

(7) management or agency contracts, whether or not exclusive, existing or proposed as to issuer or registrant;

(8) description of the securities, number and price thereof proposed to be sold and sales costs; and

(9) such other reasonably pertinent information as required by the superintendent.

C. When filed, the registration statement shall be accompanied by payment of the applicable filing fee as specified in Section 598 [59A-35-9 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 597.

59A-35-9. Registration fee.

A. With filing of the registration statement the superintendent shall collect, and the registrant shall pay to the superintendent the applicable registration statement filing fee in amount as follows:

(1) for registration by coordination or similar thereto, one hundred dollars ($100);

(2) for registration by notification or similar thereto, one hundred dollars ($100);

(3) for registration by qualification or similar thereto, fee computed upon gross proposed offering price of all securities covered by the registration as follows:

(a) one-tenth (1/10) of one percent of first million dollars ($1,000,000); and

(b) one-twentieth (1/20) of one percent of amounts in excess of the first one million dollars ($1,000,000).

B. All such fees shall be deemed earned when paid and shall not be subject to refund.

History: Laws 1984, ch. 127, § 598.

59A-35-10. Issuance, denial of permit.

A. The superintendent shall expeditiously examine a newly-filed registration statement and make such investigation of the registrant and related matters as he deems advisable.

B. Unless the superintendent finds that the permit should be denied on any of the grounds stated in Subsection C of this section, he shall promptly issue to the registrant a securities permit in appropriate form covering the offering of securities.

C. The superintendent may deny a permit on the ground that:

(1) the registration statement is incomplete and has not been completed within a reasonable time allowed therefor by the superintendent and communicated to the registrant;

(2) the proposed sale or issuance of securities would be in violation of law;

(3) the conditions or circumstances of the registrant or insurer, or the terms and conditions of the offering, would make the offering unfair or inequitable as to existing or proposed security holders or investors;

(4) funds proposed to be secured by the offering are inadequate or excessive for the purposes intended;

(5) proposed costs of the offering are excessive;

(6) any of the individuals associated or to be associated in the registrant or insurer or any affiliate thereof, or the ultimate controlling stockholder or owner of the registrant, issuer or insurer is not of good reputation as to business affairs or financial responsibility;

(7) the existing or proposed insurer would not be able to qualify for or continue to hold a certificate of authority to transact insurance in this state for any of the reasons stated in Section 59A-5-13 NMSA 1978;

(8) if an insurance holding corporation, its plan of capitalization or security options or financing are such as would be prohibited under the Insurance Code as to a newly formed domestic stock insurer;

(9) there is material variance, adverse to the registrant, as between information furnished by the registrant in the registration statement and that determined by the superintendent on investigation;

(10) information proposed to be furnished investors is incomplete, untrue, or would tend to mislead; or

(11) grant of the permit would be contrary to the best interest of the people of New Mexico, for reasons stated in the order denying the permit.

D. The superintendent shall deny the permit if the securities are of, or for financing, a foreign insurer not qualified for authority to transact insurance in New Mexico.

E. The superintendent's order denying a permit shall state the grounds therefor and be delivered to the registrant or mailed addressed to registrant at its address last of record with the superintendent.

History: Laws 1984, ch. 127, § 599; 1987, ch. 259, § 23.

59A-35-11. Terms of permit; compliance.

A. Each such securities permit issued by the superintendent shall, or may, contain provisions, as applicable, as follows:

(1) it shall state the securities which are to be offered, the number and selling price thereof;

(2) it may require that the purchase price shall be payable in lawful money of the United States or in such other securities as may be specified by class or description in the permit;

(3) it may require that all securities offered shall be offered and sold at the same price to all parties, subject, at the option of the registrant, as to subscriptions to be paid in installments, to a reasonable additional charge to cover expense and loss of interest earnings attributable to such installment subscriptions;

(4) it shall limit the portion of funds received for the securities which may be used for organization, securities sales and promotion expenses to such amount as the superintendent deems reasonably adequate under the proposed plan of sale, but in no event to exceed fifteen percent of such funds when and as actually received;

(5) it may require the founders, promoters, incorporators, or other persons directly involved in the proposed insurer or offering to subscribe and pay for immediately and in cash, at the proposed public offering price, a reasonable proportion of the same securities, and to withhold resale, transfer, assignment, or encumbrance of securities so purchased for a reasonable period, as specified in the permit, after completion of the offering, except by an executor or administrator of the estate of a deceased purchaser;

(6) it may prohibit, limit or control the granting of options to buy the securities or any of them for such reasonable period as is specified in the permit;

(7) it may require impoundment of funds received on sale of the securities, after deduction therefrom of applicable organization and sales expense as allowed under the permit, until the offering is completed, or, as to a proposed new insurer, the insurer has qualified for and received a certificate of authority to transact insurance as proposed in the registration statement, or for other reasonable period;

(8) it may make reasonable requirements as to accounting, reports, deposits and other matters as the superintendent deems advisable for protection of existing or prospective investors or policyholders;

(9) it shall specify an expiration date of the permit. In the case of a proposed new domestic insurer, the expiration date shall be one (1) year from date of incorporation, subject to extension by the superintendent for an additional one year upon good cause shown;

(10) it may require filing of a surety bond in adequate principal sum as determined by the superintendent for protection of investors or other reasonable purposes as specified by the superintendent; and

(11) it may contain other reasonable provisions which the superintendent deems advisable.

B. The registrant and all associated or affiliated directors, officers, employees, agents, founders, promoters, incorporators, and representatives shall comply with the terms of the permit.

History: Laws 1984, ch. 127, § 600.

59A-35-12. Permit as inducement.

A. The granting of a securities permit is permissive only and shall not constitute an endorsement or approval by the superintendent or any other agency or department of the state of New Mexico of any person or thing related to the offering of securities or constitute evidence of the completeness or accuracy of information presented in any prospectus or other sales publicity or literature, or a recommendation of purchase of any securities offered. The existence of the permit shall not be advertised or used as an inducement in any solicitation.

B. Each permit issued by the superintendent shall state conspicuously in boldface type the substance of Subsection A of this section in terminology prescribed by the superintendent.

History: Laws 1984, ch. 127, § 601; 1999, ch. 289, § 28; 2013, ch. 74, § 31.

59A-35-13. Public announcements of offering.

A. No registrant, issuer, or other person proposing to sell in this state any securities covered by a securities permit issued by the superintendent under this article shall publish or disseminate in this state in any manner any advertising, announcement or literature regarding the offering unless the proposed advertising, announcement or literature has first been filed with and not disapproved by the superintendent.

B. The proposed advertising, announcement or literature may be used after expiration of thirty (30) days after filing with the superintendent unless disapproved in writing by the superintendent within such thirty (30) day period. The superintendent shall disapprove any such advertising, announcement, or literature if found by him to be untrue, misleading, or likely to deceive the public. Failure of the superintendent to disapprove shall not constitute or be deemed to constitute an approval of the advertising, announcement or literature.

C. The superintendent may require insertion in any such advertising, announcement, or literature of a disclaimer similar to that required for securities permit under Section 601 [59A-35-12 NMSA 1978] of this article in terminology prescribed or accepted by the superintendent.

History: Laws 1984, ch. 127, § 602.

59A-35-14. Modification, revocation of permit.

The superintendent may for cause modify a securities permit theretofore issued; and may after a hearing thereon revoke the permit for violation of law or the terms of the permit or any proper order of the superintendent, or for material misrepresentation or practices injurious to the public interest in the offering or sale of the securities.

History: Laws 1984, ch. 127, § 603.

59A-35-15. Exclusive jurisdiction.

Securities registered with the superintendent under this article shall not be subject to registration or similar filing with any other governmental department or agency, or under any other law, of this state.

History: Laws 1984, ch. 127, § 604.

59A-35-16. Securities salespersons, license required.

No person shall in this state solicit subscription to or purchase of any security covered by a securities permit issued under this article unless such securities salesperson is licensed therefor. If the security is not one to be issued by a newly-formed or proposed new domestic insurer or holding company proposing to acquire or form a domestic insurer, the license shall be one issued by the securities division of the department of financial institutions under the laws of this state applying to public offering and sale of securities in general; otherwise, the license shall be one issued by the superintendent under the provisions of this article.

History: Laws 1984, ch. 127, § 605.

59A-35-17. Qualifications, procedure for security salesperson license.

A. Applicants for license as securities salesperson shall be qualified as follows:

(1) be an individual not less than twenty-one years of age;

(2) be honest and trustworthy, of good personal and business reputation and financially responsible;

(3) take and pass an examination as given by the superintendent, reasonably testing the knowledge of the applicant of the securities to be sold, the responsibilities of a salesperson relative thereto and competence of the applicant to act as a securities salesperson; and

(4) file with the superintendent along with application for license and thereafter maintain in force while so licensed, a surety bond issued by an authorized surety insurer or deposit of cash or cash-equivalent in lieu of the bond, in reasonable penal sum fixed by the superintendent but not less than ten thousand dollars ($10,000), for protection of the registrant, persons purchasing securities through the salesperson and the state of New Mexico and to assure compliance with law and the applicable regulations of the superintendent.

B. Procedure for application for license, examination of applicant, issuance, terms, duration and suspension or revocation of license and related matters shall be as provided by applicable provisions of Chapter 59A, Article 11 NMSA 1978. Fee for license and examination shall be as fixed in Section 59A-6-1 NMSA 1978.

C. This section shall not apply as to securities broker-dealers registered as such under the Securities Exchange Act of 1934, as amended, or as to securities the sale of which is underwritten (other than on a best efforts basis) by such a broker-dealer.

History: Laws 1984, ch. 127, § 606; 1987, ch. 259, § 24; 1999, ch. 272, § 20; 1999, ch. 289, § 29.

59A-35-18. Penalty for violation.

Any person violating any of the following provisions of this article shall upon conviction thereof be guilty of a felony punishable by a fine of not less than five hundred dollars ($500) or more than twenty thousand dollars ($20,000):

A. Section 595 [59A-35-6 NMSA 1978] (registration of security, permit required);

B. Subsection B of Section 600 [59A-35-11 NMSA 1978] (terms of permit; compliance);

C. Section 601 [59A-35-12 NMSA 1978] (permit as inducement);

D. Section 602 [59A-35-13 NMSA 1978] (public announcements of offering); and

E. Section 605 [59-35-16 NMSA 1978] (securities salesmen, license required).

History: Laws 1984, ch. 127, § 607.

ARTICLE 36
Insider Trading in Equity Security of Domestic Insurer

59A-36-1. "Equity security" defined.

The term "equity security" when used in this article means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the superintendent shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

History: Laws 1984, ch. 127, § 608.

59A-36-2. Ownership statements; filing.

Every person who is directly or indirectly the beneficial owner of more than ten percent of any class of any equity security of a domestic stock insurer, or who is a director or an officer of such insurer, shall file with the superintendent within ten (10) days after he becomes such beneficial owner, director or officer a statement, in such form as the superintendent may prescribe, of the amount of all equity securities of such insurer of which he is the beneficial owner; and within ten (10) days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file with the superintendent a statement, in such form as the superintendent may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

History: Laws 1984, ch. 127, § 609.

59A-36-3. Recovery of profits.

For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of his relationship to such insurer, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such insurer within any period of less than six (6) months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the insurer, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six (6) months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer, or by the owner of any security of the insurer or by the superintendent in the name and in behalf of the insurer if the insurer shall fail or refuse to bring such suit within sixty (60) days after

request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two (2) years after the date such profit was realized. This section shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase of the security involved, or any transaction or transactions which the superintendent by rules and regulations may exempt as not comprehended within the purpose of this section.

History: Laws 1984, ch. 127, § 610.

59A-36-4. Sale and delivery.

No such beneficial owner, director or officer shall directly or indirectly sell any equity security of such insurer if the person selling the security or his principal:

A. does not own the security sold; or

B. if owning the security, does not deliver it against such sale within twenty (20) days thereafter, or does not within five (5) days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this section if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

History: Laws 1984, ch. 127, § 611.

59A-36-5. Sales by dealers.

Section 610 [59A-36-3 NMSA 1978] (recovery of profits) of this article shall not apply to any purchase and sale, or sale and purchase, and Section 611 [59A-36-4 NMSA 1978] (sale and delivery) of this article shall not apply to any sale, of any equity security of a domestic stock insurer not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The superintendent may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

History: Laws 1984, ch. 127, § 612.

59A-36-6. Arbitrage transactions.

This article shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the superintendent may adopt in order to carry out the purposes of this article.

History: Laws 1984, ch. 127, § 613.

59A-36-7. Exemptions.

Sections 609 [59A-36-2 NMSA 1978] (ownership statements - filing), 610 [59A-36-3 NMSA 1978] (recovery of profits) and 611 [59A-36-4 NMSA 1978] (sale and delivery) of this article shall not apply to equity securities of a domestic stock insurer if:

A. such securities are registered, or are required to be registered, pursuant to Section 12 of the Securities Exchange Act of 1934; or if

B. such domestic insurer does not have any class of its equity securities held of record by one hundred (100) or more persons on the last business day of the year next preceding the year in which equity securities of the insurer would be subject to those provisions of this article referred to above except for the provisions of this Subsection B.

History: Laws 1984, ch. 127, § 614.

59A-36-8. Regulations.

The superintendent may make such rules and regulations as he deems advisable for execution of functions vested in him under this article, and may for such purpose classify domestic stock insurers, securities and other persons or matters within his jurisdiction.

History: Laws 1984, ch. 127, § 615.

ARTICLE 37
Insurance Holding Companies

59A-37-1. Short title.

Chapter 59A, Article 37 NMSA 1978 may be cited as the "Insurance Holding Company Law".

History: Laws 1984, ch. 127, § 616; 2014, ch. 59, § 28.

59A-37-2. Definitions.

As used in the Insurance Holding Company Law:

A. "acquire" means to come into possession or control of, and "acquisition" means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person and includes the acquisition of voting securities or assets, bulk reinsurance and mergers;

B. "affiliate" means a person that directly or indirectly is controlled by, is under common control with or controls another person;

C. "control" means the possession of the power to direct or cause the direction of the management and policies of a person, whether directly or indirectly, through the ownership of voting securities, through licensing or franchise agreements, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by an individual. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten or more percent of the voting securities of any other person. This presumption may be rebutted by a showing, in the manner provided by Section 59A-37-19 NMSA 1978, that control does not in fact exist. The superintendent may determine, after furnishing all persons in interest notice and an opportunity to be heard, that control exists in fact, notwithstanding the absence of a presumption to that effect, provided the determination is based on specific findings of fact in its support;

D. "enterprise risk" means an activity, a circumstance, an event or a series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its whole insurance holding company system and includes a situation that would cause a company action level event as defined in Section 59A-5A-4 NMSA 1978 or would cause the insurer to be in a hazardous financial condition as defined in Section 59A-41-24 NMSA 1978;

E. "health maintenance organization" means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis; provided that "prepaid basis" may include the payment of copayments and deductibles by enrollees;

F. "insurance holding company" is a person that controls an insurer; "insurance holding company system" means a combination of two or more affiliated persons, at least one of which is an insurer;

G. "insurer" means a person that undertakes, under contract, to indemnify a person against loss, damage or liability arising from an unknown or contingent future event. The term does not include agencies, authorities or instrumentalities of the United States, its possessions or territories, the commonwealth of Puerto Rico, the District of Columbia, a state or any of its political subdivisions or a fraternal benefit society;

H. "person" means an individual, corporation, association, partnership, joint stock company, trust, unincorporated organization or any similar entity or combination of entities;

I. "securityholder" means the owner of any security of a person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing;

J. "subsidiary" means an affiliate of a person controlled by the person either directly or indirectly through one or more intermediaries; and

K. "voting security" means a certificate evidencing the ownership or indebtedness of a person, to which is attached a right to vote on the management or policymaking of that person and includes any security convertible into or evidencing a right to acquire such a voting security.

History: Laws 1984, ch. 127, § 617; 1993, ch. 320, § 71; 1996, ch. 73, § 1; 1997, ch. 248, § 1; 1999, ch. 289, § 30; 2014, ch. 59, § 29.

59A-37-3. Subsidiaries of insurers.

A. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. A subsidiary may conduct any kind of business. Its authority to conduct one or more businesses shall not be limited by its status as a subsidiary of a domestic insurer.

B. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted pursuant to the Insurance Holding Company Law, a domestic insurer may also invest:

(1) in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries, amounts that do not exceed the lesser of ten percent of the insurer's assets or fifty percent of the insurer's surplus as regards policyholders; provided that after the investments, the insurer's surplus as regards policyholders shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included:

(a) total net money or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and

(b) all amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

(2) any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer; provided that each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in Paragraph (1) of this subsection or in Chapter 59A, Article 9 NMSA 1978 applicable to the insurer. For the purpose of this paragraph, "the total investment of the insurer" includes:

(a) any direct investment by the insurer in an asset; and

(b) the insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary; or

(3) with the approval of the superintendent, any greater amount in common stock, preferred stock, debt obligations or other securities of one or more subsidiaries; provided that after the investment, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

C. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to Subsection B of this section shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in the Insurance Code applicable to the investments of the insurer.

D. Whether any investment pursuant to Subsection B of this section meets the applicable requirements of that subsection shall be determined before the investment is made by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested and not including dividends.

E. If an insurer ceases to control a subsidiary, it shall dispose of any investment made in it pursuant to this section within three years from the time of the cessation of control or within such further time as the superintendent may prescribe, unless at any time after the investment is made, the investment meets the requirements for investment under any other section of the Insurance Code and the insurer has so notified the superintendent.

History: 1978 Comp., § 59A-37-3, enacted by Laws 1993, ch. 320, § 72; 2001, ch. 90, § 2; 2014, ch. 59, § 30.

59A-37-4. Acquisition of control of or merger with domestic insurer.

A. No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into an agreement to exchange securities for, acquire, seek to acquire, in the open market or otherwise, a voting security of a domestic insurer if, after the consummation of it, the person would, directly or indirectly or by conversion or by exercise of any right to acquire, be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer unless, at the time any such offer, request or invitation is made or an agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the superintendent and has sent to the insurer, and the insurer has sent to its shareholders, a statement containing the information required by Section 59A-37-5 NMSA 1978 and the offer, request, invitation, agreement or acquisition has been approved by the superintendent in the manner hereinafter prescribed.

B. For the purposes of Sections 59A-37-4 through 59A-37-10 NMSA 1978, the superintendent shall identify the circumstances in which a person seeking to divest or acquire an interest of control of a domestic insurer is required to obtain the superintendent's approval for the transaction. A person who controls a domestic insurer and seeks to divest its interest of control of the domestic insurer shall, at least thirty days prior to the cessation of control, file with the superintendent confidential notice of the proposed divestiture and give a copy of that notice to the insurer. Information contained in the notice shall remain confidential until the conclusion of the transaction if the superintendent has not determined that treating the information as confidential will interfere with the provisions of this section. This subsection does not apply to a statement filed pursuant to Subsection A of this section.

C. For a transaction subject to Sections 59A-37-4 through 59A-37-10 NMSA 1978, the acquiring person shall file with the superintendent a pre-acquisition notice, which shall contain the information set forth in Paragraph (1) of Subsection C of 59A-37-29 NMSA 1978. The superintendent may subject a person who fails to file the notice required by this subsection to a fine of not more than fifty thousand dollars ($50,000).

D. For the purposes of this section and Sections 59A-37-5 through 59A-37-10 NMSA 1978:

(1) "domestic insurer" includes any other person controlling a domestic insurer unless the other person, as determined by the superintendent, is either directly or through its affiliates primarily engaged in business other than the business of insurance; and

(2) "person" shall not include any securities broker holding, while in the performance of the broker's usual and customary broker's function, less than twenty percent of the voting securities of an insurer, or of any person that controls an insurer.

History: Laws 1984, ch. 127, § 619; 1993, ch. 320, § 73; 2014, ch. 59, § 31.

59A-37-5. Contents of statement.

A. The statement to be filed with the superintendent under Section 59A-37-4 NMSA 1978 shall be made under oath or affirmation and shall contain the following information:

(1) the name and address of each person, hereinafter called "acquiring party", by whom or on whose behalf the merger or other acquisition of control referred to in Section 59A-37-4 NMSA 1978 is to be effected and:

(a) if the acquiring party is an individual, the individual's principal occupation and all offices and positions held by the individual during the past five years and any conviction of crime other than minor traffic violations during the past ten years; or

(b) if the acquiring party is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as it and any of its predecessors shall have been in existence; an informative description of the business intended to be done by it and its subsidiaries; and a list of all individuals who are or who have been selected to become its directors or executive officers or who perform or will perform functions appropriate to such positions. The list shall include for each individual the information required by Subparagraph (a) of this paragraph;

(2) the source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates and the identity of persons furnishing such consideration. However, where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing the statement so requests;

(3) fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each acquiring party, or for such lesser period that the acquiring party and any of its predecessors shall have been in existence if less than five years, and similar unaudited information as of a date not earlier than ninety days prior to the date of the filing of the statement;

(4) any plans or proposals that each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any other person, or to make any other material change in its business or corporate structure or management;

(5) the number of shares of any security that each acquiring party proposes to acquire, the terms of the offer, request, invitation, agreement or acquisition and a statement as to the method by which the fairness of the proposal was determined;

(6) the amount of each class of any security referred to in Section 59A-37-4 NMSA 1978 that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) a full description of any contracts, arrangements or understandings with respect to any security referred to in Section 59A-37-4 NMSA 1978 in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into;

(8) a description of the purchase of any security referred to in Section 59A-37-4 NMSA 1978 during the twelve calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

(9) a description of any recommendations to purchase any security referred to in Section 59A-37-4 NMSA 1978 made during the twelve calendar months preceding the filing of the statement by any acquiring party or by anyone based upon interviews or at the suggestion of any acquiring party;

(10) copies of all tender offers for, requests or invitations for tenders of exchange offers for and agreements to acquire or exchange any securities referred to in Section 59A-37-4 NMSA 1978 and, if distributed, of additional soliciting material relating thereto;

(11) the terms of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in Section 59A-37-4 NMSA 1978 for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto;

(12) an agreement by the person required to file the statement that the person will provide, for as long as the person has control, an annual report pursuant to Section 59A-37-30 NMSA 1978;

(13) acknowledgment by the person required to file the statement that the person and all subsidiaries within the person's control in the insurance holding company system will provide information to the superintendent upon request and as necessary to evaluate the enterprise risk to the insurer; and

(14) such additional information as the superintendent may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders and securityholders of the insurer or in the public interest.

B. If the person required to file the statement referred to in Section 59A-37-4 NMSA 1978 is a partnership, limited partnership, syndicate or other group, the superintendent may require that the information called for by Subsection A of this section shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group and each person who controls the partner or member. If any partner, member or person is a corporation or the person required to file the statement referred to in Section 59A-37-4 NMSA 1978 is a corporation, the superintendent may require that the information called for by Subsection A of this section shall be given with respect to the corporation, each officer and director of the corporation and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of the corporation.

C. If any material change occurs in the facts set forth in the statement filed with the superintendent and sent to the insurer pursuant to Section 59A-37-4 NMSA 1978, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the superintendent and sent to the insurer within two business days after the person learns of the change, and the insurer shall send the amendment to its shareholders without delay.

D. If any offer, request, invitation, agreement or acquisition referred to in Section 59A-37-4 NMSA 1978 is proposed to be made by means of a registration statement under the federal Securities Act of 1933, as amended, or in circumstances requiring the disclosure of similar information under the federal Securities Exchange Act of 1934, as amended, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in Section 59A-37-4 NMSA 1978 may utilize such documents in furnishing the information called for by that statement.

History: Laws 1984, ch. 127, § 620; 1993, ch. 320, § 74; 2014, ch. 59, § 32.

59A-37-6. Approval by superintendent; review.

A. The superintendent shall approve any merger or other acquisition of control referred to in Section 59A-37-4 NMSA 1978 unless, after a public hearing on it, the superintendent finds that:

(1) after the change of control, the domestic insurer would not be able to satisfy the requirements for the issuance of a certificate of authority to write the line or lines of insurance for which it is presently authorized;

(2) the effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in New Mexico or tend to create a monopoly in insurance. In applying this paragraph:

(a) the informational requirements of Paragraph (1) of Subsection C of Section 59A-37-29 NMSA 1978 and the standards of Paragraph (1) of Subsection D of Section 59A-37-29 NMSA 1978 apply;

(b) the superintendent shall approve the merger or acquisition if the superintendent finds that any of the situations meeting the criteria provided in Paragraph (2) of Subsection D of Section 59A-37-29 NMSA 1978 exists; and

(c) the superintendent may condition the approval of the merger or acquisition on the removal, to take place within a specified period of time, of the circumstances that formed the basis for disapproval;

(3) the financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interests of its policyholders or the interests of any remaining security holders who are unaffiliated with the acquiring party;

(4) the plans or proposals that the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any other person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(5) the competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control;

(6) the applicable provisions of Chapter 59A, Article 34 NMSA 1978 would be violated; or

(7) the acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

B. The superintendent may retain at the acquiring party's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the superintendent's staff that are reasonably necessary to assist the superintendent to review the proposed acquisition of control.

C. The superintendent shall ensure, by imposition of conditions, if necessary, that New Mexico charitable assets are protected and preserved for the benefit of the people of New Mexico.

D. The public hearing held pursuant to Subsection A of this section shall be held within thirty days after the statement required by Section 59A-37-4 NMSA 1978 is filed, and the superintendent shall notify the person filing the statement at least twenty days before the hearing. The person filing the statement shall notify the insurer, and other persons whom the superintendent designates, no fewer than seven days before the

hearing. The superintendent shall make a determination within the sixty days before the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, a person to whom notice of hearing was sent and any other person whose interests may be affected shall be entitled to present evidence, examine and cross-examine witnesses, offer oral and written arguments and conduct discovery proceedings according to the Rules of Civil Procedure for the District Courts [Rule 1-001 NMRA et seq.]. All discovery proceedings shall conclude no later than three days before the public hearing.

E. If the proposed acquisition of control requires the approval of one or more insurance supervisory officials in other states, and if requested by the person filing the statement required by Section 59A-37-4 NMSA 1978, the public hearing held pursuant to Subsection A of this section may be conducted as a consolidated hearing. Within five days of a person's request for a consolidated hearing, that person shall file the statement referred to in Section 59A-37-4 NMSA 1978 with the national association of insurance commissioners. If the superintendent or an insurance supervisory official of another state elects not to participate in a consolidated hearing, then within ten days of receipt of the statement required by Section 59A-37-4 NMSA 1978, the superintendent or insurance supervisory official shall provide notice to the applicant of that person's election not to participate. A consolidated hearing shall be public and held within the United States before the insurance supervisory officials of the states in which the insurers are domiciled. Participating insurance supervisory officials shall hear and receive evidence. The superintendent may attend the hearing in person or by telecommunication.

F. For the change of control of a domestic insurer, a determination by the superintendent that the person acquiring control of the insurer must maintain or restore the capital of the insurer to the level required by the laws and rules of New Mexico shall be made no later than sixty days after the date of notice of the change of control submitted pursuant to Subsection A of Section 59A-37-4 NMSA 1978.

History: Laws 1984, ch. 127, § 621; 1993, ch. 320, § 75; 1999, ch. 133, § 1; 2014, ch. 59, § 33.

59A-37-7. Mailings to shareholders; expenses.

All statements, amendments or other material filed pursuant to Section 619 or 620 [59A-37-4 or 59A-37-5 NMSA 1978] of this article, and all notices of public hearings held pursuant to Section 621 [59A-37-6 NMSA 1978] of this article shall be mailed by the insurer to its shareholders within five (5) days after the insurer has received such statements, amendments, other material or notices. The expenses of mailing shall be borne by the person making the filing. As security for the payment of the expenses, the person shall file with the superintendent an acceptable bond or other deposit in an amount to be determined by the superintendent.

History: Laws 1984, ch. 127, § 622.

59A-37-8. Exemptions.

Sections 619 through 621 [59A-37-4 to 59A-37-6 NMSA 1978] of this article shall not apply to:

A. any transaction which is subject to the provisions of Sections 582 and 585 [59A-34-36 and 59A-34-39 NMSA 1978] of the Insurance Code dealing with the merger, consolidation or conversion of insurers; or

B. any offer, request, invitation, agreement or acquisition which the superintendent by order shall exempt therefrom as:

(1) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer; or

(2) as otherwise not comprehended within the purpose of Sections 619 through 621 of this article.

History: Laws 1984, ch. 127, § 623.

59A-37-9. Violations.

A. The following acts shall be violations of Sections 59A-37-4 through 59A-37-6 NMSA 1978:

(1) the failure to file any statement, amendment or other material required to be filed pursuant to Section 59A-37-4 or 59A-37-5 NMSA 1978; or

(2) the effectuation or any attempt to effectuate an acquisition of control of a domestic insurer unless the superintendent has given approval to it.

B. The failure to timely file a registration statement, a summary of the registration statement or an enterprise risk filing required by Sections 59A-37-11 through 59A-37-19.2 NMSA 1978 and Section 59A-37-30 NMSA 1978 is a violation of Sections 59A-37-11 through 59A-37-19.2 NMSA 1978 and Section 59A-37-30 NMSA 1978.

History: Laws 1984, ch. 127, § 624; 2014, ch. 59, § 34.

59A-37-10. Jurisdiction; consent to service of process.

The courts of this state are hereby vested with jurisdiction over any person not resident, domiciled or authorized to do business in this state, who files a statement with the superintendent under Sections 619 through 622 [59A-37-4 to 59A-37-7 NMSA 1978] of this article, and over all actions involving such person arising out of violations of such sections, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such person of the superintendent to be his true and

lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of a violation of such sections. Copies of all such lawful process shall be served on the superintendent and transmitted by registered or certified mail by the superintendent to such person at his address last of record with the superintendent. Service of process fee shall be paid at time of service on the superintendent in amount specified in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code.

History: Laws 1984, ch. 127, § 625.

59A-37-11. Registration of insurer member of holding company system.

A. Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the superintendent, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

(1) Sections 59A-37-11 through 59A-37-19.2 NMSA 1978;

(2) Subsection A of [Section] 59A-37-20 NMSA 1978;

(3) Sections 59A-37-21 and 59A-37-22 NMSA 1978; and

(4) either:

(a) Subsection B of Section 59A-37-20 NMSA 1978; or

(b) a provision requiring each registered insurer to keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen days after the end of the month in which it learns of each change or addition.

B. Any insurer which is subject to registration under this section shall register within fifteen days after it becomes subject to registration, and annually thereafter by the fifteenth day of April each year, unless the superintendent for good cause shown extends the time for registration, and then within such extended time. The superintendent may require any authorized insurer which is a member of a holding company system and which is not subject to registration under this section to furnish a copy of the registration statement or other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

History: Laws 1984, ch. 127, § 626; 1993, ch. 320, § 76.

59A-37-12. Registration; information; form.

Every insurer subject to registration shall file a registration statement on a form and in a format prescribed by the national association of insurance commissioners, which shall include:

A. information about the current capital structure, general financing condition, ownership and management of the insurer and any person controlling the insurer;

B. the identity of every current member of the insurance holding company system;

C. the following agreements in force, relationships subsisting and transactions currently outstanding between such insurer and its affiliates:

(1) loans, other investments or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(2) purchases, sales or exchanges of assets;

(3) transactions not in the ordinary course of business;

(4) guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(5) all management and service contracts and all cost-sharing arrangements;

(6) reinsurance agreements;

(7) dividends and other distributions to shareholders; and

(8) consolidated tax allocation agreements;

D. information about any existing pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

E. if requested by the superintendent, financial statements of or within an insurance holding company system and its affiliates. Financial statements may include existing annual audited financial statements filed with the federal securities and exchange commission pursuant to the federal Securities Act of 1933, as amended, or the federal Securities Exchange Act of 1934, as amended. An insurer may satisfy the requirement to file financial statements pursuant to this subsection by providing the superintendent with the most recent parent corporation financial statements that have been filed with the securities and exchange commission;

F. other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the superintendent;

G. statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented and continue to maintain and monitor corporate governance and internal control procedures; and

H. other information required by a rule that was promulgated by the superintendent.

History: Laws 1984, ch. 127, § 627; 1993, ch. 320, § 77; 2014, ch. 59, § 35.

59A-37-13. Materiality.

No information need be disclosed on the registration statement filed pursuant to Sections 59A-37-4 and 59A-37-5 NMSA 1978 if such information is not material for the purposes of Sections 59A-37-1 through 59A-37-19 NMSA 1978. Unless the superintendent by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of one percent or less of an insurer's admitted assets as of the most recent December 31 shall not be deemed material for the purposes of such section.

History: Laws 1984, ch. 127, § 628; 2014, ch. 59, § 36.

59A-37-14. Summary of registration.

All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

History: 1978 Comp., § 59A-37-14, enacted by Laws 1993, ch. 320, § 78.

59A-37-15. Termination of registration.

The superintendent shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

History: Laws 1984, ch. 127, § 630.

59A-37-16. Consolidated filing.

The superintendent may require or allow two or more affiliated insurers subject to registration to file a consolidated registration statement.

History: Laws 1984, ch. 127, § 631; 1993, ch. 320, § 79.

59A-37-17. Alternative registration.

The superintendent may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under Section 626 [59A-37-11 NMSA 1978] of this article, and to file all information and material required to be filed under Sections 626 through 634 [59A-37-11 to 59A-37-19 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 632.

59A-37-18. Registration exemptions.

Sections 59A-37-11 through 59A-37-19.2 NMSA 1978 shall not apply to any insurer, information or transaction if and to the extent that the superintendent by rule, regulation or order shall exempt the same from the provisions of such sections.

History: Laws 1984, ch. 127, § 633; 1993, ch. 320, § 80.

59A-37-19. Disclaimer.

Any person may file with the superintendent a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the authorized insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming an affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report that may arise out of the insurer's relationship with the person unless and until the superintendent, within thirty days after the receipt of a complete disclaimer, disallows the disclaimer. The superintendent shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance.

History: Laws 1984, ch. 127, § 634; 2014, ch. 59, § 37.

59A-37-19.1. Reporting of dividends to shareholders.

Subject to the provisions of Section 59A-37-22 NMSA 1978, each registered insurer shall report to the superintendent all dividends and other distributions to shareholders within fifteen business days following the declaration thereof.

History: 1978 Comp., § 59A-37-19.1, enacted by Laws 1993, ch. 320, § 81.

59A-37-19.2. Information of insurers.

Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where such

information is reasonably necessary to enable the insurer to comply with the provisions of Chapter 59A, Article 37 NMSA 1978.

History: 1978 Comp., § 59A-37-19.2, enacted by Laws 1993, ch. 320, § 82.

59A-37-20. Transactions with affiliates.

A. Transactions within a holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(1) the terms shall be fair and reasonable;

(2) agreements for cost-sharing services and management shall include the provisions required by rule promulgated by the superintendent;

(3) charges or fees for services performed shall be reasonable;

(4) expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(5) the books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(6) the insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

B. The following transactions involving a domestic insurer and any person in its holding company system, including amendments and modifications of affiliate agreements previously filed pursuant to this section that are subject to the materiality standards of this subsection, may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into such transactions at least thirty days prior thereto, or such shorter period as the superintendent may permit, and the superintendent has not disapproved it within that period:

(1) sales, purchases, exchanges, loans or extensions of credit, guarantees or investments, provided the transactions are equal to or exceed:

(a) with respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders as of the most recent December 31; or

(b) with respect to life insurers, three percent of the insurer's admitted assets as of the most recent December 31;

(2) loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit, provided the transactions are equal to or exceed:

(a) with respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders as of the most recent December 31; or

(b) with respect to life insurers, three percent of the insurer's admitted assets as of December 31 next preceding;

(3) reinsurance agreements or modifications to those agreements, including reinsurance pooling agreements or agreements in which the reinsurance premium or a change in the insurer's liabilities, or projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent of the insurer's surplus as regards policyholders, as of the most recent December 31, including those agreements that may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of such assets will be transferred to one or more affiliates of the insurer;

(4) all management agreements, service contracts, tax allocation agreements, guarantees and cost-sharing arrangements;

(5) guarantees made by a domestic insurer if the amount of the guarantee can be quantified and is greater than one-half of one percent of the insurer's admitted assets or ten percent of surplus as regards policyholders as of the most recent December 31, whichever is less. A guarantee whose amount cannot be quantified is subject to the notice requirements of this subsection;

(6) direct or indirect acquisitions or investments in a person who controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in the investments, exceeds two and one-half percent of the insurer's surplus as regards policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 59A-37-3 NMSA 1978 or that are authorized pursuant to another section of the Insurance Code or in nonsubsidiary insurance affiliates that are subject to the provisions of the Insurance Holding Company Law are exempt from this requirement; and

(7) any material transactions specified by regulation that the superintendent determines may adversely affect the interests of the insurer's policyholders.

Notice to the superintendent for amendments or modifications shall provide the reasons for the change and a description of the change's financial impact on the domestic insurer. Within thirty days after the termination of a previously filed agreement, a person shall notify the superintendent of that event. The superintendent shall respond by indicating the type of filing, if any, that the person must file.

Nothing contained in this subsection shall be deemed to authorize or permit any transactions that, in the case of an insurer not a member of the same holding company system, would be otherwise contrary to law.

C. A domestic insurer may not enter into transactions that are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the superintendent determines that such separate transactions were entered into over any twelve-month period for that purpose, the superintendent may exercise authority under Section 59A-37-26 NMSA 1978.

D. The superintendent, in reviewing transactions pursuant to Subsection B of this section, shall consider whether the transactions comply with the standards set forth in Subsection A of this section and whether they may adversely affect the interests of policyholders.

E. The superintendent shall be notified within thirty days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent of the corporation's voting securities.

History: 1978 Comp., § 59A-37-20, enacted by Laws 1993, ch. 320, § 83; 2014, ch. 59, § 38.

59A-37-21. Adequacy of surplus.

For the purpose of this article, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

A. the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

B. the extent to which the insurer's business is diversified among the several lines of insurance;

C. the number and size of risks insured in each line of business;

D. the extent of the geographical dispersion of the insurer's insured risks;

E. the nature and extent of the insurer's reinsurance program;

F. the quality, diversification and liquidity of the insurer's investment portfolio;

G. the recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

H. the surplus as regards policyholders maintained by other comparable insurers;

I. the adequacy of the insurer's reserves; and

J. the quality and liquidity of investments in subsidiaries made pursuant to Section 145 [59A-9-12 NMSA 1978] of the Insurance Code. The superintendent may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in his judgment such investment warrants.

History: Laws 1984, ch. 127, § 636.

59A-37-22. Dividends and other distributions.

A. No domestic stock insurer shall declare or distribute any dividend to shareholders, other than a pro rata distribution of any class of the insurer's own securities, except out of earned surplus. For purposes of this section, "earned surplus" means the portion of the surplus that represents the net earnings, gains or profits, after deduction of all losses, that have not been distributed to the shareholders as dividends or transferred to stated capital or capital surplus or applied to other purposes permitted by law, but does not include twenty-five percent of the unrealized appreciation of assets.

B. No domestic insurer shall pay an extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(1) thirty days after the superintendent has received notice of the declaration thereof and has not within such period disapproved such payment; or

(2) the superintendent shall have approved such payment within the thirty-day period.

C. For the purposes of Sections 59A-37-20 through 59A-37-22 NMSA 1978, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve months exceeds the lesser of ten percent of the insurer's surplus as regards policyholders as of the most recent December 31 or the net gain from operations of the insurer after dividends to policyholders and federal income taxes and before realized capital gains and losses, if the insurer is either a life

insurer or a health maintenance organization, or the net income, if the insurer is not a life insurer or a health maintenance organization, not including realized capital gains, for the twelve-month period ending December 31 next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

D. In determining whether a dividend or distribution is extraordinary:

(1) an insurer other than a life insurer or a health maintenance organization may carry forward net income from the previous two calendar years that has not already been paid out as dividends, which carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years; and

(2) a life insurer or a health maintenance organization may carry forward net gains from operations, not including realized capital gains from the previous two calendar years, that have not already been paid out as dividends, which carry-forward shall be computed by taking the net gain from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

E. Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditioned upon the superintendent's approval thereof, and such a declaration shall confer no rights upon shareholders until the superintendent has:

(1) approved the payment of the dividend or distribution; or

(2) not disapproved the payment within thirty days after the superintendent has received notice of the declaration.

History: Laws 1984, ch. 127, § 637; 1993, ch. 320, § 84; 1996, ch. 73, § 2; 2014, ch. 59, § 39.

59A-37-23. Examinations.

A. Pursuant to general powers of investigation and examination vested in the superintendent under Chapter 59A, Article 4 NMSA 1978, the superintendent may order an insurer registered under Section 59A-37-11 NMSA 1978 to produce such records, books or other information papers in the possession of the insurer or its affiliates as are necessary to ascertain the insurer's financial condition, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis or the insurer's compliance with the Insurance Company Holding Law. If the insurer fails to comply with the order, the superintendent may examine its affiliates to obtain the information.

B. The examination shall be conducted and otherwise be subject to applicable provisions of Chapter 59A, Article 4 NMSA 1978.

C. To determine compliance with the Insurance Holding Company Law, the superintendent may require that an insurer registered pursuant to Section 59A-37-11 NMSA 1978 produce information not possessed by the insurer if the insurer can access that information through a contractual relationship, statutory obligation or other valid method. If the insurer cannot obtain the information that the superintendent requests, the insurer shall provide the superintendent with a detailed explanation of the reasons for that inability and the identity of the holder of information. If the superintendent believes that the explanation lacks merit, the superintendent may require, after notice and a hearing, that the insurer pay a penalty of five hundred dollars ($500) for each day that the production of information is delayed, or the superintendent may suspend or revoke the insurer's license.

History: Laws 1984, ch. 127, § 638; 1993, ch. 320, § 85; 2014, ch. 59, § 40.

59A-37-24. Confidential treatment.

A. All documents, materials or other information in the possession or control of the office of superintendent of insurance that are obtained by or disclosed to the superintendent or any other person in the course of an examination or investigation made pursuant to Sections 59A-37-20 through 59A-37-22 NMSA 1978, and all information reported pursuant to Section 59A-37-4 NMSA 1978, shall be confidential and shall not be subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. Nothing in this section shall be construed as a grant of privilege or confidentiality or a bar to production of that information by an insurer in a civil suit, whether or not the office of superintendent of insurance is a party; provided that the superintendent may use the documents, materials or other information in a regulatory or legal action brought in the course of the superintendent's official duties. The documents, materials or other information shall not be made public by the superintendent or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the superintendent, after giving the insurer and its affiliates that would be affected by them, notice and an opportunity to be heard, determines that the interests of the policyholders, shareholders or the public will be served by the publication of them, in which case the superintendent may publish all or any part of them in the manner the superintendent deems appropriate.

B. Neither the superintendent nor a person who receives documents, materials or other information while acting pursuant to the authority of the superintendent or with whom such documents, materials or other information are shared pursuant to the Insurance Holding Company Law shall be permitted or required in a private civil action to testify on the confidential documents, materials or information identified in Subsection A of this section.

C. To assist in the performance of the superintendent's duties, the superintendent:

(1) may share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A of this section, with other state, federal and international regulatory agencies, with the national association of insurance commissioners, its affiliates or its subsidiaries and with state, federal and international law enforcement authorities, including members of a supervisory college described in Section 59A-37-32 NMSA 1978, if the recipient agrees in writing to maintain the confidentiality and privilege of the document, materials or other information and has cited in writing the legal authority to maintain the confidentiality;

(2) in the case of confidential and privileged documents, materials or information reported pursuant to Section 59A-37-30 NMSA 1978, and notwithstanding Paragraph (1) of this subsection, may share that information only with insurance supervisory officials of states that have statutes or regulations substantially similar to Subsection A of this section and that have agreed in writing not to disclose that information;

(3) may receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners, its affiliates or its subsidiaries and from regulatory and law enforcement officials of foreign or domestic jurisdictions but shall maintain as confidential or privileged documents, materials or other information received with notice or the understanding that the content is confidential or privileged pursuant to the laws of the jurisdiction from which the information originates; and

(4) shall, pursuant to the Insurance Holding Company Law, enter into written agreements with the national association of insurance commissioners that govern the sharing and use of information, that are consistent with this subsection and that:

(a) specify procedures and protocols for maintaining the confidentiality and security of information shared with the national association of insurance commissioners, its affiliates or its subsidiaries, including procedures and protocols for the sharing between the national association of insurance commissioners and other state, federal or international regulators;

(b) provide that the superintendent retains ownership and governs the use of information shared with the national association of insurance commissioners, its affiliates or its subsidiaries;

(c) require that the national association of insurance commissioners promptly notify an insurer whose confidential information it possesses when that information is the subject of a request or subpoena for disclosure or production; and

(d) require that, in a judicial or administrative action in which the national association of insurance commissioners, its affiliates or its subsidiaries may be required to disclose shared confidential information about the insurer, the national association of

insurance commissioners, its affiliates or its subsidiaries consent to intervention by the insurer.

D. The sharing of information by the superintendent pursuant to the Insurance Holding Company Law is not a delegation of regulatory authority or rulemaking. The superintendent alone is responsible for the administration, execution and enforcement of the provisions of the Insurance Holding Company Law.

E. The disclosure of documents, materials or information to the superintendent pursuant to this section or the sharing authorized by Subsection C of this section does not constitute a waiver of an applicable privilege or a claim of confidentiality.

History: Laws 1984, ch. 127, § 639; 2014, ch. 59, § 41.

59A-37-25. Enforcement; voting securities; civil proceedings.

A. Whenever it appears to the superintendent that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of Chapter 59A, Article 37 NMSA 1978 or of any rule, regulation or order of the superintendent hereunder, the superintendent may apply to the district court for the county in which the principal office of the insurer is located or, if such insurer has no such office in this state, then to the district court for Santa Fe county, for an order enjoining the insurer or the director, officer, employee or agent thereof from violating or continuing to violate that article or any rule, regulation or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require.

B. No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of Chapter 59A, Article 37 NMSA 1978 or of any rule, regulation or order of the superintendent hereunder may be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of such securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the superintendent has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of that article or of any rule, regulation or order of the superintendent hereunder, the insurer or the superintendent may apply to the district court for Santa Fe county or to the district court for the county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement or acquisition made in contravention of Sections 59A-37-4 through 59A-37-10 NMSA 1978, or any rule, regulation or order of the superintendent thereunder, to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders, and for such other equitable relief as the nature of

the case and the interests of the insurer's policyholders, creditors and shareholders or the public may require.

C. In any case where a person has acquired or is proposing to acquire any voting securities in violation of Chapter 59A, Article 37 NMSA 1978 or any rule, regulation or order of the superintendent hereunder, the district court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the superintendent, seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue such orders with respect thereto as may be appropriate to effectuate the provisions of that article. Notwithstanding any other provisions of law, for the purpose of that article, the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

History: Laws 1984, ch. 127, § 640; 1993, ch. 320, § 86.

59A-37-26. Enforcement, criminal proceedings; penalty.

A. Any insurer failing, without just cause, to file any registration statement as required in the Insurance Holding Company Law shall be required, after notice and hearing, to pay a penalty of fifty dollars ($50.00) for each day's delay, not to exceed a total penalty of ten thousand dollars ($10,000). The superintendent may reduce the penalty if the insurer demonstrates to the superintendent that the imposition of the penalty would constitute a financial hardship to the insurer.

B. Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly permits any officer or agent of the insurer to engage in transactions or make investments that have not been properly reported or submitted pursuant to Section 59A-37-11 NMSA 1978, Subsection B of Section 59A-37-20 NMSA 1978 or Section 59A-37-22 NMSA 1978, or that violate the Insurance Company Holding Law, shall pay, in their individual capacity, a penalty of not more than ten thousand dollars ($10,000) per violation, after notice and hearing before the superintendent. In determining the amount of the penalty, the superintendent shall take into account the appropriateness of the penalty with respect to the gravity of the violation, the history of previous violations and such other matters as justice may require.

C. Whenever it appears to the superintendent that any insurer subject to the provisions of the Insurance Holding Company Law or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract that is subject to the provisions of Sections 59A-37-20 through 59A-37-22 NMSA 1978 and that would not have been approved had the approval been requested, the superintendent may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the superintendent may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors or the public.

D. Whenever it appears to the superintendent that an insurer or any director, officer, employee or agent thereof has committed a willful violation of the Insurance Holding Company Law, the superintendent may cause criminal proceedings to be instituted in the district court for the county in which the principal office of the insurer is located or, if the insurer has no such office in the state, then in the district court for Santa Fe county against the insurer or the responsible director, officer, employee or agent thereof. Any insurer that willfully violates that law may be fined not more than twenty thousand dollars ($20,000). Any individual who willfully violates that law may be fined not more than ten thousand dollars ($10,000).

E. Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the superintendent in the performance of the superintendent's duties under the Insurance Holding Company Law, upon conviction thereof, shall be imprisoned for not more than twenty years or fined not more than one million dollars ($1,000,000), or both. Any fines imposed shall be paid by the officer, director or employee in the officer's, director's or employee's individual capacity.

F. If the superintendent suspects that a person has violated a provision of Sections 59A-37-4 through 59A-37-10 NMSA 1978, and if that violation prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation alone may provide the basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with the Insurers Conservation, Rehabilitation and Liquidation Law [Chapter 59A, Article 41 NMSA 1978].

History: Laws 1984, ch. 127, § 641; 1993, ch. 320, § 87; 2014, ch. 59, § 42.

59A-37-27. Receivership; recovery of distributions.

A. Whenever it appears to the superintendent that any person has committed a violation of Chapter 59A, Article 37 NMSA 1978 which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, then the superintendent may proceed as provided in Chapter 59A, Article 41 NMSA 1978, to take possession of the property of such domestic insurer and to conduct the business thereof.

B. If an order for liquidation or rehabilitation of a domestic insurer has been entered for any reason, the receiver appointed under such order shall have a right to recover on behalf of the insurer:

(1) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on its capital stock;

(2) any payment in the form of a bonus, termination settlement or extraordinary lump-sum salary adjustment made by the insurer or its subsidiary to a director, officer or employee; or

(3) any payment on a surplus note entered into pursuant to Section 59A-34-23 NMSA 1978, where the distribution or payment pursuant to Paragraph (1), (2) or (3) of this subsection is made at any time during the two years preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of Subsections C, D, and E of this section.

C. No such distribution shall be recoverable if the parent or affiliate shows that when paid, the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

D. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time such distributions were paid shall be liable up to the amount of distributions or payments under Subsection B of this section which the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

E. The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty associations.

F. To the extent that any person liable under Subsection D of this section is insolvent or otherwise fails to pay claims due from it pursuant to this section, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid shall be liable for any resulting deficiency in the amount recovered from its subsidiary.

History: Laws 1984, ch. 127, § 642; 1993, ch. 320, § 88.

59A-37-28. Suspension, revocation, noncontinuance of certificate of authority.

Whenever it appears to the superintendent that any person has violated a provision of Chapter 59A, Article 37 NMSA 1978 which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the superintendent may, after giving notice and an opportunity to be heard, suspend, revoke or refuse to continue the insurer's certificate of authority to do business in this state for such period as he finds necessary for protection of policyholders or the public. Any such order shall be accompanied by specific findings of fact and conclusions of law.

History: Laws 1984, ch. 127, § 643; 1993, ch. 320, § 89.

59A-37-29. Acquisitions that would lessen competition.

A. As used in this section:

(1) "acquisition" means an agreement, arrangement or activity whose consummation results in a person directly or indirectly acquiring the control of another person and includes the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers; and

(2) "involved insurer" includes an insurer that acquires or is acquired, is affiliated with an acquirer or acquired or is the result of a merger.

B. Except as provided in this subsection, this section applies to an acquisition in which there is a change of control of an insurer authorized to do business in New Mexico. This section does not apply to:

(1) a purchase of securities made solely for investment purposes if the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in an insurance market in New Mexico. If a purchase of securities results in a presumption of control as provided in Subsection C of Section 59A-37-2 NMSA 1978, this section applies to the purchase unless the insurance supervisory official of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the domiciliary insurance supervisory official communicates that disclaimer action or affirmative finding to the superintendent;

(2) the acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if the acquisition would otherwise not be excluded from this section by the provisions of another paragraph of this subsection and if the acquiring party to the acquisition files with the superintendent a notification in accordance with Paragraph (1) of Subsection C of this section at least thirty days prior to the proposed effective date of the acquisition;

(3) the acquisition of an already affiliated person;

(4) where "market" means the direct written insurance premium in New Mexico for a line of business contained in the annual statement required to be filed by an insurer licensed to do business in New Mexico, an acquisition if, as an immediate result of the acquisition:

(a) the combined market share of the involved insurers would not exceed five percent of the total market in any market;

(b) no market share would increase; or

(c) the combined market share of the involved insurers would not exceed twelve percent, and the market share would not increase by more than two percent, of the total market in any market;

(5) an acquisition for which a pre-acquisition notification would be required by the provisions of this section solely because of its effect on the ocean marine insurance line of business; and

(6) an acquisition of an insurer whose domiciliary insurance supervisory official finds that the insurer is in failing condition, that there is no feasible way to improve the condition and that the benefit to the public of improving the insurer's condition through the acquisition exceeds the benefit to the public that would arise from not lessening competition; provided that the findings are communicated to the superintendent by the domiciliary insurance supervisory official.

C. An acquisition identified in Subsection B of this section may be subject to an order pursuant to Subsection E of this section, unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired person may file a pre-acquisition notification. The superintendent shall treat as confidential information submitted pursuant to this subsection in the same manner as provided in Section 59A-37-24 NMSA 1978.

(1) Pre-acquisition notification shall contain the information and be in the form prescribed by the national association of insurance commissioners relating to the markets that, pursuant to Paragraph (4) of Subsection B of this section, subject the acquisition to the provisions of this section. The superintendent may require the submission of additional materials and information that the superintendent deems necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard identified in Subsection D of this section. Among other materials, the superintendent may require the submission of an economist's opinion relating to the competitive impact of the acquisition in New Mexico along with an addendum addressing the economist's educational background, experience and ability to render an informed opinion.

(2) A waiting period shall begin on the date that the superintendent receives a pre-acquisition notification and shall end on the thirtieth day after the date of receipt or upon the superintendent's termination of the waiting period, whichever is earlier. Prior to the end of the waiting period, the superintendent, through one request, may require the submission of additional information relevant to the proposed acquisition. A request for the submission of additional information shall trigger a new waiting period that begins on the date of receipt of the additional information and ends on the thirtieth day after that receipt or upon the superintendent's termination of the waiting period, whichever is earlier.

D. The superintendent may enter an order pursuant to Subsection E of this section if there is substantial evidence that the acquisition may substantially lessen competition in

a line of insurance in New Mexico or that the acquisition would tend to create a monopoly or if the insurer fails to file adequate information in compliance with Subsection C of this section.

(1) In determining whether a proposed acquisition would violate the competitive standard identified in this subsection, the superintendent shall consider that:

(a) an acquisition identified in Subsection B of this section that involves two or more insurers competing in the same market is prima facie evidence of a violation of the competitive standard: 1) if the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more; or

2) if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more;

(b) for the purposes of Subparagraph (a) of this paragraph, a highly concentrated market is one in which the share of the four largest insurers is seventy-five percent or more of the market; the insurer with the largest share of the market shall be deemed to be Insurer A; a percentage not shown in a table is interpolated in proportion to the percentages shown; and if more than two insurers are involved in the acquisition, exceeding the total of the two columns in the table is prima facie evidence of a violation of the competitive standard of this subsection;

(c) there is a significant trend toward increased concentration when the aggregate market share of a grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven or more percent of the market over a period of time extending from any base year five to ten years prior to the acquisition up to the time of the acquisition. An acquisition or a merger identified in Subsection B of this section that involves two or more insurers competing in the same market is prima facie evidence of a violation of the competitive standard of this subsection if: 1) there is a significant trend toward increased concentration in the market; 2) an involved insurer is in a grouping of large insurers showing the requisite increase in the market share; and 3) another involved insurer's market is two percent or more;

(d) for the purposes of this subsection: 1) "insurer" includes a company and a group of companies under common management, ownership or control; 2) "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the superintendent shall give due consideration to, among other things, existing definitions or guidelines promulgated by the national association of insurance commissioners and information submitted by the parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in New Mexico, and the relevant geographical market is assumed to be New Mexico; and 3) the superintendent bears the burden of showing prima facie evidence of a violation of the competitive standard; and

(e) an acquisition that is not prima facie evidence of a violation of the competitive standard pursuant to Subparagraphs (a) and (b) of this paragraph may establish the requisite anti-competitive effect based on other substantial evidence. Using other substantial evidence, a party may establish the absence of the requisite anti-competitive effect for an acquisition that violates the competitive standard pursuant to Subparagraphs (a) and (b) of Paragraph (2) of this subsection. In making a determination pursuant to this subparagraph, the superintendent shall consider relevant factors, including: 1) market shares; 2) volatility of the ranking of market leaders; 3) the number of competitors; 4) concentration; 5) the trend of concentration in the industry; and 6) the ease of entry and exit into the market.

(2) An order shall not be entered pursuant to Subsection E of this section if:

(a) the acquisition would yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in another way and the benefit to the public that would arise from those economies would exceed the benefits to the public that would arise from not lessening competition; or

(b) the acquisition would substantially increase the availability of insurance and the benefits to the public of the increase would exceed the benefits to the public that would arise from not lessening competition.

E. If an acquisition violates the standards of this section, the superintendent may enter an order requiring an involved insurer to cease and desist from doing business in New Mexico with respect to the line or lines of insurance involved in the violation or an order denying the application of an acquired or acquiring insurer for a license to do business in New Mexico. The superintendent shall only enter an order if notice of a hearing was issued before the end of the waiting period, but not less than fifteen days prior to the hearing, and the hearing has concluded. The superintendent shall not enter an order more than sixty days after the insurer filed with the superintendent pre-acquisition notification. A written decision by the superintendent that sets forth findings of fact and conclusions of law shall accompany an order. An order is void if the acquisition is not consummated. After notice and a hearing, the superintendent may fine

a person that violates a valid cease-and-desist order no more than ten thousand dollars ($10,000) per day of the violation or suspend or revoke the person's license, or both. The superintendent may fine an insurer or other person that fails to make a filing required by this section and fails to demonstrate a good faith effort to comply with a filing requirement no more than fifty thousand dollars ($50,000).

F. Subsections B and C of Section 59A-37-25 NMSA 1978 and Subsection A of Section 59A-37-27 NMSA 1978 do not apply to an acquisition identified in Subsection B of this section.

History: 1978 Comp., § 59A-37-29, enacted by Laws 2014, ch. 59, § 43.

59A-37-30. Enterprise risk filing.

The person who predominantly controls an insurer that is subject to registration shall file an enterprise risk report each year. The report shall reflect that person's knowledge and belief of the material risks within the insurance holding company system that pose enterprise risk to the insurer. The report shall be filed with the lead state insurance supervisory official of the insurance holding company system and in compliance with the relevant procedures outlined in the financial analysis handbook adopted by the national association of insurance commissioners.

History: 1978 Comp., § 59A-37-30, enacted by Laws 2014, ch. 59, § 44.

59A-37-31. Management of domestic insurers subject to registration.

A. The control of a domestic insurer by a person does not relieve the insurer's officers and directors of an obligation or a liability to which they are otherwise subject by law. An insurer shall be managed so that its separate operating identity is consistent with the Insurance Holding Company Law.

B. Nothing in this section precludes a domestic insurer from participating in a common management function, a cooperative or the joint use of personnel if that participation meets the standards of Subsection A of Section 59A-37-20 NMSA 1978.

C. At least two-thirds of the directors and two-thirds of the members of each committee of the board of directors of a domestic insurer shall not be officers or employees of the insurer or of an entity that controls, is controlled by or is under common control with the insurer and shall not be beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one person in that group of two-thirds of the directors shall be present prior to the transaction of business at a meeting of the board of directors or a committee of the board of directors.

D. The board of directors of a domestic insurer shall establish at least one committee composed solely of directors who are not officers or employees of the insurer

or of an entity that controls, is controlled by or is under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. The committee or committees shall:

(1) nominate the candidates for director, who shall be elected by the shareholders or policyholders;

(2) evaluate the performance of officers deemed to be principal officers of the insurer; and

(3) recommend to the board of directors the selection and compensation of the principal officers.

E. The provisions of Subsections C and D of this section do not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company or a publicly held corporation, has a board of directors and committees of the board of directors that meet the requirements of Subsections C and D of this section.

F. An insurer whose annual direct written and assumed premium, excluding premiums reinsured with the federal crop insurance corporation and the national flood insurance program, is less than three hundred million dollars ($300,000,000) may apply to the superintendent for a waiver from the requirements of this section. An insurer whose circumstances are unusual may apply to the superintendent for a waiver from the requirements of this section. In determining whether the insurer qualifies for a waiver, the superintendent may consider, among other factors, the insurer's type of business entity, the volume of its business written, the availability of qualified board members and its ownership or organizational structure.

History: 1978 Comp., § 59A-37-31, enacted by Laws 2014, ch. 59, § 45.

59A-37-32. Supervisory colleges.

A. In order to determine compliance with the Insurance Holding Company Law by an insurer registered pursuant to Section 59A-37-11 NMSA 1978, the superintendent may participate in a supervisory college for a domestic insurer that is part of an insurance holding company system with international operations. Concerning a supervisory college, the superintendent may:

(1) initiate its establishment;

(2) clarify its membership and the participation of other supervisors;

(3) clarify its functions and the role of other regulators, including the establishment of a group-wide supervisor;

(4) coordinate its ongoing activities, including planning meetings, supervision and processes for information sharing; and

(5) establish a crisis management plan.

B. A registered insurer subject to this section shall pay the reasonable expenses, including for travel, associated with the superintendent's participation in a supervisory college pursuant to Subsection C of this section. A supervisory college may be convened as a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates. The superintendent may establish a regular assessment to the insurer for the payment of these expenses.

C. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes of an insurer, and as part of the examination of individual insurers pursuant to Section 59A-37-23 NMSA 1978, the superintendent may participate in a supervisory college with other regulators charged with the supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The superintendent may enter into agreements in accordance with Subsection C of Section 59A-37-24 NMSA 1978 that provide the basis for cooperation between the superintendent and the other regulatory agencies and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the superintendent to regulate or supervise the insurer or its affiliates within its jurisdiction.

History: 1978 Comp., § 59A-37-32, enacted by Laws 2014, ch. 59, § 46.

ARTICLE 38
Lloyds Plan Automobile Insurance

59A-38-1. Lloyds Plan automobile insurance authorized.

A. Individuals, partnerships or associations of individuals, hereby designated underwriters, are authorized to make or write fire, theft, collision and comprehensive insurance on motor vehicles, on the Lloyds Plan, by executing articles of agreement expressing their purpose so to do and complying with the requirements of this article.

B. Insurers formed under this article are authorized to transact vehicle insurance as defined in Section 113 [59A-7-7 NMSA 1978] of the Insurance Code if they meet the capital fund requirements specified in Section 83 [59A-5-16 NMSA 1978] of the Insurance Code and other reasonably applicable requirements for domestic stock vehicle insurers formed and qualified under the Insurance Code.

History: Laws 1984, ch. 127, § 644.

59A-38-2. Approval of policies; attorney-in-fact.

All forms of policies proposed to be issued shall, before the issuance thereof, be approved by the superintendent. Such policies may be executed by an attorney-in-fact, which attorney-in-fact may be an individual, partnership or corporation, authorized by and acting for such underwriters under power of attorney. The principal office of the attorney-in-fact shall be located in New Mexico at such place as shall be designated by the underwriters in their articles of agreement.

History: Laws 1984, ch. 127, § 645.

59A-38-3. Application for certificate of authority.

The attorney-in-fact shall file with the superintendent an application for certificate of authority as provided in Section 88 [59A-5-21 NMSA 1978] of the Insurance Code and also accompanied by:

A. the name of the attorney-in-fact, the name under which policies or contracts of insurance are to be made, and the title under which the business is to be conducted, which title shall contain the name of Lloyds;

B. the location of the principal office of the attorney-in-fact;

C. a copy of each form of policy or contract by which such insurance is to be effected;

D. the classes of vehicle insurance to be issued;

E. a copy of the articles of agreement entered into between underwriters themselves and the attorney-in-fact;

F. the names and addresses of all underwriters, whose number shall not be less than five (5);

G. a statement that executed contracts or bona fide applications to be concurrently effective have been made for the issuance of not less than one hundred (100) separate policies of insurance; and

H. an instrument executed by each and all of the underwriters especially empowering the attorney-in-fact and the superintendent of insurance to accept service of process for each and all of the underwriters in any action on any policy or contract of insurance.

History: Laws 1984, ch. 127, § 646.

59A-38-4. Cash or security deposit.

Prior to issuance of certificate of authority applied for, the attorney-in-fact or underwriters shall deposit with the state treasurer through the superintendent for the benefit of all policies and insurance contracts issued covering risks in this state, the sum of twenty-five thousand dollars ($25,000) in cash or securities of like value to be approved by the superintendent; or, in lieu of deposit of cash or securities, the attorney-in-fact may file with the state treasurer through the superintendent a surety bond issued by an authorized surety insurer, in penal sum of twenty-five thousand dollars ($25,000) and in form as prescribed by the attorney general of New Mexico, conditioned for the benefit of all such policies and insurance contracts. Any such deposit shall be subject to the applicable provisions of Article 10 [Chapter 59A, Article 10 NMSA 1978] (administration of deposits) of the Insurance Code.

History: Laws 1984, ch. 127, § 647.

59A-38-5. Surplus required.

The superintendent shall not issue or continue a certificate of authority as to a Lloyds Plan underwriters under this article unless it has initially and thereafter maintained a surplus, over all liabilities, of admitted assets in amount of not less than fifty thousand dollars ($50,000). The initial such surplus as contributed to the attorney-in-fact shall consist of cash or of securities approved by the superintendent, and shall include the amount of cash, securities, or surety bond deposited pursuant to Section 647 [59A-38-4 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 648.

59A-38-6. Limit on volume of insurance written.

A. A Lloyds Plan underwriters shall not assume nor write insurance on risks in this state or for New Mexico residents which produces a net premium income in excess of ten (10) times the underwriters' surplus. If at any time insurance in force produces a net premium income greater than ten (10) times such surplus, the underwriters shall not write any new insurance business until they can do so without exceeding such limit of net premiums to surplus.

B. While the underwriters' surplus is in amount not less than the minimum amount of capital funds (paid-in capital stock) required to be maintained under the Insurance Code by a domestic stock insurer transacting the same kind of insurance, the limit upon volume of business written otherwise applicable under this action shall not apply.

C. If in the superintendent's judgment the underwriters have effected and maintain reinsurance or other contracts with insurers authorized to transact insurance in this state, and which reduces the net insurance risk retained by the underwriters so that their operations are safe and solvency not endangered, then the superintendent may continue the certificate of authority to the underwriters without regard to the limitation upon volume of insurance business in force otherwise provided for in this section.

History: Laws 1984, ch. 127, § 649.

59A-38-7. Determining solvency; investments.

A. In determining solvency of a Lloyds Plan underwriters there shall be considered all funds contributed to the guaranty fund by the underwriters and funds accumulated from insurance business transacted and held for the underwriters by the attorney-in-fact. Underwriters shall be deemed solvent when the admitted assets meet the requirements of this article, after deducting from gross admitted assets all outstanding liabilities, including reserve liabilities; and when the guaranty fund, at least to the minimum required amount, is unimpaired.

B. Funds of underwriters shall be invested in such property and securities as are eligible under Article 9 [Chapter 59A, Article 9 NMSA 1978] (investments) of the Insurance Code for investment of funds of a domestic stock insurer authorized to transact the same kind of insurance.

History: Laws 1984, ch. 127, § 650.

59A-38-8. Distribution of profits; how determined.

No profits out of a Lloyds Plan insurance operation shall accrue to an underwriter or underwriters except on the basis of his or their actual investment in cash or eligible securities, and no such profits shall be paid except out of surplus and in proportion to such investment. Such surplus shall be determined by the superintendent in the following manner:

A. he shall charge as liabilities the same reserves as are required of authorized stock insurers transacting the same kind of insurance;

B. he shall allow the surplus deposits of underwriters as an asset, except that if an underwriter's premium deposit is due and unpaid for ninety (90) days, the premium deposit shall first be charged against such surplus;

C. the surplus deposits of underwriters shall not be charged as liabilities;

D. all premium deposits due and unpaid for a period not exceeding ninety (90) days shall be allowed as assets; and

E. the amount of surplus shall otherwise be determined in accordance with similar determination, as applicable, of the surplus of other authorized stock and mutual insurers.

History: Laws 1984, ch. 127, § 651.

59A-38-9. Impairment.

A. Whenever it is found by the superintendent that the minimum surplus required of a Lloyds Plan underwriters under this article has become impaired, the superintendent shall immediately give notice to the attorney-in-fact to appear and show cause why the certificate of authority of the attorney-in-fact should not be revoked; and if within thirty (30) days from the giving of such notice the impairment has not been made good by the underwriters or the attorney-in-fact or otherwise, the superintendent shall forthwith revoke the certificate of authority.

B. If the attorney-in-fact or other person makes any advancement of funds to make good the impairment of surplus, the claim for funds so advanced shall as to assets be deferred to claims for losses under policies or insurance contracts.

C. If the impairment of surplus is not made good within the time prescribed, the superintendent, in addition to revocation of the certificate of authority, shall commence delinquency proceedings against the underwriters as provided for as to insurers in general under Article 41 [Chapter 59A, Article 41 NMSA 1978] (conservation, rehabilitation, liquidation) of the Insurance Code.

History: Laws 1984, ch. 127, § 652.

59A-38-10. Withdrawal of underwriters.

If the underwriters of a Lloyds Plan insurance operation desire to withdraw from the insurance business they may do so if and when they have satisfied the superintendent that adequate provision has been made through reinsurance or otherwise for payment of all unpaid losses and for reinsurance of all outstanding risks of New Mexico residents or covering property located in New Mexico. Upon being so satisfied the superintendent shall release any bond of the attorney-in-fact and release to the underwriters the deposit and remaining assets.

History: Laws 1984, ch. 127, § 653.

59A-38-11. Lloyds Plan insurance producers; licensing.

The provisions of the Insurance Code as to qualifications, appointment, licensing and regulation of insurance producers apply neither to the attorney-in-fact at Lloyds nor to a salaried representative of Lloyds who receives no commission, but do apply to any insurance producer who receives any commission.

History: Laws 1984, ch. 127, § 654; 2016, ch. 89, § 65.

59A-38-12. Lloyds Plan an "insurer".

For the purposes of the Insurance Code a Lloyds Plan insurance operation is subject to applicable provisions of this code, and may be therein referred to as an "insurer".

History: Laws 1984, ch. 127, § 655.

59A-38-13. Illegal transactions; penalty.

Any attorney-in-fact of Lloyds Plan underwriters or representative of such attorney-in-fact who exchanges or solicits or negotiates the exchange of any automobile insurance contract without compliance by the attorney-in-fact with the provisions of this article, shall be deemed guilty of a misdemeanor and upon conviction shall be punished by a fine of not to exceed five thousand dollars ($5,000).

History: Laws 1984, ch. 127, § 656.

59A-38-14. Venue of action.

Actions against the attorney-in-fact or underwriters of a domestic Lloyds Plan insurance operation may be brought either in the county in which the person or property insured is resident or located, or in which the attorney-in-fact has his principal office or place of business in this state.

History: Laws 1984, ch. 127, § 657.

ARTICLE 39
Reciprocal Insurers

59A-39-1. "Reciprocal" insurance defined.

As used in the Insurance Code, "reciprocal" insurance is that resulting from an interchange among persons, known as "subscribers," of reciprocal agreements of indemnity, the interchange being effectuated through an attorney-in-fact common to all such persons.

History: Laws 1984, ch. 127, § 658.

59A-39-2. Scope of chapter; existing insurers.

A. All authorized reciprocal insurers shall be governed by those sections of this article not expressly made applicable to domestic reciprocals.

B. After the effective date of the Insurance Code existing authorized reciprocal insurers shall comply with the provisions of this article, and shall make such amendments to their subscribers' agreement, power of attorney, policies and other documents and accounts and perform such other acts as may be required for such compliance.

History: Laws 1984, ch. 127, § 659.

59A-39-3. Insuring powers of reciprocals.

A. A reciprocal insurer may, upon qualifying therefor as provided for by the Insurance Code, transact any kind or kinds of insurance defined by the Insurance Code other than life or title insurances.

B. Such an insurer may purchase reinsurance upon the risk of any subscriber, and may grant reinsurance as to any kind of insurance it is authorized to transact direct.

History: Laws 1984, ch. 127, § 660.

59A-39-4. Name; suits.

A reciprocal insurer shall:

A. have and use a business name. The name shall include the word "reciprocal" or "interinsurer," or "interinsurance," or "exchange," or "underwriters," or "underwriting," or "association"; and

B. sue and be sued in its own name.

History: Laws 1984, ch. 127, § 661.

59A-39-5. Attorney.

A. "Attorney", as used in Chapter 59A, Article 39 NMSA 1978, refers to the attorney-in-fact of a reciprocal insurer. The attorney may be an individual, firm or corporation.

B. The attorney of a foreign reciprocal insurer, which insurer is duly authorized to transact insurance in this state, shall not, by virtue of the discharge of its duties as such attorney with respect to the insurer's transactions in this state, be thereby deemed to be doing business in this state within the meaning of any laws of this state applying to foreign persons, firms or corporations.

C. The subscribers and the attorney-in-fact comprise a reciprocal insurer and single entity for the purposes of the Insurance Premium Tax Act [7-40-1 to 7-40-10 NMSA 1978] and Sections 59A-6-3 through 59A-6-6 NMSA 1978 as to all operations under the insurer's certificate of authority.

History: Laws 1984, ch. 127, § 662; 2018, ch. 57, § 22.

59A-39-6. Organization of reciprocal insurer.

A. Twenty-five (25) or more persons domiciled in this state may organize a domestic reciprocal insurer and make application to the superintendent for a certificate of authority to transact insurance.

B. The proposed attorney shall fulfill the requirements of and shall execute and file with the superintendent when applying for a certificate of authority a declaration setting forth:

(1) the name of the insurer;

(2) the location of the insurer's principal office, which shall be the same as that of the attorney and shall be maintained within this state;

(3) the kinds of insurance proposed to be transacted;

(4) the names and addresses of the original subscribers;

(5) the designation and appointment of the proposed attorney and a copy of the power of attorney;

(6) the names and addresses of the officers and directors of the attorney, if a corporation, or its members, if a firm;

(7) the powers of the subscribers' advisory committee, and the names and terms of office of the members thereof;

(8) that all moneys paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;

(9) a statement that each of the original subscribers had in good faith applied for insurance of a kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than six (6) months at an adequate rate theretofore filed with and approved by the superintendent;

(10) a statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by Section 83 [59A-5-16 NMSA 1978] of the Insurance Code is on hand; and

(11) a copy of each policy, endorsement and application form it then proposes to issue or use.

C. The declaration shall be acknowledged by the attorney in the manner required for the acknowledgment of deeds.

History: Laws 1984, ch. 127, § 663.

59A-39-7. Certificate of authority.

A. The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

B. The superintendent may refuse, suspend or revoke the certificate of authority, in addition to other grounds therefor, for failure of the attorney to comply with any applicable provision of the Insurance Code.

History: Laws 1984, ch. 127, § 664.

59A-39-8. Power of attorney.

A. The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

B. The power of attorney must set forth:

(1) the powers of the attorney;

(2) if a domestic insurer, that the attorney is empowered to accept service of process on behalf of the insurer in actions against the insurer upon contracts exchanged;

(3) the general services to be performed by the attorney;

(4) the maximum amount, if any, to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense, if any, in addition to losses, to be paid by the insurer; and

(5) except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount which amount shall be not less than one nor more than ten (10) times the premium or premium deposit stated in the policy.

C. The power of attorney may:

(1) provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(2) impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;

(3) provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(4) contain other lawful provisions deemed advisable.

D. The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement shall be used or be effective in this state until approved by the superintendent.

History: Laws 1984, ch. 127, § 665.

59A-39-9. Modifications.

Modifications of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No such modification shall be effective retroactively, or as to any insurance contract issued prior thereto.

History: Laws 1984, ch. 127, § 666.

59A-39-10. Attorney's bond.

A. Concurrently with the filing of the declaration provided for in Section 663 [59A-39-6 NMSA 1978] of this article, the attorney of a domestic reciprocal insurer shall file with the superintendent a bond in favor of this state for the benefit of all persons damaged as a result of breach by the attorney of the conditions of this bond as set forth in Subsection B, below. The bond shall be executed by the attorney and by an authorized corporate surety, and shall be subject to the superintendent's approval.

B. The bond shall be in the penal sum of fifty thousand dollars ($50,000), aggregate in form, conditioned that the attorney will faithfully account for all moneys and other property of the insurer coming into his hands, and that he will not withdraw or appropriate to his own use from the funds of the insurer any moneys or property to which he is not entitled under the power of attorney.

C. The bond shall provide that [it] is not subject to cancellation unless thirty (30) days' advance notice in writing of cancellation is given both the attorney and the superintendent.

History: Laws 1984, ch. 127, § 667.

59A-39-11. Deposit in lieu of bond.

In lieu of the bond required under Section 667 [59A-39-10 NMSA 1978] of this article, the attorney may maintain on deposit through the superintendent, a like amount in cash or in market value of United States government bonds, subject to the same conditions as the bond.

History: Laws 1984, ch. 127, § 668.

59A-39-12. Action on bond.

An action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought by one or more subscribers suffering loss through a violation of its conditions, or by a receiver or liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety shall be limited to the amount of the penalty of such bond.

History: Laws 1984, ch. 127, § 669.

59A-39-13. Service of process; judgment.

A. Legal process shall be served upon a domestic reciprocal insurer by serving the insurer's attorney at his principal office or by serving the superintendent as the insurer's process agent under Sections 98 and 99 [59A-5-31 and 59A-5-32 NMSA 1978] of the Insurance Code.

B. Any judgment based upon legal process so served shall be binding upon each of the insurer's subscribers as their respective interests may appear, but in an amount not exceeding their respective contingent liabilities, if any, the same as though personal service of process was had upon each such subscriber.

History: Laws 1984, ch. 127, § 670.

59A-39-14. Contributions to insurer.

A. The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms such funds as it may require from time to time in its operations. Sums so advanced shall not be treated as a liability of the insurer and, except upon liquidation of the insurer, shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus. No such withdrawal or repayment shall be made without the advance approval of the superintendent.

B. This section does not apply to bank loans or to other loans made upon security.

History: Laws 1984, ch. 127, § 671.

59A-39-15. Financial condition; method of determining.

In determining the financial condition of a reciprocal insurer the superintendent shall apply the following rules:

A. he shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis;

B. the surplus deposits of subscribers shall be allowed as assets except that any premium deposits delinquent for ninety (90) days shall first be charged against such surplus deposit;

C. the surplus deposits of subscribers shall not be charged as a liability;

D. all premium deposits delinquent less than ninety (90) days shall be allowed as assets;

E. an assessment levied upon subscribers, and not collected, shall not be allowed as an asset;

F. the contingent liability of subscribers shall not be allowed as an asset; and

G. the computation of reserves shall be based upon premium deposits other than membership fees and without any deduction for expenses and the compensation of the attorney.

History: Laws 1984, ch. 127, § 672.

59A-39-16. Who may be subscribers.

A. Individuals, partnerships and corporations of this state may make application, enter into an agreement for and hold policies or contracts in or with and be a subscriber of any domestic, foreign or alien reciprocal insurer. Any corporation organized under the laws of this state prior to or after the effective date of the Insurance Code shall, in addition to the rights, powers, and franchises specified in its articles of incorporation, have full power and authority as a subscriber to exchange insurance contracts through such reciprocal insurer. The right to exchange such contracts is hereby declared to be incidental to the purposes for which such corporations are organized and to be as fully granted as the rights and powers expressly conferred upon such corporations.

B. Government or governmental agencies, a state or political subdivisions thereof, boards, associations, estates, trustees or fiduciaries are authorized to exchange nonassessable reciprocal interinsurance contracts with each other and with individuals, partnerships and corporations to the same extent that individuals, partnerships and corporations are authorized in this article to exchange reciprocal interinsurance contracts.

C. Any officer, representative, trustee, receiver or legal representative of any such subscriber shall be recognized as acting for or on its behalf for the purpose of such contract but shall not be personally liable upon such contract by reason of acting in such representative capacity.

History: Laws 1984, ch. 127, § 673.

59A-39-17. Subscribers' advisory committee.

A. The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

B. Not less than two-thirds of such committee shall be subscribers other than the attorney, or any person employed by, representing or having a financial interest in the attorney.

C. The committee shall:

(1) supervise the finances of the insurer;

(2) supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and the power of attorney;

(3) procure the audit of the accounts and records of the insurer and of attorney at the expense of the insurer; and

(4) have such additional powers and functions as may be conferred in the subscribers' agreement.

History: Laws 1984, ch. 127, § 674.

59A-39-18. Subscribers' liability.

A. The liability of each subscriber, other than as to a nonassessable policy, for the obligations of the reciprocal insurer shall be an individual, several and proportionate liability, and not joint.

B. Except as to a nonassessable policy, each subscriber shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while his policy was in force. Such contingent liability may be at the rate of not less than one nor more than ten (10) times the premium or premium deposit stated in the policy, and the maximum aggregate thereof shall be computed in the manner set forth in Section 679 [59A-39-22 NMSA 1978] of this article.

C. Each assessable policy issued by the insurer shall contain a statement of the contingent liability, set in type of not less prominence than the insuring clause.

History: Laws 1984, ch. 127, § 675.

59A-39-19. Subscribers' liability on judgment.

A. No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for thirty (30) days.

B. Any such judgment shall be binding upon each subscriber only in such proportion as his interests may appear and in an amount not exceeding his contingent liability, if any.

History: Laws 1984, ch. 127, § 676.

59A-39-20. Assessments.

A. Assessments may from time to time be levied upon subscribers of a domestic reciprocal insurer liable therefor under the terms of their policies by:

(1) the attorney upon approval in advance by the subscribers' advisory committee and the superintendent; or

(2) the superintendent in liquidation of the insurer.

B. Each subscriber's share of a deficiency for which an assessment is made, but not exceeding in any event his aggregate contingent liability as computed in accordance with Section 679 [59A-39-22 NMSA 1978] of this article, shall be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment, the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment.

C. In computing the earned premiums for the purposes of this section, the gross premium received by the insurer for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.

D. No subscriber shall have an offset against any assessment for which he is liable, on account of any claim for unearned premium or losses payable.

History: Laws 1984, ch. 127, § 677.

59A-39-21. Time limit for assessments.

Every subscriber of a domestic reciprocal insurer having contingent liability shall be liable for, and shall pay his share of any assessment as computed and limited in accordance with this article, if:

A. while his policy is in force or within one year after its termination, he is notified by either the attorney or the superintendent of his intentions to levy such assessment; or

B. if an order to show cause why a receiver, conservator, rehabilitator or liquidator of the insurer should not be appointed is issued while his policy is in force or within one year after its termination.

History: Laws 1984, ch. 127, § 678.

59A-39-22. Aggregate liability.

No one policy or subscriber to such policy, shall be assessed or charged with an aggregate of contingent liability as to obligations incurred by a domestic reciprocal insurer in any one calendar year, in excess of the amount provided for in the power of attorney or in the subscribers' agreement, computed solely upon the premium earned on such policy during that year.

History: Laws 1984, ch. 127, § 679.

59A-39-23. Nonassessable policies.

A. If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by the subscribers' advisory committee the superintendent shall issue his certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this state, and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this state for so long as all such surplus remains unimpaired.

B. Upon impairment of such surplus, the superintendent shall forthwith revoke the certificate. Such revocation shall not render subject to contingent liability any policy then in force and for the remainder of the period for which the premium has theretofore been paid; but after such revocation no policy shall be issued or renewed without providing for contingent assessment liability of the subscriber.

C. The superintendent shall not authorize a domestic reciprocal insurer so to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued, unless it qualifies to and does extinguish such liability of all its subscribers and in all such policies for all kinds of insurance transacted by it; but if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire such policies in such state and need not extinguish the contingent liability applicable to policies theretofore in force in such state.

History: Laws 1984, ch. 127, § 680.

59A-39-24. Subscribers' share in assets.

Upon the liquidation of a domestic reciprocal insurer, its assets remaining after the discharge of its indebtedness and policy obligations, the return of any contributions of the attorney or other persons to its surplus, and the return of any unused premiums, savings or credits then standing on subscribers' accounts shall be distributed to its subscribers who were such within the twelve (12) months prior to the last termination of its certificate of authority, according to such reasonable formula as the superintendent may approve.

History: Laws 1984, ch. 127, § 681.

59A-39-25. Merger or conversion.

A. A domestic reciprocal insurer upon the affirmative vote of not less than two-thirds of its subscribers who vote on such merger pursuant to due notice, and the approval of the superintendent of the terms therefor after a hearing thereon may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

B. Such a stock or mutual insurer shall be subject to the same capital or surplus requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance.

C. The superintendent shall not approve any plan for such merger or conversion which is unfair or inequitable to subscribers, or in violation of law or subject to reasonable obligation, or which, if for conversion to a stock insurer, does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to his interest in the reciprocal insurer as determined in accordance with Section 681 [59A-39-24 NMSA 1978] of this article and a reasonable length of time within which to exercise such right.

History: Laws 1984, ch. 127, § 682.

59A-39-26. Impaired reciprocals.

A. Subject to the limitation set forth in the power of attorney or policy, if the assets of a domestic reciprocal insurer are at any time insufficient to discharge its liabilities, other than any liability on account of funds contributed by the attorney or others, and to maintain the required surplus, its attorney shall forthwith make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency.

B. If the attorney fails to make up such deficiency or to make the assessment within thirty (30) days after the superintendent orders him to do so, or if the deficiency is not fully made up within sixty (60) days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by the Insurance Code.

C. If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers for such an amount, subject to the limits provided by this article, as the superintendent determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons, but including the reasonable cost of the liquidation.

History: Laws 1984, ch. 127, § 683.

ARTICLE 40
Mexican Casualty Insurers

59A-40-1. May be licensed to write certain insurance effective in Mexico.

A. Any insurer lawfully organized under the laws of the republic of Mexico, or under the laws of any state thereof, and duly authorized by such laws and by its charter or articles of association and by current license of the appropriate insurance regulatory authority of such republic or any state thereof to underwrite risks of the kinds and in the circumstances hereinafter mentioned, may issue in New Mexico, under license of the superintendent, policies of insurance affording any and all kinds of automobile insurance coverage, health insurance and other casualty insurance coverage, upon persons and personal property, to be in force only while such persons and personal property shall be physically within the boundaries of the republic of Mexico, by complying with the requirements of this article.

B. For the purposes of general provisions of the Insurance Code such license shall be deemed to be a "certificate of authority" to transact such insurance in this state, but subject to the provisions of this article.

History: Laws 1984, ch. 127, § 684.

59A-40-2. Application for license.

A. Such insurer shall file with the superintendent its written application for license to do business in this state, accompanied by a correct English translation of its charter and bylaws, duly certified by two (2) of its principal officers and by the insurance regulatory officials under whose supervision it operates in the republic of Mexico, and all of its policy forms, application forms, claim forms and other forms of every nature which it uses or expects to use in underwriting the coverage hereby authorized to be written in New Mexico, all of which shall be subject to the approval of the superintendent.

B. Before licensing and annually thereafter, the insurer shall also file with the superintendent a copy of its current license or licenses to operate in the republic of Mexico, and shall file a copy of its latest financial reports or statements, and of the latest examination reports of its affairs and financial condition by the insurance regulatory

authorities under which it operates in Mexico, with money amounts therein shown, or accompanied by statement of the amounts thereof, in United States dollars, together with statement of the basis on and date as of which pesos were so converted to dollars.

History: Laws 1984, ch. 127, § 685.

59A-40-3. Deposit or bond.

A. Before license is issued the insurer shall deposit with the treasurer of the state of New Mexico through the superintendent at least twenty-five thousand dollars ($25,000) in lawful money of the United States or in securities eligible for investment of funds of domestic casualty insurers and approved by the superintendent, which deposit shall be liable for all lawful claims and final judgments against such insurer, including taxes due New Mexico, and policy claims and other debts and obligations incurred in the course of operations as provided herein, and such deposit shall be kept replenished from time to time with like cash or approved securities to maintain a minimum total deposit of twenty-five thousand dollars ($25,000).

B. In lieu of such deposit of cash or securities, the insurer may file with the superintendent and thereafter maintain in force a surety bond in like amount and for like purposes issued by a surety insurer authorized to transact such business in this state and acceptable to the superintendent.

C. Such deposit or the unincumbered [unencumbered] balance thereof shall be returned to the insurer with approval of the superintendent, or such bond may be terminated, upon withdrawing from the business authorized hereby and upon a showing to the superintendent that all of its policies written in New Mexico hereunder have expired or have been cancelled and that all of the claims against such deposits or bond have been satisfied.

D. The superintendent, upon the approval of the court, shall pay from the deposit required herein, or require payment by the surety under such bond, any unsatisfied final judgment obtained against the insurer in any court of competent jursidiction [jurisdiction] in New Mexico based upon service of process as authorized in this article.

History: Laws 1984, ch. 127, § 686.

59A-40-4. Service of process.

Prior to issuance of license, the insurer shall file with the superintendent a power of attorney, in a form designated by the superintendent, designating the superintendent and his successors in office as attorney-in-fact for such insurer upon whom service of process may be had upon suits for any alleged liability incurred in operations of the insurer pursuant to this article, with like effect as if such process had been served personally upon the appropriate persons, representatives or officials of such insurer within its home jurisdiction in Mexico. In [the] event process is served upon the

superintendent, as provided above, he shall immediately give written notice thereof to such insurer and shall forward such process by registered mail, postage prepaid, and properly addressed to the president of such insurer at its home office as furnished to the superintendent; and no judgment by default shall be taken in any such cause until after the expiration of forty (40) days after the process and notice have been received at such home office. Until rebutted, the presumption shall obtain that such notice and process was received at the home office of the insurer on the tenth (10th) day after being deposited in the mail at Santa Fe, New Mexico, as herein provided.

History: Laws 1984, ch. 127, § 687.

59A-40-5. Reports.

The insurer shall pay any applicable fees and charges as are required under the Insurance Code to be paid by other authorized insurers transacting in New Mexico the same kind of insurance. The insurer shall make the same reports to the superintendent and the national association of insurance commissioners as are required of such other authorized insurers, but in such adapted forms as may for the purpose be prescribed by the superintendent.

History: Laws 1984, ch. 127, § 688; 2018, ch. 57, § 23.

59A-40-6. Premium rates.

Premiums charged by insurers licensed under this article shall be at rates filed with the superintendent and not disapproved by him, in the same manner as to premium rates of authorized insurers transacting in this state the same kinds of insurance.

History: Laws 1984, ch. 127, § 689.

59A-40-7. Examination.

The superintendent may examine at any and all times, at the expense of the insurer, the affairs and conditions and all books and records of the insurer for the purpose of ascertaining its financial condition and solvency, and its compliance with applicable laws of this state and of its home jurisdiction. Any such examination shall be conducted, as far as reasonably possible, in the same manner and subject to the same requirements of the insurer and staff and matters related to the examination, as provided by the Insurance Code as to examination of insurers in general.

History: Laws 1984, ch. 127, § 690.

59A-40-8. Acceptance of laws; suspension, revocation, nonrenewal of license.

Prior to issuance of license under this article the insurer shall file with the superintendent a document in English as prescribed by the superintendent and executed by the insurer's appropriate officials expressly accepting the terms of this article and agreeing that the superintendent may at any time in his lawful discretion suspend, revoke or refuse to grant or continue the license of the insurer to do business in this state as in this article authorized, upon a determination by the superintendent that the insurer is insolvent or in dangerous financial condition, or that it has violated any law of this state or of its home jurisdiction.

History: Laws 1984, ch. 127, § 691.

59A-40-9. Licensed agents required.

The insurer shall write business in New Mexico only through its resident United States agents duly appointed by it in writing and duly licensed by the superintendent under provisions of the Insurance Code applicable to insurance agents of authorized insurers. The appointment of agents shall specifically authorize the licensee to write for the Mexican insurer the insurance coverages as specified in Chapter 59A, Article 40 NMSA 1978.

History: Laws 1984, ch. 127, § 692; 1999, ch. 272, § 21; 1999, ch. 289, § 31.

ARTICLE 41
Conservation, Rehabilitation and Liquidation

59A-41-1. Short title.

This article [Chapter 59A, Article 41 NMSA 1978] constitutes and may be cited as the Insurers Conservation, Rehabilitation, and Liquidation Law.

History: Laws 1984, ch. 127, § 694.

59A-41-2. Scope of article.

The provisions of Chapter 59A, Article 41 NMSA 1978 as applicable shall apply as to:

A. all insurers that are transacting or have transacted insurance in this state and against whom claims arising from that business may exist now or in the future;

B. all insurers that purport to do insurance business in this state;

C. all insurers having insureds resident in this state;

D. all persons in process of organization, or holding themselves out as organizing, or proposing to organize in this state for the purpose of becoming an insurer;

E. all nonprofit health care plans and fraternal benefit societies;

F. all title insurance companies;

G. all health maintenance organizations and prepaid dental or other prepaid health care delivery plans;

H. all Lloyds insurers, mandatory state pooling plans, mutual assessment companies, insurance exchanges, stipulated premium insurance companies, prearranged funeral plans, motor clubs, reciprocal insurers, surplus lines insurers, alien insurers or reinsurers with assets in trust or located in New Mexico, multiple employer welfare arrangements, risk retention groups, risk purchasing groups or surety companies; and

I. all other persons to whom such provisions may otherwise be made expressly applicable by law.

History: Laws 1984, ch. 127, § 693; 1991, ch. 125, § 29.

59A-41-3. Definitions.

As used in this article and unless context otherwise requires, the words and terms defined in Sections 696 through 708 [59A-41-4 to 59A-41-16 NMSA 1978] of this article shall have the meanings ascribed to them respectively in such sections.

History: Laws 1984, ch. 127, § 695.

59A-41-4. "Ancillary state" defined.

"Ancillary state" means any state other than a domiciliary state.

History: Laws 1984, ch. 127, § 696.

59A-41-5. "Creditor" defined.

"Creditor" means a person having a claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, or absolute, fixed or contingent.

History: Laws 1984, ch. 127, § 697.

59A-41-6. "Delinquency proceeding" defined.

"Delinquency proceeding" means any proceeding commenced against an insurer pursuant to this article for the purpose of conserving, rehabilitating, reorganizing or liquidating the insurer.

History: Laws 1984, ch. 127, § 698.

59A-41-7. "Domiciliary state" defined.

"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.

History: Laws 1984, ch. 127, § 699.

59A-41-8. "Foreign country" defined.

"Foreign country" means territory not in any state.

History: Laws 1984, ch. 127, § 700.

59A-41-9. "General assets" defined.

"General assets" means all property, real, personal or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons, and as to such specifically encumbered property the term includes all such property or its proceeds in excess of the amount necessary to discharge the sums secured thereby. Assets held in trust or on deposit for the security or benefit of all policyholders or all policyholders and creditors in the United States are deemed general assets.

History: Laws 1984, ch. 127, § 701.

59A-41-10. "Impairment" defined.

"Impairment" exists as to:

A. a stock, mutual, reciprocal, or foreign Lloyds insurer, when its basic capital is less than that required to be maintained by it under Section 83 [59A-5-16 NMSA 1978] of the Insurance Code;

B. a domestic Lloyds insurer, when its surplus is less than as required under Section 83 or Article 38 [Chapter 59A, Article 38 NMSA 1978] of the Insurance Code;

C. a nonprofit health care plan, when its assets are in amount less than the sum of its required trust deposit, required reserves and other liabilities;

D. a prepaid dental care plan, when its assets are in amount less than the sum of its required bond or deposit in lieu thereof, its required reserves, and its other liabilities;

E. a motor club, when its assets are in amount less than the sum of its required bond or deposit in lieu thereof, its required reserves, and its other liabilities; and

F. any other corporation, when its assets are in amount less than the sum of its surplus required, if any, to be maintained, its paid-in capital stock, if any, and its other liabilities.

History: Laws 1984, ch. 127, § 702.

59A-41-11. "Insolvency" defined.

"Insolvency" exists as to:

A. any organization, when it is unable to meet its obligations as they mature; or

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

C. a mutual, reciprocal, or foreign Lloyds insurer, when its assets are in amount less than its liabilities exclusive of the minimum paid-in basic capital required under Section 83 [59A-5-16 NMSA 1978] of the Insurance Code for its authority to transact insurance; or

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

History: Laws 1984, ch. 127, § 703.

59A-41-12. "Preferred claim" defined.

"Preferred claim" means any claim accorded priority of payment from the insurer's or organization's general assets under applicable law.

History: Laws 1984, ch. 127, § 704.

59A-41-13. "Receiver" defined.

"Receiver" means a receiver, liquidator, rehabilitator or conservator, as context may require.

History: Laws 1984, ch. 127, § 705.

59A-41-14. "Reciprocal state" defined.

"Reciprocal state" means any state other than this state in which in substance and effect the provisions of the Uniform Insurers Liquidation Act [59A-41-17 to 59A-41-23 NMSA 1978] are in force, including provisions requiring that the commissioners, director, superintendent of insurance or the equivalent insurance supervisory officer be the receiver of a delinquent insurer; and in which effective provisions exist for avoidance of fraudulent conveyances and unlawful preferential transfer.

History: Laws 1984, ch. 127, § 706.

59A-41-15. "Secured claim" defined.

"Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow or otherwise, but not including special deposit claims or claims against general assets. "Secured claims" also include claims which more than four (4) months prior to commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets through judicial process and not invalidated.

History: Laws 1984, ch. 127, § 707.

59A-41-16. "Special deposit claim" defined.

"Special deposit claim" means any claim secured by a deposit made under a statute for the security or benefit of a limited class or classes of persons, but not including any general assets.

History: Laws 1984, ch. 127, § 708.

59A-41-17. Uniform Insurers Liquidation Act; composition, severability and interpretation.

A. Sections 695 [709] through 715 [59A-41-17 to 59A-41-23 NMSA 1978] of this article comprise and may be cited as the Uniform Insurers Liquidation Act.

B. If any provision of the Uniform Insurers Liquidation Act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid

provision or application, and to this end the provisions of the act are declared to be severable.

C. The Uniform Insurers Liquidation Act shall be so interpreted as to effectuate its general purpose to make uniform the laws of those states which enact it. To the extent that its provisions, when applicable, conflict with other provisions of the Insurance Code, the provisions of the Uniform Insurers Liquidation Act shall control.

History: Laws 1984, ch. 127, § 709.

59A-41-18. Conduct of delinquency proceedings against domestic insurers.

A. Whenever under the laws of this state a receiver is to be appointed in delinquency proceedings for an insurer domiciled in this state, the court shall appoint the superintendent as such receiver. The court shall direct the superintendent forthwith to take possession of the assets of the insurer and to administer the same under the orders of the court.

B. As domiciliary receiver the superintendent and his successors in office shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer wherever located, as of the date of entry of the order directing him to liquidate a domestic insurer or the United States branch of an alien insurer domiciled in the state and he shall have the right to recover the same and reduce the same to possession; except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are hereinafter prescribed for ancillary receivers appointed in this state as to assets located in this state. The filing or recording of the order directing possession to be taken, or a certified copy thereof, in the office where instruments affecting title to property are required to be filed or recorded shall impart the same notice as would be imparted by a deed, bill of sale or other evidence of title duly filed or recorded. The superintendent as domicilary [domiciliary] receiver shall be responsible on his official bond for the proper administration of all assets coming into his possession or control. The court may at any time require an additional bond from him or his deputies if deemed desirable for the protection of the assets.

C. Upon taking possession of the assets of a delinquent insurer the domiciliary receiver shall, subject to the direction of the court, immediately proceed to conduct the business of the insurer or to take such steps as are authorized by the laws of this state for the purposes of liquidating, rehabilitating, reorganizing or conserving the affairs of the insurer. In connection with delinquency proceedings he may appoint one or more special deputy superintendents to act for him, and may employ such counsel, clerks and assistants as he deems necessary. The compensation of the special deputies, counsel, clerks or assistants and all expenses of taking possession of the delinquent insurer and of conducting the delinquency proceedings shall be fixed by the receiver, subject to the approval of the court, and shall be paid out of the funds or assets of the insurer. Within

the limits of the duties imposed upon them special deputies shall possess all the powers given to, and, in the exercise of those powers, shall be subject to all of the duties imposed upon the receiver with respect to delinquency proceedings.

D. Upon the issuance of an order of liquidation with a finding of insolvency against a domestic insurer, the superintendent shall make application to the court requesting authority to disburse funds to the life insurance guaranty association or the property and casualty insurance guaranty association, as applicable, from time to time out of the insurer's marshalled assets as funds become available in amounts equal to disbursements made by the association for claims handling expense and covered claims obligations on the presentation of evidence that such disbursements have been made by the guaranty association. Such application shall request authority for the superintendent to make disbursements to similar associations or state funds in other states provided the life insurance guaranty association or the property and casualty insurance guaranty association, as applicable, is entitled to like payment under the laws of the association's or state fund's state of domicile in respect to insolvent insurers domiciled in the state.

E. The superintendent in determining the amounts available for disbursements to the life insurance guaranty association or property and casualty insurance guaranty association, as applicable, and similar associations or funds in other states shall reserve sufficient assets for the payment of the expenses of administration. The superintendent shall establish procedures for the ratable allocation of disbursements to the life insurance guaranty association or property and casualty insurance guaranty association and similar associations or funds in other states, and shall secure from the life insurance guaranty association or property and casualty guaranty association and each eligible similar association or fund in other states as a condition to advances in reimbursement of covered claims obligations and claim handling expenses, an agreement to return to the superintendent on demand funds previously advanced as may be required to pay the expenses of administration.

History: Laws 1984, ch. 127, § 710.

59A-41-19. Conduct of delinquency proceedings against nondomestic insurers; domiciliary receiver may sue.

A. Whenever under the laws of this state an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this state, the court shall appoint the superintendent as ancillary receiver. The superintendent shall file a petition requesting the appointment:

(1) if he finds that there are sufficient assets of such insurer located in this state to justify the appointment of an ancillary receiver; or

(2) if ten (10) or more persons resident in this state having claims against such insurer file a petition with the superintendent requesting the appointment of such ancillary receiver.

B. The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state, shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer located in this state, and he shall have the immediate right to recover balances due from the local agents and to obtain possession of any books and records of the insurer found in this state. He shall also be entitled to recover the other assets of the insurer located in this state except that upon the appointment of an ancillary receiver in this state, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. All remaining assets he shall promptly transfer to the domiciliary receiver. Subject to the foregoing provisions the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets, as a receiver of an insurer domiciled in this state.

C. The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this state to recover any assets of such insurer to which he may be entitled under the laws of this state.

History: Laws 1984, ch. 127, § 711.

59A-41-20. Filing, proving claims of nonresidents against delinquent domestic insurers.

A. In a delinquency proceeding begun in this state against an insurer domiciled in this state, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

B. Controverted claims belonging to claimants residing in reciprocal states may either:

(1) be proved in this state as provided by law; or

(2) if ancillary proceedings have been commenced in such reciprocal states, may be proved in those proceedings.

In the event a claimant elects to prove his claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state as provided in Section 713 [59A-41-21 NMSA 1978] of this article with respect

to ancillary proceedings in this state, the final allowance of such claim by the courts in the ancillary state shall be accepted in this state as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state.

History: Laws 1984, ch. 127, § 712.

59A-41-21. Filing, proving claims of residents against delinquent insurers domiciled in reciprocal states.

A. In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against such insurer who reside within this state or an insurance guaranty fund of this state, may file claims either with the ancillary receiver, if any, appointed in this state, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceeding.

B. Controverted claims belonging to claimants residing in this state may either:

(1) be proved in the domiciliary state as provided by the law of that state; or

(2) if ancillary proceedings have been commenced in this state, be proved in those proceedings.

In the event that any such claimant elects to prove his claim in this state, he shall file his claim with the ancillary receiver in the manner provided by the law of this state for the proving of claims against insurers domiciled in this state, and he shall give notice in writing to the receiver in the domiciliary state, either by registered mail or by personal service at least forty (40) days prior to the date set for the hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based and the priorities asserted, if any. If the domiciliary receiver, within thirty (30) days after the giving of such notice, shall give notice in writing to the ancillary receiver and to the claimant, either by registered mail or by personal service, of his intention to contest such claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to its priority, if any, against special deposits or other security located within this state.

History: Laws 1984, ch. 127, § 713.

59A-41-22. Priority of preferred claims, special deposit claims and secured claims.

A. In a delinquencey [delinquency] proceeding against an insurer domiciled in this state, claims owing to residents of ancillary states shall be preferred claims if like claims

are preferred under the laws of that state. All such claims, whether owing to residents or nonresidents, shall be given equal priority of payment from general assets regardless of where such assets are located.

B. In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

C. The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

D. The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this act, or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

E. The claims of policyholders and subrogated claims of a guaranty fund shall be preferred over the claims of unsecured creditors.

History: Laws 1984, ch. 127, § 714.

59A-41-23. Attachment, garnishment of assets.

During pendency of delinquency proceedings in this or any reciprocal state no action or proceeding in the nature of an attachment, garnishment or execution shall be commenced or maintained in the courts of this state against the delinquent insurer or its assets. Any lien obtained by any such action or proceeding within four (4) months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding.

History: Laws 1984, ch. 127, § 715.

59A-41-24. Hazardous financial condition; determination.

A. For the purposes of Sections 59A-41-25 and 59A-41-26 NMSA 1978, an insurer may be deemed to be in a hazardous financial condition when the superintendent has determined, after notice and hearing, that the loss experience of the insurer, when reviewed in conjunction with the kinds and characteristics of risks insured, or the insurer's financial condition, or its ownership, or the ratio of its annual premium volume in relation to its policyholders' surplus, would make further assumption of risks by the insurer hazardous to those persons doing business with the insurer or to the general public.

B. The following items may be considered by the superintendent to determine whether the continued operation of an insurer transacting an insurance business in New Mexico is hazardous to the policyholders, the creditors or the general public:

(1) adverse findings reported in financial condition and market conduct examination reports, audit reports and actuarial opinions, reports or summaries;

(2) the national association of insurance commissioners insurance regulatory information system and its other financial analysis solvency tools and reports;

(3) ratios of commission expense, general insurance expense, policy benefits and reserve increases to annual premium and net investment income;

(4) whether, according to currently accepted actuarial standards of practice, the insurer has made adequate provision for the anticipated cash flows required by the insurer's contractual obligations and related expenses, when considered in light of the insurer's assets and investment earnings on assets held for reserves and related actuarial items and the considerations anticipated to be received and retained through the insurer's policies and contracts;

(5) the ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

(6) whether the insurer's operating loss in the last twelve-month period or any shorter period of time, including net capital gain or loss, change in non-admitted assets and cash dividends paid to shareholders is greater than fifty percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

(7) whether the insurer's operating loss, excluding net capital gains, in the last twelve months or a shorter period of time is greater than twenty percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

(8) whether a reinsurer, an obligor or an entity within the insurer's insurance holding company system is insolvent, threatened with insolvency or delinquent in

payment of its monetary or other obligations and that, in the superintendent's opinion, might affect the solvency of the insurer;

(9) contingent liabilities, pledges or guaranties that individually or collectively involve a total amount that, in the superintendent's opinion, may affect the solvency of the insurer;

(10) whether any person having control of an insurer is delinquent in transmitting or paying net premiums to the insurer;

(11) the age and collectibility of receivables;

(12) whether the management of an insurer, including officers, directors or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position;

(13) whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false or misleading information concerning an inquiry;

(14) whether the insurer, for a reason not satisfactory to the superintendent, has failed to meet financial and holding company filing requirements;

(15) whether management of an insurer has filed with any regulatory authority or released to lending institutions or to the general public any false or misleading financial statements or has made a false or misleading entry or has omitted an entry of material amount in the books of the insurer;

(16) whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

(17) whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;

(18) whether management of the insurer has established reserves that do not meet the minimum standards established by New Mexico's insurance laws and rules and by statutory accounting standards, sound actuarial principles and standards of practice;

(19) whether management of the insurer persistently engages in material under-reserving that results in adverse development;

(20) whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient

value, liquidity or diversity to ensure that the insurer can meet its outstanding obligations as they mature;

(21) risk-based capital reports and other information obtained pursuant to the Risk-Based Capital Act [Chapter 59A, Article 5A NMSA 1978]; or

(22) such other material information and data as the superintendent may deem relevant.

C. For the purposes of making a determination of an insurer's financial condition under this section, the superintendent may:

(1) disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceeding;

(2) make appropriate adjustments, including disallowance, to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates that are consistent with the national association of insurance commissioners' accounting practices and procedures manual and with state laws and rules;

(3) refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(4) increase the insurer's liability in an amount equal to any contingent liability, pledge or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

History: Laws 1984, ch. 127, § 716; 1993, ch. 320, § 90; 1995, ch. 149, § 15; 2014, ch. 59, § 47.

59A-41-25. Requirements of insurer in hazardous financial condition.

A. Whenever the superintendent finds an insurer authorized to transact insurance in New Mexico to be in hazardous financial condition, as referred to in Section 59A-41-24 NMSA 1978, the superintendent may order the insurer to take such action as the superintendent deems reasonably necessary to rectify the hazardous condition, including requiring the insurer to:

(1) reduce, suspend or limit the volume of business being accepted or renewed;

(2) submit its reinsurance contracts for approval and make such further requirements as to the insurer's reinsurance arrangements as the superintendent deems necessary;

(3) bulk-reinsure all or any part of its New Mexico business with another insurer authorized to transact such business in New Mexico;

(4) increase the insurer's capital and surplus on such terms, in such amount and in such manner as the superintendent deems necessary;

(5) maintain with the superintendent a special deposit in cash or securities eligible for investment of funds of a like domestic insurer under Chapter 59A, Article 9 NMSA 1978 and in amount not less than the lesser of:

(a) the amounts required to be maintained as: 1) reserves for losses and loss adjustment expenses on New Mexico business; and 2) reserves for unearned premiums on New Mexico business. In determining the amount of deposit required, the reserves for losses, loss adjustment expenses and unearned premiums shall be reduced only for reinsurance ceded to authorized or accredited reinsurers that maintain with an independent custodian cash or marketable securities in amount not less than the sum of the reinsurer's reserves for losses, loss adjustment expenses and unearned premiums as to reinsurance assumed; or

(b) five hundred thousand dollars ($500,000).

Any deposit required by this paragraph shall be for the protection and benefit only of New Mexico policyholders or claimants, or both, and shall not be withdrawn until the superintendent terminates the requirement of the deposit. This paragraph shall not apply as to any domestic insurer, and Subparagraph (b) of this paragraph shall not apply as to any life insurer;

(6) reduce general insurance and commission expenses by specified methods;

(7) suspend or limit the declaration and payment of dividends to its stockholders or to its policyholders;

(8) file reports in a form acceptable to the superintendent concerning the market value of an insurer's assets;

(9) limit or withdraw from certain investments or discontinue certain investment practices to the extent the superintendent deems necessary;

(10) document the adequacy of premium rates in relation to the risks insured;

(11) file, in addition to regular annual statements, interim financial reports on the form adopted by the national association of insurance commissioners or on such format as required by the superintendent;

(12) correct corporate governance practice deficiencies and adopt and use governance practices acceptable to the superintendent;

(13) provide to the superintendent a business plan in order to continue to transact business in the state; or

(14) notwithstanding another provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for a non-life insurance product written by the insurer that the superintendent considers necessary to improve the financial condition of the insurer.

B. The insurer may request a hearing to review the order in accordance with Chapter 59A, Article 4 NMSA 1978; however, the superintendent shall give written notice of the hearing not less than ten days in advance of the hearing, and the hearing shall be held privately unless the insurer requests a public hearing, in which case the hearing shall be public.

History: Laws 1984, ch. 127, § 717; 1993, ch. 320, § 91; 2014, ch. 59, § 48.

59A-41-26. Hazardous financial condition; failure of insurer to comply with requirements.

If an insurer found by the superintendent to be in hazardous financial condition and subjected to certain requirements by the superintendent pursuant to Section 717 [59A-41-25 NMSA 1978] of this article fails to comply with any such requirement, the superintendent may suspend, revoke, or refuse to continue the insurer's certificate of authority, and take such further lawful action as he may deem advisable, including, but not limited to, commencement of delinquency proceedings against the insurer.

History: Laws 1984, ch. 127, § 718.

59A-41-27. Deposit of foreign insurer during examination; impoundment of assets.

A. This section shall apply as to any foreign insurer authorized to transact insurance in this state, which as shown by its most recent annual statement filed with the superintendent has thirty-five percent or more of its insurance in force issued on New Mexico risks or that thirty-five percent or more of its required reserves are applicable to New Mexico risks.

B. If during an examination of the insurer by the superintendent or by any other state the superintendent cannot pending completion of the examination determine with certainty that the insurer is financially sound, and in the superintendent's opinion additional protection for New Mexico policyholders should be required, the superintendent may require the insurer to deposit with the state treasurer assets of kinds eligible for investment of funds of a like domestic insurer and in amount equal to the total required reserves of the insurer applicable to its New Mexico risks.

C. If the insurer fails to make the deposit within thirty (30) days after such demand to do so, the superintendent may record in the office of the county clerk of any county in this state in which assets of the insurer may be located a notice to the effect that all assets of the insurer located in such county are impounded by the superintendent, and thereafter all transactions involving such assets, including release of mortgages and transfers of title to real estate, shall be invalid unless approved and consented to in writing on the face of the instrument by the superintendent. The superintendent may thereafter, as a condition precedent to approval of a transaction, require the entire proceeds of the transaction to be deposited with the state treasurer for the further protection of the insurer's policyholders in this state.

History: Laws 1984, ch. 127, § 719.

59A-41-28. Grounds for rehabilitation, liquidation of domestic insurer.

The superintendent may apply under Chapter 59A, Article 41 NMSA 1978 for an order directing him to rehabilitate or liquidate a domestic insurer or the United States branch of an alien insurer having trusteed assets in this state upon any one or more of the following grounds, that the insurer:

A. is insolvent as determined from an examination of the insurer conducted by the superintendent;

B. has refused to submit its books, papers, accounts or affairs to the reasonable inspection of the superintendent or his deputy or examiner;

C. has failed or refused to comply, within the time designated by the superintendent, with an order of the superintendent, pursuant to law, to make good an impairment of its capital, if a stock insurer, or an impairment of its minimum surplus, if a mutual, reciprocal or Lloyds insurer;

D. has, by contract of reinsurance or otherwise, transferred or attempted to transfer substantially its entire property or business or entered into any transaction the effect of which is to merge substantially its entire property or business in the property or business of any other person, without having first obtained the written approval of the superintendent;

E. is found, after an examination, to be in such condition that its further transaction of business will be hazardous to its policyholders, or to its creditors, or to the public;

F. has willfully violated its charter or any law of the state;

G. has an officer who has refused to be examined under oath, concerning its affairs;

H. after examination, is found to no longer meet the requirements for organization and incorporation to do business under the laws of this state;

I. has ceased to do business for a period of two years;

J. has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs, or to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian or sequestrator under any law except Chapter 59A, Article 41 NMSA 1978;

K. has been the subject of an application for the appointment of a receiver, trustee, custodian or sequestrator of the insurer or its property, or if a receiver, trustee, custodian or sequestrator is appointed by a federal court or if such appointment is imminent;

L. has consented to such an order through a majority of its directors, stockholders or members;

M. has not organized or completed its organization and obtained a certificate authorizing it to commence the doing of an insurance business within one year from the date of its incorporation or within such further period as may have been allowed under Section 59A-34-7 NMSA 1978;

N. has failed or refused to take such steps as may be necessary to remove from office any officer or director whom the superintendent has found, after notice to and hearing of such insurer and of such officer or director, to be a dishonest or untrustworthy person; or

O. has failed to maintain adequate risk-based capital levels as determined by the superintendent pursuant to the Risk-Based Capital Act [Chapter 59A, Article 5A NMSA 1978].

History: Laws 1984, ch. 127, § 720; 1995, ch. 149, § 16.

59A-41-29. Order of rehabilitation; termination.

A. An order to rehabilitate a domestic insurer shall direct the superintendent and his successors in office forthwith to take possession of the property of such insurer and to

conduct the business thereof, and to take such steps toward the removal of the causes and conditions which have made such proceeding necessary as the court shall direct.

B. If at any time the superintendent shall deem that further efforts to rehabilitate the insurer would be futile, he may apply to the court for an order of liquidation.

C. The superintendent or any interested person upon due notice to the superintendent, at any time may apply for an order terminating any rehabilitation proceeding and permitting such insurer to resume possession of its property and the conduct of its business, but no such order shall be granted except when, after a full hearing, the court shall determine that the purposes of the proceeding have been fully accomplished.

D. The superintendent may apply for an order directing him to liquidate the business of a domestic insurer or the United States branch of an alien insurer having trusteed assets in this state, upon any one or more of the grounds specified in Section 720 [59A-41-28 NMSA 1978] of this article regardless of whether or not there has been a prior order directing him to rehabilitate such insurer.

History: Laws 1984, ch. 127, § 721.

59A-41-30. Order of liquidation of domestic insurer; rights, liabilities.

A. An order to liquidate the business of a domestic insurer shall direct the superintendent and his successors in office forthwith to take possession of the property of such insurer and to liquidate the business of the same and to deal with the property and business of such insurer in their own names as superintendents or in the name of the insurer as the court before whom such order is returnable may direct, and to give notice to all creditors who may have claims against such insurers to present the same.

B. The superintendent and his successors shall be vested by operations of law with the title to all of the property, contracts and rights of action of such insurer as of the date of the entry of the order so directing them to liquidate. The filing or recording of such order in the office of the clerk of any county shall impart the same notice that a deed, bill of sale or other evidence of title duly filed or recorded by such insurer would have imparted. The rights and liabilities of any such insurer and of its creditors, policyholders, stockholders, members and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date of the entry of the order directing the liquidation of such insurer in the office of the clerk of the county where such insurer had its principal office for the transaction of business upon the date of the institution of proceedings under this article.

C. An order to liquidate the business of the United Sates [States] branch of an alien insurer having trusteed assets in this state shall be in the same terms as those

hereinbefore prescribed, except that only the assets of the business of such United States branch shall be included therein.

D. Where the trustee or trustees of a mortgage series consisting in whole or in part of certified mortgage investments guaranteed by such domestic insurer have distributed all of the trust estate collateral, or have been permitted by court order to abandon all or part of such collateral not distributed, the court, by order, may, upon the consent of the superintendent as liquidator of such domestic insurer, direct that the superintendent, upon being furnished with a list of certificate holders certified to by the trustee or trustees, record subsequent transfers of certificates and charge and collect a reasonable fee therefor, and distribute dividends applicable thereto upon liquidation of insurer assets in his hands, to the record owners of such certificates, and make and deduct from such dividend payments a reasonable charge for such services.

The duty of the superintendent under such order shall terminate upon the termination of the liquidation proceedings of such domestic insurer.

History: Laws 1984, ch. 127, § 722.

59A-41-31. Grounds for conservation of assets of foreign insurer.

The superintendent may apply under Chapter 59A, Article 41 NMSA 1978 for an order directing him to conserve the assets within the state of a foreign insurer upon any one or more of the grounds specified in Subsection A, B, C, D, E, F, G, J, K or O of Section 59A-41-28 NMSA 1978 or upon the ground that such foreign insurer has consented to such an order through a majority of its directors, stockholders or members, or has had its property sequestrated in its domiciliary country or state or in any other country or state. The superintendent may apply under Chapter 59A, Article 41 NMSA 1978 for an order directing him to conserve the assets within this state of an alien insurer, other than one which has its trusteed assets in this state, on any one or more of the grounds specified in Subsections A, B, C, D, E, F, G, J, K or O of Section 59A-41-28 NMSA 1978 or upon the ground that such alien insurer has failed or refused to comply, within the time designated by the superintendent, with an order of the superintendent, pursuant to law, to make good an impairment of its trusteed surplus, or that such alien insurer has consented to such an order through a majority of its directors, stockholders or members, or that it has had its property sequestrated in its domiciliary country or elsewhere.

History: Laws 1984, ch. 127, § 723; 1995, ch. 149, § 17.

59A-41-32. Order of conservation or ancillary liquidation of foreign or alien insurer.

An order to conserve the assets of a foreign or alien insurer shall direct the superintendent and his successors in office forthwith to take possession of the property of the insurer within this state and to conserve the same subject to further direction of

the court. Whenever a domiciliary receiver is appointed for the insurer in its domiciliary state which is also a reciprocal state as defined in Section 706 [59A-41-14 NMSA 1978] of this article, the court may on the superintendent's application appoint the superintendent an ancillary receiver in this state, subject to the provisions of Section 711 [59A-41-19 NMSA 1978] of this article and other provisions of the Uniform Insurers Liquidation Act [59A-41-17 through 59A-41-23 NMSA] included within this article. Subject to the provisions of the Uniform Insurers Liquidation Act the rights and duties of the superintendent as to the insurer and its assets shall include those exercised by and imposed upon ancillary receivers of foreign corporations under the general corporation laws of this state.

History: Laws 1984, ch. 127, § 724.

59A-41-33. Grounds for dissolution of domestic insurer.

The superintendent may apply under this article for an order dissolving the corporate existence of a domestic insurer:

A. upon his application for an order for liquidation, or at any time after such order has been granted; or

B. upon the grounds specified in Section 720 [59A-41-28 NMSA 1978] of this article whether or not an order of liquidation is sought or has been obtained.

History: Laws 1984, ch. 127, § 725.

59A-41-34. Commencement of a delinquency proceeding.

A. The superintendent, the attorney general or an insurance department staff attorney representing him, shall commence any proceeding under this article by an application to the district court in the judicial district in which the principal office of the insurer or organization involved is located, for an order directing the superintendent to proceed with delinquency proceedings provided for in this article. Such order with a copy of the petition therein shall be served upon the insurer or organization named in such order, if it be a domestic corporation by delivering to the president or other head of the corporation, secretary or clerk to the corporation, the cashier, the treasurer or any director or managing agent; if it be a foreign or alien corporation by delivering to the president, vice president, treasurer or assistant treasurer, secretary or assistant secretary, or any director of or managing agent, or, if the corporation lacks any of those officers within the state, to the officer performing corresponding functions under another name; if it be a voluntary, unincorporated or a joint stock association, order or society, by delivering to the president, vice president, treasurer, director, trustee or other officer or a member with managerial powers; if it be a reciprocal insurer or Lloyds underwriters, by delivering to the duly designated attorney-in-fact, a true copy of said order and petition and leaving the same with any such person within the state.

B. When it is satisfactorily proved by the verified report of the examiner made to the superintendent or by affidavit of any other person familiar with the facts that the officers, directors, trustees or managing agents or members of the corporation, association, order or society named in such order, upon whom service is required to be made as provided, or if a reciprocal insurer or Lloyds underwriters be named in the order, that the duly designated attorney-in-fact or its officers and managing agents have departed from the state or have kept themselves concealed therein or if such of the persons residing in this state and upon whom service is required to be made as above provided have resigned from their offices within forty (40) days prior to the application for an order under the provisions of this article, or that service cannot be made immediately by the exercise of reasonable diligence, such an order may provide for service thereof in such manner as the court or justice by whom the same is made, shall direct.

C. Failure of any such insurer to appear or plead before the court within five (5) days after proper service of the order and petition shall be deemed a waiver to the right to have a hearing upon the allegation contained in the petition.

History: Laws 1984, ch. 127, § 726.

59A-41-35. Change of venue.

At any time after commencement of a proceeding under this article the superintendent may apply to the court for an order changing the venue of the proceedings to any other county of this state when good cause is shown. Upon the filing of such an application for removal, the court shall direct the clerk of the county wherein such proceeding is then pending to transmit all of the papers filed therein with such clerk to the clerk of the county to which such proceeding is removed and the proceeding shall thereafter be conducted in such other county as though it has been commenced in such county.

History: Laws 1984, ch. 127, § 727.

59A-41-36. Right of guaranty association to participate in delinquency proceeding.

A. A guaranty association referred to in Article 42 [Chapter 59A, Article 42 NMSA 1978] (life and health insurance guaranty fund) or in Article 43 [Chapter 59A, Article 43 NMSA 1978] (property and casualty insurance guaranty fund) of the Insurance Code may be made a party to a delinquency proceeding by the superintendent in commencing the proceeding or by its intervention thereafter. If the superintendent does not make the association a party at the commencement of the proceedings, the superintendent shall give written notice of the commencement of the proceedings to the association.

B. A guaranty association shall not be required to bear any of the costs of such a proceeding other than such expenses for its attorney and expense related to its participation in the proceeding as are directly incurred by it.

C. The association shall have the right at any time during the delinquency proceedings to apply to the court for an appropriate order dismissing it as a party to the proceeding on such terms as the court finds proper.

History: Laws 1984, ch. 127, § 728.

59A-41-37. Exemption from filing fees.

The superintendent shall not be required to pay any fee to any public officer in this state for filing, recording, issuing a transcript or certificate or authenticating any paper or instrument pertaining to the exercise by the superintendent of any of the powers or duties conferred upon him under this article, whether or not such paper or instrument be executed by the superintendent or his deputies, employees or attorneys of record and whether or not it is connected with the commencement of an action or proceeding by or against the superintendent, or with the subsequent conduct of such an action or proceeding.

History: Laws 1984, ch. 127, § 729.

59A-41-38. Deposit of monies collected.

The superintendent shall from time to time deposit in one or more state or national banks, savings banks or trust companies the monies collected by him in a proceeding under this article. The superintendent may deposit such monies or any part thereof in a national bank or trust company as a trust fund.

History: Laws 1984, ch. 127, § 730.

59A-41-39. Borrowing on pledge of assets.

For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution of an insurer pursuant to this article, the superintendent may, subject to the approval of the court, borrow money and execute, acknowledge and deliver notes or other evidences of indebtedness therefor and secure the repayment of the same by the mortgage, pledge, assignment, transfer in trust or hypothecation of any or all of the property whether real, personal or mixed of such insurer, and the superintendent, subject to the approval of the court, may take any and all other action necessary and proper to consummate any such loans and to provide for the repayment thereof. The superintendent shall be under no obligation personally or in his official capacity as superintendent to repay any loan made pursuant to this section.

History: Laws 1984, ch. 127, § 731.

59A-41-40. Sale, disposition of assets and compromise of certain claims.

A. The superintendent may, subject to the approval of the court:

(1) sue or be sued;

(2) sell or otherwise dispose of the real or personal property, or any part thereof, of an insurer against whom a proceeding has been brought under this article; and

(3) sell or compound all doubtful or uncollectible debts or claims owed by or owing to such insurer including claims based upon assessment levied against a member of a mutual or reciprocal insurer.

B. Whenever the amount of any such debt or claim owed by or owing to such insurer does not exceed two hundred dollars ($200), the superintendent may compromise or compound the same upon such terms as he may deem for the best interests of the insurer without obtaining the approval of the court. The superintendent may, subject to the approval of the court, sell or agree to sell, or offer to sell, any assets of such an insurer to such of its creditors who may desire to participate in the purchase thereof, to be paid for, in all or in part, out of dividends payable to such creditors, and, upon the application of the superintendent, the court may designate representatives to act for such creditors in the purchase, holding and/or management of such assets, and the superintendent may, subject to the approval of the court, advance the expenses of such representatives against the security of the claims of such creditors.

History: Laws 1984, ch. 127, § 732.

59A-41-41. Time to file claims.

A. If upon entry of an order of liquidation of a domestic insurer or United States branch of an alien insurer domiciled in this state under Chapter 59A, Article 41 NMSA 1978 or at any time thereafter during liquidation proceedings the insurer is not clearly solvent, the court shall, upon a hearing after such notice as it deems proper, make and enter an order adjudging the insurer to be insolvent.

B. After entry of order of insolvency and regardless of any prior notice given to creditors, the superintendent shall notify all persons who may have claims against the insurer to file such claims, at a place and within the time specified in the notice, or that such claims may be forever barred. The time specified in the notice shall be fixed by the court for filing of claims, which shall be not less than six months after entry of the order of insolvency. The notice shall be given in such manner and for such reasonable period of time as the court may order.

C. The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(1) the existence of the claim was not known to the claimant and the claim was filed as promptly thereafter as reasonably possible after learning of it;

(2) a transfer to a creditor was avoided under Sections 59A-41-42 through 59A-41-43.1 NMSA 1978, or was voluntarily surrendered under Section 59A-41-43.3 NMSA 1978 and the filing satisfies the conditions of Section 59A-41-43.3 NMSA 1978;

(3) the valuation of security held by a secured creditor shows a deficiency, which is filed within thirty days after the valuation and deficiency is determined by the court in accordance with the provisions of Subsection D of Section 59A-41-22 NMSA 1978; or

(4) the claim is from a guaranty association for reimbursement of covered claims paid or expenses incurred subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

History: Laws 1984, ch. 127, § 733; 1993, ch. 320, § 92.

59A-41-42. Fraudulent transfers prior to petition.

A. Every transfer made or suffered and every obligation incurred by an insurer within one (1) year prior to the filing of a successful petition for rehabilitation or liquidation under the Insurance Code is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under the Insurance Code, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

B. (1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

C. Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under Subsection A if:

(1) the transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release; and

(2) any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

History: Laws 1984, ch. 127, § 734.

59A-41-43. Fraudulent transfer after petition.

A. After a petition for rehabilitation or liquidation has been filed a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

B. After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) a transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred;

(2) a person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending;

(3) a person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith; and

(4) a person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

C. Nothing in Chapter 59A, Article 41 NMSA 1978 shall impair the negotiability of currency or negotiable instruments.

D. Nothing in this section shall be constructed to give authority to any person to act on behalf of a receiver.

History: Laws 1984, ch. 127, § 735; 1993, ch. 320, § 93.

59A-41-43.1. Voidable preferences and liens.

A. (1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for rehabilitation or liquidation under Chapter 59A, Article 41 NMSA 1978, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the petition for rehabilitation, or within two years before the filing of the petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the rehabilitator or liquidator if:

(a) the insurer was insolvent at the time of the transfer;

(b) the transfer was made within four months before the filing of the petition;

(c) the creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(d) the creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer, whether or not he held such position, or any shareholder holding directly or indirectly more than five percent of any class of any equity security issued by the insurer, or any other person, firm, corporation, association or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the rehabilitator or liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

B. (1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) A transfer not perfected prior to the filling of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

C. (1) A lien obtainable by legal or equitable proceedings upon a simple contract is going one [sic] arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(2) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of transferee within the meaning of Subsection B of this section, if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of Subsection B of this section through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

D. A transfer of property for or on account of a new and contemporaneous consideration which is deemed under Subsection B of this section to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one days or any period expressly allowed by law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for [sic] on account of a new and contemporaneous consideration.

E. If any lien deemed voidable under Paragraph (2) of Subsection A of this section has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under Chapter 59A, Article 41 NMSA 1978 which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

F. The property affected by any lien deemed voidable under Subsections A and E of this section shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

G. The court before which the rehabilitation or liquidation proceeding is pending shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or less than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the

court, to the rehabilitator or liquidator, within such reasonable times as the court shall fix.

H. The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the rehabilitator or liquidator, or where the property is retained under Subsection G of this section to the extent of the amount paid to the rehabilitator or liquidator.

I. If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from him.

J. If an insurer shall, directly or indirectly, within four months before the filing of a successful petition for rehabilitation or liquidation under Chapter 59A, Article 41 NMSA 1978, or at any time in contemplation of a delinquency proceeding, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the rehabilitator or liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the rehabilitator or liquidator for the benefits of the estate; provided that where the attorney is in a position of influence in the insurer or an affiliate thereof payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provisions of Subparagraph (d) of Paragraph (2) of Subsection A.

History: 1978 Comp., § 59A-41-43.1, enacted by Laws 1993, ch. 320, § 94.

59A-41-43.2. Liability for participation in fraudulent transfer or voidable preference.

A. Every officer, manager, employee, shareholder, member, subscriber, attorney or any other person acting on behalf of the insurer who knowingly participates in giving any preference or in any fraudulent transfer when he has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference or transfer shall be personally liable to the rehabilitator or liquidator for the amount of the preference or transfer. It shall be a rebuttable presumption that such was the case if the transfer was made within four months before the date of filing of a successful petition for rehabilitation or liquidation.

B. Every person receiving any property from the insurer or the benefit thereof as a voidable preference or as a fraudulent transfer shall be personally liable therefor and shall be bound to account to the rehabilitator or liquidator.

C. Nothing in this section shall prejudice any other claim by the rehabilitator or liquidator against any person.

History: 1978 Comp., § 59A-41-43.2, enacted by Laws 1993, ch. 320, § 95.

59A-41-43.3. Claims of holders of void or voidable rights.

A. No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance voidable under Chapter 59A, Article 41 NMSA 1978 shall be allowed unless he surrenders the preference, lien, conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the rehabilitator or liquidator within thirty days from the date of the entering of the final judgment, except that the court having jurisdiction over the rehabilitation or liquidation may allow further time if there is an appeal or other continuation of the proceeding.

B. A claim allowable under Subsection A of this section by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment or encumbrance may be filed as an excused late filing under Section 59A-41-41 NMSA 1978 if filed within thirty days from the date of the avoidance, or within the further time allowed by the court under Subsection A of this section.

History: 1978 Comp., § 59A-41-43.3, enacted by Laws 1993, ch. 320, § 96.

59A-41-44. Priorities in distribution.

The priority of claims and order of distribution of the insurer's assets on liquidation shall be as stated in this section. The first fifty dollars ($50.00) of the amount allowed on each property, casualty or fidelity claim in the classes under Subsections B through F of this section, shall be deducted from the claim and included in the class under Subsection I of this section. Claims may not be cumulated by assignment to avoid application of the fifty dollar ($50.00) deductible provision. Subject to the fifty dollar ($50.00) deduction, every claim in each class shall be paid in full or adequate funds retained for payment before the members of the next class receive any payment. No subclasses shall be established within any class. Subject to the foregoing, the order of distribution and of priority shall be as follows:

A. administration costs. The costs and expenses of administration, including but not limited to the actual and necessary costs of preserving or recovering the assets of the insurer, compensation for all services rendered in the liquidation, necessary filing fees, fees and mileage payable to witnesses, attorney's fees in reasonable amount and the reasonable expenses of a guaranty association for unallocated loss adjustment expense;

B. wages. Debts due to employees of the insurer for services performed, not to exceed one thousand dollars ($1,000) to each employee, and earned within three months before commencement of delinquency proceedings. The insurer's officers shall not be entitled to the benefit of this priority. Such priority shall be in lieu of any other similar priority authorized by law as to wages or compensation of employees;

C. loss claims. All claims under policies or contracts for losses incurred, including third party claims and all claims of guaranty associations not specified in Subsection A of this section. That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to his employee shall be treated as a gratuity;

D. unearned premiums. Claims under nonassessable policies for unearned premiums or other premium refunds;

E. residual classification. All other claims, including claims of the federal or any state or local government, not falling within other classes under this section. Claims, including those of any governmental body, for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under Subsection K of this section;

F. judgments. Claims based solely on judgments. If a claimant files a claim and bases it both on the judgment and on the underlying facts, the claim shall be considered by the liquidator, who shall give the judgment such weight as he deems appropriate. The claim as allowed shall receive the priority it would receive in absence of the judgment. If the judgment is larger than the allowance on the underlying claim, the remaining portion of the judgment shall be treated as if it were a claim based solely on a judgment, except that, to the extent such judgment was obtained through fraud or collusion, it shall be disallowed;

G. interest on claims already paid. Interest at the legal rate compounded annually on all claims in the classes under Subsections A through I of this section, from date of petition for liquidation or the date on which the claim becomes due, whichever is later, until the date on which the dividend is declared. The liquidator, with the court's approval, may make reasonable classifications of claims for purposes of computing interest, may make approximate computations and may ignore certain classifications and time periods as de minimis;

H. miscellaneous subordinated claims. The remaining claims or portions of claims not already paid, with interest as in Subsection G of this section:

(1) the first fifty dollars ($50.00) of each claim in the classes under Subsections B through F of this section, subordinated under this section;

(2) claims subordinated by Section 59A-41-45 NMSA 1978;

(3) claims filed late except as provided otherwise in Subsection C of Section 59A-41-41 NMSA 1978;

(4) portions of claims subordinated under Subsection E of this section;

(5) claims or portions of claims payment of which is provided by other benefits or advantages recovered or recoverable by the claimant; and

(6) claims not otherwise provided for in this section;

I. preferred ownership claims. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Interest at the legal rate shall be added to each claim, as in Subsections G and H of this section; and

J. proprietary claims. The claims of shareholders or other owners.

History: Laws 1984, ch. 127, § 736; 1993, ch. 320, § 97.

59A-41-45. Offsets.

A. In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in Subsection B of this section.

B. No offset shall be allowed in favor of any such person where:

(1) the obligation of the insurer to such person would not at the date of entry of any liquidation order, or otherwise, as provided in Section 722 [59A-41-30 NMSA 1978] of this article entitle him to share as a claimant in the assets of the insurer; or

(2) the obligation of the insurer to such person was purchased by or transferred to such person with a view to its being used as an offset;

(3) the obligation of such person is to pay an assessment levied against the members of a mutual insurer, or against the subscribers of a reciprocal insurer, or is to pay a balance upon a subscription to the capital stock of a stock insurer; or

(4) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.

History: Laws 1984, ch. 127, § 737.

59A-41-45.1. Recovery from affiliates.

The receiver shall have a right to recover from an affiliate of the insurer property of the insurer transferred to or for the benefit of the affiliate within the five years preceding the initial petition for receivership. No transfer is recoverable under this section if the affiliate shows that, when the transfer was made:

A. the insurer was solvent;

B. the transfer was lawful; and

C. neither the insurer nor the affiliate knew or should have known that the transfer, under then-applicable statutory accounting standards, would:

(1) place the insurer in violation of applicable capital or surplus requirements;

(2) place the insurer below the risk-based capital level as defined in the Risk-Based Capital Act [Chapter 59A, Article 5A NMSA 1978];

(3) cause the insurer's filed financial statements not to present fairly the capital and surplus of the insurer; or

(4) otherwise cause the insurer to be in a hazardous financial condition.

History: Laws 2012, ch. 9, § 3.

59A-41-46. Report for assessment; domestic mutual, reciprocal insurers.

Within three (3) years from the date an order of rehabilitation or liquidation of a domestic mutual insurer or domestic reciprocal insurer was filed in the office of the clerk of the court by which such order was made, the superintendent may make a report to the court setting forth:

A. the reasonable value of the assets of the insurer;

B. the insurer's probable liabilities; and

C. the probable necessary assessment, if any, to pay all claims and expenses in full, including expenses of administration.

History: Laws 1984, ch. 127, § 738.

59A-41-47. Levy of assessment; domestic mutual, reciprocal insurers.

A. Upon the basis of the report provided for in Section 738 [59A-41-46 NMSA 1978] of this article including any amendments thereof, the court, ex parte, may levy one or more assessments against all persons who, as shown by the record of the insurer, were members (if a mutual insurer) or subscribers (if a reciprocal insurer) at any time within one year prior to the date of issuance of the court's order under Section 725 [59A-41-33 NMSA 1978] of this article.

B. Such assessment shall cover the excess of the probable liabilities over the reasonable value of the assets, together with the estimated cost of collection and percentage of incollectibility thereof. The total of all assessments against any member or subscriber with respect to any policy, whether levied pursuant to this article or pursuant to any other provisions of the laws of New Mexico, shall be for no greater amount than specified in the policy or policies of the member or subscriber and as limited under the laws of New Mexico; except that if the court finds that the policy was issued at a rate of premium below the minimum rate lawfully permitted for the risk insured, the court may determine the upper limit of such assessment upon the basis of such minimum rate.

C. No assessment shall be levied against any member or subscriber with respect to any nonassessable policy issued in accordance with the Insurance Code.

D. Where the insurer has levied an assessment prior to the court's order under the proceeding in Section 725 of this article and the superintendent has ratified such assessment with the court's approval such ratification shall in no way be deemed an assessment as set out in Subsections A, B and C of this section.

History: Laws 1984, ch. 127, § 739.

59A-41-48. Order for payment of assessment; domestic mutual, reciprocal insurers.

After levy of assessment as provided in Section 739 [59A-41-47 NMSA 1978] of this article, upon the filing of a further detailed report by the superintendent, the court shall issue an order directing each member (if a mutual insurer) or each subscriber (if a reciprocal insurer) if he shall not pay the amount assessed against him to the superintendent on or before the day to be specified in the order, to show cause why he should not be held liable to pay such assessment together with costs as set out in Section 742 [59A-41-50 NMSA 1978] of this article and why the superintendent should not have judgment therefor.

History: Laws 1984, ch. 127, § 740.

59A-41-49. Assessment order, publication and transmittal.

The superintendent shall cause a notice of an assessment order, issued pursuant to Section 740 [59A-41-48 NMSA 1978] of this article, setting forth a brief summary of the contents of such order to be:

A. published in such manner as shall be directed by the court; and

B. enclosed in a sealed envelope, addressed and mailed postage prepaid to each member or subscriber liable thereunder at his address last of record with the insurer, at least twenty (20) days before the return day of the order to show cause provided for in Section 740 of this article.

History: Laws 1984, ch. 127, § 741.

59A-41-50. Judgment upon the assessment.

A. On the return day of the order to show cause provided for in Section 740 [59A-41-48 NMSA 1978] of this article if the member or subscriber does not appear and serve verified objections upon the superintendent, the court shall make an order adjudging that such member or subscriber is liable for the amount of the assessment against him together with ten dollars ($10) costs, and that the superintendent may have judgment against the member or subscriber therefor.

B. If on such return day the member or subscriber shall appear and serve verified objections upon the superintendent there shall be a full hearing before the court or a referee to hear and determine, who, after such hearing, shall make an order either negating or affirming his liability to pay the whole or some part thereof together with twenty-five dollars ($25) costs and the necessary disbursements incurred at such hearing, and directing that the superintendent in the latter case may have judgment therefor.

C. A judgment upon any such order shall have the same force and effect, and may be entered and docketed, and may be appealed from as if it were a judgment in an original action brought in the court in which the proceeding is pending.

History: Laws 1984, ch. 127, § 742.

59A-41-51. Summary proceedings; superintendent's corrective orders authorized.

A. If the superintendent determines after a hearing that any insurer has committed or engaged in, or is committing or engaging in, or is about to commit or engage in any act, practice or transaction that would subject it to formal delinquency proceedings under this article, he shall make and serve upon the insurer and other persons involved,

such orders (other than seizure orders under Sections 746 and 747 [59A-41-54 and 59A-41-55 NMSA 1978] of this article) as he deems reasonably necessary to correct, eliminate, or remedy such conduct, condition or ground. Orders to cure impairment of capital or surplus are subject to Section 92 [59A-5-25 NMSA 1978] of the Insurance Code.

B. If the superintendent believes that irreparable harm to the insurer or its policyholders, creditors or the public may occur unless his order is issued with immediate effect, he may make and serve his order without notice and before hearing, and shall simultaneously therewith serve upon the insurer and other persons involved a notice of hearing.

C. The superintendent's order and notice of hearing shall be served by personal service in any manner provided by the New Mexico Rules of Civil Procedure.

D. This section, and Sections 744 through 749 [59A-41-52 to 59A-41-57 NMSA 1978] of this article, are supplemental to and not in contradiction or modification of Sections 716 through 718 [59A-41-24 to 59A-41-26 NMSA 1978] or any other sections of this article as to insurers in hazardous financial condition.

History: Laws 1984, ch. 127, § 743.

59A-41-52. Summary proceedings; appeal from superintendent's order.

If the superintendent has issued a summary order before hearing as provided in Subsection B of Section 743 [59A-41-51 NMSA 1978] of this article, any person upon whom such order is served may waive the superintendent's hearing and apply for an immediate judicial relief available under law and without first exhausting his administrative remedies.

History: Laws 1984, ch. 127, § 744.

59A-41-53. Summary proceedings; enforcement; penalty.

A. The superintendent may apply for and the district court for Santa Fe county or the county in which the insurer has its principal office may grant such restraining orders, temporary and permanent injunctions and other orders as may be deemed necessary to enforce the superintendent's order.

B. Violation of any order of the superintendent issued under Section 59A-41-51 NMSA 1978 by any person as to whom the order is in effect shall subject such person to a penalty of not more than ten thousand dollars ($10,000), to be collected in a civil action brought by the attorney general in the name of the state of New Mexico. The attorney general shall deposit all funds so collected with the state treasurer for credit as

provided for insurance department receipts in general under Section 59A-6-5 NMSA 1978.

History: Laws 1984, ch. 127, § 745; 1987, ch. 259, § 25.

59A-41-54. Summary proceedings; seizure under court order.

A. Upon filing by the superintendent in the district court for Santa Fe county or the county in which the insurer has its principal office of his verified petition alleging any ground for a formal delinquency proceeding against an insurer under this article and that the interests of the insurer's policyholders or creditors or the public will be jeopardized by delay, and setting forth the order deemed necessary by the superintendent, the court shall, ex parte and without notice or hearing, issue the requested order. The requested order may:

(1) direct the superintendent to take possession and control of all or part of the property, books, accounts and records of the insurer and the premises occupied by it for transaction of its business in this state; and

(2) until further order of the court, enjoin the insurer and its officers, managers, agents and employees from removal, concealment or other disposition of its property, and from transaction of its business, except with the superintendent's written consent.

B. The court's order shall be for such duration, specified in the order, as the court deems necessary to enable the superintendent to ascertain the insurer's condition. On motion of any party or on its own motion, the court may hold such hearings as it deems desirable after such notice as it deems appropriate, and extend or shorten the duration or modify the terms of the order. The court shall vacate the seizure order if the superintendent fails to commence a formal proceeding under this article after reasonable opportunity to do so; and a seizure order is automatically terminated by issuance of the court's order pursuant to formal delinquency proceedings under this article.

C. Entry of a seizure order under this section does not constitute an anticipatory breach of any contract of the insurer.

History: Laws 1984, ch. 127, § 746.

59A-41-55. Summary proceedings; seizure under superintendent's order.

A. If it appears to the superintendent that the interests of policyholders, creditors or the public will be jeopardized by delay incident to requesting a court seizure order, then on any ground which would justify a court seizure order under Section 59A-41-54 NMSA 1978, and without notice and without applying to the court, the superintendent may

issue a seizure order which must contain a statement verified by him of the grounds for his action. As directed by the seizure order, the superintendent's representatives shall forthwith take possession and control of all or part of the property, books, accounts and records of the insurer and of the premises in this state occupied by the insurer for transaction of its business. The superintendent shall retain possession and control until the order is vacated or is replaced by an order of court pursuant to Subsection B of this section, or pursuant to a formal proceeding under Chapter 59A, Article 41 NMSA 1978.

B. At any time after seizure under Subsection A of this section, the insurer may apply to the district court for Santa Fe county. The court shall thereupon order the superintendent to appear forthwith and shall thereafter proceed as if the order were a court seizure order issued under Section 59A-41-54 NMSA 1978.

C. Every peace officer of this state shall assist the superintendent in making and enforcing any such seizure, and every sheriff and police department shall furnish the superintendent with such deputies, patrolmen or officers as may be necessary for the purpose.

D. Entry of a seizure order under this section does not constitute an anticipatory breach of any contract of the insurer.

History: Laws 1984, ch. 127, § 747; 1987, ch. 259, § 26.

59A-41-56. Summary proceedings; conduct of administrative and judicial hearings.

A. The superintendent shall hold all hearings in summary proceedings privately unless the insurer requests a public hearing, in which case the hearing shall be public.

B. The court may hold all hearings in summary proceedings and judicial reviews thereof privately in chambers, and shall do so on request of the insurer proceeded against.

C. In all summary proceedings and judicial reviews thereof, all records of the insurer, other documents, and all insurance department files and court records and papers, so far as they pertain to or are part of the record of the summary proceedings, shall be and remain confidential except as necessary to obtain compliance therewith, unless the court after hearing arguments by the parties in chambers, orders otherwise, or unless the insurer requests that the matter be made public. Until the court otherwise orders, all papers filed with the clerk of the court in the matter shall be held by him in a confidential file.

D. If at any time it appears to the court that any person whose interest is or will be substantially affected by an order did not appear at the hearing and has not been served, the court may order that notice be given and the proceedings be adjourned to give such person an opportunity to appear, on such terms as may be reasonable.

History: Laws 1984, ch. 127, § 748.

59A-41-57. Summary proceedings; penalty for refusal to deliver property, records.

Any person having possession or custody of and refusing to deliver to the superintendent or his representative upon request any of the property, books, accounts, documents or other records of an insurer against which a seizure order has been issued by the superintendent or by the court, as provided in Sections 743 through 748 [59A-41-51 to 59A-41-56 NMSA 1978] of this article, unless a greater monetary or other applicable penalty is provided by other law, is upon conviction thereof guilty of a misdemeanor punishable by a fine not to exceed five hundred dollars ($500).

History: Laws 1984, ch. 127, § 749.

ARTICLE 42
Life and Health Insurance Guaranty Association

59A-42-1. Short title.

Chapter 59A, Article 42 NMSA 1978 may be cited as the "Life and Health Insurance Guaranty Association Act".

History: Laws 1984, ch. 127, § 750; 2012, ch. 9, § 4.

59A-42-2. Purpose.

The purpose of the Life and Health Insurance Guaranty Association Act is to provide a mechanism to facilitate continuation of coverage and the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and avoid financial loss to claimants or policyholders because of insolvency of an insurer, to assist in detection and prevention of insurer insolvencies and to provide an association to assess the cost of such protection among insurers.

History: Laws 1984, ch. 127, § 751; 2012, ch. 9, § 5.

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;

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" and "covered contract" means a policy or contract or 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. "health benefit plan" means any hospital or medical expense policy or certificate or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:

(1) accident-only insurance;

(2) credit insurance;

(3) dental-only insurance;

(4) vision-only insurance;

(5) medicare supplement insurance;

(6) benefits for long-term care, home health care, community-based care or any combination thereof;

(7) disability income insurance;

(8) coverage for on-site medical clinics; or

(9) specified disease, hospital confinement indemnity or limited benefit health insurance if the health benefit plans do not provide coordination of benefits and are provided under separate policies or contracts;

L. "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;

M. "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;

N. "member insurer" means an insurer or health maintenance organization that is licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided pursuant to Section 59A-42-4 NMSA 1978 and includes an insurer or health maintenance organization whose 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 prepaid dental plan;

(3) a fraternal benefit society;

(4) a mandatory state pooling plan;

(5) a mutual assessment company or other person that operates on an assessment basis;

(6) an insurance exchange;

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

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

(9) an entity similar to any of the above;

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

P. "owner" of a policy or contract, "policy owner", "policy holder" and "contract owner" means the person who is identified as the 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 member insurer. The terms "owner", "policy owner", "policy holder" and "contract owner" do not include persons with a mere beneficial interest in a policy or contract;

Q. "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;

R. "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 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, one policy holder 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 holder or contract 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;

S. "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, 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;

(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; and

(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 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 Q 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;

T. "receivership court" means the court in the insolvent or impaired insurer's domiciliary state having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer;

U. "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 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 member insurer that issued the policies or contracts;

V. "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;

W. "structured settlement factoring transaction" means a transfer of structured settlement payment rights, including portions of structured settlement payments made for consideration by means of sale, assignment, pledge or other form of encumbrance or alienation;

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

Y. "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.

History: Laws 1984, ch. 127, § 752; 1993, ch. 320, § 98; repealed and reenacted by Laws 2012, ch. 9, § 6; 2014, ch. 59, § 49; 2024, ch. 36, § 1.

59A-42-4. Coverage; limitations.

A. Coverage shall be provided for the policies and contracts specified in Subsection D of this section:

(1) to persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees, including health care providers rendering services covered under health

insurance policies or certificates, of the persons covered pursuant to Paragraph (2) of this subsection;

(2) to persons who are owners of, enrollees or certificate holders under the policies or contracts, other than unallocated annuity contracts and structured settlement annuities, and in each case who:

(a) are residents; or

(b) are not residents, but only under the following conditions: 1) the member insurer that issued the policies or contracts is domiciled in this state; 2) the states in which the persons reside have associations similar to this state's association; and 3) the persons are not eligible for coverage by an association in another state due to the fact that the member insurer or the health maintenance organization was not licensed in that state at the time specified in that state's guaranty association law;

(3) for unallocated annuity contracts specified in Subsection D of this section, to which Paragraphs (1) and (2) of this subsection shall not apply, and except as provided in Subsections B and C of this section:

(a) to persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(b) to persons who are the owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents; and

(4) for structured settlement annuities specified in Subsection D of this section, to which Paragraphs (1) and (2) of this subsection shall not apply, and except as provided in Subsections B and C of this section, to a person who is a payee under a structured settlement annuity, or a beneficiary of a payee if the payee is deceased, if the payee:

(a) is a resident, regardless of where the contract owner resides; or

(b) is not a resident, but only under the following conditions: 1) the contract owner of the structured settlement annuity is a resident or is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to this state's association; and 2) neither the payee, the payee's beneficiary or the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

B. Coverage shall not be provided to:

(1) a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded coverage by the association of another state;

(2) a person covered pursuant to Paragraph (3) of Subsection A of this section, if coverage is provided by the association of another state to that person; or

(3) a person who acquires rights to receive payments through a structured settlement factoring transaction.

C. Coverage is intended to be provided to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage pursuant to the Life and Health Insurance Guaranty Association Act is provided coverage under the laws of another state, the person shall not be provided coverage in this state. In determining the application of the provisions of this subsection in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary or assignee, the Life and Health Insurance Guaranty Association Act shall be construed in conjunction with other state laws to result in coverage by only one association.

D. Coverage shall be provided to the persons specified in Subsection A of this section for policies or contracts of direct, non-group life insurance, health insurance, which for the purposes of the Life and Health Insurance Guaranty Association Act includes health maintenance organization subscriber contracts and certificates, or annuities and supplemental contracts to any of these, for certificates under direct group policies and contracts and supplemental contracts to these and for unallocated annuity contracts issued by member insurers, except as limited by the Life and Health Insurance Guaranty Association Act. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and immediate or deferred annuity contracts.

E. Coverage shall not be provided for:

(1) a portion of a policy or contract not guaranteed by the member insurer or under which the risk is borne by the policy or contract owner;

(2) a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(3) a portion of a policy or contract, except for any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefit, to the extent that the rate of interest on which it is based, or the interest rate,

crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(a) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer pursuant to the Life and Health Insurance Guaranty Association Act, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under the Life and Health Insurance Guaranty Association Act, whichever is earlier; and

(b) on and after the date on which the member insurer becomes an impaired or insolvent insurer pursuant to the Life and Health Insurance Guaranty Association Act, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

(4) a portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under:

(a) a multiple employer welfare arrangement;

(b) a minimum premium group insurance plan;

(c) a stop-loss group insurance plan; or

(d) an administrative services only contract;

(5) a portion of a policy or contract to the extent that it provides for:

(a) dividends or experience rating credits;

(b) voting rights; or

(c) payment of fees or allowances to a person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(6) a policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(7) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension benefit guaranty corporation, regardless of whether that corporation has yet become liable to make payments with respect to the benefit plan;

(8) a portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

(9) a portion of a policy or contract to the extent that the assessments required by Section 59A-42-8 NMSA 1978 with respect to the policy or contract are preempted by federal or state law;

(10) an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation:

(a) claims based on marketing materials;

(b) claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(c) misrepresentations of or regarding policy or contract benefits;

(d) extra-contractual claims; or

(e) a claim for penalties or consequential or incidental damages;

(11) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(12) a portion of a policy or contract to the extent that it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer pursuant to the Life and Health Insurance Guaranty Association Act, whichever is earlier. If a policy or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and that are not subject to forfeiture pursuant to this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values were the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(13) a policy or contract providing hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter 18 of Chapter 7 of Title 42 of the United States Code, commonly known as medicare Parts C and D, or Subchapter 19 of Chapter 7 of Title 42 of the United States Code, commonly known as medicaid, or any regulations promulgated pursuant to those acts; or

(14) structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction.

F. The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(1) the contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

(2) with respect to one person's life, regardless of the number of policies or contracts:

(a) for life insurance death benefits, three hundred thousand dollars ($300,000) but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values;

(b) for health insurance benefits: 1) one hundred thousand dollars ($100,000) for coverages not constituting disability income insurance, health benefit plans or long-term care insurance, including net cash surrender and net cash withdrawal values; 2) three hundred thousand dollars ($300,000) for disability income insurance; 3) three hundred thousand dollars ($300,000) for long-term care insurance as defined in Section 59A-23A-4 NMSA 1978; and 4) five hundred thousand dollars ($500,000) for health benefit plans; or

(c) for annuity benefits, two hundred fifty thousand dollars ($250,000) in present value, including net cash surrender and net cash withdrawal values;

(3) with respect to each individual participating in a governmental retirement benefit plan established pursuant to Section 401, 403(b) or 457 of the federal Internal Revenue Code of 1986 covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values; or

(4) with respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if the payee is deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

G. In no event shall the association be obligated to cover:

(1) more than an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to one person's life pursuant to Paragraphs (2), (3) and (4) of Subsection F of this section, except with respect to benefits for health benefit plans pursuant to Subparagraph (b) of Paragraph (2) of Subsection F of this section, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars ($500,000) with respect to one person's life; or

(2) with respect to one owner of multiple non-group policies of life insurance, whether the policy holder or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner.

H. With respect to either one contract owner provided coverage pursuant to Subparagraph (b) of Paragraph (3) of Subsection A of this section or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in Paragraph (3) of Subsection F of this section, the benefits the association may become obligated to cover shall not exceed five million dollars ($5,000,000) irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts pursuant to the Life and Health Insurance Guaranty Association Act and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state. In no event shall the association be obligated to cover more than five million dollars ($5,000,000) in benefits with respect to all of these unallocated contracts.

I. The limitations set forth in Subsections F, G and H of this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

J. For purposes of the Life and Health Insurance Guaranty Association Act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

K. In performing its obligations to provide coverage pursuant to this section and Section 59A-42-7 NMSA 1978, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured,

reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

History: Laws 1984, ch. 127, § 753; 1993, ch. 320, § 99; repealed and reenacted by Laws 2012, ch. 9, § 7; 2024, ch. 36, § 2.

59A-42-5. Organization of association; participation.

A. All insurers shall organize and remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business covered by Section 59A-42-4 NMSA 1978. The association may take any appropriate form of legal entity available under the laws of this state and approved by the superintendent. The association shall perform its functions under the plan of operation established and approved pursuant to Section 59A-42-9 NMSA 1978 and shall exercise its powers through the board. For purposes of assessment and administration, the association shall maintain two accounts:

(1) the life insurance and annuity account, which includes the following subaccounts:

(a) a life insurance account;

(b) an annuity account, which includes annuity contracts owned by 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, but otherwise excludes unallocated annuities; and

(c) an unallocated annuity account, which excludes contracts owned by 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; and

(2) the health account.

B. The association shall be supervised by the superintendent and shall be subject to the applicable provisions of the insurance laws of New Mexico. Meetings or records of the association may be opened to the public upon majority vote of the board of the association.

History: Laws 1984, ch. 127, § 754; 2012, ch. 9, § 8; 2024, ch. 36, § 3.

59A-42-6. Board of directors.

A. The board of directors of the association shall consist of not less than seven nor more than eleven member insurers serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers

subject to the approval of the superintendent. In addition, two persons who are public representatives shall be appointed by the superintendent to the board. A public representative shall not be an officer, director or employee of an insurance company or a health maintenance organization or a person engaged in the business of insurance. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members for member insurers, subject to approval of the superintendent, and by the superintendent for public representatives.

B. In approving insurer member selections, the superintendent shall consider among other things whether all member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the association for reasonable and necessary expenses incurred by them as members of the board, but the amount of that reimbursement shall not exceed the guidelines provided by the approved plan of operation.

History: Laws 1984, ch. 127, § 755; 1993, ch. 320, § 100; 2012, ch. 9, § 9; 2024, ch. 36, § 4.

59A-42-7. Powers and duties of the association.

A. If a member insurer is an impaired insurer, the association may, in its discretion, and subject to conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the superintendent:

(1) guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, any or all of the policies or contracts of the impaired insurer; and

(2) provide such money, pledges, loans, notes, guarantees or other means as are proper to effectuate Paragraph (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action pursuant to Paragraph (1) of this subsection.

B. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1) guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, the policies or contracts of the insolvent insurer, or assure payment of the contractual obligations of the insolvent insurer, and provide money, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the association's duties; or

(2) provide benefits and coverages in accordance with the following provisions:

(a) with respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred: 1) with respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five days, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies and contracts; and 2) with respect to non-group policies, contracts and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies or contracts;

(b) make diligent efforts to provide all known insureds, enrollees or annuitants, for non-group policies and contracts, or group policy holders or contract owners with respect to group policies and contracts, thirty days' notice of the termination, pursuant to Subparagraph (a) of this paragraph, of the benefits provided;

(c) with respect to non-group policies or contracts covered by the association, and with respect to an individual formerly insured, enrolled or formerly an annuitant under a group policy or contract who is not eligible for replacement group coverage, make available to each known insured, enrollee or annuitant, or owner if other than the insured, enrollee or annuitant, substitute coverage on an individual basis in accordance with the provisions of Subparagraph (d) of this paragraph if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract or annuity or had a right only to make changes in premium by class;

(d) in providing the substitute coverage required pursuant to Subparagraph (c) of this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability and shall not provide for a waiting period or exclusion that would not have applied under the terminated policy or contract. The association may reinsure an alternative or reissued policy or contract;

(e) alternative policies or contracts adopted by the association shall be subject to the approval of the superintendent. The association may adopt alternative policies or contracts of various types for future issuance without regard to a particular impairment or insolvency. Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured but shall not reflect changes in the health of the insured after the original policy or contract was last underwritten. An alternative policy or contract issued by the

association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(f) if the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to the approval of the superintendent;

(g) the association's obligations with respect to coverage under a policy or contract of the impaired or insolvent insurer or under a reissued or alternative policy or contract shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, contract owner, enrollee, the insured or the association; and

(h) when proceeding under this subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Paragraph (3) of Subsection E of Section 59A-42-4 NMSA 1978.

C. Nonpayment of premiums within thirty-one days after the date required under the terms of a guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or coverage pursuant to the Life and Health Insurance Guaranty Association Act with respect to the policy, contract or coverage, except with respect to claims incurred or net cash surrender value that may be due in accordance with the provisions of that act.

D. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

E. The protection provided by the Life and Health Insurance Guaranty Association Act shall not apply where guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

F. In carrying out its duties pursuant to Subsection B of this section, the association may:

(1) subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guaranty, assumption or reinsurance agreement if the association finds that the amounts that can be assessed are less than the amounts needed to assure full and prompt performance of the association's duties, or if it finds that the economic or financial conditions as they affect member insurers are sufficiently

adverse to render the imposition of such permanent policy or contract liens to be in the public interest; or

(2) subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or another right to withdraw funds held in conjunction with policies or contracts, in addition to contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on another right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

G. A deposit in this state, held pursuant to law or required by the superintendent for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, pursuant to Chapter 59A, Article 10 NMSA 1978, shall be promptly paid to the association. The association is entitled to retain a portion of an amount paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. An amount paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to the Insurers Conservation, Rehabilitation and Liquidation Law [Chapter 59A, Article 41 NMSA 1978] or similar provision of the state of domicile of the impaired or insolvent insurer.

H. If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in Subsection B of this section, the superintendent shall have the powers and duties of the association with respect to the insolvent insurer.

I. The association may render assistance and advice to the superintendent, upon the superintendent's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

J. The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated pursuant to the Life and Health Insurance Guaranty Association Act or with jurisdiction over a person or property against which the association may have rights through subrogation or otherwise.

Standing shall extend to all matters germane to the powers and duties of the association, including proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a person or property against whom the association may have rights through subrogation or otherwise.

K. The association shall have subrogation rights under the Life and Health Insurance Guaranty Association Act as follows:

(1) a person receiving benefits pursuant to the Life and Health Insurance Guaranty Association Act shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising pursuant to, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverages. The association may require an assignment to it of those rights and causes of action by an enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of a right or benefit conferred upon the person;

(2) the subrogation rights of the association pursuant to this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits;

(3) in addition to Paragraphs (1) and (2) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee of a policy or contract with respect to the policy or contracts;

(4) if Paragraph (1), (2) or (3) of this subsection is invalid or ineffective with respect to a person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by another person with respect to the person or claim that is attributable to the policies or contracts, or to the portion of the policies or contracts, covered by the association; and

(5) if the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or to the portion of the policies or contracts, covered by the association.

L. In addition to its other rights and powers, the association may:

(1) enter into contracts that are necessary or proper to carry out the provisions and purposes of the Life and Health Insurance Guaranty Association Act;

(2) sue or be sued, including taking legal actions necessary or proper to recover unpaid assessments pursuant to Section 59A-42-8 NMSA 1978 and to settle claims or potential claims against it;

(3) borrow money to effect the purposes of the Life and Health Insurance Guaranty Association Act. Notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(4) employ or retain those persons necessary or appropriate to handle the financial transactions of the association and to perform other functions as become necessary or proper;

(5) take legal action that may be necessary or appropriate to avoid or recover payment of improper claims;

(6) exercise, to the extent approved by the superintendent, the powers of a domestic life insurer, health maintenance organization or health insurer, but in no case may the association issue policies or contracts other than those issued to perform its obligations pursuant to the Life and Health Insurance Guaranty Association Act;

(7) organize itself as a corporation or in other legal form permitted by the laws of this state;

(8) request information from a person seeking coverage from the association in order to aid the association in determining its obligations with respect to that person, and that person shall promptly comply with the request;

(9) unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for an actuarially justified rate or premium increase for a policy or contract for which it provides coverage under the Life and Health Insurance Guaranty Association Act; and

(10) take other necessary or appropriate action to discharge its duties and obligations or to exercise its powers.

M. The association may join an organization of one or more other state associations with similar purposes to further the purposes and administer the powers and duties of the association.

N. The association may succeed to the rights and obligations of an insolvent insurer as follows:

(1) at any time within one hundred eighty days of the date of the order of liquidation, the association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts or annuities covered, in whole or in part, by the association, in each case under one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association. The assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the association or the national organization of life and health insurance guaranty associations on its behalf sending written notice, return receipt requested, to the affected reinsurers;

(2) to facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available, upon request, to the association or to the national organization of life and health insurance guaranty associations on its behalf, as soon as possible after commencement of formal delinquency proceedings:

(a) copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether those contracts should be assumed; and

(b) notices of defaults under the reinsurance contracts or a known event or condition that with the passage of time could become a default under the reinsurance contracts;

(3) the following shall apply to reinsurance contracts assumed by the association:

(a) the association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case that relate to policies, contracts or annuities covered, in whole or in part, by the association. The association may charge policies, contracts or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator;

(b) the association shall be entitled to amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts or annuities covered, in whole or in part, by the association, provided that, upon receipt of those amounts, the association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of: 1) the amount received by the association; and 2) the excess of the amount received by the association over the amount equal to the benefits paid by the

association on account of the policy, contract or annuity less the retention of the insurer applicable to the loss or event;

(c) within thirty days following the association's election, the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the date of election with respect to policies, contracts or annuities covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver amounts due for losses or events prior to the date of the order of liquidation, subject to a setoff for premiums unpaid for periods prior to that date, and the association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the calculation described in this subparagraph. A dispute over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received amounts due the association pursuant to Subparagraph (b) of this paragraph, the receiver shall remit those amounts to the association as promptly as practicable; and

(d) if the association or receiver, on the association's behalf, within sixty days of the election described in Subparagraph (c) of this paragraph, pays the unpaid premiums due for periods both before and after the date of election that relate to policies, contracts or annuities covered, in whole or in part, by the association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premiums insofar as the reinsurance contracts relate to policies, contracts or annuities covered, in whole or in part, by the association, and the reinsurer shall not be entitled to set off unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due the association;

(4) during the period from the date of the order of liquidation, until the election date or, if the election does not occur, until one hundred eighty days after the date of the order of liquidation, neither the association nor the reinsurer shall have rights or obligations pursuant to reinsurance contracts that the association has the right to assume pursuant to Paragraphs (1), (2) and (3) of this subsection, whether for periods prior to or after the date of the order of liquidation, and the reinsurer, the receiver and the association shall, to the extent practicable, provide each other data and records reasonably requested; provided that once the association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by Paragraphs (1), (2) and (3) of this subsection;

(5) if the association does not elect to assume a reinsurance contract by the election date pursuant to Paragraphs (1), (2) and (3) of this subsection, the association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract;

(6) when policies, contracts or annuities, or covered obligations with respect to those policies, contracts or annuities, are transferred to an assuming insurer, reinsurance on the policies or annuities may also be transferred by the association, in the case of contracts assumed pursuant to Paragraphs (1), (2) and (3) of this subsection, subject to the following:

(a) unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover new policies of insurance, contracts or annuities in addition to those transferred;

(b) the obligations described in Paragraphs (1), (2) and (3) of this subsection shall no longer apply with respect to matters arising after the effective date of the transfer; and

(c) notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty days prior to the effective date of the transfer;

(7) the provisions of this subsection shall supersede the provisions of a state law or of an affected reinsurance contract that provides for or requires a payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or another person. The receiver shall remain entitled to amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions; and

(8) except as otherwise provided in this subsection, the provisions of this subsection shall not:

(a) alter or modify the terms and conditions of a reinsurance contract;

(b) abrogate or limit the rights of a reinsurer to claim that it is entitled to rescind a reinsurance contract;

(c) give a policyholder, contract owner, enrollee, certificate holder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

(d) limit or affect the association's rights as a creditor of the estate against the assets of the estate; or

(e) apply to reinsurance contracts covering property or casualty risks.

O. The board may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of the Life and Health Insurance Guaranty Association Act in an economical and efficient manner.

P. Where the association has arranged or offered to provide benefits to a covered person under a plan or arrangement that fulfills the association's obligations, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

Q. Venue in a suit against the association arising pursuant to the Life and Health Insurance Guaranty Association Act shall be in Santa Fe county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising pursuant to the Life and Health Insurance Guaranty Association Act.

R. In carrying out its duties in connection with guaranteeing, assuming, reissuing or reinsuring policies or contracts pursuant to Subsection A or B of this section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) in lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees or a different method for calculating interest or changes in value;

(2) there is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(3) the alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

History: Laws 1984, ch. 127, § 756; repealed and reenacted by Laws 2012, ch. 9, § 10; 2024, ch. 36, § 5.

59A-42-8. Assessments.

A. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess the member insurers, separately for each account, at a time and for amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at six percent a year on and after the due date.

B. There shall be two classes of assessments as follows:

(1) class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer; and

(2) class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association with regard to an impaired or an insolvent insurer.

C. The amount of a class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If the class A assessment is authorized and called on a pro rata basis, the board may provide that it be credited against future class B assessments. The amount of a class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or another standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

D. The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the superintendent. The methodology shall provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

E. Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the member insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired, bears to premiums received on business in this state for those calendar years by all assessed member insurers.

F. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of the Life and Health Insurance Guaranty Association Act. Classification of assessments pursuant to Subsection B of this section and computation of assessments pursuant to Subsections C and E of this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

G. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for

assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

H. Subject to the provisions of Subsection I of this section, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health insurance account shall not in one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

I. If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in Subsection H of this section shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

J. If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by the Life and Health Insurance Guaranty Association Act.

K. The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

L. If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to Subsection E of this section, the board shall access the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in Subsections H, I and J of this section.

M. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in an account to provide funds for the continuing expenses of the association and for a future losses claim.

N. It shall be proper for a member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance or health maintenance organization

business within the scope of the Life and Health Insurance Guaranty Association Act, to consider the amount reasonably necessary to meet its assessment obligations under that act.

O. The association shall issue to each member insurer paying an assessment, other than a class A assessment, a certificate of contribution, in a form prescribed by the superintendent, for the amount of the assessment paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in that form and for that amount, if any, and period of time as the superintendent may approve.

P. A protest to an assessment shall occur as follows:

(1) a member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or a subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest;

(2) within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest;

(3) within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the superintendent;

(4) in the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the superintendent for a final decision, with or without a recommendation from the association; and

(5) if the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

Q. The association may request information of member insurers in order to aid in the exercise of its power pursuant to this section, and member insurers shall promptly comply with a request.

History: Laws 1984, ch. 127, § 757; repealed and reenacted by Laws 2012, ch. 9, § 11; 2024, ch. 36, § 6.

59A-42-9. Plan of operation.

A. The association shall submit to the superintendent a plan of operation or amendments to the plan necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation or amendments to the plan shall become effective upon approval in writing by the superintendent or on the thirty-first day after submission to the superintendent if it has not been disapproved within that time.

B. If the association fails to submit suitable amendments to the plan, the superintendent shall, after notice and hearing, promulgate reasonable rules necessary or advisable to effectuate the provisions of the Life and Health Insurance Guaranty Association Act. The rules shall continue in force until modified by the superintendent or superseded by amendments submitted by the association and approved by the superintendent.

C. All member insurers shall comply with the plan of operation.

D. The plan of operation shall include:

(1) procedures for handling the assets of the association;

(2) the amount and method of reimbursement for members of the board;

(3) the regular places and times for meetings, including telephone conference calls of the board;

(4) procedures for records to be kept of all financial transactions of the association, its agents and the board;

(5) procedures for selecting members of the board and submitting those selections for approval to the superintendent;

(6) additional procedures for assessments;

(7) additional provisions necessary or proper for the execution of the powers and duties of the association;

(8) procedures to remove a director for cause, including the case where a member insurer director becomes an impaired or insolvent insurer; and

(9) policies and procedures for addressing conflicts of interest.

E. The plan of operation may provide that the powers and duties of the association, except those provided in Paragraph (3) of Subsection L of Section 59A-42-7 NMSA 1978 and in Section 59A-42-8 NMSA 1978, may be delegated to a corporation,

association or other organization that performs or will perform functions similar to those of the association, or its equivalent, in two or more states. That corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of other functions of the association. A delegation pursuant to this subsection shall take effect only with the approval of both the board and the superintendent, and may be made only to a corporation, association or organization that extends protection not substantially less favorable and effective than that provided by the Life and Health Insurance Guaranty Association Act.

History: Laws 1984, ch. 127, § 758; 2012, ch. 9, § 12.

59A-42-10. Duties and powers of the superintendent.

A. The superintendent shall:

(1) notify the association of the existence of an insolvent insurer not later than three days after the superintendent receives notice of the determination of the insolvency;

(2) upon request of the board, provide the association with a statement of the premiums in this or another state of each member insurer; and

(3) when an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties pursuant to the Life and Health Insurance Guaranty Association Act.

B. The superintendent may:

(1) suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of a member insurer that fails to pay an assessment when due or that fails to comply with the plan of operation. As an alternative, the superintendent may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent of the unpaid assessment a month, except that no fine shall be less than one hundred dollars ($100) a month; and

(2) revoke the designation of a servicing facility if the superintendent finds that claims are being handled unsatisfactorily.

History: Laws 1984, ch. 127, § 759; 2012, ch. 9, § 13; 2024, ch. 36, § 7.

59A-42-11. Prevention of insolvencies.

To aid in the detection and prevention of insurance insolvencies:

A. the superintendent shall:

(1) notify the superintendents in other states, within thirty days following the action taken or the date the action occurs, when the superintendent takes any of the following actions against a member insurer:

(a) revokes a license;

(b) suspends a license; or

(c) makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or a part of its business or increase capital, surplus or another account for the security of policy owners, contract owners, certificate holders or creditors;

(2) report to the board when the superintendent has taken an action set forth in Paragraph (1) of this subsection or has received a report from another superintendent indicating that an action has been taken in another state. The report to the board shall contain all significant details of the action taken or of the report received from another superintendent;

(3) report to the board when the superintendent has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the member insurer may be an impaired or insolvent insurer; and

(4) furnish to the board the national association of insurance commissioners' insurance regulatory information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners. The board may use that information in carrying out its duties and responsibilities pursuant to this section. The report shall be kept confidential by the board until it is made public by the superintendent or other lawful authority;

B. the superintendent may seek the advice and recommendations of the board concerning a matter affecting the duties and responsibilities of the superintendent regarding the financial condition of member insurers or health maintenance organizations seeking admission to transact business in this state; and

C. the board may, upon majority vote:

(1) notify the superintendent of information indicating that a member insurer may be an impaired or insolvent insurer;

(2) make reports and recommendations to the superintendent upon any matter germane to the solvency, liquidation, rehabilitation or conservation of a member insurer or germane to the solvency of an insurer or health maintenance organization

seeking to do business in this state. The reports and recommendations are not public documents; and

(3) make recommendations to the superintendent for the detection and prevention of member insurers' insolvencies.

History: Laws 1984, ch. 127, § 760; 2012, ch. 9, § 14; 2024, ch. 36, § 8.

59A-42-12. Appeals.

A. A member insurer may appeal to the superintendent from an action of the board by filing with the superintendent a notice of appeal within thirty days after that action.

B. A final order of the superintendent on appeal is subject to judicial review by an action in the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1984, ch. 127, § 761; 1998, ch. 55, § 66; 1999, ch. 265, § 69; 2012, ch. 9, § 15.

59A-42-13. Miscellaneous provisions.

A. The Life and Health Insurance Guaranty Association Act shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

B. Records shall be kept of all meetings of the board to discuss the activities of the association in carrying out its powers and duties. Records of the meetings with respect to an impaired or insolvent insurer shall be made public only upon the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the insolvency of the member insurer or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the association to render the reports required by Section 59A-42-14 NMSA 1978.

C. For the purpose of carrying out its obligations, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies or contracts reduced by amounts to which the association is entitled as a subrogee pursuant to Subsection K of Section 59A-42-7 NMSA 1978. Assets of the impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue all covered policies or contracts and pay all contractual obligations of the impaired or insolvent insurer. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets that the reserves that should have been established for those policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

D. As a creditor of the impaired or insolvent insurer and consistent with the Insurers Conservation, Rehabilitation and Liquidation Law [Chapter 59A, Article 41 NMSA 1978], the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations pursuant to the Life and Health Insurance Guaranty Association Act. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

E. Prior to the termination of a liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, contract owners, certificate holders, enrollees and policy owners of the insolvent insurer and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners, contract owners, certificate holders and enrollees of the continuing or successor member insurer.

F. No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties with respect to the member insurer has been fully recovered by the association.

History: Laws 1984, ch. 127, § 762; 2012, ch. 9, § 16; 2024, ch. 36, § 9.

59A-42-14. Examination of association; annual report.

The association is subject to examination and regulation by the superintendent. The board shall submit to the superintendent, not later than May 1 each year, a financial report for the preceding calendar year in form approved by the superintendent and a report of its activities during the preceding calendar year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

History: Laws 1984, ch. 127, § 763; 2012, ch. 9, § 17.

59A-42-15. Immunity.

There shall be no liability on the part of, and no cause of action shall arise against, a member insurer or its agents or employees, the association or its agents or employees, members of the board or the superintendent or the superintendent's representatives for an act or omission by them in the performance of their powers and duties pursuant to the Life and Health Insurance Guaranty Association Act. This immunity shall extend to

the participation in an organization of one or more other state associations with similar purposes and to that organization and its agents or employees.

History: Laws 1984, ch. 127, § 764; 2012, ch. 9, § 18.

59A-42-16. Stay of proceedings; reopening default judgments.

A proceeding in which an insolvent insurer is a party in a court in this state shall be stayed one hundred eighty days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on matters germane to its powers or duties. As to a judgment under a decision, order, verdict or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

History: Laws 1984, ch. 127, § 765; 2012, ch. 9, § 19.

59A-42-17. Prohibited advertisement; notice to policy owners.

A. No person, including a member insurer, agent or affiliate of a member insurer, shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio station or television station, or in any other way, an advertisement, announcement or statement, written or oral, that uses the existence of the association for the purpose of sales, solicitation or inducement to purchase insurance or other coverage covered by the Life and Health Insurance Guaranty Association Act. However, this subsection shall not apply to the association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

B. Within one hundred eighty days of the effective date of this act, the association shall prepare a summary document describing the general purposes and current limitations of that act and complying with Subsection C of this section. The document shall be submitted to the superintendent for approval. At the expiration of the sixtieth day after the date on which the superintendent approves the document, a member insurer shall not deliver a policy or contract to a policy owner, contract owner, certificate holder or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder or enrollee at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder or enrollee. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, certificate holder or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the Life and Health Insurance Guaranty Association Act may require. Failure to receive this document does not give

the policy owner, contract owner, certificate holder or insured greater rights than those stated in the Life and Health Insurance Guaranty Association Act.

C. The document prepared pursuant to Subsection B of this section shall contain a clear and conspicuous disclaimer on its face. The superintendent shall establish the form and content of the disclaimer. The disclaimer shall:

(1) state the name and address of the association and insurance department;

(2) prominently warn the policy owner, contract owner, certificate holder or enrollee that the association may not cover the policy or contract, if coverage is available, that it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state;

(3) state the types of policies or contracts for which guaranty funds will provide coverage;

(4) state that the member insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance or health maintenance organization coverage;

(5) state that the policy owner, contract owner, certificate holder or enrollee should not rely on coverage pursuant to the Life and Health Insurance Guaranty Association Act when selecting an insurer or health maintenance organization;

(6) explain rights available and procedures for filing a complaint to allege a violation of the provisions of the Life and Health Insurance Guaranty Association Act; and

(7) provide other information as directed by the superintendent, including sources for information about the financial condition of insurers, provided that the information is not proprietary and is subject to disclosure pursuant to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978].

D. A member insurer shall retain evidence of compliance with Subsection B of this section for as long as the policy or contract for which the notice is given remains in effect.

History: Laws 2012, ch. 9, § 20; 2024, ch. 36, § 10.

ARTICLE 42A
Provider Service Networks

59A-42A-1. Short title.

Sections 1 through 10 [59A-42A-1 to 59A-42A-9 NMSA 1978] of this act may be cited as the "Provider Service Network Act".

History: Laws 1997, ch. 107, § 1.

59A-42A-2. Definitions.

As used in the Provider Service Network Act:

A. "association" means the provider service network guaranty association;

B. "board" means the provider service network guaranty board;

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

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

E. "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;

F. "health care services" includes physical health services or community-based mental health or developmental disability services, including services for developmental delay;

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

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

I. "provider service network" means two or more providers affiliated for the purpose of providing health care services on a capitated or similar prepaid, flat-fee basis.

History: Laws 1997, ch. 107, § 2.

59A-42A-3. Provider service networks; insurance code applicability.

A. Except as provided otherwise in this section, a provider service network shall obtain and maintain a certificate of authority under the New Mexico Insurance Code.

B. A provider service network is not required to obtain or maintain a certificate of authority in connection with health care coverage for which the risk of loss is directly and fully underwritten by a health care insurer, subject to any applicable deductible, coinsurance or copayment provisions.

C. A provider service network that obtains and maintains a certificate of authority as a health care insurer may contract directly with government agencies to provide goods and services to persons receiving public assistance, including medicare and medicaid.

D. A provider service network that does not obtain or maintain a certificate of authority as a health care insurer may contract in appropriate circumstances, including membership and participation in the association, directly with government agencies to provide goods and services to persons receiving public assistance, including medicare and medicaid. The contract shall incorporate and be subject to specific financial, quality-of-service and consumer-protection standards that the contracting agency shall specify by regulation.

E. This section does not abrogate any other New Mexico Insurance Code requirements that may be applicable to provider service networks, including requirements relating to third-party administrators and examinations. This section does not bar or restrict the right of a provider service network to obtain and maintain a certificate of authority.

History: Laws 1997, ch. 107, § 3.

59A-42A-4. Guaranty association and board; created; membership.

A. The "provider service network guaranty association" is created as an independent public nonprofit corporation. The association's purpose is to guarantee health care services obligations of its members in the event of financial insolvency, bankruptcy or other inability or failure to perform based on financial difficulties. All provider service networks contracting to provide services to public assistance recipients pursuant to Subsection D of Section 3 [59A-42A-3 NMSA 1978] of the Provider Service Network Act shall organize and be members of the association. The association is not and shall not be deemed a governmental agency or instrumentality for any purpose.

B. The "provider service network guaranty board" is created. The board shall consist of the superintendent of insurance or his designee, who shall be a nonvoting, ex-officio member, and five voting members as follows:

(1) the secretary of human services or his designee;

(2) two representatives of the provider service network industry, who shall be appointed by majority vote of the association's members; and

(3) two representatives of the health insurance industry, who shall be appointed by majority vote of the association's members.

C. The association shall operate subject to the board's supervision and approval. The board is a state government entity for purposes of the Tort Claims Act [41-4-1 to 41-4-27 NMSA 1978].

D. The secretary of human services shall notify the superintendent of insurance and the association of each contract signed pursuant to Subsection D of Section 3 of the Provider Service Network Act.

E. The superintendent of insurance shall give notice at least sixty days before the proposed effective date of the first contract entered into pursuant to Subsection D of Section 3 of the Provider Service Network Act, to each provider service network so contracting, stating the time and place of the association's initial organizational meeting.

F. At the organizational meeting and at all successive meetings, each association member shall be entitled to one vote. At the organizational meeting and any subsequent meeting at which board members are to be appointed, the association members shall elect the appointive board members by majority vote. At the organizational meeting, the members shall instruct the board concerning preparation of a proposed plan of operation for the association.

G. Appointive board members shall have initial terms of three years or less, staggered so that the term of at least one such board member expires on June 30 of each year. Following the initial terms, appointive board members shall have three-year terms. When a vacancy occurs in the position of an appointive board member, the remaining board members shall appoint a successor who meets the required qualifications for that position for the balance of the unexpired term. Board members may be reimbursed by the association as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978] but shall receive no other compensation, perquisite or allowance.

History: Laws 1997, ch. 107, § 4.

59A-42A-5. Plan of operation.

A. The board shall submit to the superintendent of insurance for approval a plan of operation and any subsequent amendments necessary or suitable to assure proper and fair operation of the association.

B. After notice and hearing, the superintendent of insurance shall approve or disapprove the plan of operation or any subsequent amendments. The superintendent shall approve the plan or an amendment only if he finds that it provides for administering the association on a fair, reasonable and equitable basis and for sharing

the association's losses on an equitable basis. The plan of operation or amendment shall become effective upon the superintendent's written approval.

C. If the board fails to submit a plan of operation satisfactory to the superintendent of insurance within ninety days after the initial board is appointed or fails in a timely manner to submit any amendment the superintendent deems necessary at any time thereafter, the superintendent shall adopt and promulgate such plan of operation or amendment by rule. Any such rule shall continue in force until the superintendent modifies it or approves a plan of operation or an amendment submitted by the board that he deems to supersede the rule.

D. The plan of operation submitted to the superintendent of insurance shall:

(1) establish procedures for handling and accounting of the association's money, other assets and property;

(2) provide for payment of claims or provision of alternative health care services to public assistance recipients;

(3) establish regular times and places for board meetings;

(4) establish procedures for records to be kept of all financial transactions and for annual fiscal reporting to the superintendent;

(5) establish procedures for the determination and collection of assessments from members to pay claims or to provide alternative health care services and administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) establish penalties for nonpayment or late payment of assessments; and

(7) contain any additional provisions necessary and proper for the execution of the association's powers and duties.

History: Laws 1997, ch. 107, § 5.

59A-42A-6. Board; powers and duties.

The board has the power and authority to:

A. enter into contracts necessary or proper to carry out the provisions and purposes of the Provider Service Network Act, including contracts with independent contractors for the performance of the association's administrative functions;

B. sue or be sued;

C. determine and pay the association's obligations, including its obligation to pay claims or to provide alternative health care services to public assistance recipients on behalf of an insolvent or financially troubled provider service network;

D. borrow money to satisfy the association's obligations;

E. assess association members in accordance with the provisions of the Provider Service Network Act and make initial and interim assessments as may be reasonable and necessary for organizational or interim operating expenses. Interim expense assessments shall be credited as offsets against any regular assessments due following the close of the calendar year;

F. recoup expenditures on behalf of an insolvent or financially troubled provider service network from that provider service network or any other available source, including a governmental agency, and be subrogated to that provider service network's rights to payment to the extent of such expenditures;

G. employ or contract with appropriate legal, actuarial, clerical and other personnel as necessary to provide assistance in the operation of the association;

H. conduct periodic audits to assure the general accuracy of the financial data submitted to the association. The board shall cause the association to undergo an annual audit on a calendar-year basis of its financial records and operations by an independent certified public accountant;

I. take all other actions, whether like or unlike the foregoing, necessary or appropriate to carry out the board's or the association's duties;

J. reinsure any or all of the risk of the association; and

K. assess each original and new provider service network an initial administrative fee of five thousand dollars ($5,000) times the number of providers in the provider service network. If a provider service network adds new members to increase the number of providers, then that provider service network shall pay an additional administrative fee of five thousand dollars ($5,000) for each additional provider. An employee of a provider shall not be used in computing the administrative fee due under this subsection.

History: Laws 1997, ch. 107, § 6.

59A-42A-7. Examination; annual statement.

A. The association is subject to and responsible to pay the cost of examination by the superintendent on a periodic basis, pursuant to Chapter 59A, Article 4 NMSA 1978.

B. Not later than March 1 of each year, the board shall submit to the superintendent an annual statement in accordance with the requirements of Section 59A-5-29 NMSA 1978 and a risk-based capital report in accordance with the requirements of Section 59A-5A-3 NMSA 1978.

History: Laws 1997, ch. 107, § 7; 2014, ch. 59, § 50.

59A-42A-8. Assessments; fund created.

A. The "provider service network guarantee fund" is created in the state treasury. The fund shall be administered by the board and money in the fund is appropriated to the board to carry out the provisions of the Provider Service Network Act. Money in the fund shall be invested by the state treasurer as other state funds are invested; provided that interest on the fund shall be credited to the fund. Any unexpended or unencumbered balance remaining in the fund at the end of any fiscal year shall not revert.

B. The secretary of human services shall report to the board within thirty days of the close of each calendar quarter the amounts paid each member for services to public assistance recipients during that calendar quarter.

C. The proportion of participation of each member shall be determined annually by the board based on the secretary of human services' report, together with members' annual statements and other reports deemed necessary by the board.

D. The assessment for each member shall be determined by multiplying the member's income from services to public assistance recipients pursuant to Subsection D of Section 3 [59A-42A-3 NMSA 1978] of the Provider Service Network Act for the preceding calendar quarter by a percentage set by the board not to exceed five percent.

E. The board shall notify each member of the amount of the assessment within forty-five days of the close of a calendar quarter. The member shall pay the assessment within sixty days of the close of a calendar quarter.

F. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in Subsection A of this section. The member receiving the abatement or deferment shall remain liable to the association for the deficiency for four years.

G. If assessments exceed actual expenses in any year, the excess shall be held at interest and used by the board to offset future expenses. Any deficit incurred shall be

recouped by assessments apportioned among the association's members pursuant to the assessment formula provided by Subsection D of this section.

H. If it appears that the maximum assessment available, together with unencumbered money and other assets, will be insufficient in any year to make all necessary payments, the association's obligations shall be paid pro rata. The unpaid portion shall be paid as soon as additional assessment proceeds or other assets become available. Notwithstanding the foregoing, the association may pay its obligations in any order it deems reasonable.

History: Laws 1997, ch. 107, § 8.

59A-42A-9. Notification to pay claims or provide services.

A. The association shall be liable to pay claims or to provide alternative health care services for insolvent or financially troubled members who are not fulfilling obligations to provide such services to public assistance recipients under contracts pursuant to Subsection D of Section 3 [59A-42A-3 NMSA 1978] of the Provider Service Network Act. The association's obligation shall commence on the date the secretary of human services gives the association notice that a member is failing, because of insolvency or financial difficulties, to provide some or all of such services.

B. Nothing [in] the Provider Service Network Act shall be deemed to authorize or obligate the association to pay or otherwise assume any obligation of a provider service network prior to the date of notification, or any obligation thereafter other than the obligation to provide services to public assistance recipients under a contract pursuant to Subsection D of Section 3 of the Provider Service Network Act. In no event shall the association be liable to the creditors of a provider service network.

History: Laws 1997, ch. 107, § 9.

ARTICLE 43
Property and Casualty Insurance Guaranty Fund

59A-43-1. Short title.

This article [Chapter 59A, Article 43 NMSA 1978] may be cited as the "Property and Casualty Insurance Guaranty Law".

History: Laws 1984, ch. 127, § 767.

59A-43-2. Purpose.

The purpose of this article is to provide a mechanism for payment of covered claims under certain insurance policies to avoid excessive delay in payment and financial loss

to claimants or policyholders because of insolvency of an insurer, to assist in detection and prevention of insurer insolvencies and provide an association to assess the cost of such protection among insurers.

History: Laws 1984, ch. 127, § 768.

59A-43-3. Scope.

A. This article applies to all kinds of direct insurance except life, health, annuities, title guaranty, surety (other than fidelity), credit, mortgage guaranty, ocean marine, surplus line and other coverages written by insurers other than authorized insurers or written by Mexican casualty insurers pursuant to Article 40 [Chapter 59A, Article 40 NMSA 1978] of the Insurance Code.

B. This article also does not apply as to motor club coverages or services nor as to any coverage issued by any person not organized under laws providing expressly for formation of insurers nor engaged in business as such an insurer.

History: Laws 1984, ch. 127, § 769.

59A-43-4. Definitions.

As used in Chapter 59A, Article 43 NMSA 1978:

A. "account" means any one of the three accounts created by Section 59A-43-5 NMSA 1978;

B. "association" means the insurance guaranty association;

C. "covered claims" means an unpaid claim of an insured or of a liability claimant in excess of twenty-five dollars ($25.00), including one for unearned premiums, that arises out of and within the coverage and not in excess of the applicable limits of an insurance policy to which Chapter 59A, Article 43 NMSA 1978 applies, issued by an insurer authorized to transact insurance in this state, if such insurer becomes an insolvent insurer after April 4, 1973; and

(1) the liability claimant or insured is a resident of this state at the time of the insured event; or

(2) the property from which the claim arises is permanently located in this state.

Subject to policy limits if lower, individual "covered claims" shall be limited to one hundred thousand dollars ($100,000) and shall not include any amount in excess of one hundred thousand dollars ($100,000), and the total amount of covered claims which may be asserted by any claimant, including also covered claims brought by any party on

behalf of such claimant or as a result of injuries to such claimant shall not exceed one hundred thousand dollars ($100,000) per occurrence; except that the association shall pay the full amount of any covered claim arising under a workmen's compensation policy and that the superintendent may set a higher limit by regulation. "Covered claim" shall not include any amount due any reinsurer, insurer, insurance pool or underwriting association, as subrogation recoveries or otherwise; provided, that a claim for any such amount, asserted against a person insured under a policy issued by an insurer which has become an insolvent insurer, which if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool or underwriting association would be a "covered claim," may be filed directly with the receiver of the insolvent insurer, but in no event may any such claim be asserted in any legal action against the insured of such insolvent insurer. Covered claim shall not include any amount of an unpaid claim paid to an insured or liability claimant of an insolvent insurer by any person, including but not limited to an agent or broker whether or not an assignment is taken by such person, agent or broker. Covered claim shall not include supplementary payment obligations, including but not limited to adjustment fees and expenses, attorneys' fees and expenses, court costs, interest and bond premiums incurred prior to the determination that an insurer is an insolvent insurer;

D. "insolvent insurer" means:

(1) an insurer licensed to transact business in this state, either at the time the policy was issued or when the insured event occurred, and

(2) against which an order of liquidation with a finding of insolvency has been entered after the effective date of the Insurance Code by a court of competent jurisdiction in the insurer's state of domicile, or of this state under the provisions of Section 59A-41-30 NMSA 1978, and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order;

E. "member insurer" means any person who:

(1) writes any kind of insurance to which Chapter 59A, Article 43 NMSA 1978 applies, including the exchange of reciprocal or inter-insurance contracts; and

(2) is authorized to transact insurance in this state;

F. "net direct written premiums" means direct gross premiums written in this state on insurance policies to which Chapter 59A, Article 43 NMSA 1978 applies, less return premiums thereon and dividends paid or credited to policyholders on the direct business. Net direct written premiums do not include premiums on contracts between insurers or reinsurers;

G. "person" means any individual, corporation, partnership, association or voluntary organization; and

H. "authorized to transact insurance" means that the insurer is an "authorized insurer" as defined in Section 59A-1-8 NMSA 1978.

History: Laws 1984, ch. 127, § 770; 1989, ch. 91, § 1.

59A-43-5. Organization of association.

All member insurers shall remain members of the association as a condition of their authority to transact insurance in this state. The association may take any appropriate form of legal entity available under the laws of this state and approved by the superintendent. For purposes of administration and assessment, the association shall be divided into three (3) separate accounts:

A. the workmen's compensation insurance account;

B. the automobile insurance account; and

C. the account for all other insurance to which this article applies.

History: Laws 1984, ch. 127, § 771.

59A-43-6. Board of directors.

A. The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the superintendent. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the superintendent.

B. In approving selections to the board, the superintendent shall consider among other things whether all member insurers are fairly represented.

C. Members of the board of directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

History: Laws 1984, ch. 127, § 772.

59A-43-7. Powers and duties of the association.

A. The association shall:

(1) be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within thirty (30) days after the determination, or before the insured replaces the policy or causes its cancellation. In no event shall the

association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises;

(2) be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent;

(3) allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligation of the association under Paragraph (1) of this subsection subsequent to an insolvency, expenses of handling claims, the cost of examinations and other expenses authorized by this article. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any year on any account an amount greater than two percent of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year, in any account, an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association shall pay claims in any order which it may deem reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The association may exempt or defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer serving as a servicing facility may set off against any assessment any authorized payments made on covered claims and expenses incurred in the payment of the claims by such member insurer if they are chargeable to the account for which the assessment is made;

(4) investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested;

(5) notify persons as the superintendent directs under Paragraph 1 of Subsection B of Section 775 [59A-43-9 NMSA 1978] of this article;

(6) handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is

subject to the approval of the superintendent, but the designation of such insurer may be declined by the member insurer; and

(7) reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this article.

B. The association may:

(1) employ or retain persons necessary to handle claims and perform other duties of the association. Though not a covered claim as defined in Paragraph C of Section 770 [59A-43-4 NMSA 1978] of this article, the association may, if it determines it necessary to the settlement and disposition of claims, pay adjustment fees and expenses, and attorney's fees and expenses incurred prior to the determination that an insurer is an insolvent insurer;

(2) borrow funds necessary to effect the purpose of this article in accordance with the plan of operation;

(3) sue or be sued and intervene in any court having jurisdiction over an insolvent insurer;

(4) negotiate and become a party to contracts necessary to carry out the purpose of this article;

(5) perform other acts necessary or proper to effectuate the purpose of this article; and

(6) refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.

History: Laws 1984, ch. 127, § 773.

59A-43-8. Plan of operation.

A. The association shall submit to the superintendent a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the superintendent. If at any time the association fails to submit suitable amendments to the plan, the superintendent shall, after notice and hearing, adopt rules necessary or advisable to effectuate the provisions of this article. The rules shall continue in force until modified by the superintendent or

superseded by a plan or amendments submitted by the association and approved by the superintendent.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation, among other things, shall establish all procedures for conducting the business of the association, for handling its assets, for receiving claims, for keeping records and for the conduct of other activities necessary for execution of the powers and duties of the association.

D. The plan of operation may provide that any or all powers and duties of the association, except those under Paragraph (3) of Subsection A and Paragraph (2) of Subsection B of Section 773 [59A-43-7 NMSA 1978] of this article, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the superintendent, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

History: Laws 1984, ch. 127, § 774.

59A-43-9. Duties and powers of superintendent.

A. The superintendent shall:

(1) serve on the association a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member insurer at the same time that such complaint is filed with a court of competent jurisdiction;

(2) notify the association of the existence of an insolvent insurer not later than three (3) days after he receives notice of the determination of the insolvency; and

(3) upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

B. The superintendent may:

(1) require that the association, and agents of the insurer in New Mexico as to policyholders of the insurer in this state, notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this article. Such notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient;

(2) suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the superintendent may levy a civil penalty on any member insurer which fails to pay an assessment when due. The civil penalty shall not exceed five percent of the unpaid assessment per month, except that no civil penalty shall be less than one hundred dollars ($100) a month; and

(3) revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

History: Laws 1984, ch. 127, § 775.

59A-43-10. Effect of paid claims.

A. Any person recovering under Chapter 59A, Article 43 NMSA 1978 shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of that article shall cooperate with the association to the same extent as he would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association do not operate to reduce the liability of the insured to the receiver, liquidator or statutory successor for unpaid assessments.

B. The receiver, liquidator or statutory successor of an insolvent insurer is bound by settlements of covered claims by the association or a similar organization in another state. The association may make application to the court for reimbursement of such claims and expenses and upon proper application the court shall order appropriate disbursements to be made in accordance with the provisions of Chapter 59A, Article 41 NMSA 1978 in effect at the time the application is acted upon by the court.

C. The association shall, within the time set by the receivership court, file with the receiver or liquidator of the insolvent insurer, statements of the covered claims paid by the association and estimates of anticipated claims on the association.

History: Laws 1984, ch. 127, § 776; 1993, ch. 320, § 101.

59A-43-11. Nonduplication of recovery.

A. Any person having a claim against any insurer under any provision in an insurance policy including but not limited to uninsured motorist coverage other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first his rights under the policy. An insured of an insolvent insurer and possessing no

other insurance coverage applicable to a specific claim shall be deemed to be "uninsured" for uninsured motorist coverage purposes. Any amount payable on a covered claim under this article shall be reduced by the amount of any recovery available under such insurance policy. No action against an insured of an insolvent insurer shall be tried prior to the exhaustion of all other available sources of recovery.

B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured except that, if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the association of the location of the property, and, if it is a workmen's compensation claim, he shall seek recovery first from the association of the residence of the claimant. Any recovery under this article shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

History: Laws 1984, ch. 127, § 777.

59A-43-12. Prevention of insolvencies.

To aid in the detection and prevention of insurance insolvencies:

A. the board of directors shall, upon majority vote, notify the superintendent of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public;

B. the board of directors may, upon majority vote, request that the superintendent order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty (30) days of the receipt of such request, the superintendent shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by persons designated by the superintendent. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this does not preclude the superintendent from complying with Subsection C of this section. The superintendent shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the superintendent but it shall not be open to public inspection prior to the release of the examination report to the public;

C. the superintendent shall report to the board of directors when he has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public;

D. the board of directors may, upon majority vote, make reports and recommendations to the superintendent upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents;

E. the board of directors may, upon majority vote, make recommendations to the superintendent for the detection and prevention of insurers' insolvencies; and

F. the board of directors shall, at the conclusion of any insurance insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of the insolvency based on information available to the association and submit such report to the superintendent.

History: Laws 1984, ch. 127, § 778.

59A-43-13. Examination of association; financial reports.

The association is subject to examination and regulation by the superintendent. The board of directors shall submit, not later than June 30 each year, a financial report for the preceding calendar year in a form approved by the superintendent.

History: Laws 1984, ch. 127, § 779.

59A-43-14. Appeals.

A. A claimant whose claim is denied in whole or in part by the association may, pursuant to Chapter 59A, Article 43 NMSA 1978, request the receivership court to review the decision of the association. A request for review shall be filed within thirty days of the denial. The receivership court shall have jurisdiction of all claims and the decision of the court shall be binding on both the claimant and the association.

B. A member insurer may appeal to the superintendent from an action of the board of directors of the association by filing with the superintendent a notice of appeal within thirty days after the action appealed from.

C. A final order of the superintendent on appeal is subject to judicial review by an action in the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1984, ch. 127, § 780; 1998, ch. 55, § 67; 1999, ch. 265, § 70.

59A-43-15. Recognition of assessment in rates.

The rates and premiums charged for insurance policies to which this article apply [applies] shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer, less any amounts returned to the member insurer by the association, and such rates shall not be deemed excessive because they

contain an amount reasonably calculated to recoup assessments paid by the member insurer.

History: Laws 1984, ch. 127, § 781.

59A-43-16. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against, any member insurer, the association or its agents or employees, the board of directors or the superintendent or his representative for any action taken by them in the performance of their powers and duties under this article. The meetings, activites [activities], recommendations and decisions of the board of directors of the association as required or permitted in this article shall not be open to public inspection, nor considered public documents, nor subject to Sections 10-15-1 through 10-15-4 NMSA 1978.

History: Laws 1984, ch. 127, § 782.

59A-43-17. Stay of proceedings; reopening of default judgments.

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed for not to exceed six (6) months from the date the insolvency is determined to permit proper defense by the association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that made it and may defend against the claim on the merits.

History: Laws 1984, ch. 127, § 783.

59A-43-18. Termination; distribution of funds.

A. The superintendent shall by order terminate the operation of the association as to any kind of insurance covered by this article with respect to which he has found, after hearing, that there is in effect a statutory or voluntary plan which:

(1) is a permanent plan which is adequately funded or for which adequate funding is provided; and

(2) extends, or will extend to the New Mexico policyholders and residents protection and benefits with respect to insolvent insurers not substantially less favorable and effective to the policyholders and residents than the protection and benefits provided with respect to such kinds of insurance under this article.

B. The superintendent shall by the same order authorize discontinuance of future payments by insurers to the association with respect to the same kinds of insurance, but assessments and payments shall continue, as necessary, to liquidate covered claims of insurers adjudged insolvent prior to the order and the related expenses not covered by the other plan.

C. If operation of the association is terminated as to all kinds of insurance otherwise within its scope, the association, as soon as possible thereafter, shall distribute the balance of money and assets remaining, after discharge of the functions of the association, with respect to prior insurer insolvencies not covered by another plan, together with related expenses, to the insurers which are then writing in this state policies of the kinds of insurance covered by this article and which had made payments to the association, pro rata upon the basis of the aggregate of such payments made by the respective insurers during the period of five (5) years next preceding the date of the order. Upon completion of the distribution with respect to all of the kinds of insurance covered by this article, this shall be deemed to have expired.

History: Laws 1984, ch. 127, § 784.

ARTICLE 44
Fraternal Benefit Societies

59A-44-1. Fraternal benefit societies.

Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of Paragraph (2) of Subsection A of Section 59A-44-40 NMSA 1978, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with Chapter 59A, Article 44 NMSA 1978, is hereby declared to be a fraternal benefit society.

History: 1978 Comp., § 59A-44-1, enacted by Laws 1989, ch. 388, § 1.

59A-44-2. Lodge system.

A. A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

B. A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not

be required of such children, nor shall they have a voice or vote in the management of the society.

History: 1978 Comp., § 59A-44-2, enacted by Laws 1989, ch. 388, § 2.

59A-44-3. Representative form of government.

A society has a representative form of government when:

A. it has a supreme governing body constituted as:

(1) an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws; or

(2) a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member shall not exceed four years. Vacancies on the board between elections shall be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society;

B. the officers of the society are elected either by the supreme governing body or by the board of directors;

C. only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly; and

D. each voting member shall have one vote and no vote shall be cast by proxy.

History: 1978 Comp., § 59A-44-3, enacted by Laws 1989, ch. 388, § 3.

59A-44-4. Definitions.

As used in Chapter 59A, Article 44 NMSA 1978:

A. "benefit contract" means the agreement as described in Subsection A of Section 59A-44-19 NMSA 1978;

B. "benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract;

C. "certificate" means a contract which sets forth the insurance benefits as authorized by Section 59A-44-16 NMSA 1978, to whom benefits are payable, the insuring provisions and the terms and conditions of the certificate;

D. "law" means the society's articles of incorporation, constitution and bylaws, however designated;

E. "lodge" means subordinate member units of the society, known as camps, courts, councils, branches or by any other designation;

F. "premium" means premiums, rates, dues, certificate fees or other required contributions by whatever name known, which are payable under the certificate;

G. "rule" means all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society; and

H. "society" means a fraternal benefit society, unless otherwise indicated.

History: 1978 Comp., § 59A-44-4, enacted by Laws 1989, ch. 388, § 4.

59A-44-5. Purposes and powers.

A. A society shall operate for the benefit of members and their beneficiaries by:

(1) providing benefits as specified in Section 59A-44-16 NMSA 1978; and

(2) lawfully operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to member dependents.

Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

B. Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

History: 1978 Comp., § 59A-44-5, enacted by Laws 1989, ch. 388, § 5.

59A-44-6. Qualifications for membership.

A. A society shall specify in its laws or rules:

(1) eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than fifteen years and not greater than twenty-one years;

(2) the process for admission to membership for each membership class; and

(3) the rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

B. A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

C. Membership rights in the society are personal to a member and are not assignable.

History: 1978 Comp., § 59A-44-6, enacted by Laws 1989, ch. 388, § 6.

59A-44-7. Location of office; meetings; communications to members; grievance procedures.

A. The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one subordinate lodge, or in such other location as determined by the supreme governing body. All business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

B. A society may provide in its laws for an official publication in which any notice, report or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby

disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

C. A society may provide in its laws or rules grievance or complaint procedures for members.

History: 1978 Comp., § 59A-44-7, enacted by Laws 1989, ch. 388, § 7.

59A-44-8. No personal liability.

A. The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

B. Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that he is or was a director, officer, employee or agent of the society or of any firm, corporation or organization in which he served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed:

(1) in relation to any matter in such action, suit or proceeding as to which he shall finally be adjudged to be or have been guilty of breach of duty as a director, officer, employee or agent of the society; or

(2) in relation to any matter in such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement, unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, he had no reasonable cause to believe that his conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter in Paragraph (1) or (2) of this subsection may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction or upon a plea of no contest as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his heirs, executors and administrators.

C. A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society or who is or was serving at the request of the society as a director, officer, employee or agent of any

other firm, corporation or organization against any liability asserted against such person and incurred by him in any such capacity or arising out of his status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

History: 1978 Comp., § 59A-44-8, enacted by Laws 1989, ch. 388, § 8.

59A-44-9. Waiver.

The laws of the society may provide that no subordinate body or any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

History: 1978 Comp., § 59A-44-9, enacted by Laws 1989, ch. 388, § 9.

59A-44-10. Organization.

A domestic society organized on or after the effective date of this act shall be formed as follows:

A. ten or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a society, may make, sign and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

(1) the proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(2) the purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this article; and

(3) the names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held no later than one year from the date of issuance of the permanent certificate of authority.

B. Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the superintendent, who may require such further information as the superintendent

deems necessary. The bond with sureties approved by the superintendent shall be in such amount, not less than three hundred thousand dollars ($300,000) nor more than one million five hundred thousand dollars ($1,500,000), as required by the superintendent. All documents filed shall be in the English language. If the purposes of the society conform to the requirements of this article and all provisions of the law have been complied with, the superintendent shall so certify, retain and file the articles of incorporation and furnish to the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

C. No preliminary certificate of authority granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the superintendent upon cause shown, unless the five hundred applicants hereinafter required have been secured and the organization has been completed as herein provided. The articles of incorporation and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

D. Upon receipt of a preliminary certificate of authority from the superintendent, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, issue any certificate, pay, allow or offer or promise to pay or allow any benefit to any person until:

(1) actual bona fide applications for benefits have been secured on not less than five hundred applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(2) at least ten subordinate lodges have been established into which the five hundred applicants have been admitted;

(3) there has been submitted to the superintendent, under oath of the president or secretary or corresponding officer of the society, a list of such applicants giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and

(4) it shall have been shown to the superintendent, by sworn statement of the treasurer or corresponding officer of such society, that at least five hundred applicants have each paid in cash at least one regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least one hundred fifty thousand dollars ($150,000). The advance premium shall be held in trust during the period of

organization and if the society has not qualified for a certificate of authority within one year, as herein provided, the premiums shall be returned to said applicants.

E. The superintendent may make such examination and require such further information as the superintendent deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the superintendent shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of Chapter 59A, Article 44 NMSA 1978. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The superintendent shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

F. Any incorporated society authorized to transact business in this state at the time this article becomes effective shall not be required to reincorporate.

History: 1978 Comp., § 59A-44-10, enacted by Laws 1989, ch. 388, § 10.

59A-44-11. Amendments to laws.

A. A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified.

B. No amendment to the laws of any domestic society shall take effect unless approved by the superintendent who shall approve such amendment if the superintendent finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects and purposes of the society. Unless the superintendent shall disapprove any such amendment within sixty days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the superintendent shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the superintendent disapproves such amendment, the reasons therefor shall be stated in such written notice.

C. Within ninety days from the approval of an amendment by the superintendent, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly

addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof have been furnished the addressee.

D. Every foreign or alien society authorized to do business in this state shall file with the superintendent a duly certified copy of all amendments of, or additions to, its laws within ninety days after the enactment of same.

E. Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

History: 1978 Comp., § 59A-44-11, enacted by Laws 1989, ch. 388, § 11.

59A-44-12. Institutions.

A. A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by Paragraph (2) of Subsection A of Section 59A-44-5 NMSA 1978. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement but shall not be allowed as an admitted asset of such society.

B. No society shall own or operate funeral homes or any establishments related to undertaking.

History: 1978 Comp., § 59A-44-12, enacted by Laws 1989, ch. 388, § 12.

59A-44-13. Reinsurance.

A. A domestic society may by a reinsurance agreement cede any individual risk or risks in whole or in part to an insurer, other than to another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the superintendent, but no such society may reinsure substantially all of its insurance in force without the written permission of the superintendent. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed or otherwise becoming effective after the effective date of this act, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

B. Notwithstanding the limitation in Subsection A of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the superintendent under Section 59A-44-14 NMSA 1978.

History: 1978 Comp., § 59A-44-13, enacted by Laws 1989, ch. 388, § 13.

59A-44-14. Consolidations and mergers.

A. A domestic society may consolidate or merge with any other society by complying with the provisions of this section.

B. A domestic society shall file with the superintendent:

(1) a certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(2) a sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the superintendent but not earlier than December 31 next preceding the date of the contract;

(3) a certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each body, or, if the society's laws so permit, by mail; and

(4) evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

C. If the superintendent finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the superintendent shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the superintendent of this state, or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the superintendent of such state or territory and a certificate of such approval filed with the superintendent. In case such contract is not approved it shall be inoperative, and the fact of submission and its contents shall not be disclosed by the superintendent.

D. Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging, shall be vested in the society resulting from or remaining after the consolidation or

merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

E. The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

History: 1978 Comp., § 59A-44-14, enacted by Laws 1989, ch. 388, § 14.

59A-44-15. Conversion of society into a mutual life insurance company.

Any society may be converted and licensed as a mutual or stock life insurance company by compliance with all the requirements of the general insurance laws pertaining to such life insurers. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect unless and until approved by the superintendent who may give such approval if he finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificateholders of the society.

History: 1978 Comp., § 59A-44-15, enacted by Laws 1989, ch. 388, § 15.

59A-44-16. Benefits.

A. A society authorized to do business in this state may provide the following contractual benefits in any form:

(1) life insurance, endowment benefits and annuity benefits as defined in Section 59A-7-2 NMSA 1978;

(2) health insurance benefits as defined in Section 59A-7-3 NMSA 1978;

(3) monument or tombstone benefits to the memory of deceased members; and

(4) such other benefits as authorized for life, accident and health insurers and which are not inconsistent with Chapter 59A, Article 44 NMSA 1978, as approved by the superintendent.

B. A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in Subsection A of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person having an insurable interest as defined in Section 59A-18-4 NMSA 1978.

History: 1978 Comp., § 59A-44-16, enacted by Laws 1989, ch. 388, § 16.

59A-44-17. Beneficiaries.

A. The owner of a certificate shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the certificate.

B. A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed the sum of one thousand dollars ($1,000).

C. If, at the death of any person insured under a certificate, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the estate of the deceased insured the same as other property not exempt, provided, however, that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

History: 1978 Comp., § 59A-44-17, enacted by Laws 1989, ch. 388, § 17.

59A-44-18. Benefits not attachable.

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary or any other person who may have a right thereunder, either before or after payment by the society.

History: 1978 Comp., § 59A-44-18, enacted by Laws 1989, ch. 388, § 18.

59A-44-19. The benefit contract.

A. Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

B. Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

C. Any person upon whose life a certificate is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

D. A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body shall require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either:

(1) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(2) in lieu of or in combination with the provisions of Paragraph (1) of this subsection, the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

E. Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

F. No certificate shall be delivered or issued for delivery in this state unless a copy of the form and rates and rate increases applicable to accident and health insurance have been filed with and approved by the superintendent in accordance with Sections 59A-18-12, 59A-18-13 and 59A-18-14 NMSA 1978. Every life or accident and health

insurance certificate and every annuity certificate issued on or after one year from the effective date of this act shall meet the standard contract provision requirements consistent with Chapter 59A, Article 44 NMSA 1978, as specified in Chapter 59A, Articles 20 and 22 NMSA 1978, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

G. Certificates issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

H. A society may specify the terms and conditions on which certificates may be assigned.

History: 1978 Comp., § 59A-44-19, enacted by Laws 1989, ch. 388, § 19.

59A-44-20. Nonforfeiture benefits; cash surrender values; certificate loans and other options.

A. For certificates issued prior to one year after the effective date of this act, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to the effective date of this act.

B. For certificates issued on or after one year from the effective date of this act for which reserves are computed on the commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial table, the commissioner's 1958 standard ordinary mortality table, or the commissioner's 1980 standard mortality table or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

History: 1978 Comp., § 59A-44-20, enacted by Laws 1989, ch. 388, § 20.

59A-44-21. Investments.

A society shall invest its funds only in such investments as are authorized by Chapter 59A, Article 9 NMSA 1978 for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

History: 1978 Comp., § 59A-44-21, enacted by Laws 1989, ch. 388, § 21.

59A-44-22. Funds.

A. All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

B. A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

C. A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which Subsections B and D of Section 59A-44-19 NMSA 1978 shall not apply.

History: 1978 Comp., § 59A-44-22, enacted by Laws 1989, ch. 388, § 22.

59A-44-23. Exemptions.

Except as herein provided, societies shall be governed by Chapter 59A, Article 44 NMSA 1978 and shall be exempt from all other provisions of the insurance laws of this state unless they are expressly designated therein, or unless it is specifically made applicable by that article.

History: 1978 Comp., § 59A-44-23, enacted by Laws 1989, ch. 388, § 23.

59A-44-24. Taxation.

Every society organized or licensed under Chapter 59A, Article 44 NMSA 1978 is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate and office equipment.

History: 1978 Comp., § 59A-44-24, enacted by Laws 1989, ch. 388, § 24.

59A-44-25. Valuation.

A. Standards of valuation for certificates issued prior to one year after the effective date of this act shall be those provided by the laws applicable immediately prior to the effective date of this act.

B. The minimum standards of valuation for certificates issued on or after one year from the effective date of this act shall be based on the following tables:

(1) for certificates of life insurance, the commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial mortality table, the commissioner's 1958 standard ordinary mortality table, the commissioner's 1980 standard ordinary mortality table or any more recent table made applicable to life insurers; and

(2) for annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancelable accident and health benefits, such tables as are authorized for use by life insurers in this state.

Paragraphs (1) and (2) of this subsection shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

C. The superintendent may in his discretion accept other standards for valuation if the superintendent finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The superintendent may in his discretion vary the standards of mortality applicable to all benefit contracts on substandard lives or other extrahazardous lives by any society authorized to do business in this state.

D. Any society, with the consent of the superintendent of the state of domicile of the society, and under such conditions, if any, which the superintendent may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

History: 1978 Comp., § 59A-44-25, enacted by Laws 1989, ch. 388, § 25.

59A-44-26. Reports.

Reports shall be filed in accordance with the provisions of this section as follows:

A. every society transacting business in this state shall annually, on or before the first day of March, unless for cause shown such time has been extended by the superintendent, file with the superintendent a true statement of its financial condition, transactions and affairs for the preceding calendar year and pay the fee specified in Section 59A-14-36 [59A-44-36] NMSA 1978. The statement shall be in general form and context as approved by the national association of insurance commissioners for fraternal benefit societies and as supplemented by additional information required by the superintendent;

B. as part of the annual statement herein required, each society shall, on or before the first day of March, file with the superintendent a valuation of its certificates in force on December 31 last preceding, provided the superintendent may in his discretion for cause shown extend the time for filing such valuation for not more than two calendar months. Such valuation shall be done in accordance with the standards specified in Section 59A-44-25 NMSA 1978. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society; and

C. a society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred dollars ($100) for each day during which such neglect continues, and, upon notice by the superintendent to that effect, its authority to do business in this state shall cease while such default continues.

History: 1978 Comp., § 59A-44-26, enacted by Laws 1989, ch. 388, § 26.

59A-44-27. Certificates of authority.

Societies which are now authorized to transact business in this state may continue such business until March 1 next succeeding the effective date of this act. The authority of such societies and all societies thereafter licensed shall continue in force as long as the society is entitled thereto under that article and until suspended or revoked by the superintendent or terminated at the society's request; subject, however, to the payment of the annual continuation fee specified in Section 59A-44-36 NMSA 1978. A duly certified copy or duplicate of such certificate of authority shall be prima facie evidence that such society is a fraternal benefit society within the meaning of Chapter 59A, Article 44 NMSA 1978.

History: 1978 Comp., § 59A-44-27, enacted by Laws 1989, ch. 388, § 27.

59A-44-28. Examination of societies; no adverse publications.

A. The superintendent, or any person he may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in Section 59A-4-10 NMSA 1978 shall be applicable to the examination of societies.

B. The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined for whose certificates are valued, upon statements furnished by the superintendent.

History: 1978 Comp., § 59A-44-28, enacted by Laws 1989, ch. 388, § 28.

59A-44-29. Foreign or alien society.

A. No foreign or alien society shall transact business in this state without a license issued by the superintendent. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of Chapter 59A, Article 44 NMSA 1978 applicable to domestic societies. Any such society may be licensed to transact business in this state upon filing with the superintendent:

(1) a duly certified copy of its articles of incorporation;

(2) a copy of its bylaws, certified by its secretary or corresponding officer;

(3) a power of attorney to the superintendent as prescribed in Section 59A-44-35 NMSA 1978;

(4) a statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the superintendent, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the superintendent of this state;

(5) certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

(6) copies of its certificate forms and accident and health rates; and

(7) such other information as the superintendent may deem necessary; and upon a showing that its assets are invested in accordance with the provisions of Chapter 59A, Article 44 NMSA 1978.

B. Any foreign or alien society desiring admission to this state shall have the qualifications required of domestic societies organized under Chapter 59A, Article 44 NMSA 1978.

History: 1978 Comp., § 59A-44-29, enacted by Laws 1989, ch. 388, § 29.

59A-44-30. Injunction; liquidation; receivership of domestic society.

A. When the superintendent upon investigation finds that a domestic society:

(1) has exceeded its powers;

(2) has failed to comply with any provision of Chapter 59A, Article 44 NMSA 1978;

(3) is not fulfilling its contracts in good faith;

(4) has a membership of less than four hundred after an existence of one year or more; or

(5) is conducting business in a fraudulent manner or in a manner hazardous to its members, creditors, the public or the business;

the superintendent shall notify the society of any deficiency and state in writing the reasons for his dissatisfaction. The superintendent shall at once issue a written notice to the society requiring that any deficiency that exists be corrected. After such notice the society shall have a thirty-day period in which to comply with the superintendent's request for correction, and if the society fails to comply, the superintendent shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

B. If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the superintendent may present the facts relating thereto to the attorney general who shall, if he deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

C. The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until:

(1) the superintendent finds that the violation complained of has been corrected;

(2) the costs of such action shall have been paid by the society if the court finds that the society was in default as charged;

(3) the court has dissolved its injunction; and

(4) the superintendent has reinstated the certificate of authority.

D. If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

E. No action under this section shall be recognized in any court of this state unless brought by the attorney general upon request of the superintendent. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the superintendent as such receiver.

F. The provisions of this section relating to hearing by the superintendent, action by the attorney general at the request of the superintendent, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

History: 1978 Comp., § 59A-44-30, enacted by Laws 1989, ch. 388, § 30.

59A-44-31. Suspension, revocation or refusal of license of foreign or alien society.

A. When the superintendent upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

(1) has exceeded its powers;

(2) has failed to comply with any of the provisions of Chapter 59A, Article 44 NMSA 1978;

(3) is not fulfilling its contracts in good faith; or

(4) is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public,

the superintendent shall notify the society of any deficiency and state in writing the reasons for his dissatisfaction. The superintendent shall at once issue a written notice to the society requiring that any deficiency that exists be corrected. After such notice the society shall have a thirty-day period in which to comply with the superintendent's request for correction, and if the society fails to comply the superintendent shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do

business in this state should not be suspended, revoked or refused, the superintendent may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the superintendent that such suspension or refusal should be withdrawn or the superintendent may revoke the authority of the society to do business in this state.

B. Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business therein.

History: 1978 Comp., § 59A-44-31, enacted by Laws 1989, ch. 388, § 31.

59A-44-32. Injunction.

No application or petition for injunction against any domestic, foreign or alien society, or lodge thereof, shall be recognized in any court of this state unless made by the attorney general upon request of the superintendent.

History: 1978 Comp., § 59A-44-32, enacted by Laws 1989, ch. 388, § 32.

59A-44-33. Licensing of agents.

A. Agents of societies shall be licensed in accordance with the applicable provisions of Chapter 59A, Articles 11 and 12 NMSA 1978 regulating the licensing, revocation, suspension or termination of license of agents, but shall not be subject to the provisions of Section 59A-12-26 NMSA 1978.

B. No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes or intends to devote fifty percent or more of his services to activities other than the solicitation of fraternal insurance contracts from the public and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

C. Any person who in the preceding calendar year has solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of fifty thousand dollars ($50,000) or, in the case of any other kind of insurance that the society might write, on the persons of more than twenty-five individuals and who has received or will receive a commission or other compensation therefor shall be presumed to be devoting or intending to devote fifty percent of his time to the solicitation or procurement of insurance contracts for such society.

History: 1978 Comp., § 59A-44-33, enacted by Laws 1989, ch. 388, § 33; 1991, ch. 169, § 1; 1999, ch. 272, § 22; 1999, ch. 289, § 32.

59A-44-34. Unfair methods of competition and unfair and deceptive acts and practices.

Every society authorized to do business in this state shall be subject to the provisions of Chapter 59A, Article 16 NMSA 1978 relating to trade practices and frauds; provided, however, that nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation.

History: 1978 Comp., § 59A-44-34, enacted by Laws 1989, ch. 388, § 34.

59A-44-35. Service of process.

A. Every society authorized to do business in this state shall appoint in writing the superintendent and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served and shall agree in such writing that any lawful process against it which is served on said attorney shall be the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of such appointment, certified by said superintendent, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

B. Service shall only be made upon the superintendent, or if absent, upon the person in charge of the superintendent's office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the superintendent, the superintendent shall forthwith forward one of the duplicate copies by registered mail, prepaid, directed to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than thirty days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided. At the time of serving any process upon the superintendent, the plaintiff or complainant in the action shall pay to the superintendent a fee of ten dollars ($10.00).

History: 1978 Comp., § 59A-44-35, enacted by Laws 1989, ch. 388, § 35.

59A-44-36. Fee schedule.

A. Except as provided in Subsection B of this section, every society authorized to transact business in New Mexico shall pay to the superintendent the following fees:

(1) for annual certificate of authority continuation $100.00;

(2) for filing annual statement 100.00;

(3) for each license of agent or annual continuation thereof 30.00;

(4) for annual continuation of appointment 20.00;

and

(5) for each signature of the superintendent affixed to any instrument 10.00.

B. Every society which:

(1) issues certificates providing benefits strictly in accordance with the provisions of Chapter 59A, Article 44 NMSA 1978;

(2) limits its membership to members of one religious faith or to persons engaged in one or more hazardous occupations in the same or similar lines of business;

(3) does not employ paid solicitors or salesmen either on salary, commission or fee basis for procuring new insurance or members; and

(4) does not solicit insurance applications from the general public, but limits such solicitation to members in good standing in such society; shall be exempt from the fees specified in Subsection A of this section and in lieu thereof shall pay to the superintendent fees as follows:

(a) for annual license to transact business $50.00;

(b) for filing annual statement 50.00;

and

(c) for each seal and signature of the superintendent affixed to any instrument 10.00.

C. Failure to pay any fees imposed under Chapter 59A, Article 44 NMSA 1978 shall render the society liable to this state for the amount thereof and to the applicable penalties provided by Section 59A-6-4 NMSA 1978 as though such a society were an insurer.

History: 1978 Comp., § 59A-44-36, enacted by Laws 1989, ch. 388, § 36; 1993, ch. 320, § 102.

59A-44-37. Carrie Tingley crippled children's hospital fund.

The superintendent shall pay to the state treasurer, and the state treasurer shall convert into the fund of the Carrie Tingley crippled children's hospital, located in

Bernalillo county, all money collected by the superintendent from or as to fraternal benefit societies under Chapter 59A, Article 44 NMSA 1978.

History: 1978 Comp., § 59A-44-37, enacted by Laws 1989, ch. 388, § 37.

59A-44-38. Review.

All decisions and findings of the superintendent made under the provisions of Chapter 59A, Article 44 NMSA 1978 shall be subject to review as provided in Section 59A-4-20 NMSA 1978.

History: 1978 Comp., § 59A-44-38, enacted by Laws 1989, ch. 388, § 38.

59A-44-39. Penalties.

A. Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society, shall upon conviction be fined not less than one hundred dollars ($100) or more than one thousand dollars ($1,000).

B. Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by Chapter 59A, Article 44 NMSA 1978, or of any material fact or thing contained in a sworn statement concerning the death or disability of a member for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

C. Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall upon conviction be fined not less than one hundred dollars ($100) or more than five hundred dollars ($500).

D. Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of Chapter 59A, Article 44 NMSA 1978 for which a penalty is not otherwise prescribed shall upon conviction be subject to a fine not to exceed one thousand dollars ($1,000).

History: 1978 Comp., § 59A-44-39, enacted by Laws 1989, ch. 388, § 39.

59A-44-40. Exemption of certain societies.

A. Nothing contained in Chapter 59A, Article 44 NMSA 1978 shall be so construed as to effect or apply to:

(1) grand or subordinate lodges of societies, orders or associations now doing business in this state that provide benefits exclusively through local or subordinate lodges;

(2) orders, societies or associations that admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families and the ladies' societies or ladies' auxiliaries to such orders, societies or associations;

(3) domestic societies that limit their membership to employees of a particular city or town, designated firm, business house or corporation or that provide for a death benefit of not more than four hundred dollars ($400) or disability benefits of not more than three hundred dollars ($300) to any person in any one year, or both; or

(4) domestic societies or associations of a purely religious, charitable or benevolent description, that provide for a death benefit of not more than four hundred dollars ($400) or for disability benefits of not more than three hundred fifty dollars ($350) to any one person in any one year, or both.

B. Any such society or association described in Paragraph (3) or (4) of Subsection A of this section that provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in Paragraph (4) of Subsection A of this section that has more than one thousand members, shall not be exempted from the provisions of Chapter 59A, Article 44 NMSA 1978 but shall comply with all requirements thereof.

C. No society which, by the provisions of this section, is exempt from the requirements of Chapter 59A, Article 44 NMSA 1978, except any society described in Paragraph (2) of Subsection A of this section, shall give or allow, or promise to give or allow, to any person any compensation for procuring new members.

D. Every society that provides for benefits in case of death or disability resulting solely from accident and that does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of Chapter 59A, Article 44 NMSA 1978 except that the provisions thereof relating to medical examination, valuations of benefit certificates and incontestability, shall not apply to such society.

E. The superintendent may require from any society or association, by examination or otherwise, such information as will enable the superintendent to determine whether such society or association is exempt from the provisions of Chapter 59A, Article 44 NMSA 1978.

F. Societies exempted under the provisions of this section shall also be exempt from all other provisions of the general insurance laws of this state.

History: 1978 Comp., § 59A-44-40, enacted by Laws 1989, ch. 388, § 40.

59A-44-41. Applicability of Insurance Code.

To the extent not in conflict with the express provisions of Chapter 59A, Article 44 NMSA 1978 and the reasonable implications thereof, the following provisions of the Insurance Code [Chapter 59A NMSA 1978] shall also apply as to fraternal benefit societies, and for such purpose a society 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. Sections 59A-8-1 and 59A-8-2 NMSA 1978;

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

F. the Insurance Fraud Act [Chapter 59A, Article 16C NMSA 1978];

G. Chapter 59A, Article 18 NMSA 1978;

H. the Policy Language Simplification Law [Chapter 59A, Article 19 NMSA 1978];

I. the Medicare Supplement Act [Chapter 59A, Article 24A NMSA 1978];

J. Chapter 59A, Articles 20 and 22 NMSA 1978; and

K. the Insurers Conservation, Rehabilitation and Liquidation Law [Chapter 59A, Article 41 NMSA 1978].

History: 1978 Comp., § 59A-44-41, enacted by Laws 1989, ch. 388, § 41; 1999, ch. 289, § 33; 2001, ch. 297, § 4.

59A-44-42. Severability.

If any provision of Chapter 59A, Article 44 NMSA 1978 or the application of such provision to any circumstance is held invalid, the remainder of the article or the application of the provision to other circumstances shall not be affected thereby.

History: 1978 Comp., § 59A-44-42, enacted by Laws 1989, ch. 388, § 42.

59A-44-43 to 59A-44-45. Repealed.

59A-44-46. Fraternal benefit societies; certificate provisions relating to individuals who are eligible for medical benefits under the medicaid program.

A. Each individual or group policy or certificate of accident or health insurance issued by a society that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy or certificate to be paid to the human services department [health care authority department] when:

(1) the human services department [health care authority department] has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;

(2) payment for the services in question has been made by the human services department [health care authority department] to the medicaid provider; and

(3) the society is notified that the insured individual receives benefits under the medicaid program and that benefits must be paid directly to the human services department [health care authority department].

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the human services department [health care authority department] for insurance benefits when the claim is first submitted by the human services department [health care authority department] to the society.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any individual or group policy or certificate of accident or health insurance for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy or certificate shall be made payable to the provider. The society may be notified that the insured individual is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the society.

D. No individual or group policy or certificate of accident or health insurance issued by a society that is delivered, issued for delivery or renewed in this state on or after the effective date of this section shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state.

History: 1978 Comp., § 59A-44-46, enacted by Laws 1989, ch. 183, § 5.

ARTICLE 45
Premium Financing

59A-45-1. Short title.

This article [Chapter 59A, Article 45 NMSA 1978] may be cited as the "Insurance Premium Financing Law".

History: Laws 1984, ch. 127, § 831.

59A-45-2. Definitions.

As used in this article:

A. "person" means any individual, corporation, association, partnership or any other legal entity;

B. "insurance policy" or "insurance contract" means any contract of insurance, indemnity, medical or hospital services, suretyship or annuity issued, proposed for issuance or intended for issuance by any person;

C. "insurance premium finance agreement" means an agreement by which an insured or a prospective insured promises to pay to any person engaged in the business of premium financing, the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent or broker in payment of premiums on an insurance contract; and

D. "insurance premium finance company" means a person engaged in the business of entering into insurance premium finance agreements.

History: Laws 1984, ch. 127, § 832.

59A-45-3. Licensing requirements.

A. No person shall engage in the business of financing insurance premiums in this state without first having obtained an insurance premium financing license from the superintendent.

B. The annual license fee shall be as stated in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code. Licenses may be renewed from year to year as of the first day of May of each year upon payment of the fee specified in such Section 101.

C. Licensing procedures and requirements shall be established by the superintendent by rule and regulation.

History: Laws 1984, ch. 127, § 833.

59A-45-4. Bonding requirements for licensees.

A. Prior to the issuance of an insurance premium financing license, the applicant shall file with the superintendent a surety bond or a bank certificate of deposit in favor of the superintendent in a total aggregate amount of not less than ten thousand dollars ($10,000), conditioned to pay the actual damages resulting to the state, to any policyholder or to any member of the public from violation by the licensee of the provisions of this article. The bond shall be executed by a surety insurer authorized to do business in this state. The certificate of deposit shall be issued from a bank licensed to do business in this state.

B. Bonds and certificates of deposit shall remain in effect during the term of the license. Without prejudice to any liability accrued prior to a cancellation, sureties may cancel their bonds by giving written notice to the superintendent at least thirty (30) days prior to the effective date of the cancellation.

C. The superintendent may increase the required amount of the bond or certificate of deposit according to a business volume scale which shall be established by the superintendent through rule or regulation.

History: Laws 1984, ch. 127, § 834.

59A-45-5. Exemptions.

A. The provisions of this article shall not limit the authority of the following institutions to engage in insurance premium financing or apply to:

(1) any life insurer authorized to do business in the state;

(2) any national banking institution;

(3) any state bank;

(4) any savings and loan association;

(5) any small loan company; or

(6) any credit union.

B. The licensing and bonding provisions of this article shall not apply to:

(1) any insurer, other than those exempt from this article pursuant to Paragraph A(1); and

(2) any insurance agent licensed by this state.

C. This article shall not apply to the financing of insurance premiums in connection with a transaction under the Motor Vehicle Sales Finance Act [58-19-1 to 58-19-12 NMSA 1978], or under Sections 56-1-1 to 56-1-15 NMSA 1978.

History: Laws 1984, ch. 127, § 835.

59A-45-6. Books and records.

A. Every person engaged in the business of financing insurance premiums shall maintain records of his premium finance transactions and the records shall be open to examination and investigation by the superintendent. The superintendent may at any time require any such persons to bring such records as he may direct to the superintendent's office for examination.

B. Every person who is engaged in the business of financing insurance premiums shall preserve his records of premium finance transactions, including cards used in a card system, for at least three (3) years after making the final entry in respect to any premium finance agreement. The preservation of records in photographic forms shall constitute compliance with this requirement.

History: Laws 1984, ch. 127, § 836.

59A-45-7. Form of premium finance agreement.

A premium finance agreement shall:

A. comply with all existing federal laws;

B. comply with any requirements established by the superintendent by way of rule or regulation; and

C. contain a statement that the Insurance Premium Financing Law does not require a person to enter into an insurance premium financing agreement as a condition of the purchase of any insurance policy.

History: Laws 1984, ch. 127, § 837.

59A-45-8. Additional requirements.

The following additional provisions shall be applicable to an insurance premium finance agreement:

A. a premium finance company shall not charge, contract for, receive or collect a rate other than permitted pursuant to this article;

B. the rate is to be computed on the balance of the premium due, after subtracting the down payment made by the insured in accordance with the premium finance agreement, from the effective date of the insurance coverage for which premiums are being advanced, to and including the date when the final installment of the premium finance agreement is payable;

C. nothing contained in this article shall limit or restrict the manner of calculating the interest charges whether by way of add-on, discount, simple annual rate or otherwise, so long as the rate of interest charge does not exceed that permitted pursuant to this article. If the loan is a precomputed loan transaction:

(1) the interest charge may be calculated on the assumption that all scheduled payments will be made when due; and

(2) the effect of prepayment is governed by the provisions on rebate upon prepayment in this section;

D. if the entire unpaid balance outstanding on a precomputed loan transaction is paid by cash, renewal or otherwise, at any time prior to maturity, the premium finance company shall give a refund or credit of the unearned portion of such charge, according to the rule commonly known as "the rule of 78's", which refund or credit shall represent at least as great a portion of the original charge as the sum of the consecutive balances of the contract scheduled to be outstanding after the date of prepayment bears to the sum of all the consecutive monthly balances of the contract scheduled to be outstanding under the schedule of payments in the original instrument or instruments evidencing the loan; except, that if the contract is prepaid in cash rather than renewed or refinanced, the premium finance company shall not be required to make a refund or credit if the amount, computed as herein set forth, would be less than one dollar ($1) for each loan prior to the maturity;

E. in precomputed loan transactions where the insurer and the premium finance company execute an extension agreement for the deferral of an installment payment, the premium finance company may make an interest charge on the monthly installment that is deferred at a rate not exceeding one percent per month for each month or portion thereof that the payment has been deferred; and

F. for repayment in greater or lesser periods or amounts, or in unequal, irregular or other than monthly installment, the rate may be computed at an equivalent effective rate having due regard for the installments as scheduled.

History: Laws 1984, ch. 127, § 839.

59A-45-9. Assignee subject to defenses.

An assignee of the rights of a creditor under an insurance premium finance agreement, for the purchase of insurance primarily for personal, family or household

purposes, is a holder within the meaning of the Uniform Commercial Code (55-1-101 to 55-9-507 NMSA 1978) and is subject to all defenses of the insured notwithstanding that there is an agreement to the contrary.

History: Laws 1984, ch. 127, § 840.

59A-45-10. Delinquency charges.

A premium finance agreement may provide for the payment by the insured of a delinquency charge on each installment in default for a period of more than ten days and in an amount not to exceed five percent of each installment, or five dollars ($5.00), whichever is less, or in lieu thereof, interest after maturity of each such installment not to exceed the highest lawful contract rate; except that with respect to agreements financing coverages for other than personal, family or household purposes, the delinquency charge shall be an amount equal to five percent of the unpaid installment, but in no event more than five hundred dollars ($500). In addition, such contract may provide for the payment of an attorney's reasonable fee, where it is referred for collection to an attorney not a salaried employee of the person to whom the installment payment is due, and for court costs and disbursements.

History: Laws 1984, ch. 127, § 841; 1999, ch. 75, § 1.

59A-45-11. Cancellation of insurance contract upon default.

A. When a premium finance agreement contains a power of attorney enabling the premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be cancelled by the premium finance company unless such cancellation is made in accordance with this article.

B. Not less than ten (10) days written notice shall be mailed to the insured of the intent of the premium finance company to cancel the insurance contract unless the default is cured within the ten-day period.

C. After expiration of the ten-day period, the premium finance company may thereafter request, in the name of the insured, cancellation of such insurance contract or contracts by mailing to the insurer or its licensed agent a notice of cancellation, and the insurance contract shall be cancelled as if such notice of cancellation had been submitted by the insured himself, but without requiring the return of the insurance contract or contracts. The premium finance company shall also mail a notice of cancellation to the insured at his last known address.

D. All statutory, regulatory and contractual restrictions providing that the insurance contract may not be given to a governmental agency, mortgagee or other third party, shall apply where cancellation is made under this section. The insurer or its licensed agent shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee or other third party on or before the tenth (10) [10th]

business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation, taking into consideration the number of days' notice required to complete the cancellation.

E. Whenever an insurance contract is cancelled in accordance with this section, the insurer or its licensed agent shall return whatever gross unearned premiums are due under the insurance contract to the premium finance company effecting the cancellation for the account of the insured or insureds.

F. In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund such excess to the insured provided that no such refund shall be required if it amounts to less than one dollar ($1).

History: Laws 1984, ch. 127, § 842.

59A-45-12. Exemption from any filing requirement.

No filing of the premium finance agreement shall be necessary to perfect the validity of such agreement as a secured transaction as against creditors, subsequent purchasers, pledges and encumbrances, successor or assigns.

History: Laws 1984, ch. 127, § 843.

59A-45-13. Revocation and suspension of licenses.

A. The superintendent may revoke or suspend the insurance premium financing license of any person when after investigation it appears to the superintendent that:

(1) any license issued to such person was obtained by fraud;

(2) there was any misrepresentation in the application of the license;

(3) the holder of such license has otherwise shown himself untrustworthy or incompetent to act as a premium finance company;

(4) such person has violated any of the provisions of this article; or

(5) such person has been rebating part of any valid service charge to an insurance agent, his employee or to any other person as an inducement to the financing of any insurance policy.

B. The procedures for revocation and suspension of licenses shall be established by the superintendent through rule and regulation.

History: Laws 1984, ch. 127, § 844.

59A-45-14. Cease and desist order from the superintendent.

Upon a determination by hearing that a person has violated any provision of this article or any rules or regulations adopted thereunder, the superintendent may issue an order requiring the person to cease and desist from engaging in such violation. If the alleged violator fails to comply with the cease and desist order from the superintendent, the superintendent shall bring action for injunction in the district court in the county of Santa Fe.

History: Laws 1984, ch. 127, § 845.

59A-45-15. Civil penalties.

In addition to any penalties imposed pursuant to Sections 844 or 845 [59A-45-13 or 59A-45-14 NMSA 1978] of this article, the district court may, in an action filed by the superintendent, impose the following civil penalties:

A. for each violation of this article a penalty of not more than one thousand dollars ($1,000) but not to exceed an aggregate penalty of ten thousand dollars ($10,000) in any six-month period; and

B. for each violation of an order issued by the superintendent pursuant to Section 845 of this article, a penalty of not more than ten thousand dollars ($10,000).

History: Laws 1984, ch. 127, § 846.

59A-45-16. Other code provisions applicable.

The following additional articles and provisions of the Insurance Code shall also apply, as applicable, to insurance premium finance companies and their operations:

A. Article 1 [Chapter 59A, Article 1 NMSA 1978] (scope of code, initial definitions, general penalty);

B. Article 2 [Chapter 59A, Article 2 NMSA 1978] (department of insurance);

C. Article 4 [Chapter 59A, Article 4 NMSA 1978] (examination, hearings and appeals);

D. Article 10 [Chapter 59A, Article 10 NMSA 1978] (administration of deposits);

E. Article 16 [Chapter 59A, Article 16 NMSA 1978] (trade practices and frauds); and

F. Article 53 [not codified] (transitory provisions).

History: Laws 1984, ch. 127, § 847.

ARTICLE 46
Health Maintenance Organizations

59A-46-1. Short title.

Chapter 59A, Article 46 NMSA 1978 may be cited as the "Health Maintenance Organization Law".

History: Laws 1984, ch. 127, § 848; 1993, ch. 266, § 1.

59A-46-2. Definitions.

As used in the Health Maintenance Organization Law:

A. "basic health care services" means medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, diagnostic and therapeutic radiological services and services of pharmacists and pharmacist clinicians;

B. "capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided and includes the cost associated with operating staff model facilities;

C. "carrier" means a health maintenance organization, an insurer, a nonprofit health care plan or other entity responsible for the payment of benefits or provision of services under a group contract;

D. "copayment" means an amount an enrollee must pay in order to receive a specific service that is not fully prepaid;

E. "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider;

F. "deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment;

G. "direct services" means services rendered to an individual by a carrier or a health care practitioner, facility or other provider, which services include case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any proportion of an assessment that covers services rather than administration and for which a carrier does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided that "direct services" does not

include care coordination, utilization review or management or any other activity designed to manage utilization or services;

H. "enrollee" means an individual who is covered by a health maintenance organization;

I. "evidence of coverage" means a policy, contract or certificate showing the essential features and services of the health maintenance organization coverage that is given to the subscriber by the health maintenance organization or by the group contract holder;

J. "extension of benefits" means the continuation of coverage under a particular benefit provided under a contract or group contract following termination with respect to an enrollee who is totally disabled on the date of termination;

K. "grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee;

L. "group contract" means a contract for health care services that by its terms limits eligibility to members of a specified group and may include coverage for dependents;

M. "group contract holder" means the person to whom a group contract has been issued;

N. "health care services" means any services included in the furnishing to any individual of medical, mental, dental, pharmaceutical or optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human physical or mental illness or injury;

O. "health maintenance organization" means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles, including a carrier that issues:

(1) a short-term contract;

(2) an excepted benefit policy or contract intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies; or

(3) a policy for long-term care or disability income;

P. "health maintenance organization agent" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for health maintenance organization membership or who takes or transmits a membership fee or premium for such a policy or contract, other than for that person, or a person who advertises or otherwise makes any representation to the public as such;

Q. "individual contract" means a contract for health care services issued to and covering an individual and it may include dependents of the subscriber;

R. "insolvent" or "insolvency" means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction;

S. "managed hospital payment basis" means agreements in which the financial risk is related primarily to the degree of utilization rather than to the cost of services;

T. "net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt;

U. "participating provider" means a provider as defined in Subsection Z of this section that, under an express contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization;

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

W. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act;

X. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act;

Y. "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 carriers and interests less any premium tax paid pursuant to Section 59A-6-2 NMSA 1978 and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance;

Z. "provider" means a physician, pharmacist, pharmacist clinician, hospital or other person licensed or otherwise authorized to furnish health care services;

AA. "replacement coverage" means the benefits provided by a succeeding carrier;

BB. "short-term contract" means a nonrenewable health maintenance organization contract covering a resident of the state, regardless of where the contract is delivered, that:

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

(2) is issued only to individuals who have not been enrolled in a health maintenance organization contract that provides the same or similar nonrenewable coverage from any carrier within the three months preceding enrollment in the short-term contract;

CC. "subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the person in whose name the contract is issued; and

DD. "uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the superintendent.

History: 1978 Comp., § 59A-46-2, enacted by Laws 1993, ch. 266, § 2; 2007, ch. 244, § 1; 2015, ch. 111, § 3; 2019, ch. 235, § 10; 2019, ch. 259, § 17.

59A-46-3. Establishment of health maintenance organizations.

A. Notwithstanding any law of this state to the contrary, any person may apply to the superintendent for a certificate of authority to establish and operate a health maintenance organization in compliance with Chapter 59A, Article 46 NMSA 1978. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority under Chapter 59A, Article 46 NMSA 1978. A foreign corporation may qualify under Chapter 59A, Article 46 NMSA 1978, subject to its registration to do business in this state as a foreign corporation pursuant to Chapter 53, Article 17 NMSA 1978 and compliance with all provisions of Chapter 59A, Article 46 NMSA 1978 and other applicable state laws.

B. Any health maintenance organization that has not previously received a certificate of authority to operate as a health maintenance organization as of January 1, 1994 shall submit an application for a certificate of authority under Subsection C of this section no later than March 1, 1993. Each such applicant may continue to operate until the superintendent acts upon the application. In the event that an application is denied under Section 59A-46-4 NMSA 1978, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

C. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the superintendent and shall set forth or be accompanied by the following:

(1) a copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto;

(2) a copy of the bylaws, rules and regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses and official positions and biographical information on forms acceptable to the superintendent of the persons who are to be responsible for the conduct of the affairs and day to day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee and the principal officers in the case of a corporation or the partners or members in the case of a partnership or association;

(4) a copy of any contract form made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third party administrators, marketing consultants or persons listed in Paragraph (3) of this subsection and the health maintenance organization;

(5) a copy of the form of evidence of coverage to be issued to the enrollees;

(6) a copy of the form of group contract, if any, to be issued to employers, unions, trustees or other organizations;

(7) financial statements showing the applicant's assets, liabilities and sources of financial support, including both a copy of the applicant's most recent, regular certified financial statement and an unaudited current financial statement;

(8) a financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other person determined by the superintendent to be qualified, a three-year projection of balance sheets, a three-year projection of cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state and income and expense statements anticipated from the start of operations for three years or until the organization has had net income for at least one year, if longer, a description of the proposed method of marketing and a statement of the sources of working capital as well as any other sources of funding;

(9) a power of attorney duly executed by the applicant, if not domiciled in this state, appointing the superintendent, his successors in office and duly authorized deputies as the true and lawful attorney of such applicant in and for this state upon

whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(10) a statement or map reasonably describing the geographic area or areas to be served;

(11) a description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) a description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) a description of the procedures to be implemented to meet the protection against insolvency requirements in Section 59A-46-13 NMSA 1978;

(14) a list of the names, addresses and license numbers of all providers with which the health maintenance organization has agreements; and

(15) such other information as the superintendent may require to make the determinations required in Section 59A-46-4 NMSA 1978.

D. A health maintenance organization shall, unless otherwise provided for in Chapter 59A, Article 46 NMSA 1978, file a notice describing any substantial modification of the operation set out in the information required by Subsection C of this section. Such notice shall be filed with the superintendent prior to the modification. If the superintendent does not disapprove within thirty days of filing, such modification shall be deemed approved.

History: 1978 Comp., § 59A-46-3, enacted by Laws 1993, ch. 266, § 3.

59A-46-4. Issuance of certificate of authority.

A. Upon receipt of an application for issuance of a certificate of authority, the superintendent may transmit copies of such application and accompanying documents to the secretary of health.

B. If requested by the superintendent, the secretary of health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished, has complied with Section 59A-46-7 NMSA 1978.

C. If requested by the superintendent, the secretary of health shall certify to the superintendent, within forty-five days of receipt of the application for issuance of a certificate of authority, that the proposed health maintenance organization meets the

requirements of Section 59A-46-7 NMSA 1978 or notify the superintendent that the health maintenance organization does not meet such requirements and specify in what respects it is deficient.

D. The superintendent shall within forty-five days of receipt of certification or notice of deficiencies from the secretary of health pursuant to Subsection C of this section, or within sixty days of receipt of the application indicated in Subsection A of this section if no request has been made of the secretary of health, issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and upon the superintendent being satisfied that:

(1) the persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) any deficiencies identified by the secretary of health pursuant to Subsection C of this section have been corrected and the secretary of health has certified to the superintendent that the health maintenance organization's proposed plan of operation meets the requirements of Section 59A-46-7 NMSA 1978;

(3) the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles, or both; and

(4) the health maintenance organization is in compliance with Sections 59A-46-13 and 59A-46-15 NMSA 1978 [repealed].

E. A certificate of authority shall be denied only after the superintendent complies with the requirements of Section 59A-46-20 NMSA 1978.

History: 1978 Comp., § 59A-46-4, enacted by Laws 1993, ch. 266, § 4.

59A-46-5. Powers of health maintenance organizations.

A. The powers of a health maintenance organization include, but are not limited to, the following:

(1) the purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(2) transactions between or among affiliated entities, including loans and the transfer of responsibility under all contracts, including without limitation provider and subscriber contracts between or among affiliates or between the health maintenance organization and its parent;

(3) the furnishing of health care services through providers, provider associations or agents for providers that are under contract with or employed by the health maintenance organization;

(4) the contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(5) the contracting with an authorized insurer in this state for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) the offering of other health care services, in addition to basic health care services; and

(7) the joint marketing of products with an insurer authorized to do business in this state as long as the company that is offering each product is clearly identified.

B. A health maintenance organization shall file notice, with adequate supporting information, with the superintendent prior to the exercise of any power granted in Paragraph (1), (2) or (4) of Subsection A of this section that may affect the financial soundness of the health maintenance organization. The superintendent shall disapprove such exercise of power only if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the superintendent does not disapprove within thirty days of the filing, it shall be deemed approved, but the superintendent may in his sole discretion postpone the action for an additional thirty days as necessary for proper consideration of the effects of the proposed action.

C. The superintendent may adopt rules and regulations exempting from the filing requirement of Subsection B of this section those activities having a de minimis effect.

History: 1978 Comp., § 59A-46-5, enacted by Laws 1993, ch. 266, § 5.

59A-46-6. Fiduciary responsibilities; fidelity bond.

A. Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the organization shall be responsible for such funds in a fiduciary relationship to the organization.

B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on the employees and officers, directors and partners described in Subsection A of this section in an amount not less than two hundred fifty thousand dollars ($250,000) for each health maintenance organization or a maximum of five million dollars ($5,000,000) in aggregate maintained on behalf of health maintenance

organizations owned by a common parent corporation, or such sum as may be prescribed by the superintendent.

History: 1978 Comp., § 59A-46-6, enacted by Laws 1993, ch. 266, § 6.

59A-46-7. Quality assurance program.

A. A health maintenance organization shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. A health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and non-institutional settings. The program shall include, at a minimum, the following:

(1) a written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) a written quality assurance plan that describes the following:

(a) the health maintenance organization's scope and purpose in quality assurance;

(b) the organizational structure responsible for quality assurance activities;

(c) contractual arrangements, where appropriate, for delegation of quality assurance activities;

(d) confidentiality policies and procedures;

(e) a system of ongoing evaluation activities;

(f) a system of focused evaluation activities;

(g) a system for credentialing providers and performing peer review activities; and

(h) duties and responsibilities of the designated physician responsible for the quality assurance activities;

(3) a written statement describing the system of ongoing quality assurance activities, including:

(a) problem assessment, identification, selection and study;

(b) corrective action, monitoring, evaluation and reassessment; and

(c) interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) a written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

(5) written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

C. A health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available for examination by the superintendent and by the secretary of health if requested by the superintendent but shall not be disclosed to third parties except as permitted by the provisions of Chapter 59A, Article 46 NMSA 1978.

D. A health maintenance organization shall ensure the use and maintenance of an adequate patient record system that will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Except as otherwise restricted or prohibited by state or federal law, enrollee clinical records shall be available to the superintendent or an authorized designee for examination and review to ascertain compliance with this section or as deemed necessary by the superintendent.

F. A health maintenance organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

History: 1978 Comp., § 59A-46-7, enacted by Laws 1993, ch. 266, § 7.

59A-46-8. Requirements for group contract, individual contract and evidence of coverage.

A. Every group and individual contract holder is entitled to a group or individual contract. The contract shall not contain provisions or statements that are unjust, unfair,

inequitable, misleading, deceptive or that encourage misrepresentation as described in Section 59A-16-4 NMSA 1978. The contract shall contain a clear statement of the following:

(1) name and address of the health maintenance organization;

(2) eligibility requirements;

(3) benefits and services within the service area;

(4) emergency care benefits and services;

(5) out-of-area benefits and services, if any;

(6) copayments, deductibles or other out-of-pocket expenses;

(7) limitations and exclusions;

(8) enrollee termination;

(9) enrollee reinstatement, if any;

(10) claims procedures;

(11) enrollee grievance procedures;

(12) continuation of coverage;

(13) conversion;

(14) extension of benefits, if any;

(15) coordination of benefits, if applicable;

(16) subrogation, if any;

(17) description of the service area;

(18) entire contract provision;

(19) term of coverage;

(20) cancellation of group or individual contract holder;

(21) renewal;

(22) reinstatement of group or individual contract holder, if any;

(23) grace period; and

(24) conformity with state law.

B. An evidence of coverage may be filed as part of the group contract to describe the provisions required in Paragraphs (1) through (17) and (20) of Subsection A of this section.

C. In addition to those provisions required in Paragraphs (1) through (24) of Subsection A of this section, an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded. If services were received during the ten-day period, and the person returns the contract to receive a refund of the premium paid, he or she must pay for such services.

D. Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization. The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive or that encourage misrepresentation as described in Section 59A-16-4 NMSA 1978. The evidence of coverage shall contain a clear statement of the provisions required in Paragraphs (1) through (17) and (20) of Subsection A of this section.

E. The superintendent may adopt regulations establishing readability standards for individual contract, group contract and evidence of coverage forms.

F. No group or individual contract, evidence of coverage or amendment thereto shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the superintendent, subject to Subsections G and H of this section.

G. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the superintendent for approval.

H. Every form of group or individual contract, evidence of coverage or amendment thereto required to be filed pursuant to the provisions of Subsection F of this section shall be filed with the superintendent not less than thirty days prior to delivery or issue for delivery in this state. At any time during the initial thirty day period, the superintendent may extend the period for review for an additional thirty days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the superintendent has taken no action. The filer must notify the superintendent in writing prior to using a form that is deemed approved.

I. At any time, after thirty days notice and for cause shown, the superintendent may withdraw approval of any form of group or individual contract, evidence of coverage or amendment thereto, effective at the end of the thirty-day notice period.

J. When a filing is disapproved or approval of a form of group or individual contract, evidence of coverage or amendment thereto is withdrawn, the superintendent shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty days of receipt of the notice the health maintenance organization may request a hearing. A hearing shall be conducted within thirty days after the superintendent has received the request for hearing.

K. The superintendent may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

History: 1978 Comp., § 59A-46-8, enacted by Laws 1993, ch. 266, § 8.

59A-46-9. Annual report.

A. Every health maintenance organization shall annually, on or before the first day of March, file a report, verified by at least two principal officers, with the superintendent covering the preceding calendar year.

B. The report shall be on forms prescribed by the superintendent and shall include:

(1) a financial statement of the organization prepared pursuant to forms prescribed by the superintendent, including its balance sheet and receipts and disbursements for the preceding year;

(2) any material changes in the information submitted pursuant to Subsection C of Section 59A-46-3 NMSA 1978;

(3) the number of persons enrolled during the year and the number of enrollees as of the end of the year; and

(4) such other reasonable information materially relating to the performance of the health maintenance organization as is necessary to enable the superintendent to carry out the superintendent's duties under the Insurance Code.

C. In addition, the health maintenance organization shall file by the dates indicated:

(1) on or before March 1, an annual statement in accordance with the requirements of Section 59A-5-29 NMSA 1978 and a risk-based capital report in accordance with the requirements of Section 59A-5A-3 NMSA 1978;

(2) a list of the providers who have executed a contract that complies with Subsection E of Section 59A-46-13 NMSA 1978 on or before March 1; and

(3) a description of the grievance procedures and the total number of grievances handled through such procedures, a compilation of the causes underlying those grievances and a summary of the final disposition of those grievances, on or before March 1.

D. The superintendent may require such additional reports as are deemed necessary and appropriate to enable the superintendent to carry out the superintendent's duties under the Health Maintenance Organization Law.

History: 1978 Comp., § 59A-46-9, enacted by Laws 1993, ch. 266, § 9; 2014, ch. 59, § 51.

59A-46-10. Information to enrollees or subscribers.

A. A health maintenance organization shall provide to its subscribers or to its group contract holders for distribution to subscribers a list of providers upon enrollment and re-enrollment.

B. Every health maintenance organization shall notify its subscribers within thirty days of any material change in the operation of the organization that will affect the service to subscribers directly.

C. An enrollee shall be notified in writing by the health maintenance organization of the termination of any designated primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

D. The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services may be obtained and a number where the enrollee may contact the health maintenance organization at no cost to the enrollee.

History: 1978 Comp., § 59A-46-10, enacted by Laws 1993, ch. 266, § 10.

59A-46-11. Grievance procedures.

A. Every health maintenance organization shall establish and maintain a grievance procedure that has been approved by the superintendent to provide procedures for the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain records regarding grievances received since the date of its last examination of such grievances.

B. The superintendent or his designee may examine such grievance procedures and records.

History: 1978 Comp., § 59A-46-11, enacted by Laws 1993, ch. 266, § 11.

59A-46-12. Investments.

With the exception of investments made in accordance with Paragraph (1) of Subsection A of Section 59A-46-5 NMSA 1978, the funds of a health maintenance organization shall be invested only in accordance with Chapter 59A, Article 9 NMSA 1978 and such regulations as the superintendent may promulgate consistent with that article and the provisions of the Health Maintenance Organization Law.

History: 1978 Comp., § 59A-46-12, enacted by Laws 1993, ch. 266, § 12.

59A-46-13. Protection against insolvency.

A. Health maintenance organizations shall be subject to the following net worth requirements:

(1) before any certificate of authority is issued to a health maintenance organization, it shall have an initial net worth of one million five hundred thousand dollars ($1,500,000) and shall thereafter maintain the minimum net worth required under Paragraph (2) of this subsection;

(2) except as provided in Paragraphs (3) and (4) of this subsection, every health maintenance organization shall maintain a minimum net worth equal to the greater of:

(a) one million dollars ($1,000,000);

(b) two percent of annual premium revenues as reported on the most recent annual financial statement filed with the superintendent on the first one hundred fifty million dollars ($150,000,000) of premium revenues and one percent of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);

(c) an amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the superintendent; or

(d) an amount equal to the sum of: 1) eight percent of annual health care expenditures for enrollees under prepaid contracts except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the superintendent; and 2) four percent of annual hospital expenditures for enrollees under prepaid contracts paid on a capitated basis and a

managed hospital payment basis as reported on the most recent financial statement filed with the superintendent;

(3) a health maintenance organization licensed before the effective date of Chapter 59A, Article 46 NMSA 1978 shall maintain a minimum net worth of:

(a) twenty-five percent of the amount required by Paragraph (2) of this subsection by December 31, 1994;

(b) fifty percent of the amount required by Paragraph (2) of this subsection by December 31, 1995;

(c) seventy-five percent of the amount required by Paragraph (2) of this subsection by December 31, 1996; and

(d) one hundred percent of the amount required by Paragraph (2) of this subsection by December 31, 1997; and

(4) in determining net worth for the purposes of Paragraph (3) of this subsection:

(a) no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the superintendent and any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated;

(b) the interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses;

(c) any debt incurred by a surplus note meeting the requirements of Section 59A-34-23 NMSA 1978, and otherwise acceptable to the superintendent, shall not be considered a liability and shall be recorded as equity; and

(d) preferred stock shall not be considered debt.

B. Health maintenance organizations shall be subject to the following deposit requirements:

(1) unless otherwise provided below, each health maintenance organization shall deposit with the superintendent or, at the discretion of the superintendent, with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to him that at all times shall have a value of not less than three hundred thousand dollars ($300,000);

(2) a health maintenance organization that is in operation on the effective date of this section shall make a deposit equal to one hundred fifty thousand dollars

($150,000) and, in the second year, the amount of the additional deposit for a health maintenance organization that is in operation on the effective date of this section shall be equal to one hundred fifty thousand dollars ($150,000), for a total of three hundred thousand dollars ($300,000);

(3) the deposit shall be an admitted asset of the health maintenance organization in the determination of net worth;

(4) all income from deposits shall be an asset of the organization, but a health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other assets of equal amount and value;

(5) any securities deposited pursuant to the provisions of this subsection shall be approved by the superintendent before being deposited or substituted;

(6) the deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation;

(7) the superintendent may use a deposit made pursuant to the provisions of this subsection for administrative costs directly attributable to a receivership or liquidation, and if the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the applicable liquidation law; and

(8) the superintendent may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, insurance superintendent or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of such health maintenance organization, cash, acceptable securities or surety, and delivers to the superintendent a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

C. Every health maintenance organization shall include when determining liabilities an amount estimated in the aggregate to provide for:

(1) any unearned premium;

(2) the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, which are unpaid and for which the health maintenance organization is or may be liable;

(3) the expense of adjustment or settlement of the claims described in Paragraph (2) of this subsection; and

(4) contract liabilities for continuation of coverage or conversion rights not covered by future premiums or hold harmless agreements.

D. Liabilities described in Subsection C of this section shall be computed in accordance with regulations adopted by the superintendent upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

E. Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization. In the event that the participating provider contract has not been reduced to writing or the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

F. The superintendent shall require that each health maintenance organization have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering the plan, the superintendent may require:

(1) insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) insolvency reserves;

(4) acceptable letters of credit; or

(5) any other arrangements to assure that benefits are continued as specified above.

G. An agreement to provide health care services between a provider and a health maintenance organization shall require that if the provider terminates the agreement, the provider shall give the organization at least sixty days' advance notice of termination.

History: 1978 Comp., § 59A-46-13, enacted by Laws 1993, ch. 266, § 13.

59A-46-14. Uncovered expenditures insolvency deposit.

A. If at any time uncovered expenditures exceed ten percent of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the superintendent, with any organization or trustee acceptable to the superintendent through which a custodial or controlled account is maintained, cash or securities that are acceptable to the superintendent. Such deposit shall at all times have a fair market value in an amount of one hundred twenty percent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this subsection.

B. The deposit required under Subsection A of this section is in addition to the deposit required under Section 59A-46-13 NMSA 1978 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from such deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from such deposit or account quarterly with the approval of the superintendent.

C. A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if a substitute deposit of cash or securities of equal amount and value is made, the fair market value of the deposit exceeds the amount of the required deposit, or the required deposit under Subsection A of this section is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of the superintendent.

D. The deposit required under Subsection A of this section is in trust and may be used only as provided under this section. The superintendent may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The superintendent may by regulation prescribe the time, manner and form for filing claims under Subsection D of this section.

F. The superintendent may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports as he deems necessary

to demonstrate compliance with this section. The superintendent may require that the reports include liability for uncovered expenditures as well as an audit opinion.

History: 1978 Comp., § 59A-46-14, enacted by Laws 1993, ch. 266, § 14.

59A-46-15. Repealed.

History: 1978 Comp., § 59A-46-15, enacted by Laws 1993, ch. 266, § 15; repealed by Laws 2024, ch. 36, § 11.

59A-46-16. Filing requirements for rating information.

A. No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the superintendent. At the time the health maintenance organization files the rate with the superintendent it shall also file a schedule of benefits to which the rate applies.

B. Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of enrollees; provided that the premium applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. A certification by a qualified actuary or other qualified person acceptable to the superintendent as to the appropriateness of the rates or of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

C. The superintendent may disapprove any such rates, or methodology for determining rates, found by him to be excessive, inadequate or unfairly discriminatory, considering the benefits to be provided. If the superintendent disapproves such filing, he shall notify the health maintenance organization, specifying the reasons for his disapproval. A hearing shall be conducted within thirty days after a request in writing by the person filing. The schedule or methodology shall be deemed approved if the superintendent does not disapprove the filing within thirty days, but the superintendent in his sole discretion may postpone taking action for an additional thirty days as necessary for proper consideration of the filing.

History: 1978 Comp., § 59A-46-16, enacted by Laws 1993, ch. 266, § 16.

59A-46-17. Regulation of health maintenance organization insurance producers.

A. Requirements and procedures for licensing of health maintenance organization insurance producers shall be governed by the provisions of Chapter 59A, Articles 11 and 12 NMSA 1978 and any regulations adopted by the superintendent pertaining to those articles.

B. None of the following shall be required to hold a health maintenance organization insurance producer license:

(1) any regular salaried officer or employee of a health maintenance organization who devotes substantially all of that person's time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;

(2) employers or their officers or employees or the trustees of any employee benefit plan to the extent that such employers, officers, employees or trustees are engaged in the administration or operation of any program of employee benefits involving the use of health maintenance organization memberships, if those employers, officers, employees or trustees are not compensated directly or indirectly by the health maintenance organization issuing the health maintenance organization memberships;

(3) banks or their officers and employees to the extent that such banks, officers and employees collect and remit charges by charging same against accounts of depositors on the orders of such depositors; or

(4) any person or the employee of any person who has contracted to provide administrative, management or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount calculated as a percentage of the revenues, net income or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to the provisions of the Health Maintenance Organization Law.

C. The superintendent may by rule exempt certain classes of persons from the requirement of obtaining a license if:

(1) the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

(2) other existing safeguards make regulation unnecessary.

History: 1978 Comp., § 59A-46-17, enacted by Laws 1993, ch. 266, § 17; 2016, ch. 89, § 66.

59A-46-18. Powers of insurers.

A. An authorized insurer may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of the Health Maintenance Organization Law. Notwithstanding any other law that may be inconsistent with the cited law, any two or more such insurance companies, or

subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

B. An authorized insurer may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. Among other things, under such contracts the insurer may make benefit payments to health maintenance organizations for health care services rendered by providers.

History: 1978 Comp., § 59A-46-18, enacted by Laws 1993, ch. 266, § 18.

59A-46-19. Examinations.

A. The superintendent may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

B. The superintendent may make or request the secretary of health to make an examination concerning the quality assurance program of the health maintenance organization and of any providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state.

C. Every health maintenance organization and provider shall submit its books and records for such examinations and in every way facilitate the completion of the examination. Medical records of individuals and contract providers shall not be subject to such examination. For the purpose of examinations, the superintendent and the secretary of health may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

D. The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the superintendent.

E. In lieu of such examination, the superintendent may accept the report of an examination made by the superintendent or secretary of health of another state.

F. Examination procedures shall be governed by the applicable provisions of Chapter 59A, Article 4 NMSA 1978.

History: 1978 Comp., § 59A-46-19, enacted by Laws 1993, ch. 266, § 19.

59A-46-20. Suspension or revocation of certificate of authority.

A. Any certificate of authority issued under the provisions of the Health Maintenance Organization Law may be suspended or revoked, and any application for a certificate of authority may be denied if the superintendent finds that:

(1) the health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 59A-46-3 NMSA 1978, unless amendments to such submissions have been filed with and approved by the superintendent;

(2) the health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 59A-46-8 and 59A-46-16 NMSA 1978;

(3) the health maintenance organization does not provide or arrange for basic health care services;

(4) the secretary of health has certified to the superintendent that:

(a) the health maintenance organization does not meet the requirements of Paragraph (2) of Subsection A of Section 59A-46-4 NMSA 1978; or

(b) the health maintenance organization is unable to fulfill its obligations to furnish health care services;

(5) the health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) the health maintenance organization has failed to correct, within the time prescribed by Subsection C of this section, any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

(7) the health maintenance organization has failed to implement the grievance procedures required by Section 59A-46-11 NMSA 1978 in a reasonable manner to resolve valid complaints;

(8) the health maintenance organization, or any person on its behalf, has engaged in any practice that under Chapter 59A, Article 16 NMSA 1978 is defined or prohibited as, or determined to be, an unfair method of competition, or an unfair or deceptive act or practice, or fraudulent;

(9) the continued operation of the health maintenance organization would be hazardous to its enrollees; or

(10) the health maintenance organization has otherwise failed substantially to comply with the provisions of the Health Maintenance Organization Law.

B. In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subjected to an administrative penalty of up to five thousand dollars ($5,000) for each cause for suspension or revocation, but if the violation is willful or intentional, the administrative penalty may be up to ten thousand dollars ($10,000).

C. Whenever the superintendent finds that the net worth maintained by any health maintenance organization subject to the provisions of the Health Maintenance Organization Law is less than the minimum net worth required to be maintained pursuant to the provisions of Section 59A-46-13 NMSA 1978, he shall give written notice to the health maintenance organization of the amount of the deficiency and require the health maintenance organization to:

(1) file with the superintendent a plan for correction of the deficiency acceptable to the superintendent; and

(2) correct the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted by the superintendent.

D. A deficiency found to exist by the superintendent pursuant to the provisions of Subsection C of this section shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority of the health maintenance organization or for placing it in conservation, rehabilitation or liquidation.

E. Unless allowed by the superintendent no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue or deliver any certificate, agreement or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing such coverage is impaired, and the fact of such impairment is known to the health maintenance organization or to such person. However, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed or converted coverage.

F. A certificate of authority shall not be suspended or revoked or an application for a certificate of authority denied or an administrative penalty imposed unless:

(1) the suspension, revocation, denial or imposition is by written order and is sent to the health maintenance organization or applicant by certified or registered mail; and

(2) the written order states the grounds, charges or conduct on which the suspension, revocation, denial or imposition is based.

G. The health maintenance organization or applicant may in writing request a hearing within thirty days from the date of mailing of an order suspending or revoking a certificate of authority, denying an application or imposing an administrative penalty. If no written request is made, such order shall be final upon the expiration of the thirty days.

H. If the health maintenance organization or applicant requests a hearing pursuant to the provisions of Subsection G of this section, the superintendent shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail stating:

(1) a specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and

(2) a specific place for the hearing, which may be either in Santa Fe county or in the county where the health maintenance organization's or applicant's principal place of business is located.

I. After a hearing held pursuant to the provisions of Subsection H of this section or upon failure of the health maintenance organization to appear at the hearing, the superintendent shall take whatever action he deems necessary based on written findings and shall mail his decision to the health maintenance organization or applicant.

J. The provisions of Chapter 59A, Article 4 NMSA 1978 shall apply to proceedings under this section to the extent they are not in conflict with Subsection H of this section.

K. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

L. When the certificate of authority of a health maintenance organization is revoked, that organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The superintendent may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

History: 1978 Comp., § 59A-46-20, enacted by Laws 1993, ch. 266, § 20.

59A-46-21. Rehabilitation, liquidation or conservation of health maintenance organizations.

A. Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurer and shall be conducted under the supervision of the superintendent pursuant to the law governing the rehabilitation, liquidation or conservation of insurers. The superintendent may apply for an order directing him to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in Chapter 59A, Article 41 NMSA 1978 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

B. For purpose of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by Subsection C of Section 59A-41-44 NMSA 1978 for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets.

C. Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described in Subsection B of this section and immediately preceding the priority of distribution described in Subsection D of Section 59A-41-44 NMSA 1978.

History: 1978 Comp., § 59A-46-21, enacted by Laws 1993, ch. 266, § 21.

59A-46-22. Summary orders and supervision.

A. Whenever the superintendent determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors or the general public, or that it has violated any provision of the Health Maintenance Organization Law, he may, after notice and hearing, order the health maintenance organization to take such action as may be reasonably necessary to rectify such condition or violation, including but not limited to one or more of the following:

(1) reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the superintendent;

(2) reduce the volume of new business being accepted;

(3) reduce expenses by specified methods;

(4) suspend or limit the writing of new business for a period of time;

(5) increase the health maintenance organization's capital and surplus by contribution; or

(6) take such other steps as the superintendent may deem appropriate under the circumstances, including suspension or revocation of the certificate or authority or assessment of administrative penalties as provided in Section 59A-46-20 NMSA 1978.

B. For purposes of this section, the violation by a health maintenance organization of any law of this state to which such health maintenance organization is subject shall be deemed a violation of the provisions of the Health Maintenance Organization Law.

C. The superintendent is authorized to make rules and regulations setting uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors or the general public and setting standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in Subsection A of this section.

D. The remedies and measures available to the superintendent under this section shall be in addition to, and not in lieu of, the remedies and measures available to the superintendent under the provisions of Chapter 59A, Article 41 NMSA 1978.

History: Laws 1993, ch. 266, § 22.

59A-46-22.1. Repealed.

59A-46-23. Regulations.

The superintendent may, after notice and hearing, adopt and promulgate reasonable rules and regulations as are necessary or proper to carry out the provisions of the Health Maintenance Organization Law.

History: 1978 Comp., § 59A-46-23, enacted by Laws 1993, ch. 266, § 23.

59A-46-24. Fees.

Every health maintenance organization subject to the provisions of the Health Maintenance Organization Law shall pay to the superintendent all applicable fees specified in Section 59A-6-1 NMSA 1978.

History: 1978 Comp., § 59A-46-24, enacted by Laws 1993, ch. 266, § 24.

59A-46-25. Penalties and enforcement.

A. The superintendent may, in lieu of suspension or revocation of a certificate of authority pursuant to the provisions of Section 59A-46-20 NMSA 1978, levy an administrative penalty in an amount up to five thousand dollars ($5,000), except that if the violation is willful or intentional, the administrative penalty may be up to ten thousand dollars ($10,000). The superintendent may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

B. If the superintendent shall for any reason have cause to believe that any violation of the provisions of the Health Maintenance Organization Law has occurred or is threatened, the superintendent may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

C. A conference arranged under the provisions of Subsection B of this section shall not be governed by any formal procedural requirements, and may be conducted in such manner as the superintendent may deem appropriate under the circumstances.

D. The superintendent may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of the Health Maintenance Organization Law. Within thirty days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of that law have occurred. Such hearings shall be governed by the provisions of Chapter 59A, Article 4 NMSA 1978.

E. In the case of any violation of the provisions of the Health Maintenance Organization Law, if the superintendent elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to Subsection D of this section, the superintendent may institute a proceeding to obtain injunctive or other appropriate relief in the Santa Fe county district court.

F. Notwithstanding any other provisions of the Health Maintenance Organization Law, if a health maintenance organization fails to comply with the net worth requirement of that law, the superintendent is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

History: 1978 Comp., § 59A-46-25, enacted by Laws 1993, ch. 266, § 25.

59A-46-26. Filings and reports as public documents.

All applications, filings and reports required under the Health Maintenance Organization Law shall be treated as public documents, except those that are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 59A-46-9 NMSA 1978.

History: 1978 Comp., § 59A-46-26, enacted by Laws 1993, ch. 266, § 26.

59A-46-26.1. Employer utilization and loss experience availability.

Employer claims information, including utilization and loss experience under health insurance provided under Chapter 59A, Article 46 NMSA 1978 shall be made available by the carrier only upon the written request of and to employers of enrollees with such coverage within thirty days of an employer's written request for such information to the carrier, provided the employer's coverage extends to no less than twenty-five individual enrollees, regardless of whether family coverage is included. Each carrier shall provide to the employer claims information that provides sufficient detail, subject to state and federal privacy laws, to enable the employer to obtain and compare rates from multiple carriers or establish a plan of self-insurance.

History: Laws 2003, ch. 252, § 4; 2007, ch. 53, § 2.

59A-46-27. Confidentiality of medical information and limitation of liability.

A. Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except:

(1) to the extent that it may be necessary to carry out the purposes of the Health Maintenance Organization Law;

(2) upon the express consent of the enrollee or applicant;

(3) pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) in the event of claim or litigation between such person and the health maintenance organization in which such data or information is pertinent.

B. A health maintenance organization shall be entitled to claim any statutory privileges against disclosure of information described in Subsection A of this section that the provider who furnished the information to the health maintenance organization is entitled to claim.

C. A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent or employee of a health care review committee or who furnishes any records, information or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action, nor shall the health maintenance organization that established such committee or the officers, directors, employees or agents of such health maintenance organization be liable for the activities of any such person. The provisions of this subsection do not relieve any person of liability arising from treatment of a patient.

D. The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director or other member of a health maintenance organization or its staff engaged in assisting such committee, or any person assisting or furnishing information to such committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if such subpoena is based solely on such activities.

E. Information considered by a health care review committee and the records of its actions and proceedings that are used pursuant to Subsection D of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

F. To fulfill its obligations under Section 59A-46-7 NMSA 1978, the health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any enrollee.

History: 1978 Comp., § 59A-46-27, enacted by Laws 1993, ch. 266, § 27.

59A-46-28. Authority to contract.

The secretary of health, in carrying out his obligations as requested by the superintendent under the provisions of the Health Maintenance Organization Law, may contract with qualified persons to make recommendations concerning the determinations required to be made by him, which recommendations may be accepted in full or in part or rejected entirely.

History: 1978 Comp., § 59A-46-28, enacted by Laws 1993, ch. 266, § 28.

59A-46-29. Health maintenance organizations; contract or certificate provisions relating to individuals who are eligible for medical benefits under the medicaid program.

A. Each individual or group contract or certificate that is delivered, issued for delivery or renewed in this state shall include provisions that require any indemnity benefits payable by a health maintenance organization on behalf of an enrollee under the contract or certificate to be paid to the human services department [health care authority department] when:

(1) the human services department [health care authority department] has paid or is paying benefits on behalf of the enrollee under the state's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;

(2) payment for the services in question has been made by the human services department [health care authority department] to the medicaid provider; and

(3) the health maintenance organization is notified that the enrollee receives benefits under the medicaid program and that any indemnity benefits payable by the health maintenance organization must be paid directly to the human services department [health care authority department].

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the human services department [health care authority department] for any indemnity benefits payable by the health maintenance organization when the claim is first submitted by the human services department [health care authority department] to the health maintenance organization.

C. Notwithstanding any other provisions of law, checks in payment for claims for any indemnity benefits payable by a health maintenance organization pursuant to any individual or group contract or certificate for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers not contracting with the health maintenance organization shall be made payable to the provider. The health maintenance organization may be notified that the enrollee is eligible for medicaid benefits through an attachment to the claim by the provider for health maintenance organization benefits when the claim is first submitted by the provider to the health maintenance organization.

D. No health maintenance organization group or individual contract or certificate delivered, issued for delivery or renewed in this state on or after the effective date of this section shall contain any provision denying or limiting health maintenance organization benefits because services are rendered to an enrollee who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where a health maintenance organization has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by the health maintenance organization for those health care items or services.

History: 1978 Comp., § 59A-46-34, enacted by Laws 1989, ch. 183, § 6; recompiled as 1978 Comp., § 59A-46-29 by Laws 1993, ch. 266, § 31; 1994, ch. 64, § 8.

59A-46-30. Statutory construction and relationship to other laws.

A. The provisions of the Insurance Code [Chapter 59A NMSA 1978] 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 [59A-16B-1 to 59A-16B-10 NMSA 1978];

(10) the Insurance Fraud Act [Chapter 59A, Article 16C NMSA 1978];

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

(12) the Policy Language Simplification Law [59A-19-1 to 59A-19-7 NMSA 1978];

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

(14) the Health Insurance Portability Act [Chapter 59A, Article 23E NMSA 1978];

(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 [Chapter 59A, Article 37 NMSA 1978];

(17) the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978]; and

(18) the Surprise Billing Protection Act [59A-57A-1 to 59A-57A-13 NMSA 1978].

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.

History: 1978 Comp., § 59A-46-30, enacted by Laws 1993, ch. 266, § 29; 1997, ch. 248, § 2; 1998, ch. 107, § 13; 1999, ch. 289, § 34; 2001, ch. 297, § 5; 2009, ch. 212, § 4; 2021, ch. 108, § 26.

59A-46-31. Coordination of benefits.

A. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.

B. If health maintenance organizations adopt coordination of benefits, the provisions shall be consistent with the coordination of benefits provisions that are in general use in the state for coordinating coverage between two or more group health insurance or health care plans.

C. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the regulations established by the superintendent, health maintenance organizations shall make payments for services that are:

(1) received from non-participating providers;

(2) provided outside their service areas; or

(3) not covered under the terms of their group contracts or evidence of coverage.

History: 1978 Comp., § 59A-46-31, enacted by Laws 1993, ch. 266, § 30.

59A-46-32. Continuation of coverage and conversion rights; health care plans.

A. Every individual or group contract entered into by a health maintenance organization and that is delivered, issued for delivery or renewed in this state on or after January 1, 1985 shall provide covered family members of subscribers the right to continue such coverage through a converted or separate contract upon the death of the subscriber or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the subscriber. Where a continuation of coverage or conversion is made in the name of the spouse of the subscriber, such coverage may, at the option of the spouse, include coverage to dependent children for whom the spouse has responsibility for care and support.

B. The right to a continuation of coverage or conversion pursuant to this section shall not exist with respect to any covered family member of a subscriber in the event the coverage terminates for nonpayment of premium, nonrenewal of the contract or the expiration of the term for which the contract is issued. With respect to any covered family member who is eligible for medicare or any other similar federal or state health insurance program, the right to a continuation of coverage or conversion shall be limited to coverage under a medicare supplement insurance contract as defined by the rules and regulations adopted by the superintendent of insurance.

C. Coverage continued through the issuance of a converted or separate contract shall be provided at a reasonable, nondiscriminatory rate to the insured and shall consist of a form of coverage then being offered by the health maintenance organization as a conversion contract. Continued and converted coverages shall contain renewal provisions that are not less favorable to the subscriber than those contained in the contract from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a medicare supplement insurance contract, as defined by the rules and regulations adopted by the superintendent of insurance, after the attainment of the age of eligibility for medicare or any other similar federal or state health insurance program.

D. At the time of inception of coverage, the health maintenance organization shall provide each covered family member eighteen years of age or older a statement setting forth in summary form the continuation of coverage and conversion provisions of the subscriber's contract.

E. The eligible covered family member exercising the continuation or conversion right must notify the health maintenance organization and make payment of the applicable premium within thirty days following the date such coverage otherwise

terminates as specified in the contract from which continuation or conversion is being exercised.

F. Coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations.

G. Any probationary or waiting period set forth in the converted or separate contract is deemed to commence on the effective date of the applicant's coverage under the original contract.

History: Laws 1984, ch. 127, § 876.1; 1978 Comp., § 59A-46-30, recompiled as 1978 Comp., § 59A-46-32 by Laws 1993, ch. 266, § 31; 2019, ch. 259, § 18.

59A-46-32.1. Recompiled.

59A-46-33. Governing body.

The governing body of any health maintenance organization may include providers or other individuals, or both. Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions or through the use of other mechanisms.

History: Laws 1984, ch. 127, § 853; 1978 Comp., § 59A-46-6, recompiled as 1978 Comp., § 59A-46-33 by Laws 1993, ch. 266, § 31.

59A-46-34. Prohibited practices.

A. No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this article:

(1) a statement or item of information is deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in a health maintenance organization;

(2) a statement or item of information is deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization, if such benefit or

advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

(3) an evidence of coverage is deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care coverage and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health maintenance organization issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

B. An enrollee may not be canceled or nonrenewed on the basis of the status of his health.

C. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts or literature any of the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business if such words are used in a manner to imply that such coverages are being illegally offered by the health maintenance organization or if deceptively similar to the name or description of any insurance or surety corporation doing business in the state.

D. Any person not in possession of a valid certificate of authority issued pursuant to this article shall not use the phrase "health maintenance organization" or "HMO" in the course of operation.

History: Laws 1984, ch. 127, § 860; 1978 Comp., § 59A-46-13, recompiled as 1978 Comp., § 59A-46-34 by Laws 1993, ch. 266, § 31.

59A-46-35. Provider discrimination prohibited.

No class of licensed individual providers willing to meet the terms and conditions offered by a health maintenance organization shall be excluded from a health maintenance organization. For purposes of this section, "providers" means those persons licensed pursuant to:

A. the Optometry Act [Chapter 61, Article 2 NMSA 1978];

B. Section 61-3-23.2 NMSA 1978;

C. the Chiropractic Physician Practice Act [Chapter 61, Article 4 NMSA 1978];

D. the Dental Health Care Act [Chapter 61, Article 5A NMSA 1978];

E. the Medical Practice Act [Chapter 61, Article 6 NMSA 1978];

F. the Podiatry Act [Chapter 61, Article 8 NMSA 1978];

G. the Professional Psychologist Act [Chapter 61, Article 9 NMSA 1978];

H. Chapter 61, Article 10 NMSA 1978; or

I. the Pharmacy Act [Chapter 61, Article 11 NMSA 1978].

History: 1978 Comp., § 59A-46-32, enacted by Laws 1987, ch. 335, § 1; 1989, ch. 55, § 1; recompiled as 1978 Comp., § 59A-46-35 by Laws 1993, ch. 266, § 31; 1998, ch. 39, § 1; 2003, ch. 343, § 3.

59A-46-36. Doctor of oriental medicine; discrimination prohibited.

Doctors of oriental medicine as a class of licensed providers willing to meet the terms and conditions offered by a health maintenance organization shall not be excluded from a health maintenance organization and shall not be discriminated against relative to other classes of licensed providers regarding services provided within their scope of practice that are in compliance with nationally recognized coding systems. Health maintenance organizations may determine the specific procedure codes that a doctor of oriental medicine is contracted to provide. Health maintenance organizations may choose to contract a doctor of oriental medicine as a primary care provider.

History: Laws 1989, ch. 96, § 2; 1993, ch. 158, § 4; 1978 Comp., § 59A-46-32.1, recompiled as 1978 Comp., § 59A-46-36 by Laws 1993, ch. 266, § 31; 2003, ch. 96, § 1.

59A-46-37. Coverage for adopted children.

A. No individual or group health maintenance organization contract shall be offered, issued or renewed in New Mexico on or after July 1, 1988, unless the contract covers adopted children of the subscriber or enrollee on the same basis as other dependents.

B. The coverage required by this section is effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

C. As used in this section, "placement" means in the physical custody of the adoptive parent.

History: 1978 Comp., § 59A-46-33, enacted by Laws 1988, ch. 89, § 2; recompiled as 1978 Comp., § 59A-46-37 by Laws 1993, ch. 266, § 31.

59A-46-38. Newly born children coverage.

A. All individual and group health maintenance organization contracts delivered or issued for delivery in this state shall also provide that the health benefits applicable for children shall be payable with respect to a newly born child of the subscriber or the subscriber's spouse from the moment of birth.

B. All individual and group health maintenance organization contracts delivered or issued for delivery in this state that do not provide health benefits applicable for children shall provide for an option to add to the coverage any newly born child of the insured provided that the requirements of Subsection D of this section have been met.

C. The coverage for newly born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, where necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care facility for newly born infants.

D. If a specific payment is required to provide coverage for a child, the contract may require that a notification of birth of a newly born child and payment must be furnished to the health maintenance organization within thirty-one days after the date of birth in order to have the coverage from birth.

E. As used in this section and in Section 59A-46-28 NMSA 1978 [59A-46-39 NMSA 1978], "tertiary care facility" means a hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

History: Laws 1984, ch. 127, § 874; 1993, ch. 169, § 2; 1978 Comp., § 59A-46-27, recompiled as § 59A-46-38 by Laws 1993, ch. 266, § 31.

59A-46-38.1. Coverage of children.

A. An insurer shall not deny enrollment of a child under the health plan of the child's parent on the grounds that the child:

(1) was born out of wedlock;

(2) is not claimed as a dependent on the parent's federal tax return; or

(3) does not reside with the parent or in the insurer's service area.

B. When a child has health coverage through an insurer of a noncustodial parent, the insurer shall:

(1) provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(3) make payments on claims submitted in accordance with Paragraph (2) of this subsection directly to the custodial parent, the provider or the state medicaid agency.

C. When a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage, the insurer shall be required:

(1) to permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) if the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

(3) not to disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(a) the court or administrative order is no longer in effect; or

(b) the child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.

D. An insurer shall not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the medicaid program and covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

E. An insurer shall provide coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the early childhood education and care department, provided eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars ($3,500) annually for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel who are working in early intervention programs approved by the early childhood education and care department. No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.

History: 1978 Comp., § 59A-46-38.1, enacted by Laws 1994, ch. 64, § 9; 2005, ch. 157, § 4; 2019, ch. 48, § 32.

59A-46-38.2. Childhood immunization coverage required.

A. Each individual and group health maintenance contract delivered or issued for delivery in this state shall provide coverage for childhood immunizations, in accordance with the current schedule of immunizations recommended by the American academy of pediatrics, including coverage for all medically necessary booster doses of all immunizing agents used in childhood immunizations.

B. Coverage for childhood immunizations and necessary booster doses may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract.

History: 1978 Comp., § 59A-46-38.2, enacted by Laws 1997, ch. 250, § 4.

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.

History: Laws 2003, ch. 391, § 5; 2005, ch. 41, § 2; 2021, ch. 108, § 27.

59A-46-38.4. Coverage of circumcision for newborn males.

An individual or group health maintenance organization policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall provide coverage for circumcision for newborn males.

History: Laws 2004, ch. 122, § 8.

59A-46-38.5. Hearing aid coverage for children required.

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state shall provide coverage for a hearing aid and any related service for the full cost of one hearing aid per hearing-impaired ear up to two thousand two hundred dollars ($2,200) every thirty-six months for hearing aids for insured children under eighteen years of age or under twenty-one years of age if still attending high school. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two-thousand-two-hundred-dollar ($2,200) limit as provided in this subsection without financial or contractual penalty to the insured or to the provider of the hearing aid.

B. An insurer that delivers, issues for delivery or renews in this state an individual or group health maintenance organization contract may make available to the policyholder the option of purchasing additional hearing aid coverage that exceeds the services described in this section.

C. Hearing aid coverage offered shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a physician, licensed in New Mexico. A health maintenance organization has the discretion to determine the provider of hearing aids with which it contracts. Nothing in this section shall be construed to preclude a health maintenance organization from conducting medical necessity or utilization review for hearing aids and related services.

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

E. Coverage for hearing aids may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

F. For the purposes of this section, "hearing aid" means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

History: Laws 2007, ch. 356, § 4.

59A-46-39. Maternity transport required.

All individual and group health maintenance organization contracts delivered or issued for delivery in this state which provide maternity coverage shall also provide, where necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility as defined in Section 874 [59A-46-38 NMSA 1978] of this article for newly born infants.

History: Laws 1984, ch. 127, § 875; 1978 Comp., § 59A-46-28, recompiled as § 59A-46-39 by Laws 1993, ch. 266, § 31.

59A-46-40. Home health care service option required.

A. Each health maintenance organization which delivers or issues for delivery in this state an individual or group contract shall make available to the contract holder the option of home health care coverage which includes benefits for the services described in this section.

B. Home health care coverage offered shall include:

(1) services provided by a registered nurse or a licensed practical nurse;

(2) health services provided by physical, occupational and respiratory therapists and speech pathologists; and

(3) health services provided by a home health aide.

C. Home health care coverage may be limited to:

(1) services provided on the written order of a licensed physician, provided such order is renewed at least every sixty days;

(2) services provided, directly or through contractual agreements, by a home health agency licensed in the state in which the home health services are delivered; and

(3) services, as set forth in Subsection B of this section, without which the insured would have to be hospitalized.

D. Coverage shall be provided for at least one hundred home visits per enrollee per year, with each home visit including up to four hours of home health care services.

E. For the purposes of this section, "home health care" means health services provided on a part-time, intermittent basis to an individual confined to his home due to physical illness.

History: Laws 1984, ch. 127, § 876; 1978 Comp., § 59A-46-29, recompiled as § 59A-46-40 by Laws 1993, ch. 266, § 31.

59A-46-41. Coverage for mammograms.

Each individual and group health maintenance organization contract delivered or issued for delivery in this state shall provide coverage for low-dose screening mammograms for determining the presence of breast cancer. Such coverage shall make available one baseline mammogram to persons age thirty-five through thirty-nine, one mammogram biennially to persons age forty through forty-nine and one mammogram annually to persons age fifty and over. After July 1, 1992, coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American college of radiology accreditation standards for mammography.

History: Laws 1990, ch. 5, § 1; 1978 Comp., § 59A-46-35, recompiled as § 59A-46-41 by Laws 1993, ch. 266, § 31; 2023, ch. 12, § 7.

59A-46-41.1. Mastectomies and lymph node dissection; minimum hospital stay coverage required.

A. Each individual and group health maintenance contract delivered or issued for delivery in this state shall provide coverage for not less than forty-eight hours of inpatient care following a mastectomy and not less than twenty-four hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

B. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician and patient determine that a shorter period of hospital stay is appropriate.

C. Coverage for minimum inpatient hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same contract.

History: 1978 Comp., § 59A-46-41.1, enacted by Laws 1997, ch. 249, § 4.

59A-46-41.2. Prior authorization for gynecological or obstetrical ultrasounds prohibited.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state and that provides coverage for gynecological or obstetrical ultrasounds shall not require prior authorization for gynecological or obstetrical ultrasounds.

B. Nothing in this section shall be construed to require payment for a gynecological or obstetrical ultrasound that is not:

(1) medically necessary; or

(2) a covered benefit.

C. As used in this section, "prior authorization" means advance approval that is required by a health maintenance organization as a condition precedent to payment for medical care or related benefits rendered to a covered person, including prospective or utilization review conducted prior to the provision of covered medical care or related benefits.

History: Laws 2019, ch. 182, § 5.

59A-46-41.3. Diagnostic and supplemental breast examinations.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental breast examinations.

B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or high deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

History: Laws 2023, ch. 12, § 4.

59A-46-42. Coverage for cytologic and human papillomavirus screening.

A. Each individual and group health maintenance organization contract delivered or issued for delivery in this state shall provide coverage for cytologic and human papillomavirus screening to determine the presence of precancerous or cancerous conditions and other health problems. The coverage shall make available cytologic screening, as determined by the health care provider in accordance with national medical standards, for women who are eighteen years of age or older and for women who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening. The coverage shall make available human papillomavirus screening once every three years for women aged thirty and older.

B. Coverage for cytologic and human papillomavirus screening may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract.

C. For the purposes of this section:

(1) "cytologic screening" means a Papanicolaou test and pelvic exam for asymptomatic as well as symptomatic women;

(2) "health care provider" means any person licensed within the scope of his practice to perform cytologic and human papillomavirus screening, including physicians, physician assistants, certified nurse-midwives and certified nurse practitioners; and

(3) "human papillomavirus screening" means a test approved by the federal food and drug administration for detection of the human papillomavirus.

History: Laws 1992, ch. 56, § 1; 1978 Comp., § 59A-46-36, recompiled by § 59A-46-42 by Laws 1993, ch. 266, § 31; 2005, ch. 133, § 1.

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.

History: Laws 2007, ch. 278, § 3; 2021, ch. 108, § 28.

59A-46-43. Coverage for individuals with diabetes.

A. Each individual and group health maintenance organization contract delivered or issued for delivery in this state shall provide coverage for individuals with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care service and shall entitle each individual to the medically accepted standard of medical care for diabetes

and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given contract. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled under an individual or group health maintenance organization contract shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for individuals with disabilities, including the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled under an individual or group health maintenance contract shall be entitled to the following basic health care services:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a diagnosis from a health care practitioner that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the federal food and drug administration, each individual or group health maintenance organization contract shall:

(1) maintain an adequate formulary to provide these resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. A health maintenance organization that requires an enrollee to use a specific network provider or to purchase equipment, appliances, supplies or insulin or prescription drugs for the treatment or management of diabetes from a specific durable medical equipment supplier or other supplier as a condition of coverage, payment or reimbursement shall:

(1) maintain an adequate network of durable medical equipment suppliers and other suppliers to provide covered persons with medically necessary diabetes resources whether covered under the health maintenance organization contract's prescription drug or medical benefit;

(2) have network contracts in place for the entire contract period and shall not allow contracts with network providers, durable medical equipment suppliers and other suppliers to lapse or terminate without ensuring the availability of a replacement and continuity of care; provided that single-case agreements do not satisfy the requirements of Paragraph (1) of this subsection or this paragraph;

(3) monitor network providers, durable medical equipment suppliers and other network suppliers to ensure that medically necessary equipment, appliances, supplies

and insulin or other prescription drugs are being delivered to an enrollee in a timely manner and when needed by the enrollee;

(4) guarantee reimbursement to an enrollee within thirty days following receipt of a written demand from the enrollee who pays out of pocket for necessary equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered timely to the enrollee and the portion of payment for which the patient is responsible shall not exceed the amount for the same covered benefit obtained from a contracted supplier;

(5) pay interest at the rate of eighteen percent per year on the amount of reimbursement due to an enrollee if not paid within thirty days as required by Paragraph (4) of this subsection;

(6) beginning on April 1, 2024, submit a written report each quarter to the superintendent for the previous quarter on the following metrics:

(a) the number of written demands for reimbursement of out-of-pocket expenses from enrollees received by the health maintenance organization;

(b) the number of out-of-pocket claims for reimbursement paid and the aggregate amount of claims reimbursed by the health maintenance organization within the time required by Paragraph (4) of this subsection;

(c) the number of out-of-pocket claims for reimbursement paid more than thirty days following receipt of a written demand and the aggregate amount of these payments, excluding interest; and

(d) the aggregate amount of interest paid by the health maintenance organization pursuant to Paragraph (5) of this subsection; and

(7) beginning on April 1, 2024, submit a written report each quarter for the previous quarter to the superintendent with the following information for each durable medical equipment supplier or other supplier that was under contract with the health maintenance organization or its agent during the previous quarter:

(a) the name, address and telephone number of each supplier and, if applicable, the corresponding date upon which the respective supplier's contract expired, lapsed or was terminated during the previous quarter;

(b) the percentage of total deliveries, by description of item, that did not meet the delivery requirements specified in Paragraph (3) of this subsection; and

(c) the number of complaints received by the health maintenance organization or its agent during the previous quarter related to late deliveries, incomplete orders or incorrect orders, respectively.

G. The superintendent shall annually audit all health maintenance organizations offering contracts as described in Subsection A of this section for compliance with the requirements of this section. If the superintendent determines that a health maintenance organization has not complied with the requirements of this section, the superintendent shall impose corrective action or use any other enforcement mechanism available to the superintendent to obtain the health maintenance organization's compliance with this section.

H. Absent a change in diagnosis or in an enrollee's management or treatment of diabetes or its complications, a health maintenance organization shall not require more than one prior authorization per policy period for any single drug or category of item enumerated in this section if prescribed as medically necessary by the enrollee's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which an enrollee has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the enrollee's health care practitioner. Nothing in this subsection shall be construed to require payment for diabetes resources that are not a covered benefit.

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

J. For purposes of this section, "basic health care benefits":

(1) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(2) does not include services for alcohol or drug abuse, dental or long-term rehabilitation treatment.

History: 1978 Comp., § 59A-46-43, enacted by Laws 1997, ch. 7, § 3; 1997, ch. 255, § 3; 2020, ch. 36, § 3; 2023, ch. 50, § 4.

59A-46-43.2. Coverage for medical diets for genetic inborn errors of metabolism.

As of July 1, 2003, each health maintenance organization that delivers or issues for delivery in the state an individual or group contract shall provide coverage for the treatment of genetic inborn errors of metabolism as set forth in Chapter 59A, Article 22 NMSA 1978.

History: Laws 2003, ch. 192, § 2.

59A-46-44. Coverage for contraception.

A. Each individual and group health maintenance organization contract delivered or issued for delivery in this state that provides a prescription drug benefit shall provide, at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

B. Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) enrollee cost sharing;

(2) utilization review;

(3) prior authorization or step-therapy requirements; or

(4) any other restrictions or delays on the coverage.

C. A health maintenance organization may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method of contraception without patient cost sharing; provided that when an enrollee's health care provider determines that a particular drug or item is medically necessary, the individual or group health maintenance organization contract shall cover the brand-name pharmacy drug or item without cost sharing. Medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. An individual or group health maintenance organization contract shall grant an enrollee an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an enrollee, the enrollee's representative or the enrollee's health care provider;

(2) defer to the determination of the enrollee's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

E. An individual or group health maintenance organization contract shall not require a prescription for any drug, item or service that is available without a prescription.

F. An individual or group health maintenance organization contract shall provide coverage and shall reimburse a health care provider or dispensing entity on a per-unit basis for dispensing a six-month supply of contraceptives at one time; provided that the contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe six months of contraceptives at one time; or

(2) permit an individual or group health maintenance organization contract to limit coverage or impose cost sharing for an alternate method of contraception if an enrollee changes contraceptive methods before exhausting a previously dispensed supply.

H. The provisions of this section shall not apply to short-term travel, accident-only, hospital-indemnity-only, limited-benefit or specified disease health benefits plans.

I. The provisions of this section apply to individual or group health maintenance organization contracts delivered or issued for delivery after January 1, 2020.

J. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) "cost sharing" means a deductible, copayment or coinsurance that an enrollee is required to pay in accordance with the terms of an individual or group health maintenance organization contract; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business.

K. A religious entity purchasing individual or group health maintenance organization coverage may elect to exclude prescription contraceptive drugs or devices from the health coverage purchased.

History: Laws 2001, ch. 14, § 3; 2003, ch. 202, § 13; 2019, ch. 263, § 7.

59A-46-45. Coverage for smoking cessation treatment.

A. An individual or group health maintenance organization contract that is delivered or issued for delivery in this state and that offers maternity benefits shall offer coverage for smoking cessation treatment.

B. Coverage for smoking cessation treatment may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract.

History: Laws 2003, ch. 337, § 4.

59A-46-46. Coverage of alpha-fetoprotein IV screening test.

An individual or group health maintenance organization policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall provide coverage for an alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks of pregnancy, to screen for certain genetic abnormalities in the fetus.

History: Laws 2004, ch. 122, § 7.

59A-46-47. Coverage of part-time employees.

A health maintenance organization that provides coverage for health care services pursuant to the Health Maintenance Organization Law shall make available, upon an employer's request prior to issuance, delivery or renewal, coverage for regular part-time employees who work or are expected to work an average of at least twenty hours per week over a six-month period. Nothing in this section shall be construed to require an employer to offer or provide coverage for regular part-time employees.

History: Laws 2005, ch. 42, § 3.

59A-46-48. Coverage of colorectal cancer screening.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state shall provide coverage for colorectal screening for determining the presence of precancerous or cancerous conditions and other health problems. The coverage shall make available colorectal cancer screening, as determined by the health care provider in accordance with the evidence-based recommendations established by the United States preventive services task force.

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

History: Laws 2007, ch. 17, § 3.

59A-46-49. General anesthesia and hospitalization for dental surgery.

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state shall provide coverage for hospitalization and general anesthesia provided in a hospital or ambulatory surgical center for dental surgery for the following:

(1) insureds exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;

(2) insureds for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

(3) insured children or adolescents who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

(4) insureds with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or

(5) other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.

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

C. Coverage for dental surgery may be subject to copayments, deductibles and coinsurance subject to network and prior authorization requirements consistent with those imposed on other benefits under the same policy, plan or certificate.

History: Laws 2007, ch. 218, § 4.

59A-46-50. Coverage for autism spectrum disorder diagnosis and treatment.

A. An individual or group health maintenance contract that is delivered, issued for delivery or renewed in this state shall provide coverage to an enrollee for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the enrollee's treating physician in accordance with a treatment plan;

(2) shall not be subject to annual or lifetime dollar limits;

(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the health maintenance organization contract, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. Coverage for treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis shall not be denied to an enrollee on the basis of the enrollee's age.

D. The coverage required pursuant to Subsection A of this section shall not be subject to deductibles or coinsurance provisions that are less favorable to an enrollee

than the deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health maintenance contract, except as otherwise provided in Subsection B of this section.

E. A carrier shall not deny or refuse to issue a health maintenance organization contract for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health maintenance organization coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

F. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health maintenance organization contract to pay claims appropriately. These elements include:

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

G. This section shall not be construed as limiting benefits and coverage otherwise available to an enrollee under a health maintenance organization contract.

H. The provisions of this section shall not apply to contracts, plans or policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance contracts, plans or policies.

I. As used in this section:

(1) "autism spectrum disorder" means:

(a) a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American psychiatric association; or

(b) a condition diagnosed as autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder or childhood disintegrative disorder pursuant to diagnostic criteria published in a previous edition of the *Diagnostic*

and Statistical Manual of Mental Disorders published by the American psychiatric association; and

(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual.

History: Laws 2009, ch. 74, § 3; 2019, ch. 119, § 5.

59A-46-50.1. Coverage for orally administered anticancer medications; limits on patient costs.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state and that provides coverage for cancer treatment shall provide coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits by the plan.

B. A health maintenance organization shall not increase patient cost-sharing for anticancer medications in order to achieve compliance with the provisions of this section.

C. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, copayment, deductible or coinsurance provision that does not apply to intravenously administered or injected anticancer medication used to kill or slow the growth of cancerous cells.

D. As used in this section, "health maintenance organization contract":

(1) means:

(a) a health maintenance organization; or

(b) a managed care organization; and

(2) does not include individual policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies.

History: Laws 2011, ch. 55, § 4.

59A-46-50.2. Coverage of prescription eye drop refills.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state and that provides coverage for prescription eye drops shall not deny coverage for a renewal of prescription eye drops when:

(1) the renewal is requested by the insured at least twenty-three days for a thirty-day supply of eye drops, forty-five days for a sixty-day supply of eye drops or sixty-eight days for a ninety-day supply of eye drops from the later of the date that the original prescription was dispensed to the insured or the date that the last renewal of the prescription was dispensed to the insured; and

(2) the prescriber indicates on the original prescription that additional quantities are needed and that the renewal requested by the insured does not exceed the number of additional quantities needed.

B. As used in this section, "prescriber" means a person who is authorized pursuant to the New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978] to prescribe prescription eye drops.

History: Laws 2012, ch. 27, § 4.

59A-46-50.3. Coverage for telemedicine services.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state shall provide coverage for services provided via telemedicine to the same extent that the contract covers the same services when those services are provided via in-person consultation or contact. A carrier shall not impose any unique condition for coverage of services provided via telemedicine.

B. A carrier shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by a health maintenance organization that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978].

D. The provisions of this section shall not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. A carrier shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the health maintenance organization contract provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent.

G. A carrier may charge a deductible, copayment or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. A carrier shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the contract, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any contract year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the contract.

I. A carrier shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the carrier reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to an individual or group health maintenance organization contract intended to supplement major medical group-type coverage, such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) "consulting telemedicine provider" means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) "in real time" means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(3) "originating site" means a place at which a patient is physically located and receiving health care services via telemedicine;

(4) "store-and-forward technology" means electronic information, imaging and communication, including interactive audio, video and data communication, that is transferred or recorded or otherwise stored for asynchronous use; and

(5) "telemedicine" means the use of telecommunications and information technology to provide clinical health care from a distance. "Telemedicine" allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. "Telemedicine" allows patients in remote locations to access medical expertise without travel.

History: Laws 2013, ch. 105, § 4; 2019, ch. 255, § 4.

59A-46-50.4. Prescription drugs; prohibited formulary changes; notice requirements.

A. As of January 1, 2014, an individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall not make any of the following changes to coverage for a prescription drug within one hundred twenty days of any previous change to coverage for that prescription drug, unless a generic version of the prescription drug is available:

(1) reclassify a drug to a higher tier of the formulary;

(2) reclassify a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary;

(3) increase the cost-sharing, copayment, deductible or co-insurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

(6) impose or modify a drug's quantity limit; or

(7) impose a step-therapy restriction.

B. The health maintenance organization shall give the affected subscriber at least sixty days' advance written notice of the impending change when it is determined that one of the following modifications will be made to a formulary:

(1) reclassification of a drug to a higher tier of the formulary;

(2) reclassification of a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary;

(3) an increase in the cost-sharing, copayment, deductible or coinsurance charges for a drug;

(4) removal of a drug from the formulary;

(5) addition of a prior authorization requirement;

(6) imposition or modification of a drug's quantity limit; or

(7) imposition of a step-therapy restriction for a drug.

C. Notwithstanding the provisions of Subsections A and B of this section, the health maintenance organization may immediately and without prior notice remove a drug from the formulary if the drug:

(1) is deemed unsafe by the federal food and drug administration; or

(2) has been removed from the market for any reason.

D. The health maintenance organization shall provide to each affected subscriber the following information in plain language regarding prescription drug benefits:

(1) notice that the health maintenance organization uses one or more drug formularies;

(2) an explanation of what the drug formulary is;

(3) a statement regarding the method the health maintenance organization uses to determine the prescription drugs to be included in or excluded from a drug formulary; and

(4) a statement of how often the health maintenance organization reviews the contents of each drug formulary.

E. As used in this section:

(1) "formulary" means the list of prescription drugs covered pursuant to a health maintenance organization contract; and

(2) "step therapy" means a protocol that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are to be prescribed.

History: Laws 2013, ch. 138, § 4.

59A-46-50.5. Heart artery calcium scan coverage.

A. A group health maintenance organization contract, other than a small group health maintenance organization contract, that is delivered, issued for delivery or renewed in this state shall provide coverage for eligible enrollees to receive a heart artery calcium scan.

B. Coverage provided pursuant to this section shall:

(1) be limited to the provision of a heart artery calcium scan to an eligible enrollee to be used as a clinical management tool;

(2) be provided every five years if an eligible enrollee has previously received a heart artery calcium score of zero; and

(3) not be required for future heart artery calcium scans if an eligible enrollee receives a heart artery calcium score greater than zero.

C. At its discretion or as required by law, a carrier may offer or refuse coverage for further cardiac testing or procedures for eligible enrollees based upon the results of a heart artery calcium scan.

D. The provisions of this section do not apply to short-term travel, accident-only or limited or specified-disease policies, plans or certificates of health insurance.

E. As used in this section:

(1) "eligible enrollee" means an enrollee who:

(a) is a person between the ages of forty-five and sixty-five; and

(b) has an intermediate risk of developing coronary heart disease as determined by a health care provider based upon a score calculated from an evidence-based algorithm widely used in the medical community to assess a person's ten-year cardiovascular disease risk, including a score calculated using a pooled cohort equation;

(2) "health care provider" means a physician, physician assistant, nurse practitioner or other health care professional authorized to furnish health care services within the scope of the professional's license; and

(3) "heart artery calcium scan" means a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function.

History: Laws 2020, ch. 79, § 4.

59A-46-51. Repealed.

History: Laws 2010, ch. 94, § 3; 2013, ch. 74, § 32; 2018, ch. 57, § 24; 2019, ch. 235, § 11; 2019, ch. 235, § 12; repealed by Laws 2021, ch. 108, § 37.

59A-46-52. Prescription drug prior authorization protocols.

A. After January 1, 2014, a health maintenance organization shall accept the uniform prior authorization form developed pursuant to Sections 2 [59A-2-9.8 NMSA 1978] and 3 [61-11-6.2 NMSA 1978] of this 2013 act as sufficient to request prior authorization for prescription drug benefits.

B. No later than twenty-four months after the adoption of national standards for electronic prior authorization, a health insurer shall exchange prior authorization requests with providers who have e-prescribing capability.

C. If a health maintenance organization fails to use or accept the uniform prior authorization form or fails to respond within three business days upon receipt of a uniform prior authorization form, the prior authorization request shall be deemed to have been granted.

D. As used in this section, "health maintenance organization":

(1) means:

(a) a health maintenance organization; or

(b) a managed care organization; and

(2) does not include:

(a) a person that delivers, issues for delivery or renews an individual policy intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policy;

(b) a physician or a physician group to which a health maintenance organization has delegated financial risk for prescription drugs and that does not use a prior authorization process for prescription drugs; or

(c) a health maintenance organization or its affiliated providers if the health maintenance organization owns and operates its pharmacies and does not use a prior authorization process.

History: Laws 2013, ch. 170, § 7.

59A-46-52.1. Prescription drug coverage; step therapy protocols; clinical review criteria; exceptions.

A. Each individual or group health maintenance organization contract delivered or issued for delivery in this state that provides a prescription drug benefit for which any step therapy protocols are required shall establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with carriers, insurers, health care plans, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest; and

(b) using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a health maintenance organization contract restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy protocol, an enrollee and the practitioner prescribing the prescription drug shall

have access to a clear, readily accessible and convenient process to request a step therapy exception determination. A carrier may use its existing medical exceptions process in accordance with the provisions of Subsections D through I of this section to satisfy this requirement. The process shall be made easily accessible for enrollees and practitioners on the carrier's publicly accessible website.

D. A carrier shall expeditiously grant an exception to the health maintenance organization contract's step therapy protocol, based on medical necessity and a clinically valid explanation from the patient's prescribing practitioner as to why a drug on the health maintenance organization contract's formulary that is therapeutically equivalent to the prescribed drug should not be substituted for the prescribed drug, if:

(1) the prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

(2) the prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) while under the enrollee's current health maintenance organization contract, or under the enrollee's previous health coverage, the enrollee has tried the prescription drug that is the subject of the exception request or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or

(4) the prescription drug required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the prescription drug is expected to:

(a) cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;

(b) worsen a comorbid condition of the patient; or

(c) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

E. Upon the granting of an exception to a health maintenance organization contract's step therapy protocol, a carrier shall authorize coverage for the prescription drug that is the subject of the exception request for no less than the duration of the therapeutic effect of the drug. A carrier shall include in its evidence of coverage language describing an enrollee's rights pursuant to this subsection.

F. A carrier shall respond with its decision on an enrollee's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, a carrier shall respond within twenty-four hours of receipt of the exception request. In the event the carrier does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. A carrier's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978].

H. After an enrollee has made an exception request in accordance with the provisions of this section, a carrier shall authorize continued coverage of a prescription drug that is the subject of the exception request pending the determination of the exception request.

I. The provisions of this section shall not be construed to prevent:

(1) a health maintenance organization contract from requiring a patient to try a biosimilar, interchangeable biologic or generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

J. The superintendent shall promulgate rules as may be necessary to appropriately implement the provisions of this section.

K. Nothing in this section shall be interpreted to interfere with the superintendent's authority to regulate prescription drug coverage benefits under other state and federal law.

L. As used in this section, "medical necessity" or "medically necessary" means health care services determined by a practitioner, in consultation with the carrier, to be appropriate or necessary, according to:

(1) any applicable, generally accepted principles and practices of good medical care;

(2) practice guidelines developed by the federal government or national or professional medical societies, boards or associations; or

(3) any applicable clinical protocols or practice guidelines developed by the carrier consistent with federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

History: Laws 2018, ch. 9, § 5; 2024, ch. 42, § 5.

59A-46-52.2. Pharmacist prescriptive authority services; reimbursement parity.

A carrier shall reimburse a participating provider that is a certified pharmacist clinician or pharmacist certified to provide a prescriptive authority service who provides a service pursuant to an individual or group contract at the standard contracted rate that the carrier reimburses, for the same service under that individual or group contract, any licensed physician or physician assistant licensed pursuant to the Medical Practice Act [Chapter 41, Article 5 NMSA 1978] or any advanced practice certified nurse practitioner licensed pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978].

History: Laws 2020, ch. 58, § 5; 2021, ch. 54, § 13.

59A-46-52.3. Calculating an enrollee's cost-sharing obligation for prescription drug coverage.

A. When calculating an enrollee's cost-sharing obligation for covered prescription drugs, pursuant to an individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state, the insurer shall credit the enrollee for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

History: Laws 2023, ch. 206, § 5.

59A-46-53. Pharmacy benefits; prescription synchronization.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits shall allow an enrollee to fill or refill a prescription for less than a thirty-day supply of the prescription drug, and apply a prorated daily copayment or coinsurance for the fill or refill, if:

(1) the prescribing practitioner or the pharmacist determines the fill or refill to be in the best interest of the enrollee;

(2) the enrollee requests or agrees to receive less than a thirty-day supply of the prescription drug; and

(3) the reduced fill or refill is made for the purpose of synchronizing the enrollee's prescription drug fills.

B. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits shall not:

(1) deny coverage for the filling of a chronic medication when the fill is made in accordance with a plan to synchronize multiple prescriptions for the enrollee pursuant to Subsection A of this section established among the health maintenance organization, the prescribing practitioner and a pharmacist. The health maintenance organization shall allow a pharmacy to override any denial indicating that a prescription is being refilled too soon for the purposes of medication synchronization; and

(2) prorate a dispensing fee to a pharmacy that fills a prescription with less than a thirty-day supply of prescription drug pursuant to Subsection A of this section. The health maintenance organization shall pay in full a dispensing fee for a partially filled or refilled prescription for each prescription dispensed, regardless of any prorated copayment or coinsurance that the enrollee may pay for prescription synchronization services.

History: Laws 2015, ch. 65, § 5.

59A-46-54. Provider credentialing; requirements; deadline.

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The superintendent shall approve no more than two forms of application to be used for the credentialing of providers.

B. A carrier shall not require a provider to submit information not required by a credentialing application established pursuant to Subsection A of this section.

C. The provisions of this section apply equally to initial credentialing applications and applications for recredentialing.

D. The rules that the superintendent adopts and promulgates shall require primary credential verification no more frequently than every three years and allow provisional credentialing for a period of one year.

E. Nothing in this section shall be construed to require a carrier to credential or provisionally credential a provider.

F. The rules that the superintendent adopts and promulgates shall establish that a carrier or a carrier's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within thirty calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration;

(3) within ten working days after receipt of a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the carrier requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be reasonably related to the information in the application; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen days as described in Paragraph (2) of this subsection, load into the carrier's provider payment system all provider information, including all information needed to correctly reimburse a newly approved provider according to the provider's contract. The carrier or carrier's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the carrier's provider payment system.

G. A carrier shall reimburse a provider for covered health care services for any claims from the provider that the carrier receives with a date of service more than thirty calendar days after the date on which the carrier received a complete credentialing application for that provider if:

(1) the provider:

(a) has submitted a complete credentialing application and any supporting documentation that the carrier has requested in writing within the time frame established in Paragraph (3) of Subsection F of this section;

(b) has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and

(c) has professional liability insurance or is covered under the Medical Malpractice Act; and

(2) the carrier:

(a) has approved, or has failed to approve or deny, the applicant's complete credentialing application within the time frame established pursuant to Paragraph (1) or (2) of Subsection F of this section; or

(b) fails to load the approved applicant's information into the carrier's provider payment system in accordance with Paragraph (4) of Subsection F of this section.

H. A provider who, at the time services were rendered, was not employed by a practice or group that has contracted with the carrier to provide services at specified rates of reimbursement shall be paid by the carrier in accordance with the carrier's standard reimbursement rate.

I. A provider who, at the time services were rendered, was employed by a practice or group that has contracted with the carrier to provide services at specified rates of reimbursement shall be paid by the carrier in accordance with the terms of that contract.

J. The superintendent shall adopt and promulgate rules to provide for the resolution of disputes relating to reimbursement and credentialing arising in cases where credentialing is delayed beyond thirty days after application.

K. A carrier shall reimburse a provider pursuant to Subsections G, H and I of this section until the earlier of the following occurs:

(1) the carrier's approval or denial of the provider's complete credentialing application; or

(2) the passage of three years from the date the carrier received the provider's complete credentialing application.

History: Laws 2015, ch. 111, § 4; 2016, ch. 20, § 4; 2023, ch. 175, § 3.

59A-46-55. Coverage exclusion. (Contingent repeal. *See* note below.)

Coverage of vasectomy and male condoms pursuant to Section 7 [59A-46-44 NMSA 1978] of this 2019 act is excluded for high-deductible individual or group health maintenance organization contracts with health savings accounts delivered or issued for delivery in this state until an enrollee's deductible has been met.

History: Laws 2019, ch. 263, § 8.

59A-46-56. Physical rehabilitation services; limits on cost sharing.

A. An individual or group health maintenance contract that is delivered, issued for delivery or renewed in this state shall not impose a member cost share for physical rehabilitation services that is greater than that for primary care services on a coinsurance percentage basis when coinsurance is applied or on an absolute dollar amount when a copay is applied.

B. As used in this section:

(1) "physical rehabilitation services" means services aimed at maximizing an individual's level of function, returning to a prior level of function or maintaining or slowing the decline of function, which services are provided by or under the direction of a licensed physical therapist, occupational therapist or speech therapist; and

(2) "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.

History: Laws 2019, ch. 188, § 4.

59A-46-57. Behavioral health services; elimination of cost sharing.

A. Until January 1, 2027, an individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of this section:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing method that requires an enrollee to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same individual or group health maintenance organization contract;

(3) "copayment" means a cost-sharing method that requires an enrollee to pay a fixed dollar amount when health care services are received, with the carrier paying the balance of the allowable amount; provided that there may be different

copayment requirements for different types of services under the same individual or group health maintenance organization contract; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of an individual or group health maintenance organization contract.

History: Laws 2021, ch. 136, § 8.

59A-46-58. Anatomical gift nondiscrimination.

A. As used in this section, "organ transplant" includes parts or the whole of organs, eyes or tissue.

B. A health maintenance organization contract that provides coverage for organ transplants or associated care shall not:

(1) deny coverage for organ transplantation or associated care to an enrollee solely on the basis of the enrollee's physical or mental disability;

(2) deny to an enrollee with a physical or mental disability eligibility or continued eligibility to enroll or to renew enrollment under the terms of the health maintenance organization's benefit policy or plan solely for the purpose of avoiding the requirements of this section;

(3) penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a health care provider to induce that health care provider not to provide an organ transplant or associated care to an enrollee with a disability; or

(4) reduce or limit benefits to an enrollee with a physical or mental disability for associated care related to organ transplantation as determined in consultation with the physician and patient.

History: Laws 2023, ch. 171, § 5.

59A-46-59. Chiropractic physician services; limits on cost sharing and coinsurance.

A. An individual or group health maintenance contract that is delivered, issued for delivery or renewed in this state that offers coverage of the services of a chiropractic physician shall not impose a copayment or coinsurance on those chiropractic physician services that exceeds the copayment or coinsurance imposed for primary care services.

B. As used in this section, "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.

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

History: Laws 2023, ch. 51, § 4.

59A-46-60. Sexually transmitted infection care; cost sharing eliminated.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state that offers coverage for preventive care or treatment of sexually transmitted infections shall not impose cost sharing on eligible enrollees.

B. Pursuant to this section, preventive care or treatment of sexually transmitted infections shall not be conditioned upon the gender identity of the insured.

C. The provisions of Subsection A of this section do not apply to high-deductible health care plans with health savings accounts until an eligible enrollee's deductible has been met, unless otherwise allowed pursuant to federal law.

D. For the purposes of this section:

(1) "cost sharing" means policy deductibles, copayments or coinsurance;

(2) "preventive care" means screening, testing, examination or counseling and the administration, dispensing or prescribing of preventive drugs, devices or supplies incidental to the prevention of a sexually transmitted infection;

(3) "sexually transmitted infection" means chlamydia, syphilis, gonorrhea, HIV and relevant types of hepatitis, as well as any other sexually transmitted infection regardless of mode of transportation, as designated by rule upon making a finding that the particular sexually transmitted infection is contagious; and

(4) "treatment" means medically necessary care for the management of an existing sexually transmitted infection.

History: Laws 2023, ch. 99, § 4.

59A-46-61. Definitions.

As used in Sections 25 through 33 [59A-46-61 to 59A-46-69 NMSA 1978] of this 2023 act:

A. "generally recognized standards" means standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

(1) psychiatry;

(2) psychology;

(3) social work;

(4) clinical counseling;

(5) addiction medicine and counseling; or

(6) family and marriage counseling; and

B. "mental health or substance use disorder services" means:

(1) professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder; or

(2) professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act [Chapter 61, Article 9A NMSA 1978].

History: Laws 2023, ch. 114, § 25.

59A-46-62. Benefits required.

A health maintenance organization, other than a small group health maintenance organization contract that is delivered, issued for delivery or renewed in this state, shall provide coverage for all mental health or substance use disorder services required by generally recognized standards of care.

History: Laws 2023, ch. 114, § 26.

59A-46-63. Parity for coverage of mental health or substance use disorder services.

A. The office of superintendent of insurance shall ensure that a carrier complies with federal and state laws, rules and regulations applicable to coverage for mental health or substance use disorder services.

B. A carrier shall not impose quantitative treatment limitations, financial restrictions, limitations or requirements on the provision of mental health or substance use disorder services that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on substantially all of the coverage of benefits for other conditions.

C. A carrier shall not impose non-quantitative treatment limitations for the treatment of mental health or substance use disorders or conditions unless factors, including the processes, strategies or evidentiary standards used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to and are applied no more restrictively than the factors used in applying the limitation with respect to medical or surgical benefits in the classification.

History: Laws 2023, ch. 114, § 27.

59A-46-64. Provider network adequacy.

A. A carrier shall maintain an adequate provider network to provide mental health or substance use disorder services.

B. The superintendent shall ensure access to mental health or substance use disorder services providers, including parity with medical and surgical services provider access, through regulation and review of claims processing, provider reimbursement procedures, network adequacy and provider reimbursement rate adequacy.

C. A carrier shall ensure that the process by which reimbursement rates for mental health and substance use disorder services are determined is comparable to and no more stringent than the process for reimbursement of medical or surgical benefits. In developing provider reimbursement rates, a carrier shall demonstrate that it has performed a comparability analysis of provider:

(1) reimbursement rates in surrounding states;

(2) reimbursement rates between mental health and substance use disorder providers and medical or surgical providers; and

(3) credentialing processes for mental health and substance use disorder providers and medical or surgical providers.

D. A carrier shall undertake all efforts, including increasing provider reimbursement rates through the processes and strategies described in Subsection C of this section, to ensure state-mandated network adequacy for the provision of mental health or substance use disorder services.

E. When in-network access to mental health or substance use disorder services are not reasonably available, a carrier shall provide access to out-of-network services with the same cost-sharing obligations to an enrollee as those required for in-network services.

History: Laws 2023, ch. 114, § 28.

59A-46-65. Utilization review of mental health or substance use disorder services.

A. A carrier shall, at least monthly, review and update the carrier's utilization review process to reflect the most recent evidence and generally recognized standards of care.

B. When performing a utilization review of mental health or substance use disorder services, including level of care placement, continued stay, transfer and discharge, a carrier shall apply criteria in accordance with generally recognized standards of care.

C. A carrier shall provide utilization review training to staff and contractors undertaking activities related to utilization review.

D. A carrier shall:

(1) develop utilization review policies regarding quantitative and non-quantitative limitations for mental health or substance use disorder services coverage that are no more restrictive than the utilization review policies regarding quantitative and non-quantitative limitations for medical and surgical care; and

(2) make utilization review policies available to providers or enrollees.

History: Laws 2023, ch. 114, § 29.

59A-46-66. Prohibited exclusions of coverage for mental health or substance use disorder services.

A carrier shall not exclude provider prescribed coverage for mental health or substance use disorder services otherwise included in its coverage when:

A. it is available pursuant to federal or state law for individuals with disabilities;

B. it is otherwise ordered by a court or administrative agency;

C. it is available to an enrollee through a public benefit program; or

D. an enrollee has a concurrent diagnosis.

History: Laws 2023, ch. 114, § 30.

59A-46-67. Level of care determinations for the provision of mental health or substance use disorder services.

A. A carrier shall provide coverage for all in-network mental health or substance use disorder services, consistent with generally recognized standards of care, including placing an enrollee into a medically necessary level of care.

B. Changes in level and duration of care shall be determined by the enrollee's provider in consultation with the carrier.

C. Level of care determinations shall include placement of an enrollee into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility or an outpatient treatment program.

D. Level of care services for an enrollee with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the enrollee rather than arbitrary time limits.

History: Laws 2023, ch. 114, § 31.

59A-46-68. Coordination of care.

At the request of an enrollee, a carrier may facilitate communication between mental health or substance use disorder services providers and the enrollee's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the enrollee.

History: Laws 2023, ch. 114, § 32.

59A-46-69. Confidentiality provisions.

A carrier shall protect the confidentiality of an enrollee receiving mental health or substance use disorder treatment.

History: Laws 2023, ch. 114, § 33.

59A-46-70. Exceptions.

The provisions of Sections 25 through 33 [59A-46-61 to 59A-46-69 NMSA 1978] of this 2023 act do not apply to short-term plans subject to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978].

History: Laws 2023, ch. 114, § 34.

59A-46-71. Biomarker testing coverage.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state shall provide coverage for eligible enrollees to receive biomarker testing.

B. Coverage provided pursuant to this section shall be for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of an enrollee's disease or condition when the test is supported by medical and scientific evidence, including:

(1) labeled indications for a United States food and drug administration-approved or -cleared test;

(2) indicated tests for a United States food and drug administration-approved drug;

(3) warnings and precautions on United States food and drug administration labels;

(4) federal centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations; or

(5) nationally recognized clinical practice guidelines.

C. A health maintenance organization contract providing coverage for biomarker testing pursuant to this section shall ensure that:

(1) coverage is provided in a manner that limits disruptions in care, including coverage for multiple biopsies or biospecimen samples; and

(2) a patient and a practitioner who prescribes biomarker testing have clear, accessible and convenient processes to request an appeal of a benefit denial by the carrier and that those processes are accessible on the carrier's website.

D. Coverage for biomarker testing may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract.

E. The provisions of this section do not apply to accident-only or limited or specified disease policies, plans or certificates of health insurance.

F. As used in this section:

(1) "biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. "Biomarker" includes gene mutations, characteristics of genes or protein expression;

(2) "biomarker testing" means analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker and includes single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing; and

(3) "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that are:

(a) developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy; and

(b) used to establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

History: Laws 2023, ch. 138, § 5.

59A-46-72. Medical necessity and nondiscrimination standards for coverage of prosthetics and orthotics.

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state that covers essential health benefits and covers prosthetic and custom orthotic devices shall consider these benefits habilitative or rehabilitative benefits for purposes of state or federal requirements on essential health benefits coverage.

B. When performing a utilization review for a request for coverage of prosthetic or orthotic benefits, an insurer shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Such standards may be named by the superintendent in rule.

C. An insurer shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely based on an insured's actual or perceived disability.

D. An insurer shall not deny a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

E. A health benefits plan that is delivered, issued for delivery or renewed in this state that offers coverage for prosthetics and custom orthotic devices shall include language describing an insured's rights pursuant to Subsections C and D of this section in its evidence of coverage and any benefit denial letters.

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual or group health plan may impose cost sharing on prosthetic or custom orthotic devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. An individual or group health plan that provides coverage for prosthetic or orthotic services shall ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the managed care plan's provider network located in the state. In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the insurer shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

H. If coverage for prosthetic or custom orthotic devices is provided, payment shall be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(1) a change in the physiological condition of the patient;

(2) an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than sixty percent of the cost of a replacement device or of the part being replaced.

I. Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

J. The provisions of this section do not apply to excepted benefits plans subject to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978].

History: Laws 2023, ch. 196, § 5.

ARTICLE 47
Nonprofit Health Care Plans

59A-47-1. Short title.

Chapter 59A, Article 47 NMSA 1978 may be cited as the "Nonprofit Health Care Plan Law".

History: Laws 1984, ch. 127, § 878; 2003, ch. 391, § 6.

59A-47-2. Purpose; exemptions.

A. The purpose of this article is to provide for the reasonable regulation of membership corporations organized for the purpose of making health care expense payments on a service benefit basis or on an indemnity benefit basis, or both, for persons who become subscribers under contracts with such corporation.

B. Nothing in this article shall apply to any professional or hospital association which accepts health care expense payments for health care on a service basis or on an indemnity basis, or both, which are underwritten by any authorized insurer.

History: Laws 1984, ch. 127, § 879.

59A-47-3. Definitions.

A. "acquisition expenses" includes all expenses incurred in connection with the solicitation and enrollment of subscribers;

B. "administration expenses" means all expenses of the health care plan other than the cost of health care expense payments and acquisition expenses;

C. "agent" means a person appointed by a health care plan authorized to transact business in this state to act as its representative in any given locality for soliciting health care policies and other related duties as may be authorized;

D. "chiropractor" means any person holding a license provided for in the Chiropractic Physician Practice Act [Chapter 61, Article 4 NMSA 1978];

E. "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider;

F. "direct services" means services rendered to an individual by a health care plan, 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 a health care plan or a health insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act [Chapter 59A, Article 54 NMSA 1978]; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

G. "doctor of oriental medicine" means any person licensed as a doctor of oriental medicine under the Acupuncture and Oriental Medicine Practice Act [Chapter 61, Article 14A NMSA 1978];

H. "health care" means the treatment of persons for the prevention, cure or correction of any illness or physical or mental condition, including optometric services;

I. "health care expense payment" means a payment for health care to a purveyor on behalf of a subscriber, or such a payment to the subscriber;

J. "health care plan" means an organization that demonstrates to the superintendent that it has been granted exemption from the federal income tax by the United States commissioner of internal revenue as an organization described in Section 501(c)(3) of the United States Internal Revenue Code of 1986, as that section may be amended or renumbered, and is authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments, including an organization that issues:

(1) a short-term health care plan;

(2) an excepted benefit health care plan intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies; or

(3) a policy or plan for long-term care or disability income;

K. "indemnity benefit" means a payment that the purveyor has not agreed to accept as payment in full for health care furnished the subscriber;

L. "item of health care" means a service or material used in health care;

M. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act [Chapter 61, Article 11 NMSA 1978];

N. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act [61-11B-1 to 61-11B-3 NMSA 1978];

O. "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 premium tax paid pursuant to Section 59A-6-2 NMSA 1978 and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance;

P. "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in the state;

Q. "purveyor" means a person who furnishes any item of health care and charges for that item;

R. "service benefit" means a payment that the purveyor has agreed to accept as payment in full for health care furnished the subscriber;

S. "short-term health care plan" means a nonrenewable health care plan covering a resident of the state, regardless of where the plan is delivered, that:

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

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

T. "solicitor" means a person employed by the licensed agent of a health care plan for the purpose of soliciting health care policies and other related duties in connection with the handling of the business of the agent as may be authorized and paid for the person's services either on a commission basis or salary basis or part by commission and part by salary;

U. "subscriber" means any individual who, because of a contract with a health care plan entered into by or for the individual, is entitled to have health care expense payments made on the individual's behalf or to the individual by the health care plan; and

V. "underwriting manual" means the health care plan's written criteria, approved by the superintendent, that defines the terms and conditions under which subscribers may

be selected. The underwriting manual may be amended from time to time, but the amendment will not be effective until approved by the superintendent. The superintendent shall notify the health care plan filing the underwriting manual or the amendment thereto of the superintendent's approval or disapproval thereof in writing within thirty days after filing or within sixty days after filing if the superintendent shall so extend the time. If the superintendent fails to act within such period, the filing shall be deemed to be approved.

History: Laws 1984, ch. 127, § 879.1; 1989, ch. 96, § 3; 1993, ch. 158, § 5; 2007, ch. 244, § 2; 2015, ch. 111, § 5; 2018, ch. 57, § 25; 2019, ch. 235, §13; 2019, ch. 235, § 14.

59A-47-4. Organization; profit corporations prohibited; merger and consolidation of health care plans.

A. A corporation may be organized under the laws of this state which provide for the organization of nonprofit corporations, as a nonprofit corporation organized for making health care expense payments on a service benefit basis or an indemnity basis, or both, for subscribers under contract with such corporation.

B. The articles of incorporation of each domestic health care plan shall have endorsed thereon or annexed thereto the consent of the superintendent prior to filing. The amendment of the articles of incorporation of any domestic health care plan shall have endorsed thereon or annexed thereto the consent of the superintendent prior to filing.

C. The directors of a domestic health care plan shall be chosen in accordance with the bylaws of the corporation, subject to the following:

(1) at least twenty-five percent of the directors shall be members of the general public; and

(2) the balance of the directors shall be either representatives of purveyors or members of the general public.

D. No domestic health care plan shall be converted into a corporation organized for pecuniary profit; and any such plan shall be maintained and operated primarily for the benefit of its subscribers.

E. A domestic health care plan may merge only with another domestic health care plan in accordance with applicable provisions of the Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978] and the Nonprofit Corporation Act [Chapter 53, Article 8 NMSA 1978].

History: Laws 1984, ch. 127, § 879.2; 1999, ch. 133, § 2.

59A-47-5. Qualifications for health care plan authority.

The superintendent shall not authorize any proposed health care plan to solicit preliminary applications from subscribers or to transact business as a health care plan unless he finds after such investigation and hearings as he deems advisable that the proposed health care plan is qualified therefor as follows:

A. it shall be duly incorporated as a health care plan under the laws of a state governing incorporation of nonprofit corporations;

B. its sponsors shall have financial stability and its directors and officers shall be individuals of good personal and business reputation and integrity;

C. its proposed management shall possess experience and competence as to the business in which to engage;

D. it shall have ready access to health care facilities in this state reasonably sufficient to provide the health care services to be covered by its subscriber contracts, whether on service or indemnity bases;

E. it shall actually or prospectively have sufficient funds to finance preliminary solicitation of subscribers and to conduct its operations with reasonable margin of financial safety;

F. its proposed contracts to be offered subscribers shall be well drafted and provide substantial health care coverage and benefits at reasonable premium rates;

G. operation of the health care plan in the area of this state proposed to be served would be in the public interest and of convenience to its residents; and

H. if it [is] a newly formed health care plan, prior to being granted an initial certificate of authority to engage in business, it shall have applied for and received from the superintendent a preliminary permit to solicit subscribers' applications for health care contracts as proposed to be offered, and thereunder have solicited and received, within one year from date of the preliminary permit, applications for coverage of not less than one thousand individuals under such contracts together with payment in advance of one month's premium therefor or if it is a foreign health care plan with a certificate of authority from its state of domicile, it must already cover not less than one thousand individuals.

History: Laws 1984, ch. 127, § 879.3; 1987, ch. 259, § 30; 1999, ch. 133, § 3.

59A-47-6. Preliminary permit for solicitations.

A. A newly-formed health care plan shall not solicit any subscriber or enter into any proposed contract for health care expense payments unless and until it obtains from the superintendent a preliminary permit to do so. The proposed health care plan shall file

with the superintendent its application in writing for the permit in form as prescribed and furnished by the superintendent and calling for information as follows:

(1) name and business address of applicant;

(2) area of this state proposed to be served;

(3) names, residence addresses, occupations, business experience, biographical data, and such proof of identity as the superintendent may require of the incorporators, sponsors, directors, officers and proposed management personnel;

(4) health care coverage proposed to be provided and premium rates therefor, as shown by two (2) copies of proposed subscribers' contracts and premium rate schedules filed with the application;

(5) financial resources, present or prospective, of applicant; and

(6) such other information as to applicant's qualifications as the superintendent may reasonably require.

The application shall be accompanied by a copy of applicant's articles of incorporation and its bylaws, its current financial statement, and such other documentation as the form of application may require. Upon filing the application the applicant shall pay to the superintendent the filing fee specified therefor in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code.

B. If after such investigation of the applicant and its sponsors and personnel, and hearings held, as he deems advisable the superintendent finds that the applicant meets the qualifications stated in Section 879.3 [59A-47-5 NMSA 1978] of this article and is otherwise in compliance with this article, he shall issue a preliminary permit in appropriate terms; otherwise he shall deny the permit by his written order stating the reasons for the denial.

History: Laws 1984, ch. 127, § 879.4.

59A-47-7. Escrow of preliminary premiums.

With its application for a preliminary permit as provided for in Section 879.4 [59A-47-6 NMSA 1978] of this article the applicant shall file with the superintendent documentation of an escrow arrangement made by applicant and satisfactory to the superintendent adequate to insure return to applicants for subscribers' health care contracts of advance premium payments made, if within one year from date of issuance of the preliminary permit an initial certificate of authority to do business as a health care plan has not been issued to the applicant by the superintendent.

History: Laws 1984, ch. 127, § 879.5.

59A-47-8. Certificate of authority required; application and conditions; exceptions.

A. No health care plan shall make health care expense payments unless and until it has obtained from the superintendent a certificate of authority to do business. Violation of this provision shall constitute a misdemeanor punishable upon conviction by a fine of not to exceed one thousand dollars ($1,000).

B. A newly formed health care plan's application for initial certificate of authority must be filed with the superintendent prior to expiration of one year from date of issuance of the preliminary permit referred to in Section 59A-47-6 NMSA 1978.

C. The application for certificate of authority shall be in the form prescribed and furnished by the superintendent consistent with Chapter 59A, Article 47 NMSA 1978, and be verified by two of the applicant's officers. The application shall include or be accompanied by such proof as the superintendent may reasonably require that the applicant is qualified for the certificate of authority under this article. At filing of the application the applicant shall pay to the superintendent the applicable filing fee as specified in Section 59A-6-1 NMSA 1978. The filing fee shall not be refundable.

D. No such certificate of authority shall be required for a health care plan formerly so authorized, to enable it to investigate and settle losses under its contracts lawfully written in New Mexico, or to liquidate assets and liabilities (other than collection of new premiums) resulting from its former authorized operations in this state. A health care plan not transacting new business in this state but continuing collection of premiums on and servicing contracts remaining in force as to residents of or risks located in this state, is transacting business in New Mexico for the purpose of premium tax requirements only and is not required to have a certificate of authority.

History: Laws 1984, ch. 127, § 879.6; 1999, ch. 133, § 4.

59A-47-9. Issuance and denial of initial certificate of authority.

A. If after such investigation as he deems advisable the superintendent finds that the applicant is in sound financial condition and is otherwise qualified therefor, he shall issue to the applicant a certificate of authority as a health care plan.

B. If the superintendent does not so find, he shall deny issuance of the certificate of authority and notify the applicant thereof in writing stating the reasons for such denial.

History: Laws 1984, ch. 127, § 879.7; 1999, ch. 133, § 5.

59A-47-10. Trust deposit.

A. Every health care plan shall make and thereafter maintain a deposit in trust with the state treasurer through the superintendent for the benefit and protection of all of its subscribers, as a condition to being authorized to transact business. The deposit shall consist of United States treasury bonds or other securities of the United States government or agency thereof, or in bonds or obligations of any state, county or other political subdivision in the United States, or in certificates of deposit of solvent financial institutions located in New Mexico, purchased within this state and having at all times a market value of not less than one hundred thousand dollars ($100,000).

B. Any such trust deposit shall be released in the following instances only:

(1) upon extinguishment of all liabilities of the health care plan for the security of which the deposit is held;

(2) upon the health care plan ceasing to transact business in New Mexico, and all fixed or contingent liabilities for which the deposit was a security have been satisfied or terminated, or have been assumed by some other company authorized to transact business in New Mexico; or

(3) upon proper order of a court of competent jurisdiction, the trust deposit may be released to the receiver, conservator, rehabilitator or liquidator of the health care plan for whose account the deposit is held.

No such release shall be made except on application and written order of the superintendent made upon proof satisfactory to him of the existence of one or more of such grounds. Before directing the release of any securities the superintendent may require such evidence as he deems satisfactory that the health care plan is entitled to the release and return of the securities or a part thereof. The superintendent shall have no personal liability for any such release of any trust deposit or any part thereof so made in good faith.

History: Laws 1984, ch. 127, § 879.8.

59A-47-11. Expiration, continuance of certificate of authority.

The certificate of authority of a health care plan issued under this article shall be subject to continuation or expiration upon the same applicable procedures and time periods as provided in Article 5 [Chapter 59A, Article 5 NMSA 1978] (authorization of insurers and general requirements) of the Insurance Code with respect to authorized insurers, and upon payment of the applicable fees specified in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code.

History: Laws 1984, ch. 127, § 879.9.

59A-47-12. Suspension, revocation or refusal to continue certificate of authority.

The superintendent may suspend, revoke or refuse to continue the certificate of authority of any health care plan if the health care plan no longer fulfills the qualifications therefor as stated in this article or on any applicable ground, procedure and conditions on which he could suspend, revoke or refuse continuance of the certificate of authority of an insurer under Article 5 [Chapter 59A, Article 5 NMSA 1978] (authorization of insurers and general requirements) of the Insurance Code.

History: Laws 1984, ch. 127, § 879.10.

59A-47-13. Service of process; superintendent as attorney.

Prior to issuance of its initial certificate of authority, the health care plan shall appoint the superintendent and his successors as its true and lawful attorney upon whom may be served all lawful process in any action or legal proceedings against it by a resident of New Mexico or where the cause of action arises in this state. In the appointment the health care plan shall agree that any such process so served shall be of the same effect and validity as if served on the health care plan direct. The appointment shall continue in force irrevocably so long as any liability of the health care plan under a subscriber's contract in this state remains outstanding. Process shall be served upon the superintendent in the same manner and subject to the same conditions as provided in Section 99 [59A-5-32 NMSA 1978] of the Insurance Code as for service of process against insurers.

History: Laws 1984, ch. 127, § 879.11.

59A-47-14. Annual statement.

As prerequisite to continuance of its certificate of authority, each health care plan shall on or before March 1 each year file with the superintendent and with the national association of insurance commissioners an annual statement in accordance with the requirements of Section 59A-5-29 NMSA 1978 and a risk-based capital report in accordance with the requirements of Section 59A-5A-3 NMSA 1978.

History: Laws 1984, ch. 127, § 879.12; 2014, ch. 59, § 52.

59A-47-15. Assets.

In determining the financial condition of a health care plan there shall be allowed as assets only such assets allowed as to life or health insurers under Sections 118 [59A-8-1 NMSA 1978] ("assets" defined) and 119 [59A-8-2 NMSA 1978] (assets not allowed) of the Insurance Code.

History: Laws 1984, ch. 127, § 879.13.

59A-47-16. Reserves.

A health care plan shall establish and maintain reserves in amount clearly adequate, as determined by the superintendent, to cover all liabilities for losses incurred and unpaid.

History: Laws 1984, ch. 127, § 879.14.

59A-47-17. Examination.

A health care plan, or organizaion [organization] proposing or purporting to be a health care plan, shall be subject to investigation and examination by the superintendent upon the same bases, in the same manner and subject to the same provisions as to conduct of the examination, payment of expense or costs of the examination, making, approval and filing of examination report, and all related provisions, as apply as to investigation or examination of insurers under Article 4 [Chapter 59A, Article 4 NMSA 1978] (examinations, hearings and appeals) of the Insurance Code.

History: Laws 1984, ch. 127, § 879.15.

59A-47-18. Investments.

A health care plan shall invest its funds only in such securities and assets as are eligible for investment of the funds of health insurers under Article 9 [Chapter 59A, Article 9 NMSA 1978] (investments) of the Insurance Code, and subject to the provisions of that article as to investments and assets of such insurers.

History: Laws 1984, ch. 127, § 879.16.

59A-47-19. Limitation upon acquisition and administration expenses.

No health care plan shall during any one calendar year incur expense for acquisition of its business more than ten percent of its premium income earned during that year; nor incur during any such year for expense of administration more than twenty percent of such earned premiums.

History: Laws 1984, ch. 127, § 879.17.

59A-47-20. Conflicts of interest as to certain transactions.

A. No director or officer of any health care plan, or employee of such plan having authority for investment or expenditure of funds, shall accept except for the health care plan or be beneficiary of any fee, brokerage, gift or other emolument in addition to his fixed salary or compensation, because of any investment, loan, deposit, purchase, sale, exchange, reinsurance or other similar transaction made by or for the health care plan,

or be pecuniarily interested therein in any capacity except on behalf of the health care plan.

B. No health care plan shall guarantee the financial obligation of any of its officers, directors or employees.

C. This section shall not prohibit such a director, officer or employee from becoming a subscriber of the health care plan and enjoying thereunder the rights customarily provided to such subscribers, nor shall it prevent any director, officer or employee from being a purveyor or from being associated with or employed by a purveyor, who receives in ordinary course of business health care expense payments made by the health care plan for services or materials furnished to subscribers.

History: Laws 1984, ch. 127, § 879.18.

59A-47-21. Joint coverage, reinsurance.

Two (2) or more health care plans may enter into and carry out cooperative agreements under which subscribers may subscribe jointly to and receive the benefits of all such plans; and any health care plan may enter into and carry out reinsurance agreements.

History: Laws 1984, ch. 127, § 879.19.

59A-47-22. Transfer of subscribership.

A. A health care plan may enter into agreements with another health care plan or mutual company similarly engaged in this state or another state or country for transfer of subscribers from one such plan to the other, subject to prior approval of any such agreement by the superintendent. The superintendent shall disapprove any such agreement if he finds on basis of such investigation as he deems advisable that the agreement in reasonable probability would result in loss to the health care plan authorized to do business in this state or is otherwise unfair or inequitable. The superintendent shall approve the agreement if he finds that the transfer of subscribership is to be accompanied by transfer of funds representing reserves in amount adequate to cover all liabilities to be incurred by the assuming health care plan through such transfer, that the transfer meets the applicable requirements of Chapter 59A, Article 34 NMSA 1978 and of the Nonprofit Corporation Act [Chapter 53, Article 8 NMSA 1978] for disposition or distribution of assets and that the agreement is otherwise fair and equitable to the insurers and subscribers involved.

B. The superintendent shall ensure, by imposition of conditions, if necessary, that New Mexico charitable assets are protected and preserved for the benefit of the people of New Mexico.

History: Laws 1984, ch. 127, § 879.20; 1999, ch. 133, § 6.

59A-47-23. Subscriber contracts; coverage period.

Every health care expense payments contract made by a health care plan under this article shall provide coverage for the subscribers thereunder for a period of not less than one month; and no such contract shall be made which provides for an effective date which is more than six (6) months prior to or after the date when the contract was actually issued by the health care plan.

History: Laws 1984, ch. 127, § 879.21.

59A-47-24. Subscriber contracts; requirements and provisions.

Every health care expense payments contract issued under this article shall be in writing and comply with requirements and contain provisions in substance as follows:

A. a provision that the policy, the application of the policyholder (if it or a copy thereof is attached to the policy) and the individual applications, if any, submitted in connection with such policy by the employees or members, constitutes the entire contract between the parties, that no statement therein is a warranty in the absence of fraud and that no such statement shall avoid the obligation of the health care plan provided in the policy or reduce benefits thereunder unless contained in a written application for such contract, attached to and made part of the policy;

B. if such contract is a group contract, a provision that the health care plan will furnish to the subscriber, for delivery to each employee or member of any covered group, an individual certificate, or an identification card, or other evidence of such coverage, setting forth in summary form a statement of the essential features of the contract of all persons included in the coverage;

C. if such contract is a group contract, a provision that eligible new employees or members or dependents, as the case may be, may be added from time to time to the group originally covered, in accordance with the terms of the contract;

D. the amount payable to the health care plan by the subscriber, and the time at which and manner in which such amount is to be paid;

E. the nature of the benefits which will be furnished and the period during which they will be furnished and, if there are any benefits to be excepted, a detailed statement of such exceptions;

F. any specific term or condition to the effect that the contract may be canceled or otherwise terminated by the health care plan, including the manner and time of such termination; provided a contract may not be canceled during the period for which the premium has been paid unless written notice is delivered to the insured, or mailed to his last address as shown by the records of the health care plan, stating when, not less than five days thereafter such cancellation shall be effective;

G. that the contract includes the endorsements thereon and attached papers, if any, and constitutes the entire contract;

H. that after two years no statement (except a fraudulent statement) by the subscriber in the application for a contract shall void the contract or be used against the subscriber in any legal action or proceedings relating to the contract unless such application or a true copy thereof is included in or attached to such contract; a statement that no change in the contract shall be valid until approved by an executive officer of the health care plan and unless such approval and countersignature be endorsed on or attached to such contract; and a statement that no agent has authority to change the contract or waive any of its provisions. No claim for loss incurred or disability (as defined in the policy) shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of such policy;

I. that if the subscriber defaults in making any payment under the contract, the subsequent acceptance of an application for reinstatement and accompanying payment or its failure to take any action with respect thereto within thirty days following receipt of such application for reinstatement, by such health care plan or any duly authorized agent thereof reinstates the contract. The reinstated policy shall cover only loss resulting from such accidental injury as may [be] sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the subscriber and the health care plan shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed thereon or attached thereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which a premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement. (The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty (50) or (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from the date of its issue); and

J. the period of grace which will be allowed the subscriber for making any payment due under the contract, which period shall not be less than ten (10) days.

History: Laws 1984, ch. 127, § 879.22.

59A-47-25. Subscriber contracts; filing, approval.

No health care plan shall make or issue any health care expense payments contract or certificate therefor unless it has first filed with the superintendent a copy of the form of the proposed contract or certificate and a copy of all applications, riders and endorsements to be used in connection with or for renewal thereof, and the same have been approved by the superintendent. If the superintendent finds that the proposed

forms are in compliance with applicable requirements of this article and are not to be disapproved by him as stated below, he shall approve the forms. The superintendent may disapprove any such form on any of the grounds for disapproval of a health insurance policy under Section 344 [59A-18-14 NMSA 1978] of the Insurance Code. The superintendent shall notify the health care plan of his approval or disapproval within thirty (30) days after such filing, or within sixty (60) days after such filing if he so extends the time; and if the superintendent fails to act within such period the form shall be deemed approved.

History: Laws 1984, ch. 127, § 879.23.

59A-47-26. Premium rates; filing and approval.

A. No health care plan shall enter into any contract with a subscriber unless it has first filed with the superintendent a full schedule of premium rates to be paid by the subscribers. The superintendent shall notify the health care plan of his approval or disapproval of such rates within fifteen (15) days after the filing thereof, or within thirty (30) days after such filing if he shall so extend the time, and if the superintendent fails to act within such period, the rates shall be deemed approved.

B. At the time the health care plan files such rates with the superintendent, it shall also file a full schedule of all health care expense payments to be made under the contracts.

C. The superintendent may disapprove any such rate found by him to be excessive, inadequate or unfairly discriminatory, considering the health care expense payments to be made.

History: Laws 1984, ch. 127, § 879.24.

59A-47-27. Coverage for newly born children, maternity transport, home health care.

Subscriber contracts of a health care plan shall also be subject to coverage as required of health insurers under Sections 59A-22-34 through 59A-22-36 NMSA 1978.

History: Laws 1984, ch. 127, § 879.25; 1987, ch. 259, § 31.

59A-47-27.1. Coverage of circumcision for newborn males.

An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall provide coverage for circumcision for newborn males.

History: Laws 2004, ch. 122, § 10.

59A-47-28. Coverage for service of chiropractor.

All individual and group subscriber contracts delivered or issued for delivery in New Mexico, which, on a service basis or on an indemnity basis, or both, provide for treatment of persons for the prevention, cure or correction of any illness or physical or mental condition shall include coverage for the services of a chiropractor.

History: Laws 1984, ch. 127, § 879.26.

59A-47-28.1. Coverage for service of certified nurse-midwives and registered lay midwives.

A. Any individual and group subscriber contracts delivered in New Mexico which provide for obstetrical and/or maternity benefits on a service basis or an indemnity basis, or both, provide for treatment of persons for the prevention, cure or correction of any illness or physical or mental condition shall include coverage for the services of a certified nurse-midwife or registered lay midwife as defined in Subsection B of this section. Deductibles, limits of coverage or other terms and conditions of coverage for such services shall not differ substantially from coverage for the same or similar services provided by other practitioners.

B. As used in this section:

(1) "certified nurse-midwife" means any person who is licensed by the board of nursing as a registered nurse and who is registered with the health services division of the health and environment department [department of health] as a certified nurse-midwife; and

(2) "registered lay midwife" means any person who practices lay midwifery and who is registered as a registered lay midwife by the health services division of the health and environment department [department of health].

History: 1978 Comp., § 59A-47-28.1, enacted by Laws 1985, ch. 192, § 2.

59A-47-28.2. Doctor of oriental medicine discrimination prohibited.

All individual and group subscriber contracts delivered or issued for delivery in New Mexico by a nonprofit health care plan that, on a service or indemnity basis, or both, provide for treatment of persons for the prevention, cure or correction of any illness or physical or mental condition shall not contain any provisions that exclude a licensed doctor of oriental medicine as a provider of oriental medical services and shall not discriminate in the reimbursement levels for such services between types of licensed health care providers.

History: 1978 Comp., § 59A-47-28.2, enacted by Laws 1991, ch. 145, § 1; 1993, ch. 158, § 6.

59A-47-28.3. Provider discrimination prohibited.

All individual and group subscriber contracts delivered or issued for delivery in New Mexico that, on a prepaid, service or indemnity basis, or all of them, provide for treatment of persons for the prevention, cure or correction of an illness or physical or mental condition shall include coverage for the services of a physician assistant and a certified nurse practitioner. Deductibles, limits of coverage or other terms and conditions of coverage for certified nurse practitioners and physician assistants shall not differ substantially from coverage for the same or similar services provided by other practitioners. Nothing in this section shall restrict a health care plan from including in the terms of its coverage any benefit differences based on differences in the scope of practice of health care practitioners.

History: 1978 Comp., § 59A-47-28.3, enacted by Laws 1998, ch. 39, § 2; 2008, ch. 9, § 6.

59A-47-28.4. Coverage for collaborative practice; dental therapists; dental hygienists.

An individual or group subscriber contract delivered or issued for delivery in New Mexico that, on a prepaid, service or indemnity basis, provides for treatment of persons for the prevention, cure or correction of any illness or physical or mental condition shall include coverage for the services of a dental therapist and a dental hygienist in a collaborative practice pursuant to the Dental Health Care Act [Chapter 61, Article 5A NMSA 1978].

History: Laws 2003, ch. 343, § 4; 2019, ch. 107, § 16.

59A-47-29. Settlement of disputes; appeal.

The parties to a dispute between a health care plan and a purveyor arising out of a health care expense payments contract may submit the dispute to the superintendent for his final decision and his final decision shall then be binding upon the parties to the contract. A party to the contract may seek review of the superintendent's decision by filing an appeal in the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1984, ch. 127, § 879.28; 1998, ch. 55, § 68; 1999, ch. 265, § 71.

59A-47-30. Licensed insurance producers required; qualifications, licensing procedures and conditions.

A. Solicitation of subscriberships for a health care plan shall be made only by insurance producers of the plan who are duly qualified, appointed and licensed as such under the Insurance Code. This provision shall not apply to salaried officers or employees of health care plans who are visiting or instructing their licensed insurance producers and who do not receive any part of the commission for any business written by such insurance producers with their assistance.

B. No person shall be appointed or licensed as a health care plan insurance producer unless qualified as follows:

(1) is an individual at least eighteen years of age;

(2) has had, or will receive, reasonable experience or instruction in the health care plan for which license is applied;

(3) is trustworthy and of good business reputation;

(4) intends to engage in a bona fide way in the business of the health care plan; and

(5) passes an examination for license given by or under authorization of the superintendent.

C. A health care plan insurance producer shall be appointed by and at any one time represent only one health care plan.

D. Subject to the other provisions of this section, procedures for appointment and licensing insurance producers, examination, issuance or denial of license, continuation or expiration, suspension, revocation or refusal to continue license and other applicable matters relating to licensing and licenses shall be as provided as to licenses of insurance producers as to health insurance under Chapter 59A, Article 11 NMSA 1978. Fee for application for license and continuation of license shall be as specified in Section 59A-6-1 NMSA 1978, and neither fee shall be refundable.

History: Laws 1984, ch. 127, § 879.29; 1999, ch. 272, § 23; 1999, ch. 289, § 35; 2016, ch. 89, § 67.

59A-47-31. Rehabilitation, liquidation or dissolution.

If the superintendent finds that expenses incurred by a health care plan for acquisition of business or administration exceed the limits prescribed under Section 879.17 [59A-47-19 NMSA 1978] of this article, or that the health care plan is at any time unable or prospectively unable to fulfill its outstanding contracts and also to meet the requirements of this article as to expenses, reserves, deposit and surplus funds, or is otherwise insolvent or likely to become insolvent, the superintendent may institute and maintain proceedings to conserve, rehabilitate, liquidate or dissolve such health care

plan pursuant to the provisions of Article 41 [Chapter 59A, Article 41 NMSA 1978] (conservation, rehabilitation, liquidation) of the Insurance Code as applicable to insurers.

History: Laws 1984, ch. 127, § 879.30.

59A-47-32. Unauthorized contract or adjustment transactions; penalty.

A. Any person writing or attempting to write, solicit or procure health care plan contracts within this state without a certificate of authority or license duly issued in accordance with the Insurance Code and then required and subsisting, and any person adjusting, settling or knowingly accepting adjustment or settlement of any loss covered by a contract written or issued by any health care plan not holding a subsisting certificate of authority issued by the superintendent, shall be guilty of a misdemeanor, and upon conviction thereof shall be fined not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000), or imprisoned in the county jail for not less than thirty (30) nor more than sixty (60) days, or both such fine and imprisonment in the court's discretion.

B. The exemptions from certificate of authority requirements of insurers as provided in Section 78 [59A-5-11 NMSA 1978] of the Insurance Code shall to the extent applicable also apply as to health care plans and their contracts under this section.

History: Laws 1984, ch. 127, § 879.31.

59A-47-33. Other provisions applicable.

The provisions of the Insurance Code [Chapter 59A NMSA 1978] 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 [repealed];

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 Chapter 59A, Article 37 NMSA 1978, except Section 59A-37-7 NMSA 1978;

Z. Section 59A-46-15 NMSA 1978 [repealed];

AA. the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978]; and

BB. the Surprise Billing Protection Act [59A-57A-1 to 59A-57A-13 NMSA 1978].

History: Laws 1984, ch. 127, § 879.32; 1988, ch. 89, § 5; 1990, ch. 5, § 4; 1992, ch. 56, § 4; 1993, ch. 320, § 103; 1994, ch. 64, § 10; 1994, ch. 75, § 34; 1997, ch. 7, § 4; 1997, ch. 248, § 3; 1997, ch. 255, § 4; 1998, ch. 107, § 14; 1999, ch. 289, § 36; 2001, ch. 14, § 4; 2001, ch. 297, § 6; 2003, ch. 337, § 5; 2007, ch. 278, § 4; 2009, ch. 212, § 5; 2021, ch. 108, § 29.

59A-47-34. Continuation of coverage and conversion rights; health care plans.

A. Every individual or group contract entered into by a health care plan that provides for health care expense payments on a service benefit basis or an indemnity benefit basis or both and that is delivered, issued for delivery or renewed in this state on or after July 1, 1984 shall provide covered family members of subscribers the right to continue such coverage through a converted or separate contract upon the death of the subscriber or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the subscriber. Where a continuation of coverage or conversion is made in the name of the spouse of the subscriber, such coverage may, at the option of the spouse, include coverage to dependent children for whom the spouse has responsibility for care and support.

B. The right to a continuation of coverage or conversion pursuant to this section shall not exist with respect to any covered family member of a subscriber in the event the coverage terminates for nonpayment of premium, nonrenewal of the contract or the expiration of the term for which the contract is issued. With respect to any covered family member who is eligible for medicare or any other similar federal or state health insurance program, the right to a continuation of coverage or conversion shall be limited to coverage under a medicare supplement insurance contract as defined by the rules and regulations adopted by the superintendent of insurance.

C. Coverage continued through the issuance of a converted or separate contract shall be provided at a reasonable, nondiscriminatory rate to the insured and shall consist of a form of coverage then being offered by the health care plan as a conversion contract in the jurisdiction where the person exercising the conversion right resides that most nearly approximates the coverage of the contract from which conversion is exercised. Continued and converted coverages shall contain renewal provisions that are not less favorable to the subscriber than those contained in the policy from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a medicare supplement insurance contract, as defined by the rules and regulations adopted by the superintendent of insurance, after the attainment of the age of eligibility for medicare or any other similar federal or state health insurance program.

D. At the time of inception of coverage, the health care plan shall provide each covered family member eighteen years of age or older a statement setting forth in summary form the continuation of coverage and conversion provisions of the subscriber's contract.

E. The eligible covered family member exercising the continuation or conversion right must notify the health care plan and make payment of the applicable premium within thirty days following the date such coverage otherwise terminates as specified in the contract from which continuation or conversion is being exercised.

F. Coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations.

G. Any probationary or waiting period set forth in the converted or separate contract is deemed to commence on the effective date of the applicant's coverage under the original contract.

History: Laws 1984, ch. 127, § 879.33; 2019, ch. 259, § 19.

59A-47-35. Alcohol dependency coverage.

A. Each health care plan that delivers or issues for delivery in this state a group contract providing for health care expense payments on a service benefit basis or an indemnity benefit basis or both shall offer and make available benefits for the necessary care and treatment of alcohol dependency. Such benefits shall:

(1) be subject to annual deductibles and coinsurance consistent with those imposed on other benefits within the same contract;

(2) provide no less than thirty days necessary care and treatment in an alcohol dependency treatment center and thirty outpatient visits for alcohol dependency treatment; and

(3) be offered for benefit periods of no more than one year and may be limited to a lifetime maximum of no less than two benefit periods.

Such offer of benefits shall be subject to the rights of the group contract holder to reject the coverage or to select any alternative level of benefits if that right is offered by or negotiated with that health care plan.

B. For purposes of this section, "alcohol dependency treatment center" means a facility that contracts with the health care plan and that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a physician or meeting the quality standards of the department of health and which facility also:

(1) is affiliated with a hospital under a contractual agreement with an established system for patient referral;

(2) is accredited as such a facility by the joint commission on accreditation of hospitals; or

(3) meets at least the minimum standards adopted by the department of health.

C. This section applies to contracts delivered or issued for delivery or renewed, extended or amended in this state on or after July 1, 1983 or upon expiration of a collective bargaining agreement applicable to a particular contract holder, whichever is later; provided that this section does not apply to blanket, short-term travel, accident-only, limited or specified disease, individual conversion contracts or contracts designed for issuance to persons eligible for coverage under Title 18 of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental plans. With respect to any contract forms approved by the insurance division prior to the effective date of this section, an insurer is authorized to comply with this section by the use of endorsements or riders, provided such endorsements or riders are approved by the insurance division as being in compliance with this section and applicable provisions of the Insurance Code.

D. If an organization offering group health benefits to its members makes more than one health care plan or health insurance plan policy available to its members on a member option basis, the organization shall not require alcohol dependency coverage from one health care plan or health insurer without requiring the same level of alcohol dependency coverage for all other health care plans or health insurance policies that the organization makes available to its members.

History: Laws 1984, ch. 127, § 879.34; 1999, ch. 270, § 8.

59A-47-36. Nonprofit health care plans; contract or certificate provisions relating to individuals who are eligible for medical benefits under the medicaid program.

A. Each individual or group contract for health care expense payments or certificate therefor that is delivered, issued for delivery or renewed in this state by a health care plan shall include provisions that require benefits paid on behalf of a subscriber under the contract or certificate to be paid to the human services department [health care authority department] when:

(1) the human services department [health care authority department] has paid or is paying health care expenses on behalf of the subscriber under the state's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;

(2) payment for the expenses in question has been made by the human services department [health care authority department] to the medicaid provider; and

(3) the health care plan is notified that the subscriber receives benefits under the medicaid program and that benefits must be paid directly to the human services department [health care authority department].

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the human services department [health care authority department] for health care expense payments when the claim is first submitted by the human services department [health care authority department] to the health care plan.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any individual or group contract for health care expense payments or certificate therefor for health care services provided to subscribers who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the contract or certificate shall be made payable to the provider. The health care plan may be notified that the subscriber is eligible for medicaid benefits through an attachment to the claim by the provider for health care expense payments when the claim is first submitted by the provider to the health care plan.

D. No individual or group contract for health care expense payments or certificate therefor delivered, issued for delivery or renewed in this state on or after the effective date of this section shall contain any provision denying or limiting contract benefits because services are rendered to a subscriber who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where a health care plan has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by the health care plan for those health care items or services.

History: 1978 Comp., § 59A-47-36, enacted by Laws 1989, ch. 183, § 7; 1994, ch. 64, § 11.

59A-47-37. Coverage of children.

A. An insurer shall not deny enrollment of a child under the health plan of the child's parent on the grounds that the child:

(1) was born out of wedlock;

(2) is not claimed as a dependent on the parent's federal tax return; or

(3) does not reside with the parent or in the insurer's service area.

B. When a child has health coverage through an insurer of a noncustodial parent, the insurer shall:

(1) provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(3) make payments on claims submitted in accordance with Paragraph (2) of this subsection directly to the custodial parent, the provider or the state medicaid agency.

C. When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall be required:

(1) to permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) if the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

(3) not to disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(a) the court or administrative order is no longer in effect; or

(b) the child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.

D. An insurer shall not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the medicaid program and covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

E. An insurer shall provide coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the early childhood education and care department, provided eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars ($3,500) annually for medically necessary

early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel who are working in early intervention programs approved by the early childhood education and care department. No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.

History: Laws 1994, ch. 64, § 12; 2005, ch. 157, § 5; 2019, ch. 48, § 33.

59A-47-37.1. Hearing aid coverage for children required.

A. An individual or group health insurance policy, health care plan or certificate of health insurance delivered or issued for delivery in this state shall provide coverage for a hearing aid and any related service for the full cost of one hearing aid per hearing-impaired ear up to two thousand two hundred dollars ($2,200) every thirty-six months for hearing aids for insured children under eighteen years of age or under twenty-one years of age if still attending high school. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two-thousand-two-hundred-dollar ($2,200) limit as provided in this subsection without financial or contractual penalty to the insured or to the provider of the hearing aid.

B. An insurer that delivers, issues for delivery or renews in this state an individual or group health insurance policy, health care plan or certificate of health insurance may make available to the policyholder the option of purchasing additional hearing aid coverage that exceeds the services described in this section.

C. Hearing aid coverage offered shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a physician, licensed in New Mexico.

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

E. Coverage for hearing aids may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

F. For the purposes of this section, "hearing aid" means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

History: Laws 2007, ch. 356, § 5.

59A-47-38. Coverage for medical diets for genetic inborn errors of metabolism.

As of July 1, 2003, subscriber contracts of a health care plan shall also be subject to coverage for special medical diets for genetic inborn errors of metabolism as required of health insurers in Chapter 59A, Article 22 NMSA 1978.

History: Laws 2003, ch. 192, § 3.

59A-47-39. Employer utilization and loss experience availability.

Employer claims information, including utilization and loss experience under health insurance provided under Chapter 59A, Article 47 NMSA 1978 shall be made available by the carrier only upon the written request of and to employers of subscribers with such coverage within thirty days of an employer's written request to the carrier for such information, provided the employer's coverage extends to no less than twenty-five individual subscribers, regardless of whether family coverage is included. Each carrier shall provide to the employer claims information that provides sufficient detail, subject to state and federal privacy laws, to enable the employer to obtain and compare rates from multiple carriers or establish a plan of self-insurance.

History: Laws 2003, ch. 252, § 5; 2007, ch. 53, § 3.

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.

History: Laws 2003, ch. 391, § 7; 2005, ch. 41, § 3; 2021, ch. 108, § 30.

59A-47-41. Coverage of alpha-fetoprotein IV screening test.

An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall provide coverage for an alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks of pregnancy, to screen for certain genetic abnormalities in the fetus.

History: Laws 2004, ch. 122, § 9.

59A-47-41.1. Prior authorization for gynecological or obstetrical ultrasounds prohibited.

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 and that

provides coverage for gynecological or obstetrical ultrasounds shall not require prior authorization for gynecological or obstetrical ultrasounds.

B. Nothing in this section shall be construed to require payment for a gynecological or obstetrical ultrasound that is not:

(1) medically necessary; or

(2) a covered benefit.

C. As used in this section:

(1) "health care plan" means an organization that demonstrates to the office of superintendent of insurance that it has been granted exemption from the federal income tax by the United States commissioner of internal revenue as an organization described in Section 501(c)(3) of the United States Internal Revenue Code of 1986, as that section may be amended or renumbered, and is authorized by the office of superintendent of insurance to enter into contracts with subscribers and make health care expense payments; and

(2) "prior authorization" means advance approval that is required by a health care plan as a condition precedent to payment for medical care or related benefits rendered to a covered person, including prospective or utilization review conducted prior to the provision of covered medical care or related benefits.

History: Laws 2019, ch. 182, § 6.

59A-47-42. Coverage of part-time employees.

A health care plan that provides coverage for health care pursuant to the Nonprofit Health Care Plan Law shall make available, upon an employer's request prior to issuance, delivery or renewal, coverage for regular part-time employees who work or are expected to work an average of at least twenty hours per week over a six-month period. Nothing in this section shall be construed to require an employer to offer or provide coverage for regular part-time employees.

History: Laws 2005, ch. 42, § 4.

59A-47-43. Coverage of colorectal cancer screening.

A. An individual or group health policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall provide coverage for colorectal screening for determining the presence of precancerous or cancerous conditions and other health problems. The coverage shall make available colorectal cancer screening, as determined by the health care provider in accordance

with the evidence-based recommendations established by the United States preventive services task force.

B. Coverage for colorectal screening 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.

History: Laws 2007, ch. 17, § 4.

59A-47-44. General anesthesia and hospitalization for dental surgery.

A. An individual or group health insurance policy, health care plan or certificate of health insurance delivered or issued for delivery in this state shall provide coverage for hospitalization and general anesthesia provided in a hospital or ambulatory surgical center for dental surgery for the following:

(1) insureds exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;

(2) insureds for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

(3) insured children or adolescents who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

(4) insureds with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or

(5) other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.

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

C. Coverage for dental surgery may be subject to copayments, deductibles and coinsurance subject to network and prior authorization requirements consistent with those imposed on other benefits under the same policy, plan or certificate.

History: Laws 2007, ch. 218, § 5.

59A-47-45. Coverage for autism spectrum disorder diagnosis and treatment.

A. An individual or group health insurance policy, health care plan or certificate of health insurance delivered or issued for delivery in this state shall provide coverage to a subscriber for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the subscriber's treating physician in accordance with a treatment plan;

(2) shall not be subject to any annual or lifetime dollar limits;

(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the health care plan, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. Coverage for treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis shall not be denied to a subscriber on the basis of the subscriber's age.

D. The coverage required pursuant to Subsection A of this section shall not be subject to deductibles or coinsurance provisions that are less favorable to an insured than the deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health maintenance contract, except as otherwise provided in Subsection B of this section.

E. A health care plan shall not deny or refuse to issue health care plan coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

F. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health care plan to pay claims appropriately. These elements include:

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

G. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a health care plan.

H. The provisions of this section shall not apply to plans, contracts or policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance plans, contracts or policies.

I. As used in this section:

(1) "autism spectrum disorder" means:

(a) a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American psychiatric association; or

(b) a condition diagnosed as autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder or childhood disintegrative disorder pursuant to diagnostic criteria published in a previous edition of the *Diagnostic*

and Statistical Manual of Mental Disorders published by the American psychiatric association; and

(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual.

History: Laws 2009, ch. 74, § 4; 2019, ch. 119, § 6.

59A-47-45.1. Coverage for orally administered anticancer medications; limits on patient costs.

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 and that provides coverage for cancer treatment shall provide coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits by the plan.

B. A nonprofit health care plan shall not increase patient cost-sharing for anticancer medications in order to achieve compliance with the provisions of this section.

C. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, copayment, deductible or coinsurance provision that does not apply to intravenously administered or injected anticancer medication used to kill or slow the growth of cancerous cells.

D. As used in this section, "nonprofit health care plan":

(1) means:

(a) a nonprofit health insurer;

(b) a nonprofit health service provider;

(c) a nonprofit health maintenance organization;

(d) a nonprofit managed care organization; or

(e) a nonprofit provider service organization; and

(2) does not include individual policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies.

History: Laws 2011, ch. 55, § 5.

59A-47-45.2. Coverage of prescription eye drop refills.

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 and that provides coverage for prescription eye drops shall not deny coverage for a renewal of prescription eye drops when:

(1) the renewal is requested by the insured at least twenty-three days for a thirty-day supply of eye drops, forty-five days for a sixty-day supply of eye drops or sixty-eight days for a ninety-day supply of eye drops from the later of the date that the original prescription was dispensed to the insured or the date that the last renewal of the prescription was dispensed to the insured; and

(2) the prescriber indicates on the original prescription that additional quantities are needed and that the renewal requested by the insured does not exceed the number of additional quantities needed.

B. As used in this section, "prescriber" means a person who is authorized pursuant to the New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978] to prescribe prescription eye drops.

History: Laws 2012, ch. 27, § 5.

59A-47-45.3. Coverage for telemedicine services.

A. An individual or group health insurance policy, health care plan or certificate of health insurance delivered or issued for delivery in this state shall provide coverage for services provided via telemedicine to the same extent the health care plan covers the same services when those services are provided via in-person consultation or contact. A health care plan shall not impose any unique condition for coverage of services provided via telemedicine.

B. A health care plan shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by a nonprofit health plan that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act.

D. The provisions of this section shall not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. A health care plan shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the health care plan provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent.

G. A health care plan may charge a deductible, copayment or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. A health care plan shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the health care plan, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any plan year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health care plan.

I. A health care plan shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the carrier reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to an individual or group health care plan intended to supplement major medical group-type coverage, such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) "consulting telemedicine provider" means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) "health care provider" means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of the professional's license;

(3) "in real time" means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(4) "originating site" means a place at which a patient is physically located and receiving health care services via telemedicine;

(5) "store-and-forward technology" means electronic information, imaging and communication, including interactive audio, video and data communication, that is transferred or recorded or otherwise stored for asynchronous use; and

(6) "telemedicine" means the use of telecommunications and information technology to provide clinical health care from a distance. "Telemedicine" allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. "Telemedicine" allows patients in remote locations to access medical expertise without travel.

History: Laws 2013, ch. 105, § 5; 2019, ch. 255, § 5.

59A-47-45.4. Prescription drugs; prohibited formulary changes; notice requirements.

A. As of January 1, 2014, an individual or group health care plan that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall not make any of the following changes to coverage for a prescription drug within one hundred twenty days of any previous change to coverage for that prescription drug, unless a generic version of the prescription drug is available:

(1) reclassify a drug to a higher tier of the formulary;

(2) reclassify a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary;

(3) increase the cost-sharing, copayment, deductible or co-insurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

(6) impose or modify a drug's quantity limit; or

(7) impose a step-therapy restriction.

B. The health care plan shall give the affected subscriber at least sixty days' advance written notice of the impending change when it is determined that one of the following modifications will be made to a formulary:

(1) reclassification of a drug to a higher tier of the formulary;

(2) reclassification of a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary;

(3) an increase in the cost-sharing, copayment, deductible or coinsurance charges for a drug;

(4) removal of a drug from the formulary;

(5) addition of a prior authorization requirement;

(6) imposition or modification of a drug's quantity limit; or

(7) imposition of a step-therapy restriction for a drug.

C. Notwithstanding the provisions of Subsections A and B of this section, the health care plan may immediately and without prior notice remove a drug from the formulary if the drug:

(1) is deemed unsafe by the federal food and drug administration; or

(2) has been removed from the market for any reason.

D. The health care plan shall provide to each affected subscriber the following information in plain language regarding prescription drug benefits:

(1) notice that the health care plan uses one or more drug formularies;

(2) an explanation of what the drug formulary is;

(3) a statement regarding the method the health care plan uses to determine the prescription drugs to be included in or excluded from a drug formulary; and

(4) a statement of how often the health care plan reviews the contents of each drug formulary.

E. As used in this section:

(1) "formulary" means the list of prescription drugs covered by a health care plan; and

(2) "step therapy" means a protocol that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are to be prescribed.

History: Laws 2013, ch. 138, § 5.

59A-47-45.5. Coverage for contraception.

A. A health care plan delivered or issued for delivery in this state that provides a prescription drug benefit shall provide, at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

B. Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) cost sharing for subscribers;

(2) utilization review;

(3) prior authorization or step-therapy requirements; or

(4) any restrictions or delays on the coverage.

C. A health care plan may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method category of contraception without cost sharing by the subscriber; provided that when a subscriber's health care provider determines that a particular drug or item is medically necessary, the health care plan shall cover the brand-name pharmacy drug or item without cost sharing. A determination of medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. A health care plan shall grant a subscriber an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on a subscriber, the subscriber's representative or the subscriber's health care provider;

(2) defer to the determination of the subscriber's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

E. A health care plan shall not require a prescription for any drug, item or service that is available without a prescription.

F. A health care plan shall provide coverage and shall reimburse a health care provider or dispensing entity on a per unit basis for dispensing a six-month supply of contraceptives; provided that the contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe six months of contraceptives at one time; or

(2) permit a health care plan to limit coverage or impose cost sharing for an alternate method of contraception if a subscriber changes contraceptive methods before exhausting a previously dispensed supply.

H. The provisions of this section shall not apply to short-term travel, accident-only, hospital-indemnity-only, limited-benefit or specified-disease health care plans.

I. The provisions of this section apply to health care plans delivered or issued for delivery after January 1, 2020.

J. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms;

spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) "cost sharing" means a deductible, copayment or coinsurance that a subscriber is required to pay in accordance with the terms of a health care plan; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business.

K. A religious entity purchasing individual or group health care plan coverage may elect to exclude prescription contraceptive drugs or items from the health insurance coverage purchased.

History: Laws 2019, ch. 263, § 9.

59A-47-45.6. Coverage exclusion. (Contingent repeal. *See* note.)

Coverage of vasectomy and male condoms pursuant to Section 9 [59A-47-45.5 NMSA 1978] of this 2019 act is excluded for high-deductible health care plans with health savings accounts until a covered person's deductible has been met.

History: Laws 2019, ch. 263, § 10.

59A-47-45.7. Heart artery calcium scan coverage.

A. A group health care plan, other than a small group health care plan, that is delivered, issued for delivery or renewed in this state shall provide coverage for eligible subscribers to receive a heart artery calcium scan.

B. Coverage provided pursuant to this section shall:

(1) be limited to the provision of a heart artery calcium scan to an eligible subscriber to be used as a clinical management tool;

(2) be provided every five years if an eligible subscriber has previously received a heart artery calcium score of zero; and

(3) not be required for future heart artery calcium scans if an eligible subscriber receives a heart artery calcium score greater than zero.

C. At its discretion or as required by law, a health care plan may offer or refuse coverage for further cardiac testing or procedures for eligible subscribers based upon the results of a heart artery calcium scan.

D. The provisions of this section do not apply to short-term travel, accident-only or limited or specified- disease policies, plans or certificates of health insurance.

E. As used in this section:

(1) "eligible subscriber" means a subscriber who:

(a) is a person between the ages of forty-five and sixty-five; and

(b) has an intermediate risk of developing coronary heart disease as determined by a health care provider based upon a score calculated from an evidence-based algorithm widely used in the medical community to assess a person's ten-year cardiovascular disease risk, including a score calculated using a pooled cohort equation;

(2) "health care provider" means a physician, physician assistant, nurse practitioner or other health care professional authorized to furnish health care services within the scope of the professional's license; and

(3) "heart artery calcium scan" means a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function.

History: Laws 2020, ch. 79, § 5.

59A-47-45.8. Coverage for individuals with diabetes.

A. Each health care plan delivered or issued for delivery in this state shall provide coverage for individuals with diabetes who use insulin, individuals with diabetes who do not use insulin and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care benefit and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as otherwise provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same plan as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given plan. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary

alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health care plans described in that subsection shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for persons with disabilities, including the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of persons with disabilities, including the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health care plans described in that subsection shall be entitled to the following basic health care benefits:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a diagnosis from a health care practitioner that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the federal food and drug administration, all health care plans as described in Subsection A of this section shall:

(1) maintain an adequate formulary to provide those resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drugs, insulin or supplies described in this subsection within the limits of the health care plan.

F. A health care plan that requires a subscriber to use a specific network provider or to purchase equipment, appliances, supplies or insulin or prescription drugs for the treatment or management of diabetes from a specific durable medical equipment supplier or other supplier as a condition of coverage, payment or reimbursement shall:

(1) maintain an adequate network of durable medical equipment suppliers and other suppliers to provide subscribers with medically necessary diabetes resources whether covered under the health care plan's prescription drug or medical benefit;

(2) have network contracts in place for the entire plan period and shall not allow contracts with network providers, durable medical equipment suppliers and other suppliers to lapse or terminate without ensuring the availability of a replacement and continuity of care; provided that single-case agreements do not satisfy the requirements of Paragraph (1) of this subsection or this paragraph;

(3) monitor network providers, durable medical equipment suppliers and other network suppliers to ensure that medically necessary equipment, appliances, supplies and insulin or other prescription drugs are being delivered to a subscriber in a timely manner and when needed by the subscriber;

(4) guarantee reimbursement to a subscriber within thirty days following receipt of a written demand from the subscriber who pays out of pocket for necessary equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered timely to the subscriber and the portion of payment for

which the patient is responsible shall not exceed the amount for the same covered benefit obtained from a contracted supplier;

(5) pay interest at the rate of eighteen percent per year on the amount of reimbursement due to a subscriber if not paid within thirty days as required by Paragraph (4) of this subsection;

(6) beginning on April 1, 2024, submit a written report each quarter to the superintendent for the previous quarter on the following metrics:

(a) the number of written demands for reimbursement of out-of-pocket expenses from subscribers received by the health care plan;

(b) the number of out-of-pocket claims for reimbursement paid and the aggregate amount of claims reimbursed by the health care plan within the time required by Paragraph (4) of this subsection;

(c) the number of out-of-pocket claims for reimbursement paid more than thirty days following receipt of a written demand and the aggregate amount of these payments, excluding interest; and

(d) the aggregate amount of interest paid by the health care plan pursuant to Paragraph (5) of this subsection; and

(7) beginning on April 1, 2024, submit a written report each quarter for the previous quarter to the superintendent with the following information for each durable medical equipment supplier or other supplier that was under contract with the health care plan or its agent during the previous quarter:

(a) the name, address and telephone number of each supplier and, if applicable, the corresponding date upon which the respective supplier's contract expired, lapsed or was terminated during the previous quarter;

(b) the percentage of total deliveries, by description of item, that did not meet the delivery requirements specified in Paragraph (3) of this subsection; and

(c) the number of complaints received by the health care plan or its agent during the previous quarter related to late deliveries, incomplete orders or incorrect orders, respectively.

G. The superintendent shall annually audit all health care plans as described in Subsection A of this section for compliance with the requirements of this section. If the superintendent determines that a health care plan has not complied with the requirements of this section, the superintendent shall impose corrective action or use any other enforcement mechanism available to the superintendent to obtain the health care plan's compliance with this section.

H. Absent a change in diagnosis or in a subscriber's management or treatment of diabetes or its complications, a health care plan shall not require more than one prior authorization per plan period for any single drug or category of item enumerated in this section if prescribed as medically necessary by the subscriber's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a subscriber has received prior authorization during the plan year shall not be subject to additional prior authorization requirements in the same plan year if prescribed as medically necessary by the subscriber's health care practitioner. Nothing in this subsection shall be construed to require payment for diabetes resources that are not covered benefits.

I. The provisions of this section do not apply to:

(1) a short-term health care plan;

(2) an excepted benefit health care plan intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies;

(3) a policy or plan for long-term care or disability income; or

(4) short-term travel policy or plan.

J. For purposes of this section, "basic health care benefits":

(1) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(2) does not include services for alcohol or drug abuse, dental or long-term rehabilitation treatment.

History: Laws 2023, ch. 50, § 5.

59A-47-45.9. Biomarker testing coverage.

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state shall provide coverage for subscribers to receive biomarker testing.

B. Coverage provided pursuant to this section shall be for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a subscriber's disease or condition when the test is supported by medical and scientific evidence, including:

(1) labeled indications for a United States food and drug administration-approved or -cleared test;

(2) indicated tests for a United States food and drug administration-approved drug;

(3) warnings and precautions on United States food and drug administration labels;

(4) federal centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations; or

(5) nationally recognized clinical practice guidelines.

C. Health care plans providing coverage for biomarker testing pursuant to this section shall ensure that:

(1) coverage is provided in a manner that limits disruptions in care, including coverage for multiple biopsies or biospecimen samples; and

(2) a patient and a practitioner who prescribes biomarker testing have clear, accessible and convenient processes to request an appeal of a benefit denial by the health care plan and that those processes are accessible on the health care plan's website.

D. Coverage for biomarker testing may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate.

E. The provisions of this section do not apply to short-term travel, accident-only or limited or specified disease policies, plans or certificates of health insurance.

F. As used in this section:

(1) "biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. "Biomarker" includes gene mutations, characteristics of genes or protein expression;

(2) "biomarker testing" means analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker and includes single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing; and

(3) "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that are:

(a) developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy; and

(b) used to establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

History: Laws 2023, ch. 138, § 6.

59A-47-45.10. Calculating a subscriber's cost-sharing obligation for prescription drug coverage.

A. When calculating a subscriber's cost-sharing obligation for covered prescription drugs, pursuant to an individual or group health insurance policy, health care plan or certificate of health insurance issued for delivery or renewed in this state, the insurer shall credit the subscriber for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans, tax favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

History: Laws 2023, ch. 206, § 6.

59A-47-46. Repealed.

History: Laws 2010, ch. 94, § 4; 2013, ch. 74, § 33; 2018, ch. 57, § 26; 2019, ch. 235, § 15; 2019, ch. 235, § 16; repealed by Laws 2021, ch. 108, § 37.

59A-47-47. Prescription drug prior authorization protocols.

A. After January 1, 2014, a health care plan shall accept the uniform prior authorization form developed pursuant to Sections 2 [59A-2-9.8 NMSA 1978] and 3 [61-11-6.2 NMSA 1978] of this 2013 act as sufficient to request prior authorization for prescription drug benefits.

B. No later than twenty-four months after the adoption of national standards for electronic prior authorization, a health insurer shall exchange prior authorization requests with providers who have e-prescribing capability.

C. If a health care plan fails to use or accept the uniform prior authorization form or fails to respond within three business days upon receipt of a uniform prior authorization form, the prior authorization request shall be deemed to have been granted.

D. As used in this section, "health care plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments but does not include:

(1) a person that only issues a limited-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;

(2) a physician or a physician group to which a health care plan has delegated financial risk for prescription drugs and that does not use a prior authorization process for prescription drugs; or

(3) a health care plan or its affiliated providers, if the health care plan owns and operates its pharmacies and does not use a prior authorization process.

History: Laws 2013, ch. 170, § 8.

59A-47-47.1. Prescription drug coverage; step therapy protocols; clinical review criteria; exceptions.

A. Each individual or group nonprofit health care plan contract delivered or issued for delivery in this state that provides a prescription drug benefit for which any step therapy protocols are required shall establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with health care plans, insurers, health maintenance organizations, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest; and

(b) using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a health care plan restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy protocol, a subscriber and the practitioner prescribing the prescription drug shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. A health care plan may use its existing medical exceptions process in accordance with the provisions of Subsections D through I of this section to satisfy this requirement. The process shall be made easily accessible for subscribers and practitioners on the health care plan's publicly accessible website.

D. A health care plan shall expeditiously grant an exception to the health care plan's step therapy protocol, based on medical necessity and a clinically valid explanation from the patient's prescribing practitioner as to why a drug on the health care plan's formulary that is therapeutically equivalent to the prescribed drug should not be substituted for the prescribed drug, if:

(1) the prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

(2) the prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) while under the subscriber's current health care plan, or under the subscriber's previous health coverage, the subscriber has tried the prescription drug that is the subject of the exception request or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or

(4) the prescription drug required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the prescription drug is expected to:

(a) cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;

(b) worsen a comorbid condition of the patient; or

(c) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

E. Upon the granting of an exception to a health care plan's step therapy protocol, a health care plan shall authorize coverage for the prescription drug that is the subject of the exception request for no less than the duration of the therapeutic effect of the drug. A health care plan shall include in its evidence of coverage language describing a subscriber's rights pursuant to this subsection.

F. A health care plan shall respond with its decision on a subscriber's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, a health care plan shall respond within twenty-four hours of receipt of the exception request. In the event the insurer does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. A health care plan's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978].

H. After a subscriber has made an exception request in accordance with the provisions of this section, a health care plan shall authorize continued coverage of a prescription drug that is the subject of the exception request pending the determination of the exception request.

I. The provisions of this section shall not be construed to prevent:

(1) a health care plan from requiring a patient to try a biosimilar, interchangeable biologic or generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

J. The superintendent shall promulgate rules as may be necessary to appropriately implement the provisions of this section.

K. Nothing in this section shall be interpreted to interfere with the superintendent's authority to regulate prescription drug coverage benefits under other state and federal law.

L. As used in this section, "medical necessity" or "medically necessary" means health care services determined by a practitioner, in consultation with the health care plan, to be appropriate or necessary, according to:

(1) any applicable, generally accepted principles and practices of good medical care;

(2) practice guidelines developed by the federal government or national or professional medical societies, boards or associations; or

(3) any applicable clinical protocols or practice guidelines developed by the health care plan consistent with federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

History: Laws 2018, ch. 9, § 6; 2024, ch. 42, § 6.

59A-47-47.2. Pharmacist prescriptive authority services; reimbursement parity.

A health care plan shall reimburse a participating provider that is a certified pharmacist clinician or pharmacist certified to provide a prescriptive authority service who provides a service pursuant to a subscriber at the same rate that the carrier reimburses, for the standard contracted service under that subscriber contract, any licensed physician or physician assistant licensed pursuant to the Medical Practice Act [Chapter 41, Article 5 NMSA 1978] or any advanced practice certified nurse practitioner licensed pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978].

History: Laws 2020, ch. 58, § 6; 2021, ch. 54, § 14.

59A-47-48. Pharmacy benefit; prescription synchronization.

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state and that provides a prescription drug benefit shall allow a subscriber to fill or refill a prescription for less than a thirty-day supply of the prescription drug, and apply a prorated daily copayment or coinsurance for the fill or refill, if:

(1) the prescribing practitioner or the pharmacist determines the fill or refill to be in the best in the best [sic] interest of the subscriber;

(2) the subscriber requests or agrees to receive less than a thirty-day supply of the prescription drug; and

(3) the reduced fill or refill is made for the purpose of synchronizing the subscriber's prescription drug fills.

B. An individual or group health care plan that is delivered, issued for delivery or renewed in this state and that provides a prescription drug benefit shall not:

(1) deny coverage for the filling of a chronic medication when the fill is made in accordance with a plan to synchronize multiple prescriptions for the subscriber pursuant to Subsection A of this section established among the health care plan, the prescribing practitioner and a pharmacist. The health care plan shall allow a pharmacy to override any denial indicating that a prescription is being refilled too soon for the purposes of medication synchronization; and

(2) prorate a dispensing fee to a pharmacy that fills a prescription with less than a thirty-day supply of prescription drug pursuant to Subsection A of this section. The health care plan shall pay in full a dispensing fee for a partially filled or refilled prescription for each prescription dispensed, regardless of any prorated copayment or coinsurance that the subscriber may pay for prescription synchronization services.

History: Laws 2015, ch. 65, § 6.

59A-47-49. Provider credentialing; requirements; deadline.

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The superintendent shall approve no more than two forms of application to be used for the credentialing of providers.

B. A health care plan shall not require a provider to submit information not required by a credentialing application established pursuant to Subsection A of this section.

C. The provisions of this section apply equally to initial credentialing applications and applications for recredentialing.

D. The rules that the superintendent adopts and promulgates shall require primary credential verification no more frequently than every three years and allow provisional credentialing for a period of one year.

E. Nothing in this section shall be construed to require a health care plan to credential or provisionally credential a provider.

F. The rules that the superintendent adopts and promulgates shall establish that a health care plan or a health care plan's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within thirty calendar days of receipt of a complete credentialing

application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration;

(3) within ten working days after receipt of a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the insurer requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be reasonably related to the information in the application; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen days as described in Paragraph (2) of this subsection, load into the health care plan's provider payment system all provider information, including all information needed to correctly reimburse a newly approved provider according to the provider's contract. The health care plan or health care plan's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the health care plan's provider payment system.

G. A health care plan shall reimburse a provider for covered health care services for any claims from the provider that the insurer receives with a date of service more than thirty calendar days after the date on which the health care plan received a complete credentialing application for that provider if:

(1) the provider:

(a) has submitted a complete credentialing application and any supporting documentation that the health care plan has requested in writing within the time frame established in Paragraph (3) of Subsection F of this section;

(b) has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and

(c) has professional liability insurance or is covered under the Medical Malpractice Act; and

(2) the health care plan:

(a) has approved, or has failed to approve or deny, the applicant's complete credentialing application within the time frame established pursuant to Paragraph (1) or (2) of Subsection F of this section; or

(b) fails to load the approved applicant's information into the health care plan's provider payment system in accordance with Paragraph (4) of Subsection F of this section.

H. A provider who was not, at the time services were rendered, employed by a practice or group that has contracted with the health care plan to provide services at specified rates of reimbursement shall be paid by the health care plan in accordance with the health care plan's standard reimbursement rate.

I. A provider who was, at the time services were rendered, employed by a practice or group that has contracted with the health care plan to provide services at specified rates of reimbursement shall be paid by the health care plan in accordance with the terms of that contract.

J. The superintendent shall adopt and promulgate rules to provide for the resolution of disputes relating to reimbursement and credentialing arising in cases where credentialing is delayed beyond thirty days after application.

K. A health care plan shall reimburse a provider pursuant to Subsections G, H and I of this section until the earlier of the following occurs:

(1) the insurer's approval or denial of the provider's complete credentialing application; or

(2) the passage of three years from the date the health care plan received the provider's complete credentialing application.

History: Laws 2015, ch. 111, § 6; 2016, ch. 20, § 5; 2023, ch. 175, § 4.

59A-47-50. Physical rehabilitation services; limits on cost sharing.

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state shall not impose a member cost share for physical rehabilitation services that is greater than that for primary care services on a coinsurance percentage basis when coinsurance is applied or on an absolute dollar amount when a copay is applied.

B. As used in this section:

(1) "physical rehabilitation services" means services aimed at maximizing an individual's level of function, returning to a prior level of function or maintaining or slowing the decline of function, which services are provided by or under the direction of a licensed physical therapist, occupational therapist or speech therapist; and

(2) "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.

History: Laws 2019, ch. 188, § 5.

59A-47-51. Behavioral health services; elimination of cost sharing.

A. Until January 1, 2027, an individual or group health care plan that is delivered, issued for delivery or renewed in this state that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of this section:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing method that requires a subscriber to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same individual or group health care plan;

(3) "copayment" means a cost-sharing method that requires a subscriber to pay a fixed dollar amount when health care services are received, with the health care plan paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same individual or group health care plan; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of a subscriber other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of an individual or group health care plan.

History: Laws 2021, ch. 136, § 9.

59A-47-52. Anatomical gift nondiscrimination.

A. For purposes of this section:

(1) "covered person" means a policyholder or other person covered by a health benefit plan; and

(2) "organ transplant" includes parts or the whole of organs, eyes or tissue.

B. All individual and group health insurance policies delivered or issued for delivery in this state that provide coverage for organ transplants or associated care shall not:

(1) deny coverage for organ transplantation or associated care to a covered person solely on the basis of that person's physical or mental disability;

(2) deny to a covered person with a physical or mental disability eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit policy or plan solely for the purpose of avoiding the requirements of this section;

(3) penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a health care provider to induce that health care provider not to provide an organ transplant or associated care to a covered person with a physical or mental disability; or

(4) reduce or limit coverage benefits to a covered person with a physical or mental disability for associated care related to organ transplantation as determined in consultation with the physician and patient.

History: Laws 2023, ch. 171, § 6.

59A-47-53. Diagnostic and supplemental breast examinations.

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental breast examinations.

B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or high deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

History: Laws 2023, ch. 12, § 5.

59A-47-54. Chiropractic physician services; limits on cost sharing and coinsurance.

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state that offers coverage of the services of a chiropractic physician shall not impose a copayment or coinsurance on those chiropractic physician services that exceeds the copayment or coinsurance imposed for primary care services.

B. As used in this section, "primary care services" means the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiation of referrals for other health care services and maintenance of the continuity of care when appropriate.

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

History: Laws 2023, ch. 51, § 5.

59A-47-55. Sexually transmitted infection care; cost sharing eliminated.

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state that offers coverage for preventive care or treatment of sexually transmitted infections shall not impose cost sharing on eligible subscribers.

B. Pursuant to this section, preventive care or treatment of sexually transmitted infections shall not be conditioned upon the gender identity of the insured.

C. The provisions of Subsection A of this section do not apply to high-deductible health care plans with health savings accounts until an eligible subscriber's deductible has been met, unless otherwise allowed pursuant to federal law.

D. For the purposes of this section:

(1) "cost sharing" means policy deductibles, copayments or coinsurance;

(2) "preventive care" means screening, testing, examination or counseling and the administration, dispensing or prescribing of preventive drugs, devices or supplies incidental to the prevention of a sexually transmitted infection;

(3) "sexually transmitted infection" means chlamydia, syphilis, gonorrhea, HIV and relevant types of hepatitis, as well as any other sexually transmitted infection regardless of mode of transportation, as designated by rule upon making a finding that the particular sexually transmitted infection is contagious; and

(4) "treatment" means medically necessary care for the management of an existing sexually transmitted infection.

History: Laws 2023, ch. 99, § 5.

59A-47-56. Definitions.

As used in Sections 35 through 43 [59A-47-56 to 59A-47-64 NMSA 1978] of this 2023 act:

A. "generally recognized standards" means standards of care and clinical practice, established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

(1) psychiatry;

(2) psychology;

(3) social work;

(4) clinical counseling;

(5) addiction medicine and counseling; or

(6) family and marriage counseling; and

B. "mental health or substance use disorder services" means:

(1) professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder; or

(2) professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act [Chapter 61, Article 9A NMSA 1978].

History: Laws 2023, ch. 114, § 35.

59A-47-57. Benefits required.

A health care plan, other than a small health care plan, that is delivered, issued for delivery or renewed in this state shall provide coverage for all mental health or substance use disorder services required by generally recognized standards of care.

History: Laws 2023, ch. 114, § 36.

59A-47-58. Parity for coverage of mental health or substance use disorder services.

A. The office of superintendent of insurance shall ensure that a health care plan complies with federal and state laws, rules and regulations applicable to coverage for mental health or substance use disorder services.

B. A health care plan shall not impose quantitative treatment limitations, financial restrictions, limitations or requirements on the provision of mental health or substance use disorder services that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on substantially all of the coverage of benefits for other conditions.

C. A health care plan shall not impose non-quantitative treatment limitations for the treatment of mental health or substance use disorders or conditions unless factors, including the processes, strategies or evidentiary standards used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to and are applied no more restrictively than the factors used in applying the limitation with respect to medical or surgical benefits in the classification.

History: Laws 2023, ch. 114, § 37.

59A-47-59. Provider network adequacy.

A. A health care plan shall maintain an adequate provider network to provide mental health or substance use disorder services.

B. The superintendent shall ensure access to mental health or substance use disorder services providers, including parity with medical and surgical services provider access, through regulation and review of claims processing, provider reimbursement procedures, network adequacy and provider reimbursement rate adequacy.

C. A health care plan shall ensure that the process by which reimbursement rates for mental health and substance use disorder services are determined is comparable to and no more stringent than the process for reimbursement of medical or surgical benefits. In developing provider reimbursement rates, a health care plan shall demonstrate that it has performed a comparability analysis of provider:

(1) reimbursement rates in surrounding states;

(2) reimbursement rates between mental health and substance use disorder providers and medical or surgical providers; and

(3) credentialing processes for mental health and substance use disorder providers and medical or surgical providers.

D. A health care plan shall undertake all efforts, including increasing provider reimbursement rates through the processes and strategies described in Subsection C of this section, to ensure state-mandated network adequacy for the provision of mental health or substance use disorder services.

E. When in-network access to mental health or substance use disorder services are not reasonably available, a health care plan shall provide access to out-of-network services with the same cost-sharing obligations to a subscriber as those required for in-network services.

History: Laws 2023, ch. 114, § 38.

59A-47-60. Utilization review of mental health or substance use disorder services.

A. A health care plan shall, at least monthly, review and update the health care plan's utilization review process to reflect the most recent evidence and generally recognized standards of care.

B. When performing a utilization review of mental health or substance use disorder services, including level of care placement, continued stay, transfer and discharge, a health care plan shall apply criteria in accordance with generally recognized standards of care.

C. A health care plan shall provide utilization review training to staff and contractors undertaking activities related to utilization review.

D. A health care plan shall:

(1) develop utilization review policies regarding quantitative and non-quantitative limitations for mental health or substance use disorder services coverage that are no more restrictive than the utilization review policies regarding quantitative and non-quantitative limitations for medical and surgical care; and

(2) make utilization review policies available to providers or subscribers.

History: Laws 2023, ch. 114, § 39.

59A-47-61. Prohibited exclusions of coverage for mental health or substance use disorder services.

A health care plan shall not exclude provider prescribed coverage for mental health or substance use disorder services otherwise included in its coverage when:

A. it is available pursuant to federal or state law for individuals with disabilities;

B. it is otherwise ordered by a court or administrative agency;

C. it is available to a subscriber through a public benefit program; or

D. a subscriber has a concurrent diagnosis.

History: Laws 2023, ch. 114, § 40.

59A-47-62. Level of care determinations for the provision of mental health or substance use disorder services.

A. A health care plan shall provide coverage for all in-network mental health or substance use disorder services, consistent with generally recognized standards of care, including placing a subscriber into a medically necessary level of care.

B. Changes in level and duration of care shall be determined by the subscriber's provider in consultation with the insurer.

C. Level of care determinations shall include placement of a subscriber into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility or an outpatient treatment program.

D. Level of care services for a subscriber with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the subscriber rather than arbitrary time limits.

History: Laws 2023, ch. 114, § 41.

59A-47-63. Coordination of care.

At the request of a subscriber, a health care plan may facilitate communication between mental health or substance use disorder services providers and the subscriber's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the subscriber.

History: Laws 2023, ch. 114, § 42.

59A-47-64. Confidentiality provisions.

A health care plan shall protect the confidentiality of a subscriber receiving mental health or substance use disorder treatment.

History: Laws 2023, ch. 114, § 43.

59A-47-65. Exceptions.

The provisions of Sections 35 through 43 [59A-47-56 to 59A-47-64 NMSA 1978] of this 2023 act do not apply to short-term plans subject to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978].

History: Laws 2023, ch. 114, § 44.

59A-47-66. Medical necessity and nondiscrimination standards for coverage of prosthetics and orthotics.

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state that covers essential health benefits and covers prosthetic and custom orthotic devices shall consider these benefits habilitative or rehabilitative benefits for purposes of state or federal requirements on essential health benefits coverage.

B. When performing a utilization review for a request for coverage of prosthetic or orthotic benefits, an insurer shall apply the most recent version of evidence-based

treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Such standards may be named by the superintendent in rule.

C. An insurer shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely based on an insured's actual or perceived disability.

D. An insurer shall not deny a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

E. A health benefits plan that is delivered, issued for delivery or renewed in this state that offers coverage for prosthetics and custom orthotic devices shall include language describing an insured's rights pursuant to Subsections C and D of this section in its evidence of coverage and any benefit denial letters.

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual or group health care plan may impose cost sharing on prosthetic or custom orthotic devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. An individual or group health plan that provides coverage for prosthetic or orthotic services shall ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the managed care plan's provider network located in the state. In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the insurer shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

H. If coverage for prosthetic or custom orthotic devices is provided, payment shall be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(1) a change in the physiological condition of the patient;

(2) an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than sixty percent of the cost of a replacement device or of the part being replaced.

I. Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

J. The provisions of this section do not apply to excepted benefits plans subject to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978].

History: Laws 2023, ch. 196, § 6.

ARTICLE 48
Prepaid Dental Plans

59A-48-1. Short title.

This article [Chapter 59A, Article 48 NMSA 1978] may be cited as the "Prepaid Dental Plan Law".

History: Laws 1984, ch. 127, § 880.

59A-48-2. Definitions.

As used in this article:

A. "member" means an individual who is enrolled in a group prepaid dental plan as a principal subscriber together with such person's dependents who are entitled to dental care services under the plan solely because of their status as dependents of the principal subscriber;

B. "membership coverage" means any certificate or contract issued to a member setting out the dental coverage to which such member is entitled;

C. "prepaid dental plan" means any contractual arrangement whereby any prepaid dental plan organization undertakes to provide directly or to arrange for prepaid dental services and to pay or make reimbursement for any remaining portion of such prepaid dental services on a prepaid basis through insurance or otherwise;

D. "prepaid dental plan organization" means any person who undertakes to conduct one or more prepaid dental plans providing only dental services; provided, that this article shall not apply to nonprofit health care plans or accident and health insurance programs;

E. "prepaid dental services" means services included in the practice of dentistry as defined in the Dental Act [61-5-1 to 61-5-9, 61-5-11 to 61-5-22 NMSA 1978][repealed]; and

F. "provider" means any person licensed under the Dental Act [repealed] or otherwise authorized to furnish prepaid dental services in New Mexico.

History: Laws 1984, ch. 127, § 881.

59A-48-3. Certificate of authority required.

No person may establish or operate a prepaid dental plan organization in New Mexico, or sell or offer to sell or solicit offers to purchase, or receive advance or periodic consideration in conjunction with a prepaid dental plan without obtaining and maintaining a certificate of authority pursuant to the provisions of this article.

History: Laws 1984, ch. 127, § 882.

59A-48-4. Application for certificate of authority.

A. An application for a certificate of authority to operate as a prepaid dental plan organization shall be filed with the superintendent in form prescribed by the superintendent, shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by the following:

(1) a copy of any basic organizational document of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents together with all amendments to such documents;

(2) a copy of any bylaws, rules and regulations or similar document regulating the internal affairs of the applicant;

(3) a list of the names, addresses and official positions of the persons who are responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation and the partners or members in the case of a partnership or association;

(4) if the prepaid dental plan organization is a corporation, evidence that the corporation's board of directors includes:

(a) dentists, duly licensed pursuant to the provisions of the Dental Act [61-5-1 to 61-5-9, 61-5-11 to 61-5-22 NMSA 1978][repealed], who have contracted with the corporation to render dental services to members;

(b) members of the prepaid dental plan, who shall comprise at least one-third of the members of the board; and

(c) at least one director who is a licensed dentist who has not contracted to render dental services to members;

(5) a copy of any contract made or to be made between any providers or persons listed in Paragraph (3) of this subsection and the applicant;

(6) a statement generally describing the prepaid dental plan organization, its dental plan or plans, facilities and personnel, as approved by the director of the health services division of the health and environmental department [department of health];

(7) a copy of the form of membership coverage to be issued to members;

(8) a copy of the form of any group contract which is to be issued to employers, unions, trustees or other applicants;

(9) financial statements showing the applicant's assets, liabilities and sources of financial support. If the applicant's financial affairs are audited by independent certified accountants, a copy of the applicant's most recent regular certified financial statement shall satisfy this requirement unless the superintendent determines that additional or more recent financial information is required for the proper administration of this article;

(10) a description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of the initial operating results anticipated and a statement as to the sources of working capital as well as any other sources of funding;

(11) a power of attorney duly executed by the applicant, if not domiciled in New Mexico, which appoints the superintendent, his successors in office and his duly authorized deputies as the true and lawful attorney of such applicant in and for this state, upon whom all lawful process in any legal action or proceeding against any prepaid dental plan organization may be served in any cause of action arising in New Mexico;

(12) a statement reasonably describing the geographic area or areas to be served, as approved by the director of health services division of the health and environment department [department of health];

(13) a fee for filing application for certificate of authority as specified in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code; and

(14) such other information as the superintendent may require.

B. Within ten (10) days following any significant modification of information previously furnished pursuant to Subsection A of this section, a prepaid dental plan organization shall file notice of such modification with the superintendent.

History: Laws 1984, ch. 127, § 883.

59A-48-5. Issuance of certificate of authority.

A. Issuance of a certificate of authority shall be granted by the superintendent if the superintendent is satisfied that the following conditions are met:

(1) the persons responsible for conducting the affairs of the prepaid dental plan organization are competent and trustworthy and are professionally capable of providing or arranging for the provision of services offered;

(2) the prepaid dental plan organization constitutes an appropriate mechanism to achieve an effective prepaid dental plan, in accordance with regulations issued by the director of the health services division of the health and environment department [department of health], which shall include at least the basic dental services appropriate to such plan as determined by the director of the health services division of the health and environment department;

(3) the prepaid dental plan organization is financially responsible and may reasonably be expected to meet its obligations to members and prospective members. In making this determination, the superintendent shall consider at least:

(a) the financial soundness of the prepaid dental plan's arrangement for services and the schedule of charges used;

(b) any agreement with an insurer, a hospital or a medical service corporation, a government or any other organization for insuring the payment of the cost of prepaid dental services or the provisions for automatic applicability of an alternative coverage in the event of the discontinuance of the plan; and

(c) the sufficiency of an agreement with providers for the provision of prepaid dental services; and

(4) each officer responsible for conducting the affairs of the prepaid dental plan organization is covered under an individual or blanket fidelity bond in the amount of fifty thousand dollars ($50,000), and such bond has been filed with and approved by the superintendent.

B. A certificate of authority shall be subject to continuance, expiration, termination, suspension or revocation on the same applicable bases as provided under Article 5 [Chapter 59A, Article 5 NMSA 1978] of the Insurance Code as to insurers in general.

History: Laws 1984, ch. 127, § 884.

59A-48-6. Deposit requirement; exception.

A. A prepaid dental plan organization shall maintain on deposit with the state treasurer through the superintendent a surety bond guaranteeing services under the plan, or cash or securities eligible for investments of capital funds of health insurers under Chapter 59A, Article 9 NMSA 1978, in the following amounts depending on the number of members entitled to dental care services pursuant to contracts issued by the plan:

Number of Members	Deposit
2,500 or less	$25,000
2,501 - 5,000	30,000
5,001 - 7,500	40,000
7,501 - 10,000	50,000
10,001 - 15,000	75,000
15,001 - 20,000	100,000
20,001 - 25,000	125,000
25,001 - 30,000	150,000
30,001 - 40,000	175,000
40,001 and above	200,000

B. The deposit prescribed by Subsection A of this section shall be held by the state treasurer in trust for the benefit and protection of persons covered by a prepaid dental plan.

C. Any securities within the description of Subsection A of this section, with the approval of the superintendent may be exchanged for similar securities or cash of equal amount. Interest on securities deposited shall be payable to the prepaid dental plan organization depositing such securities.

D. An unpaid final judgment arising from a membership coverage shall be a lien on the deposit described in Subsection A of this section, subject to execution after thirty days from the entry of final judgment. If the deposit is reduced, it shall be replenished within ninety days by the prepaid dental plan organization.

E. Upon liquidation or dissolution of a prepaid dental plan organization and the satisfaction of all its debts and liabilities, any balance remaining of the cash or securities deposit prescribed in Subsection A of this section, together with any other assets of the prepaid dental plan organization, shall be returned by the superintendent to the prepaid dental plan organization.

F. The deposit prescribed by Subsection A of this section shall not apply with respect to a prepaid dental plan organization which is funded by the federal, state or a municipal government or any political subdivision or body to the extent and for such period of time that the prepaid dental plan organization can demonstrate to the superintendent the presence of operational commitments from such sources equivalent to such deposit.

History: Laws 1984, ch. 127, § 885; 1993, ch. 320, § 104.

59A-48-7. Reserve requirement; exception.

A. A prepaid dental plan organization at all times shall maintain for protection of the members a financial reserve consisting of two percent of prepaid charges collected from members for the plan, until such reserve totals five hundred thousand dollars ($500,000). Such reserve shall be in addition to the deposit prescribed by Section 885 [59A-48-6 NMSA 1978] of this article.

B. The reserve prescribed by Subsection A of this section shall not apply with respect to a prepaid dental plan organization which is funded by the federal, state or a municipal government or any political subdivision or body and meets the requirement of Subsection F of Section 885 of this article.

History: Laws 1984, ch. 127, § 886.

59A-48-8. Membership coverage.

A. Every member in a prepaid dental plan shall be issued a membership coverage form by the prepaid dental plan organization.

B. Any contract applied for that provides family coverage shall, as to such coverage of individuals in the family, also provide that the benefits applicable for children shall be payable with respect to a newly-born child of the insured from the instant of such child's birth to the same extent that such coverage applies to other individuals in the family. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth of a newly-born child and payment of the required premium shall be furnished to the insurer within thirty-one (31) days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.

C. No membership coverage or amendment shall be issued or delivered to any person in this state until a copy of the form of the membership coverage or amendment has been filed with and approved by the superintendent.

D. A membership coverage shall contain a clear and complete statement of a contract, or a reasonably complete summary if a certificate of contract, of:

(1) the prepaid dental services or other benefits to which the member is entitled under the prepaid dental plan;

(2) any limitations of the services, kinds of services or benefits to be provided, including any deductible or copayment feature;

(3) where and in what manner information is available as to how services may be obtained; and

(4) the member's obligation respecting charges for the prepaid dental plan.

E. A membership coverage shall contain no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive or which encourage misrepresentation or which are untrue.

F. The superintendent shall approve any form of membership coverage if the requirements of Subsections D and E of this section are met and the prepaid dental plan is able in the judgment of the superintendent to meet its financial obligations under the membership coverage. It is unlawful to issue such form until approved. If the superintendent does not disapprove any such form within thirty (30) days after the filing, it shall be deemed approved. If the superintendent disapproves a form of membership coverage, the superintendent shall notify the prepaid dental plan organization, specifying the reasons for disapproval. The superintendent shall grant a hearing on such disapproval within fifteen (15) days after a request in writing is received from the prepaid dental plan organization.

History: Laws 1984, ch. 127, § 887.

59A-48-9. Examination of prepaid dental plan organization.

A. The superintendent may once in each six (6) months for the first three (3) years after organization and once each year thereafter, or more often if deemed necessary by the superintendent or director of the health services division of the health and environmental [environment] department [department of health], visit each prepaid dental plan organization organized under the law of this state and examine its financial condition, its ability to meet its liabilities and its compliance with the laws of this state affecting the conduct of its business. The superintendent may annually visit and examine each prepaid dental plan organization not organized under the laws of this state but authorized to transact business in this state.

B. The superintendent may in like manner examine each prepaid dental plan organization applying for an initial certificate of authority to do business in this state.

C. In lieu of making an examination, the superintendent may accept a full report of the most recent examination of a foreign or alien prepaid dental plan organization, certified to by the appropriate examining official of another state.

D. The director of the health services division of the health and environment department [department of health] may participate in the examinations and visits described in this section to verify the existence of an effective prepaid dental plan and to review the delivery of services by the prepaid dental plan organization.

E. The examination and all related matters shall otherwise be subject to the applicable provisions of Article 4 [Chapter 59A, Article 4 NMSA 1978] (examination, hearings and appeals) of the Insurance Code.

History: Laws 1984, ch. 127, § 888.

59A-48-10. Annual report to superintendent.

A. Every prepaid dental plan organization annually on or before the first day of March shall file with the superintendent a report covering its activities for the preceding calendar year in form as prescribed by the superintendent, verified by at least two principal officers of the corporation. A copy of the report shall be sent by the prepaid dental plan organization to the department of health.

B. Such reports shall be on forms prescribed by the superintendent and shall include:

(1) an annual statement in accordance with the requirements of Section 59A-5-29 NMSA 1978 and a risk-based capital report in accordance with the requirements of Section 59A-5A-3 NMSA 1978;

(2) any material changes in the information;

(3) the number of persons who become members during the year, the number of members as of the end of the year and the number of memberships terminated during the year;

(4) the costs of all care provided and the number of units of care provided; and

(5) such other information relating to the performance of the prepaid dental plan organization as is necessary to enable the superintendent to carry out the duties prescribed by The [the] Prepaid Dental Plan Law.

C. The fee for filing the annual report shall be as specified in Section 59A-6-1 NMSA 1978.

History: Laws 1984, ch. 127, § 889; 2014, ch. 59, § 53.

59A-48-11. Repealed.

59A-48-12. Operational expenses.

No more than thirty percent of prepaid charges in the first year of operation, twenty-five percent in the second year of operation and twenty percent of prepaid charges in any subsequent year shall be used for the marketing and administrative expenses of a prepaid dental plan organization, including costs related to soliciting members and providers.

History: Laws 1984, ch. 127, § 891.

59A-48-13. Prohibited practices.

Article 16 [Chapter 59A, Article 16 NMSA 1978] of the Insurance Code relating to unfair trade practices and frauds shall apply to prepaid dental plan organizations, except as to the extent the superintendent determines that the nature of prepaid dental plan organizations render particular provisions of such law inappropriate.

History: Laws 1984, ch. 127, § 892.

59A-48-14. Agents and solicitors.

Solicitation of memberships in a prepaid dental plan shall be conducted by agents duly appointed by the dental plan organization or solicitors duly appointed by such agents, while licensed as such agents or solicitors under the same provisions and requirements of Articles 11 [Chapter 59A, Article 11 NMSA 1978] (licensing procedures) and 12 [Chapter 59A, Article 12 NMSA 1978] (insurance agents, brokers and solicitors) of the Insurance Code as apply to health insurance agents and solicitors. The fees for such licensing shall be the same as for such insurance agents and as specified in Section 101 [59A-6-1 NMSA 1978] (fee schedule) and Paragraph I of Section 185 [59A-11-6 NMSA 1978] of the Insurance Code.

History: Laws 1984, ch. 127, § 893.

59A-48-15. Suspension or revocation of certificate of authority.

A. The superintendent may suspend or revoke any certificate of authority of a prepaid dental plan organization if he finds that any of the following conditions exist:

(1) the prepaid dental plan organization is operating contrary to its basic organizational documents or in a manner contrary to that described in, and reasonably inferred from, any other information submitted pursuant to Section 883 [59A-48-4 NMSA 1978] of this article;

(2) the prepaid dental plan organization issued membership coverage which does not comply with the requirements of Section 887 [59A-48-8 NMSA 1978] of this article;

(3) the prepaid dental plan does not provide or arrange for basic dental services appropriate to such plan as determined by the director of the health services division of the health and environment department [department of health];

(4) the prepaid dental plan organization can no longer be expected to meet the obligations to members or prospective members;

(5) the prepaid dental plan organization, or any authorized person on its behalf, has advertised or merchandized [merchandised] its services in an untrue, misleading, deceptive or unfair manner; or

(6) the prepaid dental plan organization has failed to substantially comply with this article or any rules and regulations promulgated thereunder.

B. When the certificate of authority of a prepaid dental plan organization is suspended the organization shall not, during the period of such suspension, accept any additional members except newborn children or other newly acquired dependents of existing members and shall not engage in any advertising or solicitation.

C. When the certificate of authority of a prepaid dental plan organization is revoked, such organization shall proceed immediately following the effective date of the order of revocation, to conclude its affairs and shall conduct no further business except as may be essential to the orderly conclusion of solicitation. The superintendent by written order, may permit such further operation of the organization as the superintendent finds to be in the best interest of members to the end that members shall be afforded the greatest practical opportunity to obtain continuing prepaid dental plan coverage.

D. Notwithstanding the provisions of Subsections B and C of this section, a prepaid dental plan organization which has had its certificate of authority denied, suspended or revoked, or has suffered an adverse decision by the superintendent shall be entitled to a hearing pursuant to Article 4 [Chapter 59A, Article 4 NMSA 1978] (examinations, hearings and appeals) of the Insurance Code.

History: Laws 1984, ch. 127, § 894.

59A-48-16. Approval of advertising and sales material.

A. The prepaid dental plan organization shall prior to use thereof file with the superintendent for his approval all advertising and sales material proposed to be used by it, through agents, solicitors, or otherwise, in advertising solicitation or sale of membership coverage to be offered by such organization.

B. Within thirty (30) days after such filing the superintendent shall either approve or disapprove the advertising matter or sales material so filed; and if not disapproved within such period or within such extension of not to exceed an additional thirty (30) days as may be requested by the superintendent and communicated by him in writing to the prepaid dental plan organization, the advertising matter and sales material shall be deemed approved.

C. The superintendent shall disapprove any such advertising matter or sales material if found by him to be in whole or part untrue, deceptive, misleading, or conducive to misrepresentation.

D. The superintendent may withdraw any previous approval, or negate any prior failure to disapprove within the applicable period, as to any advertising matter or sales material found by him to be subject to disapproval on any of the grounds stated in this section. Any such withdrawal of a prior approval or negation of prior failure to disapprove, shall allow a reasonable period for withdrawal of the advertising matter or sales material involved.

E. Any such disapproval, withdrawal, or negation shall be by the superintendent's order stating the grounds therefor.

F. No prepaid dental plan organization and no representative thereof shall use or permit to be outstanding, any advertising matter or sales material as to which the superintendent's disapproval then exists. In addition to other applicable penalties for violation of this section, the superintendent may without additional cause withdraw approval of any membership coverage or other form as to which such advertising or sales material is used.

History: Laws 1984, ch. 127, § 895.

59A-48-17. Solicitation not violation of certain laws relating to providers.

Solicitation by prepaid dental plan organizations or anyone acting on their behalf to educate members and potential members of the coverage and operation of the organization's plan shall not be construed to be a violation of any provisions of law relating to solicitation or advertising by prepaid dental plan providers, if such solicitation including advertising and sales material:

A. is approved in advance by the superintendent as provided for in Section 895 [59A-48-16 NMSA 1978] of this article;

B. does not identify the providers nor describe their professional qualifications, except upon the request of the person being solicited;

C. does not describe the professional experience or attainments of such providers individually or as a group or contain language that directly or indirectly states, evaluates or lauds the professional competence, skills or reputations of such providers; and

D. shall not otherwise cause any of such providers to violate any professional ethics or laws prohibiting the solicitation of patients, except as permitted in this article.

History: Laws 1984, ch. 127, § 896.

59A-48-18. Conservation, rehabilitation, liquidation.

Any conservation, rehabilitation or liquidation of a prepaid dental plan organization shall be deemed to be that of an insurer and shall be conducted pursuant to Article 41 [Chapter 59A, Article 41 NMSA 1978] of the Insurance Code.

History: Laws 1984, ch. 127, § 897.

59A-48-19. Other provisions applicable.

In addition to those referred to in Chapter 59A, Article 48 NMSA 1978, the following articles and provisions of the Insurance Code [Chapter 59A NMSA 1978] shall also apply, to the extent reasonably applicable and subject to the provisions of that article, as to prepaid dental plan organizations, their sponsors, directors, officers, personnel and representatives and member contracts. For the purposes of this provision, such organizations may be referred to as "insurers" and such contracts as "policies":

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. Section 59A-5-33 NMSA 1978;

F. Sections 59A-6-1, 59A-6-3, 59A-6-4 and 59A-6-6 NMSA 1978;

G. Section 59A-7-11 NMSA 1978 [repealed];

H. Chapter 59A, Article 8 NMSA 1978;

I. Chapter 59A, Article 10 NMSA 1978;

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

K. the Insurance Fraud Act [Chapter 59A, Article 16C NMSA 1978];

L. Chapter 59A, Article 18 NMSA 1978;

M. the Policy Language Simplification Law [Chapter 59A, Article 19 NMSA 1978];

N. Section 59A-34-10 NMSA 1978, as to domestic prepaid dental plans; and

O. The Insurance Holding Company Law [Chapter 59A, Article 37 NMSA 1978].

History: Laws 1984, ch. 127, § 898; 2001, ch. 297, § 7; 2007, ch. 282, § 12.

ARTICLE 49
Prearranged Funeral Plans

59A-49-1. Short title.

This article [Chapter 59A, Article 49 NMSA 1978] may be cited as the "Prearranged Funeral Plan Regulatory Law".

History: Laws 1984, ch. 127, § 899.

59A-49-2. Purpose of article.

Money for funeral and burial purposes usually comes from one or more sources, such as the proceeds of life insurance, allowances of governmental agencies, union and fraternal organization benefits and savings and estate funds. Sometimes funeral insurance is also sold for such purposes. Experience in this and other states has proven that contract payments for funeral insurance are customarily to be made within a short period of time as compared to the average lapse of time until performance of the funeral insurance; that during the long interval between full receipt of the purchase price and contract performance, the possibilities for fraud are great and risk of insolvency, with consequent inability to perform, are inherent; and that, in addition to regulation of funeral plans in the same manner as life insurance, providing for the establishment of trust funds to require reserves sufficient to assure the purchasers that the sellers of funeral plans will be able to complete their contracts when the time for performance arrives and other restrictions are required to protect the public welfare, health and safety. The purpose of this article is to regulate funeral plans and related matters as experience has proven necessary in order to protect against fraud and deceit and otherwise to accomplish and promote the protection and welfare of the public.

History: Laws 1984, ch. 127, § 900.

59A-49-3. Prearranged funeral plans and purchases; regulation and control.

The superintendent shall regulate and control, in the same manner and with the same powers as he regulates the business of life insurance, the granting, sale or offering for sale of prearranged funeral plans. Provided however, that the provisions governing prearranged funeral plans contained in this article that require stricter control or higher obligations on the part of the seller shall control.

History: Laws 1984, ch. 127, § 901.

59A-49-4. Definitions.

As used in this article:

A. "funeral plan" means any contract, agreement, certificate, share, membership, right or interest or other form of instrument which is sold, providing for the future delivery of one or any combination of the following:

(1) any personal property customarily furnished in connection with funerals or other services attending the disposition of human bodies after death;

(2) the use of any facilities customarily furnished in connection with funerals or other services attending the disposition of human bodies after death;

(3) any services customarily furnished in connection with funerals or other services attending the disposition of human bodies after death; or

(4) any amount of money designated for any of the property, facilities or services mentioned in this subsection, if there is named in the instrument evidencing the prearranged funeral plan any person who furnishes or aids in the furnishing of any of such property, facilities or services or any condition or designation which designation would deprive or tend to deprive the person desiring to acquire such property, facilities or services of the advantages of competition in connection with their acquisition;

B. "funeral plan" shall not be construed to include the present sale of land for burial space, the sale of a lot, grave, crypt, niche or vault or the sale of the special care of any lot, grave, crypt or niche, or the family mausoleum, memorial, marker or monument, which is controlled under the provisions of the Endowed Care Cemetery Act of 1961 [Chapter 58, Article 17 NMSA 1978], provided that the seller thereof is in compliance with the provisions of that act, or which is specifically exempted from the provisions of this article;

C. "future delivery" means delivery which is or may be contingent upon the death of any person for whose benefit, or for the disposition of the remains of whom, the funeral plan was obtained. The fact that the instrument provides for the possibility of immediate

delivery at the option of either party does not exclude the instrument from the provisions of this article, if the delivery contingent on death is a possible option;

D. "trustee" means any bank or savings and loan association located in New Mexico whose deposits or accounts are insured by an agency of the United States;

E. "depositor" means any person to whom money has been paid by or on behalf of a purchaser of a funeral plan and who is obligated under this article to place it in trust;

F. "beneficiary" shall be the person for whom a trust fund required by this article was established; and

G. "person" means any individual, estate, trust, receiver, association, cooperative, club, corporation, company, firm, partnership, joint venture or syndicate, and includes an officer or employee of a corporation, a member or employee of a partnership or any individual who, as such, is under a duty to perform any act or to refrain from any act by reason of which a violation occurs.

History: Laws 1984, ch. 127, § 902.

59A-49-5. Restrictions on persons, places for sale of funeral plans.

A. No person who works in, or owns any interest in, any business which sells or furnishes any of the property, facilities or services customarily furnished in connection with funerals, burials or other services attending the disposition of human bodies after death may be licensed or otherwise authorized to sell prearranged funeral plans, but may be licensed or otherwise authorized to sell life insurance specifically designed to fund funeral plans.

B. No person licensed or otherwise authorized to sell funeral plans may pay any retainer, salary, commission or premium to any person who sells or furnishes any personal property, facilities or services customarily furnished in connection with funerals or other services attending the disposition of human bodies after death for soliciting or otherwise promoting the sale of funeral plans.

History: Laws 1984, ch. 127, § 903; 1987, ch. 48, § 1.

59A-49-6. Trust fund; accounting; deposit, reserves and premium tax.

A. In all cases where funeral plans are sold, all money paid, directly or indirectly, under such agreement, or under any agreement collateral thereto, shall be held in trust for the purpose for which it was paid until the obligation is fulfilled according to its terms; provided, however, that any payment made pursuant to this section shall be released upon death of the person for whose benefit such payment was made, and no payments

so made shall be subject to forfeiture. Accruals of interest upon this money shall be subject to the same trust.

B. All funds received as herein provided shall be placed in trust with a trustee pursuant to an agreement executed by the depositor and trustee that shall provide that the trustee shall hold the same in trust for the purposes for which deposited; that the trustee shall pay the same to the depositor upon the filing of a certified copy of the death certificate or other satisfactory evidence of the death of the beneficiary; and that the beneficiary or the beneficiary's duly appointed guardian may, in writing, demand the return of the money, together with accrued interest, if any, less cost incurred in the operation of such trust, and the depositor shall be entitled to receive such money from the trustee for payment to the beneficiary upon delivery of such written demand to the trustee. The payment of such funds and accumulated interest, pursuant to the terms of the Prearranged Funeral Plan Regulatory Law and the agreement herein referred to, shall relieve the trustee of any further liabilities with regard to such funds or interest thereon.

C. Each seller of funeral plans shall submit such accounting or accountings of all money collected or received on account of or in connection with the sale of funeral plans and of all money deposited or withdrawn from a trustee, as the superintendent may reasonably direct, by regulation or order.

D. Funds collected and placed in trust pursuant to this section shall not be used as the basis for the calculation of the capital and surplus, general deposits and fees otherwise required under Section 59A-5-16 NMSA 1978.

History: Laws 1984, ch. 127, § 904; 2018, ch. 57, § 27.

59A-49-7. May not enforce contract sold in violation; insurer may not pay to restricted persons without consent.

A. No person may enforce in any court of this state any asserted obligation of a purchaser of a funeral plan sold in violation of this article.

B. No authorized insurer shall pay or permit to be paid any money accruing as a benefit of a policy to any person restricted from selling funeral plans under Subsection A of Section 903 [59A-49-5 NMSA 1978] of this article without the written consent of the person or persons entitled to such benefit after accrual thereof.

History: Laws 1984, ch. 127, § 905.

59A-49-8. Criminal penalties.

Any seller of prearranged funeral plans who sells any such plan without having been properly licensed to do so, or who violates any of the requirements of this article or any lawful regulation or order of the superintendent in connection with the sale of funeral

plans, is guilty of a misdemeanor, and upon conviction shall be punished by a fine not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000). Each sale of each instrument shall be considered a separate offense, and each day in which any seller fails to comply with a lawful order of the superintendent is a separate offense. The penalties contained in this section shall be in addition to and not in lieu of any other penalties which may apply.

History: Laws 1984, ch. 127, § 906.

ARTICLE 50
Motor Clubs

59A-50-1. Short title.

This article [Chapter 59A, Article 50 NMSA 1978] may be cited as the "Motor Club Law".

History: Laws 1984, ch. 127, § 907.

59A-50-2. Definitions.

As used in this article and unless context otherwise requires:

A. "motor club" means a person engaged, directly or indirectly either as principal or agent, in selling or offering for sale, furnishing or procuring motor club service to members or subscribers. The definition of a motor club does not include any person whose services are provided predominately on a reimbursable basis since these services constitute insurance and are subject to the insurance laws of this state;

B. "licensee" means a motor club to which a certificate of authority has been issued under this article;

C. "applicant" means any person, firm, association, partnership, corporation or other legal entity, applying for a certificate of authority or renewal thereof under this article;

D. "bail bond service" means the furnishing of or arranging for a cash deposit, bond or undertaking, required and acceptable by law, for a member or subscriber accused of a violation of any motor vehicle or traffic law or ordinance so as to obtain his release from custody pending trial;

E. "emergency road service" means the adjustment, repair or replacement of the equipment, tires or mechanical parts of a motor vehicle so that such motor vehicle may be operated under its own power;

F. "financial service" means the arranging for loans or other advances of money to members or subscribers in connection with providing any other motor club service;

G. "legal fee reimbursement service" means the payment for or reimbursing of members or subscribers for fees charged by an attorney for his advice or services rendered to them in defense of a traffic offense;

H. "motor club service" means the rendering, furnishing or procuring of or the payment or reimbursement for, in whole or in part, such services as community traffic safety services, travel and touring service, theft or reward service, map service, towing service, emergency road service, legal fee reimbursement service in the defense of traffic offenses, license and title service, notary service, check cashing service, discount service, financial service and ticket and reservation service, or any one or more thereof, to any person, in connection with the ownership, operation, use or maintenance of a motor vehicle by such person, in consideration of such other person being or becoming a member or subscriber of any motor club, or being or becoming in any manner affiliated therewith, or being or becoming entitled to receive membership or other motor club service therefrom by virtue of any agreement or understanding with any such person;

I. "insurance service" means the selling or making available, of individual or group insurance policies or certificates other than service contracts as a result of membership in or affiliation with a motor club; such policies, if sold or made available, shall be issued only by an insurer duly authorized to do business in this state;

J. "theft service" means the offering of assistance in locating, identifying or recovering stolen or missing motor vehicles owned by members or subscribers, or the offering of a reward for the purpose of detecting or apprehending the person guilty of the theft;

K. "towing service" means the furnishing to members or subscribers of means to move a motor vehicle, under power other than its own, from one place to another, by any lawful wrecker service;

L. "representative" or "motor club representative" means any salesman or other individual who, for compensation, solicits or sells memberships, subscriptions or franchises on behalf of any motor club. This definition does not include any person performing only work of a clerical nature in the office of the motor club;

M. "service contract" means an agreement whereby a motor club, for a consideration, promises to render, furnish, procure or reimburse club members or subscribers specified services; and

N. "discount service" means obtaining merchandise for members or subscribers at a discount.

History: Laws 1984, ch. 127, § 908.

59A-50-3. Certificate of authority required; fees.

No person shall provide motor club services or do business as a motor club in this state without having first met the requirements of this article, and having obtained a certificate of authority from the superintendent. The fee for such certificate shall be as specified in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code.

History: Laws 1984, ch. 127, § 909.

59A-50-4. Requirements and application for certificate of authority.

A. Each motor club shall obtain a certificate of authority by filing a written application with the superintendent as hereinafter provided and otherwise in such form and manner as the superintendent shall require.

B. The applicant shall furnish to the superintendent such data and information as the superintendent may deem reasonably necessary to enable the superintendent to determine, in accordance with the provisions of Chapter 59A, Article 50 NMSA 1978, whether or not a certificate of authority should be issued to the applicant. It shall be executed under oath by the applicant, or if other than an individual, by an authorized officer of the applicant, and the information filed with the application shall include the following:

(1) if such applicant is a corporation, a certificate of good standing from the secretary of state, together with the names and addresses of all officers and directors, and the names and addresses of all persons owning in excess of ten percent of the capital stock of the corporation issued and outstanding;

(2) if not incorporated, a list of all persons owning an interest in the applicant, the officers thereof and the parties to any operating or management agreement affecting the applicant, together with a copy of such agreement;

(3) a financial statement certified by a registered or certified public accountant, as of the end of the next preceding calendar year, presenting fairly, in accordance with generally accepted accounting principles, the financial position of the applicant and containing such other information as the superintendent may prescribe;

(4) a copy of its service contract, the terms of which shall not:

(a) contain inconsistent, ambiguous or misleading clauses or exceptions or conditions that deceptively affect the risk purported to be assumed or the service to be performed;

(b) contain any inequitable provision or provisions without substantial benefit to the member or subscriber; or

(c) provide for the payment of fees that are unreasonable in relation to the services agreed to be performed;

(5) security in the form of a deposit or bond of not less than twenty-five thousand dollars ($25,000) nor more than two hundred thousand dollars ($200,000) with the amount to be based upon annual membership fees collected from state residents at the following rates:

Annual Resident Fees	Amount of Deposit or Bond
$1.00 to $150,000.00	$ 25,000.00
$150,001.00 to $250,000.00	$ 40,000.00
$250,001.00 to $500,000.00	$ 80,000.00
$500,001.00 to $1,000,000.00	$150,000.00
$1,000.001.00 and over	$200,000.00

The security shall be deposited with the superintendent in trust or in any other manner the superintendent may direct, and the applicant may deposit either government securities having a market value equal to the amount of security required, or a corporate surety bond in the proper amount in such form as the superintendent may prescribe. The bond shall be issued by a surety insurer authorized to do business in this state, and conditioned upon faithful performance by the applicant of its obligations under Chapter 59A, Article 50 NMSA 1978, including payment of any fines, fees or penalties imposed on it or restitution ordered, but the aggregate liability of the surety for all breaches of the conditions of the bond shall in no event exceed the amount of the bond. The surety on the bond shall have the right to cancel the bond by giving thirty days' notice to the superintendent and thereafter shall be relieved of liability for any breach of condition occurring after the effective date of cancellation. The superintendent may promulgate rules and regulations specifying conditions concerning the bond and providing methods for its termination; and

(6) the bond or deposit provided for in Paragraph (5) of this subsection shall be maintained so long as the licensee has any outstanding liability or obligation in this state. Upon proof satisfactory to the superintendent that the licensee has ceased to do business and that all its liabilities and obligations have been satisfied, the superintendent shall return the security to the licensee.

History: Laws 1984, ch. 127, § 910; 2013, ch. 75, § 22.

59A-50-5. Issuance, refusal of certificate of authority; continuance or expiration.

A. Within a reasonable time after application for certificate of authority is filed, the superintendent shall either issue or refuse to issue the certificate. The superintendent shall issue the certificate to the applicant unless:

(1) the applicant has not met all requirements of this article; or

(2) the applicant does not, in the superintendent's judgment, have sufficient financial responsibility to engage in business as a motor club; or

(3) the applicant has failed to make a reasonable showing that all of its owners, managers, officers, directors or representatives are persons of reliability and integrity.

B. If the superintendent refuses to issue the certificate of authority he shall notify the applicant as soon as practicable, stating the reasons for such refusal, and inform the applicant of its right to a hearing on the matter as provided in Section 59 [59A-4-15 NMSA 1978] (hearings, in general) of the Insurance Code.

C. All certificates of authority issued under this article shall be subject to continuance and expiration in the same applicable manner and on dates as provided in Article 5 [Chapter 59A, Article 5 NMSA 1978] of the Insurance Code with respect to certificates of authority of insurers, and for the purpose thereof a motor club may be referred to as an "insurer" therein. As prerequisite to continuance of the certificate of authority the superintendent may require the motor club to file with him its financial statement for the previous calendar year in such form as he may prescribe or accept.

History: Laws 1984, ch. 127, § 911.

59A-50-6. Additional security.

A. In addition to the security deposited by a motor club at the time application for certificate of authority is made, the superintendent may require the motor club to establish and maintain reserves out of the receipts from the sale of motor club services under contract. The amount required, if any, may be established from time to time as the superintendent determines is reasonable and necessary for the protection of motor club members but in any event shall not exceed fifty percent of the receipts collected for the period of the service contract. Funds received under this section shall be placed in trust and released as directed by regulation or order of the superintendent.

B. Notwithstanding the provisions of Section 910 [59A-50-4 NMSA 1978] of this article and Subsection A of this section the superintendent may require additional general deposits, in a reasonable amount and in admitted assets of the types of securities authorized by law, whenever he deems it necessary.

History: Laws 1984, ch. 127, § 912.

59A-50-7. Service contracts.

A. Any motor club service contract form, amendment thereof and agreement collateral thereto shall be filed with the superintendent before final execution of any such document. The superintendent shall prohibit the use of any language, condition or requirement in such service contracts, amendments and collateral agreements which is false, misleading, unfair, inequitable or otherwise contrary to public interest. Any prohibition of language, condition or requirement shall be made by the superintendent within thirty (30) days after the date the document is filed or shall be made anytime thereafter pursuant to the administrative hearing procedures provided for in Article 4 [Chapter 59A, Article 4 NMSA 1978] of the Insurance Code.

B. Each service contract shall contain a provision that if the motor club is unable to perform a contract obligation either on a service or indemnity basis the cash retail equivalent shall be paid to the member.

History: Laws 1984, ch. 127, § 913.

59A-50-8. Investigations, examinations.

The superintendent shall have the same powers and authority under this article to conduct investigations, and to conduct examinations of books, records and accounts at the expense of the person so examined, as vested in him with respect to insurers and other persons under Article 4 [Chapter 59A, Article 4 NMSA 1978] of the Insurance Code and subject to the applicable provisions of such Article 4.

History: Laws 1984, ch. 127, § 914.

59A-50-9. Suspension, revocation or refusal to continue certificate of authority.

The superintendent may suspend, revoke, or refuse to continue the certificate of authority of a motor club upon finding, after notice and opportunity for hearing, that the motor club has:

A. violated any provision of this article;

B. failed to maintain the standards required for issuance of its original certificate of authority as specified in this article;

C. become insolvent;

D. liabilities in excess of its assets;

E. engaged in one or more fraudulent or deceptive acts; or

F. entered into a service contract the form of which has not been filed with the superintendent, or containing language, condition or requirement prohibited by the superintendent pursuant to Section 913 [59A-50-7 NMSA 1978] of this article.

History: Laws 1984, ch. 127, § 915.

59A-50-10. Name, trademarks, emblems.

The superintendent may disapprove the name, trademarks and emblems which a motor club employs or proposes to employ in connection with its business. If such a name, trademarks or emblems are distinctive and are not similar to or in conflict with a local organization or a nationally registered or copyrighted name, emblem or insignia and not likely to confuse or mislead the public as to the nature or identity of the motor club using or proposing to use it, and will not interfere with the transactions of a motor club already operating in this state, then they shall be approved. Otherwise, the superintendent may disapprove their use and order that the motor club cease to use them.

History: Laws 1984, ch. 127, § 916.

59A-50-11. Violation hearings.

A. If as a result of investigation or examination the superintendent has cause to believe that any person is violating any provision of this article, he shall send notice of the violation by certified mail to the person so believed to be in violation. The notice shall state the time and place for a hearing to be held on the alleged violation, within not less than thirty (30) days from the date of the notice.

B. The hearing shall be conducted and be subject to provisions relative to hearings of the superintendent in general under Article 4 [Chapter 59A, Article 4 NMSA 1978] of the Insurance Code.

History: Laws 1984, ch. 127, § 917.

59A-50-12. Service of process; superintendent appointed attorney.

A. Every authorized motor club shall file with the superintendent its appointment of the superintendent in writing, on form as prescribed and furnished by the superintendent, as its true and lawful attorney, upon whom all lawful process in any action or proceeding against the motor club may be served. In the power of attorney the motor club shall stipulate and agree that all such process served upon the superintendent, or, in his absence, upon any employee in apparent charge of his office, shall be of the same legal force and validity as if served on the motor club itself, and that the authority shall continue in force so long as any liability or obligation remains outstanding in this state against the motor club by reason of its operations under this article.

B. Whenever such process is served upon the superintendent three (3) copies thereof shall be furnished. The superintendent shall forthwith forward by certified mail (return receipt requested) one copy of the process to the motor club and one copy to its resident manager or other similar official, if any, in this state, directed to the address of the motor club, manager or official at address thereof last of record with the superintendent. The server of the process shall at time of such service pay to the superintendent the service of process fee in amount specified in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code, taxable as costs in the action or proceeding.

C. Process so served upon the superintendent and copies mailed as hereinabove required shall constitute effective service of such process upon the motor club.

History: Laws 1984, ch. 127, § 918.

59A-50-13. Registered representatives required; qualifications for registration.

A. No person shall be, act as or purport to be a representative of a motor club in this state unless then registered as such with the superintendent by the motor club.

B. To qualify for registration the applicant shall:

(1) be an individual not less than eighteen years of age;

(2) be of good personal and business reputation;

(3) not previously have been refused registration or had registration revoked;

(4) be suitable and competent to act as such representative; and

(5) intend in good faith to act and hold himself out as such a representative.

C. As part of an application for registration, a nonresident applicant shall appoint the superintendent, on a form prescribed and furnished by the superintendent, as agent on whom may be served all legal process issued by a court in this state in any action involving the nonresident registrant. The appointment is irrevocable and continues for so long as an action involving the nonresident registrant could arise. Duplicate copies of process shall be served upon the superintendent or other person in apparent charge of the insurance division during the superintendent's absence, accompanied by payment of the process service fee specified in Section 59A-6-1 NMSA 1978. Upon service the superintendent shall promptly forward a copy by certified mail, return receipt requested, to the nonresident registrant at his last address of record with the superintendent. Process served and copy forwarded as so provided constitutes personal service upon the nonresident registrant.

D. A nonresident registrant shall also file with the superintendent a written agreement to appear before the superintendent pursuant to a notice of hearing, show cause order or subpoena issued by the superintendent and deposited, postage paid, by certified mail in a letter depository of the United States post office, addressed to the nonresident registrant at his last address of record with the superintendent, and that upon failure of the nonresident registrant to appear, the nonresident registrant consents to subsequent suspension, revocation or refusal of the superintendent to continue the license.

History: Laws 1984, ch. 127, § 919; 1999, ch. 272, § 24; 1999, ch. 289, § 37.

59A-50-14. Registration procedure and matters relating to registration of representatives.

Appointment of representatives, issuance or refusal of certificate of registration, continuance or expiration of registration, suspension, revocation or refusal to continue registration, and all related matters shall be governed by the applicable provisions of Article 11 [Chapter 59A, Article 11 NMSA 1978] (licensing procedures) of the Insurance Code as though registration of a motor club representative were the same as licensing of an agent by a casualty insurer, except that applicant for registration as motor club representative shall not be required to take and pass an examination, whether written or oral, as a qualification for registration. The fee for filing application for registration and annual continuance of registration shall be as specified in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code.

History: Laws 1984, ch. 127, § 920.

59A-50-15. Motor club bound.

The motor club shall be bound by the acts of its representative while so registered and acting within his actual or apparent authority.

History: Laws 1984, ch. 127, § 921.

59A-50-16. Representing unauthorized motor club prohibited.

No person shall in this state be, act as, or purport to be a salesman, solicitor or representative of a motor club doing business in this state and not then holding certificate of authority issued by the superintendent.

History: Laws 1984, ch. 127, § 922.

59A-50-17. Limitations upon advertising.

Motor clubs shall make no reference to their certificate of authority or approval from the superintendent or the state in any advertising, circular, contract or membership card nor shall any such motor club advertise or describe its services in such a manner as would lead the public to believe that such services include motor vehicle insurance.

History: Laws 1984, ch. 127, § 923.

59A-50-18. Service contract and membership card.

Every motor club shall furnish to its members a service contract and membership card together with the following information:

A. the exact name of the motor club;

B. the exact location of the motor club's home office, and of its usual place or places of business in this state, giving telephone numbers, street numbers, city and zip code; and

C. a description of the services or benefits to which the member or subscriber is entitled. The completed application and the description of services shall constitute the service contract unless the motor club otherwise provides and the superintendent approves another form of service contract.

History: Laws 1984, ch. 127, § 924.

59A-50-19. Administrative penalty.

Upon a determination by hearing that this article has been violated, the superintendent may issue an order requiring the person to cease and desist from engaging in such violation or, if such conduct is in violation of the express provisions of this article, the superintendent may suspend or revoke the person's certificate of authority or registration.

History: Laws 1984, ch. 127, § 925.

59A-50-20. Civil penalties.

In addition to any penalties imposed pursuant to other provisions of this article, the district court of the county in which the violation occurred may, in an action filed by the superintendent, impose the following civil penalties:

A. for each violation of this article which the person knew or reasonably should have known was such a violation, a penalty of not more than five thousand dollars ($5,000) for each violation but not to exceed an aggregate penalty of fifty thousand dollars ($50,000) in any six-month period;

B. for each violation of this article which the person did not know nor reasonably should have known was such a violation, a penalty of not more than one thousand dollars ($1,000) for each violation but not to exceed an aggregate penalty of ten thousand dollars ($10,000) in any six-month period; and

C. for each violation of an order issued by the superintendent pursuant to Section 925 [59A-50-19 NMSA 1978] of this article, while such order is in effect, a penalty of not more than ten thousand dollars ($10,000).

History: Laws 1984, ch. 127, § 926.

59A-50-21. Other provisions applicable.

In addition to those referred to in Chapter 59A, Article 50 NMSA 1978 as to particular matters, the following articles and provisions of the Insurance Code [Chapter 59A NMSA 1978] shall also, to the extent reasonably applicable and not in conflict with the provisions of Chapter 59A, Article 50 NMSA 1978 and the reasonable implications thereof, apply as to motor clubs, their sponsors, directors, officers, representatives, personnel and operations. For the purposes of such applicability, a motor club may be referred to in such articles and provisions 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. Chapter 59A, Article 10 NMSA 1978;

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

F. Chapter 59A, Article 16 NMSA 1978;

G. the Insurance Fraud Act [Chapter 59A, Article16C NMSA 1978]; and

H. the Insurers Conservation, Rehabilitation and Liquidation Law [Chapter 59A, Article 41 NMSA 1978].

History: Laws 1984, ch. 127, § 927; 2001, ch. 297, § 8.

ARTICLE 51
Bail Bondsmen Licensing

59A-51-1. Short title.

Chapter 59A, Article 51 NMSA 1978 may be cited as the "Bail Bondsmen Licensing Law".

History: Laws 1984, ch. 127, §928; 2005, ch. 259, § 1.

59A-51-2. Definitions.

As used in the Bail Bondsmen Licensing Law:

A. "bail bondsman" means a limited surety agent or a property bondsman as hereafter defined;

B. "insurer" means any surety insurer that is authorized to transact surety business in this state;

C. "limited surety agent" means any individual appointed by an insurer by power of attorney to execute or countersign bail bonds in connection with judicial proceedings and receives or is promised money or other things of value therefor;

D. "property bondsman" means any person who pledges United States currency, United States postal money orders or cashier's checks or other property as security or surety for a bail bond in connection with a judicial proceeding and receives or is promised therefor money or other things of value; and

E. "solicitor" means a person employed by a bail bondsman for the purpose of assisting the bail bondsman in presenting the defendant in court when required, or to assist in the apprehension and surrender of the defendant to the court or in keeping the defendant under necessary surveillance, and to solicit bail bond business, to sign property bonds and to assist in other conduct of the business all as authorized by the employer bail bondsman. This does not affect the right of a bail bondsman to hire counsel or to ask assistance of law enforcement officers. A bail bondsman shall register a solicitor with the superintendent within seven days of employment.

History: Laws 1984, ch. 127, § 929; 2014, ch. 21, § 1.

59A-51-3. License required; exemption.

A. No person shall act as property bondsman, limited surety agent or solicitor, or perform any functions or duties or exercise any of the powers prescribed for bail bondsmen or solicitors in Chapter 59A, Article 51 NMSA 1978 unless such person is qualified and licensed as provided in that article.

B. Nothing in Chapter 59A, Article 51 NMSA 1978 shall be construed as to prevent any duly licensed and appointed agent of a surety insurer authorized to transact such business in this state from writing bail bonds for such insurer, and such agent shall be

subject to and governed by all laws, rules and regulations relating to bail bondsmen under that article while engaged in the activities thereof.

C. Any bail bondsman licensed under the provisions of the Bail Bondsman Licensing Law shall be entitled to post bail bonds in any court in New Mexico subject to court rules regulating the posting of bonds in that court.

History: Laws 1984, ch. 127, § 930; 1987, ch. 228, § 3.

59A-51-4. Qualifications for license.

Applicants for license as bail bondsman or solicitor pursuant to the provisions of the Bail Bondsmen Licensing Law shall:

A. be an individual not less than eighteen years of age;

B. be a high school graduate or have passed a high school equivalency examination;

C. not be a law enforcement, adjudication, jail, court or prosecution official or an employee thereof or an attorney, official authorized to admit to bail or state or county officer;

D. if for license as bondsman, pass a written examination testing the applicant's knowledge and competence to engage in the bail bondsman business;

E. be of good personal and business reputation;

F. if to act as a property bondsman, be financially responsible and provide the surety bond or deposit in lieu thereof as required in accordance with Section 59A-51-8 NMSA 1978;

G. if to act as a limited surety agent, be appointed by an authorized surety insurer; and

H. if for license as a solicitor, have been so appointed by a licensed bail bondsman subject to issuance of the solicitor license.

History: Laws 1984, ch. 127, § 931; 1999, ch. 272, § 25; 1999, ch. 289, § 38; 2005, ch. 259, § 2; 2014, ch. 21, § 2; 2021, ch. 70, § 5.

59A-51-4.1. Educational requirements.

A. In order to be eligible to take the examination required to be licensed as a bail bondsman or solicitor, the applicant shall complete pre-licensing requirements as prescribed by rule. Pre-licensing requirements shall include formal classroom education,

the form and content of which shall be subject to approval by the superintendent. In addition, the applicant shall complete thirty hours of on-the-job training under the direct supervision of a licensed bail bondsman who shall certify in writing that the applicant has been taught the subjects pertinent to the duties and responsibilities of a bail bondsman, including ethics and all laws and rules related to the bail bond business, and that the applicant is prepared to take the examination.

B. Prior to renewal of a bail bondsman's or solicitor's license, a licensee shall complete annually continuing education requirements as prescribed by rule.

C. It is a violation of the New Mexico Insurance Code for a person to falsely represent to the superintendent that the education requirements of this section have been complied with or to fail to register with the superintendent.

D. The superintendent shall adopt and promulgate such rules as are necessary for the effective administration of this section.

History: Laws 1999, ch. 296, § 1; 2014, ch. 21, § 3.

59A-51-5. Application for license.

A. An individual desiring to be licensed as bail bondsman or solicitor under the Bail Bondsmen Licensing Law shall file with the superintendent a written application on a form as prescribed and furnished by the superintendent, together with an application for a qualifying examination.

B. With application for license to act as property bondsman the applicant shall file with the superintendent a detailed financial statement under oath.

C. Application for a solicitor's license must be endorsed by the appointing bail bondsman, who shall therein be obligated to supervise the solicitor's activities in the bondsman's behalf.

D. The application shall be accompanied by a recent credential-sized full-face photograph of the applicant together with such additional proof of identity as the superintendent may reasonably require.

E. As part of an application for a license, a nonresident applicant shall appoint the superintendent, on a form prescribed and furnished by the superintendent, as agent on whom may be served all legal process issued by a court in this state in any action involving the nonresident licensee. The appointment is irrevocable and continues for so long as an action involving the nonresident licensee could arise. Duplicate copies of process shall be served upon the superintendent or other person in apparent charge of the office of superintendent of insurance during the superintendent's absence, accompanied by payment of the process service fee specified in Section 59A-6-1 NMSA 1978. Upon service, the superintendent shall promptly forward a copy by certified mail,

return receipt requested, to the nonresident licensee at the nonresident licensee's last address of record with the superintendent. Process served and copy forward as so provided constitutes personal service upon the nonresident licensee.

F. A nonresident licensee shall also file with the superintendent a written agreement to appear before the superintendent pursuant to a notice of hearing, show cause order or subpoena issued by the superintendent and deposited, postage paid, by certified mail in a letter depository of the United States post office, addressed to the nonresident licensee at the nonresident licensee's last address of record with the superintendent, and that upon failure of the nonresident licensee to appear, the nonresident licensee consents to subsequent suspension, revocation or refusal of the superintendent to continue the license.

History: Laws 1984, ch. 127, § 932; 1999, ch. 272, § 26; 1999, ch. 289, § 39; 2014, ch. 21, § 4.

59A-51-6. Licensing fees.

Fees for filing application for license and examination and for continuance of license shall be paid to the superintendent in advance and shall be in respective amounts as specified in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code.

History: Laws 1984, ch. 127, § 933.

59A-51-7. Examination for license.

Examination of an applicant for license as bail bondsman shall be given and conducted by or under authorization of the superintendent and shall otherwise be subject to the provisions governing examination of applicants for license set forth in Article 11 [Chapter 59A, Article 11 NMSA 1978] (licensing procedures) of the Insurance Code.

History: Laws 1984, ch. 127, § 934.

59A-51-8. Bonding requirements, property bondsmen.

A. Prior to the issuance of a license to act as property bondsman, the applicant therefor shall deposit with the superintendent a surety bond in favor of the superintendent, or in lieu thereof a certificate of deposit, securities or a letter of credit issued by an institution, acceptable to the superintendent, and which letter is irrevocable for the term of the license, in a total aggregate amount of not less than twenty-five thousand dollars ($25,000), conditioned to pay the actual damages resulting to the state or to any member of the public from any violation by the property bondsman of the provisions of the Bail Bondsmen Licensing Law or any other insurance laws. Surety bonds shall be executed by a surety insurer authorized to do business in this state.

B. The bond or deposit shall be maintained for the duration of the license, or, in the case of a surety bond, until the surety is released from liability by the superintendent or until the bond is canceled by the surety. In addition, the bond or deposit shall be maintained until all bonds that have been posted with all courts become exonerated. Without prejudice to any liability incurred prior to expiration or cancellation, the bond may expire, or the surety may cancel a bond by giving written notice to the superintendent at least thirty days prior to the effective date of the cancellation. The licensee shall immediately replace a bond expired or so canceled or make the required deposit in lieu thereof.

History: Laws 1984, ch. 127, § 935; 2014, ch. 21, § 5.

59A-51-9. Issuance, refusal of license.

The superintendent shall act upon application for license under this article within a reasonable period after the application has been filed with him. If the superintendent finds that the application is complete, that the applicant has taken and passed any required examination, has paid all applicable fees and is otherwise qualified for the license, he shall issue to the applicant in appropriate form the license applied for. Otherwise, the superintendent shall refuse to issue the license and shall promptly notify the applicant thereof in writing stating the grounds for the refusal.

History: Laws 1984, ch. 127, § 936.

59A-51-10. Duration, continuation, expiration of license.

A. Every bail bondsman and solicitor license issued under this article shall be dated and become effective as of date of issue, and shall continue in force for so long as the licensee remains qualified therefor, unless terminated by the licensee or suspended or revoked, subject to continuation annually by payment in advance of the continuation fee specified therefor in Section 101 [59A-6-1 NMSA 1978] (fee schedule) of the Insurance Code. Unless so continued the license shall expire as of midnight on April 30th of the current license effective period.

B. Prior to continuation of license of a property bondsman the superintendent may require filing of the licensee's financial statement as of the end of the calendar year next preceding, and may require of all licensees such information in writing concerning operations under the license during the next preceding calendar year as the superintendent deems advisable.

History: Laws 1984, ch. 127, § 937.

59A-51-11. Return of license; property bondsman notice to courts.

A. Every license issued under the article is at all times the property of the state of New Mexico, and upon any expiration, termination, suspension or revocation thereof the

licensee shall promptly return the license to the superintendent for holding (in case of suspension) or cancellation.

B. Any property bondsman who discontinues writing bail bonds during the period for which he is licensed shall notify the clerks of the courts with whom he is registered of such discontinuance. Within thirty (30) days after such discontinuance the licensee shall return his license to the superintendent for cancellation.

History: Laws 1984, ch. 127, § 938.

59A-51-12. Appointment or termination of solicitors.

A. Every licensed bail bondsman may appoint as solicitor any individual who holds or has qualified for a solicitor's license. Each bail bondsman shall annually, prior to March 1, file with the superintendent an alphabetical list of all solicitors whose appointment and license in this state is to be continued in effect, accompanied by payment of the applicable continuation fees.

B. A bail bondsman terminating the appointment of a solicitor shall, within thirty (30) days, file written notice thereof with the superintendent, together with a statement that he has given or mailed notice to the solicitor. Such notice filed with the superintendent shall state the reasons, if any, for such termination. Information so furnished to the superintendent shall be privileged and shall not be used as evidence in any action against the bail bondsman.

History: Laws 1984, ch. 127, § 939.

59A-51-13. Practices.

A. A bail bondsman or solicitor shall not:

(1) suggest or advise the employment of or name for employment any particular attorney to represent the bail bondsman's or solicitor's principal;

(2) pay a fee or rebate or give or promise anything of value to a jailer, policeman, peace officer, committing magistrate or any other person who has power to arrest or to hold in custody or to any public official or public employee in order to secure a settlement, compromise, remission or reduction of the amount of any bail bond or estreatment thereof or to secure delay or other advantage;

(3) pay a fee or rebate or give anything of value to an attorney in bail bond matters, except in defense of any action on a bond;

(4) pay a fee or rebate or offer a reduction in rates, charges or premiums or give or promise anything of value to the principal or anyone on behalf of the principal;

(5) participate in the capacity of an attorney at a trial or hearing of one on whose bond the bail bondsman or solicitor is surety;

(6) except for the premium received for the bond, fail to return any collateral security within a reasonable time after the termination of liability on the bond; or

(7) charge or accept anything of value except the premium on the bond and any extraterritorial recovery expenses, but the bondsman may accept collateral security or other indemnity if:

(a) such collateral security or other indemnity is reasonable in relation to the amount of the bond;

(b) no collateral or security in tangible property is taken by pledge or debt instrument that allows retention, sale or other disposition of such property upon default of premium payment;

(c) no collateral or security interest in real property is taken by deed or any other instrument unless the bail bondsman's interest in the property is limited to one hundred percent of the amount of the bond;

(d) the collateral or security taken by the bondsman is not pledged directly to any court as security for an appearance bond; and

(e) the person from whom the collateral or security is taken is given a receipt describing the condition of the collateral or security at the time it is taken into the custody of the bondsman.

B. When a bail bondsman accepts cash as collateral, the bondsman shall deposit the cash in the bondsman's trust account and give a written receipt for same, and this receipt shall give in detail a full account of the collateral received.

C. Law enforcement, adjudication and prosecution officials and their employees, attorneys-at-law, officials authorized to admit to bail and state and county officers shall not directly or indirectly receive any benefits from the execution of any bail bond.

D. A bail bondsman shall not sign nor countersign in blank any bond, nor shall the bondsman give a power of attorney to or otherwise authorize anyone to countersign the bondsman's name to bonds unless the person so authorized is a licensed bondsman directly employed by the bondsman giving such power of attorney.

E. No bail bond agency shall advertise as or hold itself out to be a surety insurer.

F. Every bail bondsman shall have a permanent street address, and all bail bond business shall be conducted from that address.

G. Every bail bondsman shall transact all bail bond business, surety or property, in the bondsman's proper individual name or one agency name as stated on the application for license and on the license as issued by the superintendent.

History: Laws 1984, ch. 127, § 940; 1987, ch. 228, § 4; 2005, ch. 259, § 3; 2014, ch. 21, § 6.

59A-51-13.1. Premium rates.

The superintendent shall conduct public hearings for the purpose of promulgating the premium rates, schedule of charges and rating plan to be charged and used by bail bondsmen. No premium rate that has not been promulgated or otherwise approved by the superintendent shall be charged for any bail bond. Premium rates promulgated by the superintendent shall not be excessive, inadequate or unfairly discriminatory.

History: Laws 2014, ch. 21, § 9.

59A-51-14. Denial, suspension, revocation or refusal to continue license.

A. The superintendent may deny, suspend, revoke or refuse to continue any license issued under the Bail Bondsmen Licensing Law for any of the following reasons:

(1) any cause for which issuance of the license could have been refused had it then existed and been known to the superintendent;

(2) a material misstatement, misrepresentation or fraud in obtaining the license;

(3) any violation of the laws of this state relating to bail or the bail bond business;

(4) misappropriation, conversion or unlawful withholding of money belonging to insurers or others and received in the conduct of business under the license;

(5) fraudulent or dishonest practices in the conduct of business under the license;

(6) failure to comply with, or willful violation of, any provision of the Bail Bondsmen Licensing Law or proper order, rule or regulation of the superintendent or any court of this state;

(7) any activity prohibited in Section 59A-51-13 NMSA 1978;

(8) failure or refusal, upon demand, to pay over to any insurer that the licensee represented, any money coming into the licensee's hands belonging to the insurer;

(9) failure to preserve without use and retain separately or to return collateral taken as security on any bond to the principal, indemnitor or depositor of collateral when the principal, indemnitor or depositor is entitled to such collateral;

(10) for knowingly having in the bail bondsman's employ a person whose bail bond business license has been revoked, suspended or denied in this or any other state; or

(11) failure, neglect or refusal to supervise a solicitor's activities on the bail bondsman's behalf.

B. When, in the judgment of the superintendent, the licensee in the conduct of affairs under the license has demonstrated incompetency, untrustworthiness, conduct or practices rendering the licensee unfit to engage in the bail bond business, or making the licensee's continuance in such business detrimental to the public interest, or that the licensee is no longer in good faith engaged in the bail bond business, or that the licensee is guilty of rebating, or offering to rebate the licensee's commissions in the case of limited surety agents or premiums in the case of property bondsmen, and for such reasons is found by the superintendent to be a source of detriment, injury or loss to the public, the superintendent shall revoke or suspend the license.

C. In case of the suspension or revocation of license of any bail bondsman, the license of any or all other bail bondsmen who are members of the same agency and any or all solicitors employed by such agency, who knowingly were parties to the act that formed the ground for the suspension or revocation shall likewise be suspended or revoked, except for the purpose of completing pending matters, and those persons who knowingly were parties to the act are prohibited from being licensed as a member of or bail bondsman or solicitor for some other agency.

D. No license under the Bail Bondsmen Licensing Law shall be issued, renewed or permitted to exist when the same is used directly or indirectly to circumvent the provisions of the Bail Bondsmen Licensing Law.

History: Laws 1984, ch. 127, § 941; 2003, ch. 202, § 14; 2005, ch. 259, § 4; 2014, ch. 21, § 7.

59A-51-15. Duration of suspension; relicensing after revocation.

A. The superintendent in his order suspending a license, shall specify the period during which the suspension is to be in effect, but such period shall not exceed one year subject to modification in the superintendent's discretion. A license which has been suspended shall not be reinstated except upon request for such reinstatement, but the

superintendent shall not grant reinstatement if he finds that the circumstances for which the previous license was revoked still exist or are likely to recur.

B. When an individual's license has been revoked, the superintendent shall have the right to refuse to accept an application for another license under this article for a period of one year from the effective date of such revocation, or, if judicial review of such revocation is sought, within two (2) years from the date of final court order or decree affirming the revocation. The superintendent shall not, however, grant a new license to any individual if he finds that the circumstances for which the previous license was revoked still exist or are likely to recur.

C. If licenses as bail bondsman or solicitor as to the same individual have been revoked at two (2) separate times, the superintendent shall not thereafter grant or issue any license to such individual under this article.

D. During the period of suspension or after revocation of the license, the former licensee shall not engage in or attempt or profess to engage in any transaction or business for which a license is required under this article, except that the former licensee may collect premiums on business written prior to the date of the suspension or revocation.

History: Laws 1984, ch. 127, § 942.

59A-51-16. Administrative fine in lieu.

A. The superintendent may, in the superintendent's discretion, in lieu of license suspension, revocation or refusal, and except on a second offense, impose upon the licensee an administrative penalty of one hundred dollars ($100), or, if the superintendent has found wilful misconduct or wilful violation on the part of the licensee, an administrative penalty not to exceed one thousand dollars ($1,000).

B. The superintendent may allow the licensee a reasonable period, not to exceed thirty days, within which to pay to superintendent the amount of the penalty so imposed. If the licensee fails to pay the penalty in its entirety to the superintendent within the period so allowed, the license of the licensee shall stand suspended or revoked, or continuation refused, as the case may be, upon expiration of such period and without any further proceedings.

History: Laws 1984, ch. 127, § 943; 2014, ch. 21, § 8.

59A-51-17. Probation.

If the superintendent finds that one or more causes exist for the suspension, revocation or refusal to continue any license issued under this article the superintendent may, in his discretion, in lieu of such suspension, revocation or refusal, or in connection with any administrative monetary penalty imposed, place the offending licensee on

probation for a period not to exceed two (2) years, as specified by the superintendent in his order.

History: Laws 1984, ch. 127, § 944.

59A-51-18. Repealed.

History: Laws 1984, ch. 127, § 945; repealed by Laws 2014, ch. 21, § 11.

59A-51-19. Other provisions applicable.

In addition to other provisions of the Insurance Code applicable as to licensing and licensees as referred to in Chapter 59A, Article 51 NMSA 1978, the following provisions of the Insurance Code shall also apply, subject to the provisions of that article and to extent reasonably so applicable, as though the bail bond business was also an insurance business and licensees were also agents or representatives:

A. Chapter 59A, Article 1 NMSA 1978;

B. Chapter 59A, Article 2 NMSA 1978;

C. Chapter 59A, Article 4 NMSA 1978;

D. Chapter 59A, Article 10 NMSA 1978;

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

F. Chapter 59A, Article 16 NMSA 1978; and

G. Chapter 59A, Article 6 NMSA 1978.

History: Laws 1984, ch. 127, § 946; 1988, ch. 74, § 3.

ARTICLE 52
State Fire Marshal

59A-52-1. State fire marshal's office created; state fire marshal created.

A. The "state fire marshal's office" is created as a division under the homeland security and emergency management department.

B. The position of "state fire marshal" is created as the director of the state fire marshal's office.

C. The office consists of the:

(1) firefighter training academy program;

(2) fire service support program;

(3) fire investigations program; and

(4) fire code enforcement program.

History: Laws 1984, ch. 127, § 947; 1998, ch. 108, § 38; 2007, ch. 161, § 5; 2020, ch. 9, § 29.

59A-52-1.1. State fire marshal; appointment; powers and duties.

A. The state fire marshal shall be appointed by the secretary of homeland security and emergency management. The state fire marshal shall be appointed solely on the basis of fitness to perform the duties of state fire marshal and without reference to political party affiliation. The state fire marshal shall be well versed in fire services, including structural fires, training, investigations and code enforcement, as well as administrative duties, including personnel, operating budgets and capital planning and expenditures. The state fire marshal shall have an understanding of insurance services office requirements, wildland firefighting and legislative advocacy.

B. The state fire marshal shall be an at-will employee and is exempt from the federal Fair Labor Standards Act of 1938.

C. The state fire marshal shall:

(1) oversee and manage the state fire marshal's office and direct its activities;

(2) promulgate rules pursuant to the State Rules Act relating to the state fire marshal's office and the fire services council; and

(3) consider advice from the fire services council concerning the adoption of fire safety management policies of the state fire marshal's office.

History: Laws 2020, ch. 9, § 52.

59A-52-2. State fire marshal to administer article.

The state fire marshal shall administer the provisions of Chapter 59A, Article 52 NMSA 1978.

History: Laws 1984, ch. 127, § 948; 1998, ch. 108, § 39.

59A-52-3. Deputy state fire marshal and other employees; qualifications of deputy.

The state fire marshal may employ with the consent of the secretary of homeland security and emergency management deputy state fire marshals and other employees to assist in the execution of the marshal's duties.

History: Laws 1984, ch. 127, § 949; 1998, ch. 108, § 40; 2007, ch. 161, § 6; 2020, ch. 9, § 30.

59A-52-4. Bonding of employees.

The state fire marshal shall require the bonding of those employees whose duties in the marshal's opinion require such bonds and in an amount determined by the marshal.

History: Laws 1984, ch. 127, § 950; 2020, ch. 9, § 31.

59A-52-5. Cooperation with other agencies for prevention and control of fires.

The state fire marshal is authorized to cooperate with all other groups, organizations and agencies in this state or in other states in the collection, dissemination and evaluation of information, statistics and suggestions for prevention or control of fires.

History: Laws 1984, ch. 127, § 951; 2020, ch. 9, § 32.

59A-52-6. Fire protection training programs.

The state fire marshal shall establish and conduct training programs throughout the state for demonstrating and teaching firefighters proper methods of preventing and extinguishing fires.

History: Laws 1984, ch. 127, § 952; 2020, ch. 9, § 33.

59A-52-7. Teaching fire prevention and control in public schools; rules for school building evacuation.

The state fire marshal shall prescribe reasonable rules and programs for the teaching to all schoolchildren in the state, whether in public or private schools, the proper methods of fire prevention and control. Such rules and programs shall be submitted to the public education department on or before August 1 of each year. Among other things, such rules and programs shall prescribe drills for evacuating school buildings.

History: Laws 1984, ch. 127, § 953; 2020, ch. 9, § 34.

59A-52-8. Investigation of fire hazards; abatement.

The state fire marshal is authorized to make investigations, or require the marshal's deputy to make investigations, and reports of existing conditions in the state that are fire hazards and to make reasonable orders for the alleviation of such situations as the marshal may deem necessary. If the orders of the marshal are not carried out by persons to whom they are directed, the marshal shall institute proper proceedings under municipal ordinances or state laws to require compliance with the orders, as the marshal may deem necessary.

History: Laws 1984, ch. 127, § 954; 2020, ch. 9, § 35.

59A-52-9. May enter upon premises.

The state fire marshal or the marshal's deputy, authorized officer or designated agent shall have authority at all normal hours of operation to enter in and upon all buildings and premises subject to Chapter 59A, Article 52 NMSA 1978 for the purpose of examination and inspection.

History: Laws 1984, ch. 127, § 955; 2020, ch. 9, § 36.

59A-52-10. Investigation of fires and explosions; hearings; use of state police laboratory.

The state fire marshal or the marshal's deputies or employees are authorized to make investigations deemed necessary of any fire or explosion or attempt to cause any fire or explosion in the state. The marshal is authorized to require reports from the marshal's deputies concerning all fires and explosions in their districts. For the purpose of such investigations, the marshal and the marshal's deputies or designated persons are authorized to conduct hearings, subpoena witnesses, take testimony and enter upon and examine any building or premises where any fire or explosion or attempt to cause a fire or explosion shall have occurred, or which at the time may be burning. The marshal or the marshal's deputies or designated persons shall also have the power to cause to be produced before them such papers as they may require in making such examination. In addition, the marshal or the marshal's deputies or designated persons may, in their discretion, take full control and custody of such buildings and premises, and place someone in charge of the building and premises as they may deem proper, until their examination and investigation is completed. For evaluation of the evidence, the marshal shall have access to the facilities and personnel of the department of public safety forensic laboratories bureau, and the executive head of the bureau shall cooperate fully with the marshal.

History: Laws 1984, ch. 127, § 956; 2020, ch. 9, § 37.

59A-52-11. Witnesses; per diem and mileage.

Witnesses or persons subpoenaed pursuant to Chapter 59A, Article 52 NMSA 1978 shall be paid at per diem and mileage rates on the same bases and at the same rates as currently apply as to state employees in general.

History: Laws 1984, ch. 127, § 957; 2020, ch. 9, § 38.

59A-52-12. Records of fires open to public.

The state fire marshal shall keep open to public inspection, at reasonable hours, all records of fires occurring within the state.

History: Laws 1984, ch. 127, § 958; 2020, ch. 9, § 39.

59A-52-13. Transmittal of evidence indicating criminal acts.

The state fire marshal shall furnish to the proper law enforcement officers any evidence that the marshal may discover in the marshal's investigations that indicates criminal acts.

History: Laws 1984, ch. 127, § 959; 2020, ch. 9, § 40.

59A-52-14. Appropriations.

For the purposes of Chapter 59A, Article 52 NMSA 1978, an appropriation to the homeland security and emergency management department shall be included in the general appropriation act of each legislature, the appropriation to be made from the fire protection fund, which funds are to be paid out by the secretary of finance and administration on vouchers signed by the secretary of homeland security and emergency management.

History: Laws 1984, ch. 127, § 960; 2020, ch. 9, § 41.

59A-52-14.1. Firefighter training academy; use fee fund created.

The "training academy use fee fund" is created in the state treasury. All fees received by the state fire marshal for use of the firefighter training academy and its services shall be deposited into the fund; provided that no fee shall be charged the state of New Mexico or any of its agencies, instrumentalities or political subdivisions; and provided further that each contract for services in which a fee is collected shall be entered into pursuant to a business plan that has been approved by the department of finance and administration and reviewed by the legislative finance committee. Balances in the fund shall be available for appropriation to the state fire marshal for paying the operating and capital expenses of the firefighter training academy. Earnings of the fund shall be credited to the fund, and the unexpended or unencumbered balance in the fund shall not revert to any other fund.

History: Laws 2001, ch. 80, § 1; § 8-8-9.1, recompiled as § 59A-52-14.1 by Laws 2020, ch. 9, § 57.

59A-52-15. Fire prevention; public occupancies regulations.

A. For prevention and control of fires, pursuant to the State Rules Act [Chapter 14, Article 4 NMSA 1978], the state fire marshal shall formulate, adopt and promulgate, and amend or revise rules for fire prevention and safe conduct or use of public occupancies and rules concerning the sale, servicing or use of fire safety, prevention, detection or suppression equipment or materials. For the purposes of this provision, "public occupancies" consist of places of assembly, educational occupancies, institutional occupancies, residential occupancies consisting of four or more family units, mercantile occupancies, office occupancies, industrial occupancies, storage occupancies and miscellaneous structures consisting of towers, underground structures and windowless buildings and all buildings owned or occupied by the state government or any political subdivision thereof or by municipal governments.

B. The rules shall follow nationwide standards except in the area of life safety codes, which shall be compatible with the Uniform Building Code, as revised from time to time, issued by the international conference of building officials.

C. The rules shall allow reasonable provision under which facilities in service prior to the effective date of the rules and not in strict conformity therewith may be continued in service. Nonconforming facilities in service prior to the adoption of rules that are found by the state fire marshal to constitute a distinct hazard to life or property shall not be exempt from rules nor permitted to continue in service.

History: Laws 1984, ch. 127, § 961; 2020, ch. 9, § 42.

59A-52-15.1. Fire and smoke damper and fire control systems; commission rules.

A. The public regulation commission shall issue rules requiring the inspection and testing of fire and smoke dampers and smoke control systems in accordance with national fire protection association standards in places of assembly, educational occupancies, institutional occupancies, residential occupancies consisting of four or more family units, mercantile occupancies, office occupancies, industrial occupancies, storage occupancies and miscellaneous structures consisting of towers, underground structures and windowless buildings and all buildings owned or occupied by the state or any political subdivision thereof or by municipal governments.

B. The rules shall require that:

(1) inspection and testing be conducted by the state or a political subdivision of the state with a fire and life safety enforcement program or other person possessing a

fire life safety certification from a program accredited by the American national standards institute; and

(2) the person conducting the inspection or test shall submit findings of noncompliance to the owner of the public occupancy and to the state fire marshal.

History: Laws 2019, ch. 66, § 1.

59A-52-16. Flammable liquids rules; nationwide standards; definition.

A. The state fire marshal shall adopt rules for the safe vehicular transportation, storage, handling and use of flammable and combustible liquids; provided that the state fire marshal shall not adopt any rule conflicting with the jurisdiction of the department of environment over the regulation of storage tanks pursuant to the Hazardous Waste Act [Chapter 74, Article 4 NMSA 1978] or the Ground Water Protection Act [Chapter 74, Article 6B NMSA 1978].

B. The rules shall be in keeping with the latest generally recognized safety standards for flammable and combustible liquids. Rules in substantial conformity with the published standards of the national fire protection association for vehicular transportation, storage, handling and use of flammable and combustible liquids shall be deemed to be in substantial conformity with the generally accepted and recognized standards of safety concerning the same subject matter.

C. The rules shall include reasonable provisions under which facilities in service prior to the effective date of the rules and not in strict conformity therewith may be continued in service. Nonconforming facilities in service prior to the adoption of the rules that are found by the state fire marshal to constitute a distinct hazard to life or property may not be excepted from the rules or permitted to continue in service. For guidance in enforcement, the rules may delineate those types of nonconformities that should be considered distinctly hazardous and those nonconformities that should be evaluated in light of local conditions. If the need for compliance with any rule is conditioned on local factors, the rules shall provide that reasonable notice be given to the proprietor of the facility affected of intention to evaluate the need for compliance and of the time and place at which the proprietor may appear and offer evidence thereon.

D. As used in Chapter 59A, Article 52 NMSA 1978, the term "flammable liquid" means any liquid having a flash point below one hundred degrees Fahrenheit, and "combustible liquid" means any liquid having a flash point at or above one hundred degrees Fahrenheit and below two hundred degrees Fahrenheit.

History: Laws 1984, ch. 127, § 962; 2001, ch. 325, § 1; 2020, ch. 9, § 43.

59A-52-17. Rules; public hearing.

No rule shall be adopted or revised under Section 59A-52-16 NMSA 1978 or made effective until after public hearing thereon, of which at least twenty days' written notice shall be given by certified mail to each motor carrier, producer, refiner, distributor or other person that shall have registered its name and mailing address with the state fire marshal as a party interested in such proceedings, and at which any such interested party may appear and present testimony. Every such notice shall contain a copy of each rule proposed for adoption or revision pursuant to such hearing.

History: Laws 1984, ch. 127, § 963; 2020, ch. 9, § 44.

59A-52-18. Rules; statewide effect; reserved power of municipalities; training.

A. The rules promulgated pursuant to Chapter 59A, Article 52 NMSA 1978 shall have uniform force and effect throughout the state and no municipality or subdivision shall enact or enforce any ordinances or rules inconsistent with the statewide rules promulgated pursuant to that article. Nothing in that article shall in any way impair the power of any municipality to regulate the use of its land by zoning, building codes or restricted fire district rules.

B. The state fire marshal shall offer training to certified firefighters to assist with fire and fire safety inspections.

History: Laws 1984, ch. 127, § 964; 2020, ch. 9, § 45.

59A-52-19. Police power of state fire marshal; cooperation of state officers.

A. The state fire marshal or the marshal's deputy, authorized officer or designated agent shall have full powers as peace officers to enforce the provisions of Chapter 59A, Article 52 NMSA 1978 and all rules issued pursuant to that article.

B. The revenue officers and law enforcement officers of the state shall cooperate with the marshal or the marshal's deputy, authorized officer or designated agent whenever called upon by any of them for assistance in enforcing Chapter 59A, Article 52 NMSA 1978.

History: Laws 1984, ch. 127, § 965; 2020, ch. 9, § 46.

59A-52-20. Cease and desist orders; certain violations are misdemeanors.

A. When the state fire marshal or the marshal's deputy, authorized officer or designated agent finds any violation of the rules issued in compliance with Chapter 59A, Article 52 NMSA 1978, the marshal or the marshal's deputy, authorized officer or

designated agent shall issue an order to the owner or the owner's agent to cease and desist such violations.

B. When there is found any violation of any statute or rules concerning flammable liquids, a cease and desist order shall be issued if the violation constitutes an immediate and distinct hazard to life or property, and any such violation shall constitute a misdemeanor punishable by a fine not to exceed five hundred dollars ($500). Each day such violation continues constitutes a separate offense.

History: Laws 1984, ch. 127, § 966; 2020, ch. 9, § 47.

59A-52-21. Administrative appeal of orders and modifications.

Any person aggrieved by any order of the state fire marshal or the marshal's deputy, authorized officer or designated agent may appeal to the fire services council within ten days from the date of the service of such order. The council shall hear such party within twenty days after receipt of an appeal request and shall give not less than ten days' written notice of the hearing. Within fifteen days after such hearing, the council shall file its decision and, unless by its authority the order is revoked or modified, the order shall be complied with within the time fixed in the decision, with such time to be not less than thirty days.

History: Laws 1984, ch. 127, § 967; 1998, ch. 108, § 41; 2020, ch. 9, § 48.

59A-52-22. Judicial review of order.

A person aggrieved by a decision of the state fire marshal may appeal to the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1984, ch. 127, § 968; 1998, ch. 55, § 69; 1999, ch. 265, § 72.

59A-52-23. Enforcement of cease and desist orders.

After expiration of time for an administrative appeal, and if no such appeal has been taken, the state fire marshal may commence an action in the district court for Santa Fe county to enforce the cease and desist order by injunction or other appropriate remedy as the district court may adjudge. The fire services council may likewise commence an action in the district court for Santa Fe county to enforce its decision rendered on appeal from the cease and desist order of the state fire marshal.

History: Laws 1984, ch. 127, § 969; 1998, ch. 108, § 42; 2020, ch. 9, § 49.

59A-52-24. Penalty for violation of law or rules.

Violation of any of the provisions of Chapter 59A, Article 52 NMSA 1978 or of any of the rules lawfully enacted pursuant to that article shall constitute a misdemeanor for which the punishment shall be a fine of not more than five hundred dollars ($500). Each day any such violation continues shall constitute a separate offense.

History: Laws 1984, ch. 127, § 970; 2020, ch. 9, § 50.

59A-52-25. Penalty for violation of cease and desist order.

Any person, firm or corporation that violates any final cease and desist order shall be subject to a penalty in the sum of five hundred dollars ($500) for each day such violation continues. The attorney general is empowered to bring a civil suit for the enforcement of this section on the relation of the state fire marshal.

History: Laws 1984, ch. 127, § 971; 2020, ch. 9, § 51.

59A-52-26. Volunteer firefighters; stipend.

To the extent consistent with the federal Fair Labor Standards Act of 1938 in order to maintain volunteer status, a volunteer firefighter may be paid a stipend by a public agency to perform the services for which the firefighter volunteered if:

A. the stipend represents only actual expenses, reasonable benefits or a nominal fee; and

B. the services are not the same type of services that the volunteer is employed to perform for the same public agency paying the stipend.

History: Laws 2013, ch. 80, § 1.

59A-52-27. Fire services council created; membership.

A. The "fire services council" is created to advise the state fire marshal's office on fire and emergency services policy. The council consists of ten members as follows:

(1) the presiding officer or designee of each of the:

(a) New Mexico fire chiefs association;

(b) fire and emergency managers affiliate of New Mexico counties;

(c) New Mexico state firefighters association;

(d) New Mexico emergency medical technician association;

(e) New Mexico fire marshals association;

(f) metro fire chiefs association; and

(g) New Mexico professional fire fighters association;

(2) one person appointed by the governor;

(3) one person appointed by the president pro tempore of the senate; and

(4) one person appointed by the speaker of the house of representatives.

B. The fire services council shall select from among its members a chair and vice chair, who shall serve one-year terms. No member shall serve as chair or vice chair for more than two consecutive years.

C. The fire services council shall meet as frequently as necessary to conduct business or hold hearings but no less than four times per year. A majority of members of the council constitutes a quorum.

D. Council members shall be reimbursed for their per diem and mileage expenses in accordance with the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978]. Council members shall otherwise serve without compensation.

E. The fire services council is subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978] and the Open Meetings Act [Chapter 10, Article 15 NMSA 1978]. Individual members of the fire services council are subject to the Governmental Conduct Act [Chapter 10, Article 16 NMSA 1978] and the Financial Disclosure Act [10-16A-1 to 10-16A-8 NMSA 1978].

F. An employee of the state fire marshal's office who serves as staff for the fire services council shall not reveal to any person, except another council staff person, any requests or statements disclosed in confidence by a council member, except that this restriction shall not apply to any disclosure that is:

(1) protected pursuant to the Whistleblower Protection Act [10-16C-1 to 10-16C-4 NMSA 1978]; or

(2) required by law.

History: Laws 2020, ch. 9, § 53.

59A-52-27.1. Fire services council; duties.

The fire services council shall:

A. review and comment on proposed changes in fire codes and the proposed budget of the state fire marshal's office;

B. consider complaints regarding the performance of the state fire marshal's office and make recommendations to the state fire marshal;

C. provide to the secretary of homeland security and emergency management a recommendation on the appointment of the state fire marshal; and

D. hear administrative appeals of state fire marshal or deputy state fire marshal orders and modifications.

History: Laws 2020, ch. 9, § 54.

ARTICLE 53
Fire Protection Fund

59A-53-1. Short title.

Chapter 59A, Article 53 NMSA 1978 may be cited as the "Fire Protection Fund Law".

History: Laws 1984, ch. 127, § 972; 1989, ch. 312, § 1.

59A-53-2. Purpose.

It is the purpose of the Fire Protection Fund Law to provide for distribution of funds from the fire protection fund referred to in Section 59A-6-5 NMSA 1978 to municipalities and to county fire districts, in proportion to their respective needs, for use in operation, maintenance and betterment of local fire departments, to the end that the hazard of loss by fire and fire insurance rates may be reduced and the public safety thereby promoted.

History: Laws 1984, ch. 127, § 973; 1989, ch. 312, § 2; 2012, ch. 20, § 1.

59A-53-2.1. Definitions.

As used in the Fire Protection Fund Law:

A. "marshal" means the state fire marshal as further identified in Chapter 59A, Article 52 NMSA 1978; and

B. "municipality" means an incorporated city, town or village.

History: Laws 2012, ch. 20, § 2.

59A-53-3. Determination and certification of needs.

A. Annually, on or before the last day of May, the marshal shall consider and determine, in the marshal's reasonable discretion, the relative needs of municipalities and county fire districts for money in the fire protection fund, based upon the information available to the marshal, and shall certify to the state treasurer the names of the municipalities and county fire districts that the marshal determines need the assistance of a distribution from the money in the fire protection fund, and the amount required by each, in accordance with the provisions of Chapter 59A, Article 53 NMSA 1978. In making this determination and certification, the marshal shall consider the intent and purpose of that article that no municipality or county fire district shall receive money distributed from the fire protection fund merely for the purpose of accumulation when the money is not required to accomplish the purposes of that article.

B. In making a determination and certification of needs, the marshal shall consider and provide for any debt obligations of existing or previously existing fire departments or fire districts.

History: Laws 1984, ch. 127, § 974; 1989, ch. 312, § 3; 1995, ch. 141, § 24; 2012, ch. 20, § 3.

59A-53-4. Criteria for determination of needs; municipal fire department.

A. In making the determination of needs pursuant to Section 59A-53-3 NMSA 1978, the marshal shall first determine that each municipality to be certified has maintained an official fire department created by and regulated in accordance with a duly enacted ordinance for a period of at least one year prior to the date of certification and possesses fire equipment and apparatus in serviceable condition to respond to a fire incident. The marshal shall also determine the number of fire stations and substations to be certified and shall certify to the state treasurer the amount to be distributed to each municipality for the purpose of maintaining each fire station and each substation, if any, that meets the requirements of the marshal and the requirements of this section. Unless adjusted pursuant to Section 59A-53-5.1 NMSA 1978, the amounts distributed in a fiscal year for a class insurance rating shall equal the following:

class	main station	substation
number 1	$ 82,592	$ 30,606
number 2	77,086	28,780
number 3	70,919	26,724
number 4	64,751	24,667
number 5	61,667	22,612
number 6	58,584	20,555
number 7	55,501	19,530
number 8	52,418	18,502
number 9	39,058	15,425

number 10	34,944	none.

B. Any municipality may permit its fire department to service an area adjacent and contiguous to its corporate limits but within the corporate limits of another municipality or a county; provided that the other municipality or county by resolution or law duly adopted or enacted consents to the service and to the boundaries of the other area serviced. Before commencement of service, a plat showing the geographic limits and boundaries of the additional area to be serviced shall be filed with and approved by the marshal. A municipality may apply for fire protection fund eligibility for any fire station located within the additional area to be serviced.

C. Any municipality may apply for fire protection fund eligibility for a fire station located at a municipally owned airport, whether located outside or within its corporate limits.

History: Laws 1984, ch. 127, § 975; 1989, ch. 312, § 4; 1996, ch. 40, § 1; 1998, ch. 76, § 1; 2006, ch. 103, § 1; 2012, ch. 20, § 4.

59A-53-5. Establishment of fire districts.

A. The county commissioners of any county may establish one or more fire districts. The marshal shall determine the number of fire stations and substations to be certified and shall certify to the state treasurer the amount to be distributed to each fire district for the purpose of maintaining each fire station and each substation, if any, that meets the requirements of the marshal and the requirements of this section. Unless adjusted pursuant to Section 59A-53-5.1 NMSA 1978, the amounts distributed in a fiscal year for a class insurance rating shall equal the following:

class	main station	substation
number 1	$ 82,592	$ 30,606
number 2	77,086	28,780
number 3	70,919	26,724
number 4	64,751	24,667
number 5	61,667	22,612
number 6	58,584	20,555
number 7	55,501	19,530
number 8	52,418	18,502
number 9	39,058	15,425
number 10	34,944	none.

B. Additionally, prior to the disbursement of any funds, the following must be established to the satisfaction of the marshal:

(1) the fire district has maintained an official fire department for a period of at least one year, established and governed by appropriate resolution of the board of county commissioners and possesses fire apparatus and equipment in serviceable condition to respond to a fire incident;

(2) the geographic limits and boundaries of the fire district have been clearly defined and established in a plat showing the geographic limits and boundaries accepted and filed as part of the official record of proceedings of the board of county commissioners and a certified copy thereof filed with the marshal; and

(3) there is available within the geographic limits and boundaries of the fire district an adequate water supply to be used in connection with the firefighting facilities of the fire district.

C. The county commissioners of any county may permit a county fire district to service an area adjacent and contiguous to the district but within another county or municipality; provided that the county commissioners of the other county or the municipality consent by resolution or law duly adopted or enacted to the service and to the boundaries of the other area serviced. Before commencement of service, a plat showing the geographic limits and boundaries of the county fire district and of the additional area to be serviced shall be filed with and approved by the marshal. Any county may apply for fire protection fund eligibility for any fire station located within the additional area to be serviced.

History: 1978 Comp., § 59A-53-5, enacted by Laws 1989, ch. 312, § 5; 1996, ch. 40, § 2; 1998, ch. 76, § 2; 2006, ch. 103, § 2; 2012, ch. 20, § 5.

59A-53-5.1. Maximum amounts to be certified.

A. For fiscal year 2007 and each fiscal year thereafter, the marshal shall certify a total amount equal to the higher of the amount that would be certified pursuant to Sections 59A-53-4 and 59A-53-5 NMSA 1978 or an amount to be determined by adding:

(1) the total increase in the fire protection fund receipts in the previous fiscal year minus the appropriations, from all sources, to the volunteer firefighters retirement fund in the current fiscal year; and

(2) the total distribution pursuant to Sections 59A-53-4 and 59A-53-5 NMSA 1978 for the previous fiscal year.

B. The marshal shall adjust the distributions for each class in proportion to the increase in the total distribution.

History: 1978 Comp., § 59A-53-5.1, enacted by Laws 1998, ch. 76, § 3; 2006, ch. 103, § 3.

59A-53-5.2. Appropriations and transfers from the fire protection fund.

A. For each fiscal year, the amount to be distributed by the marshal pursuant to Sections 59A-53-4, 59A-53-5 and 59A-53-5.1 NMSA 1978 is appropriated from the fire protection fund to the state fire marshal for the purpose of making the following distributions:

(1) the total amount to be distributed during the fiscal year pursuant to Sections 59A-53-4, 59A-53-5 and 59A-53-5.1 NMSA 1978;

(2) the total amount of other appropriations from the fire protection fund for the fiscal year;

(3) on June 30, 2017, no distribution shall be made to the fire protection grant fund;

(4) in fiscal years 2019 through 2021, periodic allotments not to exceed forty and two-tenths percent of the projected remaining balance in the fire protection fund shall be distributed to the fire protection grant fund; and

(5) beginning in fiscal year 2022, periodic allotments equaling the total projected remaining balance in the fire protection fund shall be distributed to the fire protection grant fund.

B. As of June 30 of each year, the remaining unexpended balance in the fire protection fund shall be transferred to the general fund.

History: Laws 2007, ch. 152, § 1; 2009, ch. 3, § 6; 2010, ch. 52, § 1; 2011, ch. 164, § 1; 2016 (2nd S.S.), ch. 1, § 2; 2017, ch. 1, § 5; 2021, ch. 125, § 1.

59A-53-5.3. Fire station and fire protection services across jurisdictional lines.

A. Nothing in the Fire Protection Fund Law shall be construed to prohibit fire protection fund eligibility to a municipal or county fire station or substation that otherwise meets the requirements of the marshal and the requirements of the Fire Protection Fund Law but is not located within the municipality or county.

B. Nothing in the Fire Protection Fund Law shall be construed to prohibit mutual aid agreements between municipalities or counties to provide fire protection services across jurisdictional lines.

History: Laws 2012, ch. 20, § 6.

59A-53-6. Appeal and review of determination.

The marshal shall promptly notify each municipality and county fire district affected of the marshal's determination of needs, and a municipality or county fire district may appeal from the determination of the marshal to the commission, within ten days after the determination of needs. The commission shall review the determination of the marshal in such informal and summary proceedings as it deems proper and shall certify to the state treasurer annually, on or before the last day of June, the results of all appeals from the determinations of the marshal. The certification by the commission, or by the marshal if no appeal is taken, shall be final and binding on all concerned and not subject to any further review.

History: Laws 1984, ch. 127, § 977; 1989, ch. 312, § 6; 1998, ch. 108, § 43; 2012, ch. 20, § 7.

59A-53-7. Distribution of fire protection fund.

A. Based on periodic allotments approved by the marshal, the state treasurer shall distribute from the money in the fire protection fund, to each municipality and county fire district, the amount that the marshal or the secretary of homeland security and emergency management has certified to the state treasurer. Payment shall be made to the treasurer of any municipality and to the county treasurer of the county in which any county fire district is located for credit to the county fire district.

B. The state treasurer is authorized to redirect a distribution to the New Mexico finance authority in the amount that the marshal or the secretary of homeland security and emergency management, as the case may be, has certified to the state treasurer pursuant to an ordinance or a resolution passed by the municipality or county and a written agreement of the municipality or county in which any county fire district is located and the New Mexico finance authority.

C. In addition to the distributions made pursuant to Subsections A and B of this section, upon certification by the marshal that the balance of the firefighters' survivors fund is less than one million dollars ($1,000,000), the state treasurer shall distribute an amount from the fire protection fund to the firefighters' survivors fund so that the balance of the firefighters' survivors fund equals one million dollars ($1,000,000).

History: Laws 1984, ch. 127, § 978; 1989, ch. 312, § 7; 1994, ch. 54, § 3; 1996, ch. 28, § 5; 1998, ch. 108, § 44; 2007, ch. 149, § 6; 2012, ch. 20, § 8; 2015, ch. 24, § 1; 2017, ch. 1, § 6; 2020, ch. 9, § 55; 2023, ch. 111, § 2.

59A-53-8. Expenditure of fire protection fund money.

Money distributed from the fire protection fund to a municipality or to a county fire district:

A. may be expended only for the:

(1) maintenance of its fire department;

(2) purchase or refinance of land for its fire stations and substations;

(3) purchase, refinance, construction, maintenance, repair and operation of its fire stations and substations;

(4) purchase or refinance of fire apparatus and equipment;

(5) payment of insurance premiums on fire stations, substations, fire apparatus and equipment and insurance premiums for injuries or deaths of firefighters as otherwise provided by law;

(6) payment of fire department emergency medical services, except salaries; and

(7) payment of firefighters' attendance at fire schools and conventions approved by the marshal;

B. shall not, without approval by the marshal, be expended for any purpose related to:

(1) its water supply systems or the improvement or construction of those systems;

(2) the purchase, rental, installation or maintenance of fire hydrants; or

(3) any other appurtenance related to the distribution or use of water from its water supply system; and

C. shall not be expended for any public, private or other water system used for potable water supply.

History: Laws 1984, ch. 127, § 979; 1989, ch. 312, § 8; 1994, ch. 53, § 3; 2011, ch. 162, § 1; 2012, ch. 20, § 9; 2019, ch. 55, § 1.

59A-53-9. Limitations on expenditures.

No amount so distributed from the fire protection fund to a municipality or to any county fire district shall be expended in connection with the construction, purchase or equipment of any fire station or substation in addition to those existing upon the date of distribution by the state treasurer, during the year following such distribution, without the prior written approval of the marshal.

History: Laws 1984, ch. 127, § 980; 1989, ch. 312, § 9; 2012, ch. 20, § 10.

59A-53-10. Interest in land for fire stations or substations.

Money distributed from the fire protection fund to a municipality or to a county fire district may be expended or obligated for the construction of buildings for fire stations or substations only if:

A. the municipality or county fire district proposing to expend or obligate for that purpose holds fee simple title, not encumbered by any lien, to the land on which it proposes to construct the building; or

B. the land is donated in whole or in part to the municipality or county fire district for the purpose, and use of fire protection fund money for the construction or location, where the donor has reserved right of reversion of the land under stated conditions, if the use of money is approved by the marshal in advance and after full investigation and determination that the use would be appropriate and reasonable.

History: Laws 1984, ch. 127, § 981; 1989, ch. 312, § 10; 2012, ch. 20, § 11; 2019, ch. 55, § 2.

59A-53-11. Vouchers.

A. Amounts so distributed from the fire protection fund to a municipality or to any county fire district shall be expended under the direction of the chief of the fire department of the municipality or county fire district, upon duly executed vouchers approved as required by law.

B. In no event is any amount to be expended for any purpose that does not relate directly to the permitted purposes specifically stated in Sections 59A-53-8 and 59A-53-9 NMSA 1978.

History: Laws 1984, ch. 127, § 982; 1989, ch. 312, § 11; 2012, ch. 20, § 12.

59A-53-12. Promulgation of rules.

The marshal has authority to promulgate, modify, amend and revoke from time to time rules, including those for mutual aid among and between fire departments; provided that no such rules shall allow any fire department to extend its service in any manner that would jeopardize the fire insurance rates within its municipality or county fire district, as the marshal may determine, in the marshal's discretion, to be necessary, advisable or proper to accomplish the objectives of the Fire Protection Fund Law. Among other things, these rules shall include, but not be limited to, a list of firefighting equipment, apparatus and other items that may properly be purchased by a municipality or by any county fire district from funds distributed from the fire protection fund, and standards of quality, construction and performance to be met by major firefighting

appliances, training requirements, firefighting protective clothing and equipment standards, and by fire stations and substations, proposed to be purchased or constructed by a municipality or district from money distributed from the fire protection fund. All rules shall be filed and published as required by law. Rules of this nature heretofore promulgated by the superintendent and now in effect shall continue in effect until hereafter revoked or modified. Nothing in this section shall be construed to grant regulatory authority over the Volunteer Firefighters Retirement Act to the marshal.

History: Laws 1984, ch. 127, § 983; 1989, ch. 312, § 12; 2012, ch. 20, § 13.

59A-53-13. Liability for unauthorized expenditure.

Any person who shall expend, or direct or permit the expenditure of, any money distributed from the fire protection fund for purposes not expressly authorized by Chapter 59A, Article 53 NMSA 1978 or by rules duly promulgated by the marshal pursuant to that article shall be personally liable to the state of New Mexico for the full amount of the money wrongfully expended, together with interest thereon and costs. An action to recover the amount of any wrongful expenditure may be commenced by the attorney general or the district attorney in the county in which the wrongful expenditure was made, upon the filing with the officer of a verified statement describing the wrongful expenditure.

History: Laws 1984, ch. 127, § 984; 1989, ch. 312, § 13; 2012, ch. 20, § 14.

59A-53-14. Closure of fire department.

A. If any fire department operated by a municipality or county fire district should go out of existence or for any reason cease to operate and function for a period of ninety days, title to all firefighting equipment and apparatus paid for in whole with distributions from the fire protection fund and held by or for the benefit of the fire department shall vest in the marshal and all money distributed from the fire protection fund and held by or for the fire department shall revert to the fire protection fund. Any person having custody or control of any such firefighting equipment and apparatus shall forthwith deliver it as directed by the marshal, and any person having custody or control of the money shall forthwith remit it to the state treasurer, who shall again deposit the money in the state treasury to the credit of the fire protection fund. An action to recover the possession and control of such firefighting equipment and apparatus, or the money, may be commenced by the attorney general or the district attorney in the county in which the equipment and apparatus or money are situate upon the filing with the officer of a verified statement of the circumstances.

B. Notwithstanding the provisions of Subsection A of this section, money distributed from the fire protection fund needed to pay debt service on bonds or other obligations issued by or on behalf of a fire department or fire district may be used to pay such debt service, and the marshal and the state treasurer shall continue to make distributions

from the fire protection fund for and on behalf of the fire department or fire district until the bonds or other obligations are paid in full.

History: Laws 1984, ch. 127, § 985; 1989, ch. 312, § 14; 1995, ch. 141, § 25; 2006, ch. 103, § 4; 2012, ch. 20, § 15.

59A-53-15. Repealed.

History: Laws 1984, ch. 127, § 986; 1989, ch. 312, § 15; 2007, ch. 152, § 2.

59A-53-16. New fire departments.

Whenever the marshal, after the last day of May in any year, determines that a municipality or county fire district, operating a new fire department, has met the requirements of Chapter 59A, Article 53 NMSA 1978 for the first time, the marshal may certify to the state treasurer the name of the municipality or county fire district and the amount required, on the same basis as provided in that article, but not to exceed an amount commensurate with the period of time for which such pro rata distribution is made; and distribution of the amount certified shall be made as otherwise provided in that article.

History: Laws 1984, ch. 127, § 987; 1989, ch. 312, § 16; 2012, ch. 20, § 16.

59A-53-17. Mutual assistance.

Notwithstanding the provisions of Sections 59A-53-5 and 59A-53-12 NMSA 1978, or any other provision of law to the contrary, fire districts may render assistance to other fire districts, and equipment of fire districts may be used outside the district, if the use is authorized by the county fire marshal, and the county fire marshal before he authorizes the use, provides for standby equipment or move-up equipment, so that the assisting district which goes to the aid of another district has equipment available from an adjacent district for use in the assisting district in the event of a fire in the assisting district.

History: Laws 1984, ch. 127, § 988; 2006, ch. 103, § 6.

59A-53-18. Fire protection grant fund; created; uses.

The "fire protection grant fund" is created in the state treasury. The fund shall consist of transfers, distributions, appropriations, gifts, grants, donations and bequests made to the fund. Income from the fund shall be credited to the fund, and money in the fund shall not revert or be transferred to any other fund at the end of a fiscal year. Money in the fund is appropriated to the fire protection grant council for the purposes of making distributions approved by the council for the critical needs of municipal fire departments and county fire districts. Expenditures from the fund shall be made on

warrant of the secretary of finance and administration pursuant to vouchers signed by the marshal.

History: Laws 2006, ch. 103, § 7; 2012, ch. 20, § 17; 2017, ch. 1, § 7; 2021, ch. 125, § 2.

59A-53-19. Fire protection grant council; duties.

A. The "fire protection grant council" is created. The council consists of:

(1) a representative of the New Mexico municipal league;

(2) a representative of the New Mexico association of counties;

(3) two members appointed by the fire services council, who shall serve at the pleasure of the council;

(4) three members, one from each congressional district, appointed by the governor who shall serve at the pleasure of the governor; and

(5) the marshal, who shall serve as a nonvoting advisory member. The council shall elect a chair and vice chair from its membership.

B. The public members are entitled to receive per diem and mileage as provided in the Per Diem and Mileage Act [10-8-1 through 10-8-8 NMSA 1978] and shall receive no other compensation, perquisite or allowance.

C. The council shall develop criteria for assessing the critical needs of municipal fire departments and county fire districts for:

(1) fire apparatus and equipment;

(2) communications equipment;

(3) equipment for wildfires;

(4) fire station construction or expansion;

(5) equipment for hazardous material response;

(6) stipends for volunteer firefighters; and

(7) recruiting and retention programs for volunteer firefighters.

D. Applications for grant assistance from the fire protection grant fund shall be made by fire districts to the council in accordance with the requirements of the council. Using

criteria developed by the council, the council shall evaluate applications and prioritize those applications most in need of grant assistance from the fund. To the extent that money in the fund is available, the council shall award grant assistance for those prioritized applications.

E. In awarding grant assistance, the council may require conditions and procedures necessary to ensure that the money is expended in the most prudent manner.

F. When considering applications for grant assistance to pay stipends to volunteer firefighters, the council shall:

(1) ensure the proposed stipends will comply with the federal Fair Labor Standards Act of 1938 and United States department of labor requirements for maintaining volunteer status;

(2) require a basic level of training before a volunteer may receive a stipend;

(3) consider whether the fire district requires a service commitment from its volunteer firefighters in exchange for stipends; and

(4) weight the applications against other criteria or requirements determined by the council.

History: Laws 2006, ch. 103, § 8; 2009, ch. 266, § 1; 2010, ch. 69, § 1; 2012, ch. 20, § 18; 2013, ch. 74, § 34; 2020, ch. 9, § 56; 2021, ch. 125, § 3.

ARTICLE 54
Medical Insurance Pool

59A-54-1. Short title.

Chapter 59A, Article 54 NMSA 1978 may be cited as the "Medical Insurance Pool Act". Any reference in any law, rule, division bulletin or other legal document to the Comprehensive Health Insurance Pool Act shall be deemed to refer to the Medical Insurance Pool Act.

History: 1978 Comp., § 59A-54-1, enacted by Laws 1987, ch. 154, § 1; 2001, ch. 352, § 1.

59A-54-2. Purpose.

The purpose of the Medical Insurance Pool Act is to provide access to health insurance coverage to all residents of New Mexico who are denied adequate health insurance and are considered uninsurable.

History: 1978 Comp., § 59A-54-2, enacted by Laws 1987, ch. 154, § 2; 2001, ch. 352, § 2.

59A-54-3. Definitions.

As used in the Medical Insurance Pool Act:

A. "board" means the board of directors of the pool;

B. "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;

(5) 10 USCA Chapter 55;

(6) the Medical Insurance Pool Act;

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

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

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

C. "federally defined eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under the Medical Insurance Pool Act, the aggregate of the periods of creditable coverage is eighteen or more months;

(2) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage, as those plans or coverage are defined in Section 59A-23E-2 NMSA 1978, offered in connection with that plan;

(3) who is not eligible for coverage under a group health plan, Part A or Part B of Title 18 of the Social Security Act or a state plan under Title 19 or Title 21 of the

Social Security Act or a successor program and who does not have other health insurance coverage;

(4) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(5) who, if offered the option of continuation of coverage under a continuation provision pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or a similar state program, elected this coverage; and

(6) who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in Paragraph (5) of this subsection;

D. "health care facility" means an entity providing health care services that is licensed by the department of health;

E. "health care services" means services or products included in the furnishing to an individual of medical care or hospitalization, or incidental to the furnishing of that care or hospitalization, as well as the furnishing to a person of other services or products for the purpose of preventing, alleviating, curing or healing human illness or injury;

F. "health insurance" means a hospital and medical expense-incurred policy; nonprofit health care service plan contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity or specified disease policy; disability income contracts; limited benefit insurance; credit insurance; or as defined by Section 59A-7-3 NMSA 1978. "Health insurance" does not include insurance arising out of the Workers' Compensation Act [Chapter 52, Article 1 NMSA 1978] or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in a liability insurance policy;

G. "health maintenance organization" means a person who provides, at a minimum, either directly or through contractual or other arrangements with others, basic health care services to enrollees on a fixed prepayment basis and who is responsible for the availability, accessibility and quality of the health care services provided or arranged, or as defined by Subsection M of Section 59A-46-2 NMSA 1978;

H. "health plan" means an arrangement by which persons, including dependents or spouses, covered or making application to be covered under the pool have access to hospital and medical benefits or reimbursement, including group or individual insurance or subscriber contract; coverage through health maintenance organizations, preferred provider organizations or other alternate delivery systems; coverage under prepayment, group practice or individual practice plans; coverage under uninsured arrangements of group or group-type contracts, including employer self-insured, cost-plus or other

benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. "Health plan" includes coverage through health insurance;

I. "insured" means an individual resident of this state who is eligible to receive benefits from an insurer or other health plan;

J. "insurer" means an insurance company authorized to transact health insurance business in this state, a nonprofit health care plan, a health maintenance organization and self-insurers not subject to federal preemption. "Insurer" does not include an insurance company that is licensed under the Prepaid Dental Plan Law [Chapter 59A, Article 48 NMSA 1978] or a company that is solely engaged in the sale of dental insurance and is licensed not under that act, but under another provision of the Insurance Code [Chapter 59A NMSA 1978];

K. "medicare" means coverage under Part A or Part B of Title 18 of the Social Security Act, as amended;

L. "pool" means the New Mexico medical insurance pool;

M. "preexisting condition" means a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant within six months before the effective date of coverage, except that pregnancy is not considered a preexisting condition for a federally defined eligible individual; and

N. "therapist" means a licensed physical, occupational, speech or respiratory therapist.

History: 1978 Comp., § 59A-54-3, enacted by Laws 1987, ch. 154, § 3; 1991, ch. 200, § 1; 1993, ch. 118, § 1; 1997, ch. 243, § 32; 1998, ch. 41, § 25; 2001, ch. 352, § 3; 2003, ch. 395, § 1; 2008, ch. 88, § 1.

59A-54-4. Pool created; board.

A. There is created a nonprofit entity to be known as the "New Mexico medical insurance pool". All insurers shall organize and remain members of the pool as a condition of their authority to transact insurance business in this state. The board is a governmental entity for purposes of the Tort Claims Act [41-4-1 to 41-4-27 NMSA 1978].

B. The superintendent shall, within sixty days after the effective date of the Medical Insurance Pool Act, give notice to all insurers of the time and place for the initial organizational meetings of the pool. Each member of the pool shall be entitled to one vote in person or by proxy at the organizational meetings.

C. The pool shall operate subject to the supervision and approval of the board. The board shall consist of the superintendent or his designee, who shall serve as the chairman of the board, four members appointed by the members of the pool and six members appointed by the superintendent. The members appointed by the superintendent shall consist of four citizens who are not professionally affiliated with an insurer, at least two of whom shall be individuals who are insured by the pool, who would qualify for pool coverage if they were not eligible for particular group coverage or who are a parent, guardian, relative or spouse of such an individual. The superintendent's fifth appointment shall be a representative of a statewide health planning agency or organization. The superintendent's sixth appointment shall be a representative of the medical community.

D. The members of the board appointed by the members of the pool shall be appointed for initial terms of four years or less, staggered so that the term of one member shall expire on June 30 of each year. The members of the board appointed by the superintendent shall be appointed for initial terms of five years or less, staggered so that the term of one member expires on June 30 of each year. Following the initial terms, members of the board shall be appointed for terms of three years. If the members of the pool fail to make the initial appointments required by this subsection within sixty days following the first organizational meeting, the superintendent shall make those appointments. Whenever a vacancy on the board occurs, the superintendent shall fill the vacancy by appointing a person to serve the balance of the unexpired term. The person appointed shall meet the requirements for initial appointment to that position. Members of the board may be reimbursed from the pool subject to the limitations provided by the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978] and shall receive no other compensation, perquisite or allowance.

E. The board shall submit a plan of operation to the superintendent and any amendments to it necessary or suitable to assure the fair, reasonable and equitable administration of the pool.

F. The superintendent shall, after notice and hearing, approve the plan of operation, provided it is determined to assure the fair, reasonable and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the superintendent consistent with the date on which coverage under the Medical Insurance Pool Act is made available. If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the board, or any time thereafter fails to submit necessary amendments to the plan of operation, the superintendent shall, after notice and hearing, adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of the Medical Insurance Pool Act. Rules promulgated by the superintendent shall continue in force until modified by him or superseded by a subsequent plan of operation submitted by the board and approved by the superintendent.

G. Any reference in law, rule, division bulletin, contract or other legal document to the New Mexico comprehensive health insurance pool shall be deemed to refer to the New Mexico medical insurance pool.

History: 1978 Comp., § 59A-54-4, enacted by Laws 1987, ch. 154, § 4; 1991, ch. 200, § 2; 2001, ch. 352, § 4; 2003, ch. 395, § 2.

59A-54-5. Plan of operation.

The plan of operation submitted by the board to the superintendent shall:

A. establish procedures for the handling and accounting of assets and money of the pool;

B. establish regular times and places for meetings of the board;

C. establish procedures for records to be kept of all financial transactions and for annual fiscal reporting to the superintendent;

D. contain additional provisions necessary and proper for the execution of the powers and duties of the pool;

E. establish procedures for the collection of assessments from all members of the pool to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

F. establish the amount of assessment pursuant to Section 59A-54-10 NMSA 1978 that shall be imposed annually at the end of each calendar year and that shall be due and payable within thirty days of the receipt of the assessment notice;

G. establish procedures for the selection of an administrator in accordance with Section 59A-54-11 NMSA 1978;

H. develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment in the plan and to maintain public awareness of the plan; and

I. establish penalties for noncollection of assessments from pool members.

History: 1978 Comp., § 59A-54-5, enacted by Laws 1987, ch. 154, § 5; 1991, ch. 200, § 3.

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.

History: 1978 Comp., § 59A-54-6, enacted by Laws 1987, ch. 154, § 6; 1991, ch. 200, § 4; 2021, ch. 108, § 31.

59A-54-7. Board; powers and duties.

The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance business. In addition, the board shall have the specific authority to:

A. enter into contracts as are necessary or proper to carry out the provisions and purposes of the Medical Insurance Pool Act, including the authority, with the approval of the superintendent, to enter into contracts with similar pools of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions. The pool shall comply with the Procurement Code [13-1-28 to 13-1-199 NMSA 1978], except as otherwise provided in the Medical Insurance Pool Act;

B. sue or be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

C. establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices;

D. assess members of the pool in accordance with the provisions of the Medical Insurance Pool Act and make initial and interim assessments as may be reasonable and necessary for the organizational or interim operating expenses of the pool. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year. Interim assessments may include anticipated expenses of the next year that the board determines are reasonable and necessary for the operating expenses of the pool;

E. issue policies of insurance in accordance with the requirements of the Medical Insurance Pool Act;

F. issue a policy of insurance, in accordance with the requirements of the Medical Insurance Pool Act, for a small group that is formed voluntarily through an employer, association, cooperative, mutual alliance or other organization; provided, however, that an employer group may not have more than fifty persons;

G. appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design and any other function within the authority of the pool; and

H. conduct periodic audits to assure the general accuracy of the financial data submitted to the pool. The board shall cause the pool to have an annual audit of its operations by an independent certified public accountant.

History: 1978 Comp., § 59A-54-7, enacted by Laws 1987, ch. 154, § 7; 1991, ch. 200, § 5; 2001, ch. 352, § 5; 2005, ch. 294, § 1.

59A-54-7.1. Prescription drug program; cost-sharing.

A. The board may establish a prescription drug program, in whole or in part, including a pilot or phase-in program, to offer selected eligible persons the ability to purchase prescription drugs. The board may establish varying levels of eligibility and cost-sharing criteria as needed for selected eligible persons and, if established, shall ensure that cost-containment mechanisms are included in the program.

B. The board may establish the cost-sharing amounts payable by a person enrolled in the prescription drug program, including the premium, deductible, coinsurance, co-payment and other out-of-pocket expenses.

C. If the board establishes a prescription drug program, the board shall establish the assessments pursuant to Section 59A-54-10 NMSA 1978.

D. If the board establishes a prescription drug program, the assessment for a pool member shall be determined in the same manner as provided in this section provided that a pool member shall be allowed a fifty percent credit for the prescription drug program assessment on the premium tax return for that member.

E. The board may issue a pool prescription drug program benefit policy for a person who is over the age of sixty-five and unable to purchase or is ineligible for a similar prescription drug program. The board may issue a pool prescription drug program benefit policy for a person who is eligible for a state-funded or state-operated low-income pharmacy benefit program.

F. If the board establishes a prescription drug program, the board shall cooperate with other state and federal prescription drug initiatives.

History: Laws 2003, ch. 396, § 1.

59A-54-7.2. Expansion of programs pursuant to federal law.

The board may:

A. establish a health plan to offer selected eligible individuals the ability to purchase or enroll in a program pursuant to federal law that provides expanded coverage for state high-risk pools;

B. establish eligibility and coverage criteria as needed for selected eligible individuals;

C. establish the cost-sharing amounts payable by a selected eligible individual enrolled in the health plan, including the premium, deductible, coinsurance, co-payment or other out-of-pocket expenses; and

D. participate with and receive funding from any federal agency designated to administer expanded coverage programs for state high-risk pools.

History: Laws 2010, ch. 92, § 1.

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.

History: 1978 Comp., § 59A-54-8, enacted by Laws 1987, ch. 154, § 8; 2021, ch. 108, § 32.

59A-54-9. Policy forms.

All policy forms issued by the pool shall conform in substance to prototype forms developed by the pool and shall be filed with and approved by the superintendent before they are issued.

History: 1978 Comp., § 59A-54-9, enacted by Laws 1987, ch. 154, § 9; 1991, ch. 200, § 6.

59A-54-10. Assessments.

A. Following the close of each fiscal year, the pool administrator shall determine the net premium, being premiums less administrative expense allowances, the pool expenses and claim expense losses for the year, taking into account investment income and other appropriate gains and losses. The assessment for each insurer shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges or their equivalent for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums and subscriber contract charges written in the state; provided that premium income shall include receipts of medicaid managed care premiums but shall not include any payments by the secretary of human services pursuant to a contract issued under Section 1876 of the Social Security Act, as amended. The board may adopt other or additional methods of adjusting the formula to achieve equity of assessments among pool members, including assessment of health insurers and reinsurers based upon the number of persons they cover through primary, excess and stop-loss insurance in the state.

B. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

C. The proportion of participation of each member in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed with it by the member. Any deficit incurred by the pool shall be recouped by assessments apportioned among the members of the pool pursuant to the assessment formula provided by Subsection A of this section.

D. The board may abate or defer, in whole or in part, the assessment of a member of the pool if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligation. In the event an assessment against a member of the pool is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in Subsection A of this section. The member receiving the abatement or deferment shall remain liable to the pool for the deficiency for four years.

History: 1978 Comp., § 59A-54-10, enacted by Laws 1987, ch. 154, § 10; 1991, ch. 200, § 7; 1994, ch. 58, § 1; 2001, ch. 352, § 6; 2003, ch. 395, § 3; 2005, ch. 301, § 5; 2005, ch. 305, § 5; 2007, ch. 361, § 9; 2018, ch. 57, § 28.

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.

History: 1978 Comp., § 59A-54-11, enacted by Laws 1987, ch. 154, § 11; 1991, ch. 200, § 8; 2021, ch. 108, § 33.

59A-54-12. Eligibility; policy provisions.

A. Except as provided in Subsection B of this section, a person is eligible for a pool policy only if on the effective date of coverage or renewal of coverage the person is a New Mexico resident, and:

(1) is not eligible as an insured or covered dependent for a health plan that provides coverage for comprehensive major medical or comprehensive physician and hospital services;

(2) is currently paying a rate for a health plan that is higher than one hundred twenty-five percent of the pool's standard rate;

(3) has a mental health diagnosis and has individual health insurance coverage that does not include coverage for mental health services;

(4) has been rejected for coverage for comprehensive major medical or comprehensive physician and hospital services;

(5) is only eligible for a health plan with a rider, waiver or restrictive provision for that particular individual based on a specific condition;

(6) has a medical condition that is listed on the pool's prequalifying conditions;

(7) has as of the date the individual seeks coverage from the pool an aggregate of eighteen or more months of creditable coverage, the most recent of which was under a group health plan, governmental plan or church plan as defined in Subsections P, N and D, respectively, of Section 59A-23E-2 NMSA 1978, except, for the purposes of aggregating creditable coverage, a period of creditable coverage shall not be counted with respect to enrollment of an individual for coverage under the pool if, after that period and before the enrollment date, there was a ninety-five day or longer period during all of which the individual was not covered under any creditable coverage; or

(8) is entitled to continuation coverage pursuant to Section 59A-23E-19 NMSA 1978.

B. Notwithstanding the provisions of Subsection A of this section:

(1) a person's eligibility for a policy issued under the Health Insurance Alliance Act [repealed] shall not preclude a person from remaining on or purchasing a pool policy; provided that a self-employed person who qualifies for an approved health plan under the Health Insurance Alliance Act [repealed] by using a dependent as the second employee may choose a pool policy in lieu of the health plan under that act; and

(2) if a pool policyholder becomes eligible for any group health plan, the policyholder's pool coverage shall not be involuntarily terminated until any preexisting condition period imposed on the policyholder by the plan has been exhausted.

C. Coverage under a pool policy is in excess of and shall not duplicate coverage under any other form of health insurance.

D. A policyholder's newborn child or newly adopted child is automatically eligible for thirty-one consecutive calendar days of coverage for an additional premium.

E. Except for a person eligible as provided in Paragraph (7) of Subsection A of this section, a pool policy may contain provisions under which coverage is excluded during a six-month period following the effective date of coverage as to a given individual for preexisting conditions.

F. The preexisting condition exclusions described in Subsection E of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage that was involuntarily terminated, if the application for pool coverage is made not later than ninety-five days following the involuntary termination. In that case, coverage in the pool shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in a pool policy that is more favorable to the insured than that specified in this subsection.

G. An individual is not eligible for coverage by the pool if:

(1) except as provided in Subsection I of this section, the individual is, at the time of application, eligible for medicare or medicaid that would provide coverage for amounts in excess of limited policies such as dread disease, cancer policies or hospital indemnity policies;

(2) the individual has voluntarily terminated coverage by the pool within the past twelve months and did not have other continuous coverage during that time, except that this paragraph shall not apply to an applicant who is a federally defined eligible individual;

(3) the individual is an inmate of a public institution or is eligible for public programs for which medical care is provided;

(4) the individual is eligible for coverage under a group health plan;

(5) the individual has health insurance coverage as defined in Subsection R of Section 59A-23E-2 NMSA 1978;

(6) the most recent coverages within the coverage period described in Paragraph (7) of Subsection A of this section were terminated as a result of nonpayment of premium or fraud; or

(7) the individual has been offered the option of continuation coverage under a federal COBRA continuation provision as defined in Subsection F of Section 59A-23E-2 NMSA 1978 or under a similar state program and the individual has elected the coverage and did not exhaust the continuation coverage under the provision or program, provided, however, that an unemployed former employee who has not exhausted COBRA coverage shall be eligible.

H. A person whose health insurance coverage from a qualified state high risk pool health policy is terminated because of nonresidency in another state may apply for coverage under the pool. If the coverage is applied for within ninety-five days after that termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

I. The board may issue a pool policy for individuals who:

(1) are enrolled in both Part A and Part B of medicare because of a disability; and

(2) except for the eligibility for medicare, would otherwise be eligible for coverage pursuant to the criteria of this section.

History: 1978 Comp., § 59A-54-12, enacted by Laws 1987, ch. 154, § 12; 1991, ch. 200, § 9; 1997, ch. 243, § 33; 1998, ch. 41, § 26; 2001, ch. 352, § 7; 2003, ch. 395, § 4; 2005, ch. 301, § 6; 2005, ch. 305, § 6 2007, ch. 211, § 1; 2008, ch. 88, § 2.

59A-54-13. Benefits.

A. The health insurance policy issued by the pool shall pay for medically necessary eligible health care services rendered or furnished for the diagnoses or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under Section 59A-54-14 NMSA 1978 and are not otherwise limited or excluded. Eligible expenses are the charges for the health care services and items for which benefits are extended under the pool policy. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations shall be established by the board and shall, at a minimum, reflect the levels of health insurance coverage generally available in New Mexico for small group policies; provided that a health insurance policy issued by the pool shall not include a lifetime maximum benefit. The superintendent shall approve the benefit package developed by the board to ensure its compliance with the Medical

Insurance Pool Act. The benefit package shall include therapy services and hearing aids.

B. The Medical Insurance Pool Act shall not be construed to prohibit the pool from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board, may be of benefit to the citizens of New Mexico.

C. The board may design and employ cost containment measures and requirements, including preadmission certification and concurrent inpatient review, for the purpose of making the pool more cost effective.

History: 1978 Comp., § 59A-54-13, enacted by Laws 1987, ch. 154, § 13; 1991, ch. 200, § 10; 2001, ch. 352, § 8; 2008, ch. 88, § 3.

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.

History: 1978 Comp., § 59A-54-14, enacted by Laws 1987, ch. 154, § 14; 1991, ch. 200, § 11; 2001, ch. 352, § 9; 2021, ch. 108, § 34.

59A-54-15. Dependent family member required coverage; employer responsibilities.

A. An employer is authorized to make a payroll deduction from the compensation of an employee for the portion of the pool policy premium the employee is responsible for, and an employer shall contribute the same dollar amount of the cost of that policy on behalf of the employee that the employer contributes for other similar employees for health insurance.

B. An employer shall offer and make available to dependent family members of an employee covered by the pool the same group plan offered to other employees of the

group. The employer shall charge a dependent family member a premium equal to that amount charged to other employees and shall contribute the difference between the amount the employer would pay for the employee under its group family coverage and the amount the employer has paid to the pool on behalf of the employee pursuant to Subsection A of this section. In no event shall an employer be required to pay more for a family with the employee being a high risk than for a standard family in the employer's group plan.

History: 1978 Comp., § 59A-54-15, enacted by Laws 1987, ch. 154, § 15.

59A-54-16. Pool policy.

A. A pool policy offered under the Medical Insurance Pool Act shall contain provisions under which the pool is obligated to renew the contract until the day on which the individual in whose name the contract is issued first becomes eligible for medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the durational requirement of this subsection.

B. The pool shall not change the rates for pool policies except on a class basis with a clear disclosure in the policy of the right of the pool to do so.

C. In the case of a small group policy, a pool policy offered under the Medical Insurance Pool Act shall provide covered family members the right to continue the policy as the named insured or through a conversion policy upon the death of the named insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the named insured by election to do so within a period of time specified in the contract subject to the requirements of this section.

History: 1978 Comp., § 59A-54-16, enacted by Laws 1987, ch. 154, § 16; 2001, ch. 352, § 10; 2008, ch. 88, § 4.

59A-54-17. Rules.

The superintendent shall:

A. adopt rules that provide for disclosure by members of the pool of the availability of insurance coverage from the pool;

B. adopt rules that implement the provisions of the Medical Insurance Pool Act; and

C. adopt any other rules deemed necessary in order to carry out the provisions of the Medical Insurance Pool Act.

History: 1978 Comp., § 59A-54-17, enacted by Laws 1987, ch. 154, § 17; 2001, ch. 352, § 11.

59A-54-18. Collective action.

Neither the participation by insurers in the pool, the establishment of rates, forms or procedures for coverages issued by the pool nor any other joint or collective action required by the Medical Insurance Pool Act shall be the basis of any legal action, civil or criminal liability or penalty against the members of the pool either jointly or separately.

History: 1978 Comp., § 59A-54-18, enacted by Laws 1987, ch. 154, § 18; 2001, ch. 352, § 12.

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.

History: 1978 Comp., § 59A-54-19, enacted by Laws 1987, ch. 154, § 19; 1991, ch. 200, § 12; 1994, ch. 58, § 2; 2001, ch. 352, § 13; 2009, ch. 190, § 1; 2021, ch. 108, § 35.

59A-54-20. Benefit payments reduction.

A. The pool shall be the last payer of benefits whenever any other benefit is available. Benefits otherwise payable under pool coverage shall be reduced by all

amounts paid or payable through any other health insurance or health benefit plan, including a self-insured plan and by all hospital and medical expense benefits paid or payable under any workmen's compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law program.

B. The administrator or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subsection.

History: 1978 Comp., § 59A-54-20, enacted by Laws 1987, ch. 154, § 20.

59A-54-21. Exemption.

The pool is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

History: 1978 Comp., § 59A-54-21, enacted by Laws 1987, ch. 154, § 21.

ARTICLE 55
Risk Retention and Purchasing Groups

59A-55-1. Short title.

Sections 1 through 26 [59A-55-1 to 59A-55-26 NMSA 1978] of this act may be cited as the "Risk Retention and Purchasing Group Act".

History: Laws 1988, ch. 125, § 1.

59A-55-2. Purpose.

The purpose of the Risk Retention and Purchasing Group Act is to regulate the formation and operation of risk retention groups and purchasing groups in New Mexico formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 to the extent permitted by that act.

History: Laws 1988, ch. 125, § 2.

59A-55-3. Definitions.

As used in the Risk Retention and Purchasing Group Act:

A. "completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by:

(1) any person who performs that work; or

(2) any person who hires an independent contractor to perform that work; "completed operations liability" includes liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability;

B. "domicile", for purposes of determining the state in which a purchasing group is domiciled, means:

(1) for a corporation, the state in which the purchasing group is incorporated; or

(2) for an unincorporated entity, the state of its principal place of business;

C. "hazardous financial condition" means that based on its present or reasonably anticipated financial condition, a risk retention group although not yet financially impaired or insolvent is unlikely to be able to:

(1) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(2) pay other obligations in the normal course of business;

D. "insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of New Mexico;

E. "liability":

(1) means legal liability for damages, including costs of defense, legal costs and fees and other claims expenses, because of injuries to other persons, damage to their property or other damage or loss to such other persons resulting from or arising out of:

(a) any business whether profit or nonprofit, trade, product, services including professional services, premises or operations; or

(b) any activity of any state or local government or any agency or political subdivision thereof; and

(2) does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act;

F. "personal risk liability" means liability for damages because of injury to any person, damage to property or other loss or damage resulting from any personal, familial or household responsibilities or activities, rather than from responsibilities or activities referred to in Paragraph (1) of Subsection F [E] of this section;

G. "plan of operation or feasibility study" means an analysis which presents the expected activities and results of a risk retention group including information required by the superintendent by regulation;

H. "product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage, including damages resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred;

I. "purchasing group" means any group which:

(1) has as one of its purposes the purchase of liability insurance on a group basis;

(2) purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in Paragraph (3) of Subsection I of this section;

(3) is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, service, premises or operation; and

(4) is domiciled in any state;

J. "risk retention group" means any corporation or other limited liability association:

(1) whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;

(2) which is organized for the primary purpose of conducting the activity described under Paragraph (1) of Subsection J of this section;

(3) which:

(a) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(b) before January 1, 1985 was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as such terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the Liability Risk Retention Act of 1986;

(4) which does not exclude any person from membership in the group solely to provide members of such a group competitive advantage over such a person;

(5) which:

(a) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(b) has as its sole owner an organization which: 1) has as its members only persons who comprise the membership of the risk retention group; and 2) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

(6) whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, service, premises or operation;

(7) whose activities do not include the provision of insurance other than:

(a) liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(b) reinsurance with respect to the liability of any other risk retention group or any members of such other group which is engaged in business or activities so that such group or member meets the requirement described in Paragraph (6) of Subsection J of this section, from membership in the risk retention group which provides such reinsurance; and

(8) the name of which includes the phrase "risk retention group";

K. "state" means any state of the United States or the district of Columbia; and

L. "superintendent" means the superintendent of insurance in New Mexico or the commissioner, director or superintendent of insurance in any other state.

History: Laws 1988, ch. 125, § 3.

59A-55-4. Risk retention groups authorized in New Mexico.

A. A risk retention group seeking a New Mexico certificate of authority shall, pursuant to the provisions of the New Mexico Insurance Code, be licensed to write only liability insurance pursuant to the Risk Retention and Purchasing Group Act and, except as provided elsewhere in that act, must comply with all of the laws, rules, regulations and requirements applicable to insurers obtaining a certificate of authority as a domestic insurer and with Sections 5 through 16 [59A-55-5 to 59A-55-16 NMSA 1978] of the Risk Retention and Purchasing Group Act to the extent such requirements are not a limitation on the laws, rules, regulations or requirements of New Mexico.

B. Before it may offer insurance in any state, each New Mexico domiciled risk retention group shall submit for approval to the New Mexico superintendent a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within ten days of any such change. The group shall not offer any additional kinds of liability insurance in this state or in any other state until a revision of such plan or study is approved by the superintendent.

C. At the time of filing its application for a certificate of authority, the risk retention group shall provide to the superintendent any information and fees the superintendent requires for the application process.

History: Laws 1988, ch. 125, § 4.

59A-55-5. Risk retention groups not having a New Mexico certificate of authority.

A. Risk retention groups chartered and licensed in states other than New Mexico and seeking to do business as a risk retention group in New Mexico shall provide to the superintendent before engaging in the business of insurance in New Mexico:

(1) a notice of operation in New Mexico which shall include the information required by the superintendent;

(2) a copy of its plan of operation or feasibility study submitted to the superintendent of the state in which the risk retention group is chartered or licensed unless exempted by regulation;

(3) as required by the superintendent, a copy of its financial statement prepared by one acceptable to the superintendent and any examinations or audit conducted of the risk retention group; and

(4) a designation of the superintendent as its agent for the purpose of receiving service of legal documents or process, with a filing fee determined by the superintendent.

B. The risk retention group shall also submit to the superintendent a copy of any revisions to its plan of operation or feasibility study required by the superintendent of the state in which it is chartered or licensed as well as any information required to verify its continuing qualification as a risk retention group under Subsection J of Section 3 [59A-55-3 NMSA 1978] of the Risk Retention and Purchasing Group Act.

History: Laws 1988, ch. 125, § 5.

59A-55-6. Risk retention groups; reports.

A. Each risk retention group shall report to the superintendent the net premium written for risks resident or located within New Mexico.

B. To the extent a licensed insurance producer is utilized pursuant to Section 59A-55-24 NMSA 1978, the licensed insurance producer shall report to the superintendent the premiums for direct business for risks resident or located within this state that the insurance producers have placed with or on behalf of a risk retention group not licensed in this state.

C. To the extent that an insurance producer is utilized pursuant to Section 59A-55-24 NMSA 1978, the insurance producer shall keep a complete and separate record of all policies procured from each such risk retention group, which record shall be open to examination by the superintendent and shall contain the information required by the superintendent by rule.

History: Laws 1988, ch. 125, § 6; 2016, ch. 89, § 68; 2018, ch. 57, § 29.

59A-55-7. Compliance with unfair claims settlement practices.

All risk retention groups doing business in New Mexico and their agents and representatives shall comply with the provisions of Section 59A-16-20 NMSA 1978.

History: Laws 1988, ch. 125, § 7.

59A-55-8. Deceptive, false or fraudulent practices.

All risk retention groups doing business in New Mexico shall comply with the laws contained in the New Mexico Insurance Code regarding deceptive, false or fraudulent acts or practices.

History: Laws 1988, ch. 125, § 8.

59A-55-9. Examination regarding financial condition.

Each risk retention group shall submit to an examination by the superintendent to determine its financial condition if the superintendent of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty days after a request by the New Mexico superintendent. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the national association of insurance commissioner's handbook. All such examinations shall be paid for by the risk retention group pursuant to Section 59A-4-14 NMSA 1978.

History: Laws 1988, ch. 125, § 9.

59A-55-10. Notice to purchasers.

The superintendent may require risk retention groups to provide notice to purchasers concerning the limitation of regulatory oversight of risk retention groups and the lack of insolvency guaranty fund protection.

History: Laws 1988, ch. 125, § 10.

59A-55-11. Prohibited acts regarding solicitation or sale.

The following acts by a risk retention group are prohibited:

A. the solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

B. the solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

History: Laws 1988, ch. 125, § 11.

59A-55-12. Prohibition on ownership by an insurance company.

No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

History: Laws 1988, ch. 125, § 12.

59A-55-13. Prohibited coverage.

The terms of any insurance policy issued by any risk retention group shall not provide or be construed to provide coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state whose law applies to such policy.

History: Laws 1988, ch. 125, § 13.

59A-55-14. Delinquency proceedings.

A risk retention group not having a New Mexico certificate of authority that is doing business in New Mexico shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state superintendent if there has been a finding of financial impairment after an examination under Section 9 [59A-55-9 NMSA 1978] of the Risk Retention and Purchasing Group Act.

History: Laws 1988, ch. 125, § 14.

59A-55-15. Penalties.

A risk retention group that violates any provision of the Risk Retention and Purchasing Group Act shall be subject to fines and penalties, including revocation of its right to do business in New Mexico, applicable to licensed insurers generally.

History: Laws 1988, ch. 125, § 15.

59A-55-16. Operation prior to enactment of act.

In addition to complying with the requirements of the Risk Retention and Purchasing Group Act, any risk retention group operating in New Mexico prior to enactment of that act shall, within thirty days after the effective date of that act, comply with the provisions of Section 4 or 5 [59A-55-4 or 59A-55-5 NMSA 1978] of that act.

History: Laws 1988, ch. 125, § 16.

59A-55-17. Compulsory associations.

A. No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in New Mexico nor shall any risk retention group or its insureds or claimants against its insureds receive any benefit from any such fund for claims arising under the insurance policies issued by such risk retention group.

B. When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks wherever resident or located shall be covered by any insurance guaranty fund or similar mechanism in this state.

C. When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state shall be covered by the state guaranty fund.

History: Laws 1988, ch. 125, § 17.

59A-55-18. Purchasing groups' exemption from certain laws.

A purchasing group and its insurer or insurers shall be subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers shall be exempt in regard to liability insurance for the purchasing group from any law that would:

A. prohibit the establishment of a purchasing group;

B. make it unlawful for an insurer to provide or offer to provide insurance on a basis providing to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters;

C. prohibit a purchasing group or its members from purchasing insurance on a group basis described in Subsection B of this section;

D. prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

E. require that a purchasing group must have a minimum number of members, common ownership or affiliation or certain legal form;

F. require that a certain percentage of a purchasing group must obtain insurance on a group basis;

G. otherwise discriminate against a purchasing group or any of its members; or

H. require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in New Mexico.

History: Laws 1988, ch. 125, § 18.

59A-55-19. Notice and registration requirements of purchasing groups.

A. A purchasing group which intends to do business in New Mexico shall, prior to doing business, furnish notice to the superintendent. The notice shall contain all information requested by the superintendent.

B. The purchasing group shall register with and designate the superintendent as its agent solely for the purpose of receiving service of legal documents or process, for which a filing fee shall be imposed by the superintendent, except that such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the federal Product Liability Risk Retention Act of 1981 and:

(1) which in any state:

(a) was domiciled before April 1, 1986; and

(b) is domiciled on and after October 27, 1986; or

(2) which:

(a) before October 27, 1986 purchased insurance from an insurance carrier licensed in any state; and

(b) since October 27, 1986 purchased its insurance from an insurance carrier licensed in any state;

(3) which was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(4) which does not purchase insurance that was not authorized for purposes of an exemption under the Product Liability Risk Retention Act of 1981, as in effect before October 27, 1986.

C. Each purchasing group that is required to give notice pursuant to Subsection A of this section shall also furnish such information as may be required by the superintendent.

D. Any purchasing group which was doing business in this state prior to the enactment of the Risk Retention and Purchasing Group Act shall, within thirty days after the effective date of that act, furnish notice to the commissioner pursuant to the provisions of Subsection A of this section and furnish such information as may be required pursuant to Subsections B and C of this section.

History: Laws 1988, ch. 125, § 19.

59A-55-20. Restrictions on insurance purchased by purchasing groups.

A. A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the

purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of the state.

B. A purchasing group may purchase insurance for its members in this state or covering its members' risks resident or located in this state only from insurers admitted in this state, from insurers that are eligible surplus lines insurers in this state or from risk retention groups that have registered in this state.

C. A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk retention group shall inform each of the members of such group that have a risk resident or located in this state that such risk is not protected by an insurance insolvency guaranty fund in this state and that such risk retention group or such insurer may not be subject to all insurance laws and regulations of this state.

D. No purchasing group may purchase insurance providing for a deductible or self-insured retention unless the deductible or self-insured retention is the sole responsibility of each individual member of the purchasing group.

History: Laws 1988, ch. 125, § 20; 1999, ch. 289, § 40.

59A-55-21. Repealed.

History: Laws 1988, ch. 125, § 21; repealed by Laws 2018, ch. 57, § 31.

59A-55-22. Administrative and procedural authority regarding risk retention groups and purchasing groups.

The superintendent is authorized to make use of any of the powers established under the New Mexico Insurance Code to enforce the laws of New Mexico not specifically preempted by the Risk Retention Act of 1986 including the superintendent's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceedings or litigation, the procedural laws of New Mexico shall apply. The injunctive authority of the superintendent, in regard to risk retention groups, is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

History: Laws 1988, ch. 125, § 22.

59A-55-23. Penalties.

A risk retention group that violates any provision of the Risk Retention and Purchasing Group Act shall be subject to fines and penalties applicable to licensed insurers generally, including revocation of its certificate of authority or the right to do business in New Mexico, or both.

History: Laws 1988, ch. 125, § 23.

59A-55-24. Duty of insurance producers to obtain license.

A. No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in New Mexico from a risk retention group unless such person, firm, association or corporation is licensed as an insurance producer pursuant to the provisions of the New Mexico Insurance Code.

B. No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance:

(1) in New Mexico for a purchasing group from an authorized insurer or a risk retention group chartered in a state, unless such person, firm, association or corporation is licensed as an insurance producer pursuant to the provisions of the New Mexico Insurance Code;

(2) in New Mexico for any members of a purchasing group under a purchasing group's policy, unless such person, firm, association or corporation is licensed as an insurance producer pursuant to the provisions of the New Mexico Insurance Code; or

(3) from an insurer not authorized to do business in New Mexico on behalf of a purchasing group located in this state, unless such person, firm, association or corporation is licensed as a surplus lines agent or excess line broker pursuant to the provisions of the New Mexico Insurance Code.

C. Every person, firm, association or corporation licensed pursuant to the provisions of the New Mexico Insurance Code on business placed with risk retention groups or written through a purchasing group shall inform each prospective insured of the provisions of the notice required by Section 59A-55-10 NMSA 1978 in the case of a purchasing group.

History: Laws 1988, ch. 125, § 24; 1999, ch. 272, § 27; 1999, ch. 289, § 41; 2016, ch. 89, § 69.

59A-55-25. Binding effect of orders issued in United States district court.

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance or operating in any state upon a finding that such a group is in hazardous financial or financially impaired condition shall be enforceable in the state courts of New Mexico.

History: Laws 1988, ch. 125, § 25.

59A-55-26. Rules and regulations.

The superintendent may establish and from time to time amend such regulations relating to risk retention groups and purchasing groups as may be necessary or desirable to carry out the provisions of the Risk Retention and Purchasing Group Act.

History: Laws 1988, ch. 125, § 26.

ARTICLE 56
Health Insurance Alliances (Repealed.)

59A-56-1. Repealed.

History: Laws 1994, ch. 75, § 1; 1997, ch. 243, § 34; repealed by Laws 2013, ch. 54, § 15.

59A-56-2. Repealed.

History: Laws 1994, ch. 75, § 2; 1997, ch. 243, § 35; repealed by Laws 2013, ch. 54, § 15.

59A-56-3. Repealed.

History: Laws 1994, ch. 75, § 3; 1997, ch. 243, § 36; 1998, ch. 41, § 27; 2003, ch. 391, § 8; 2013, ch. 74, § 35; repealed by Laws 2013, ch. 54, § 15.

59A-56-4. Repealed.

History: Laws 1994, ch. 75, § 4; 1997, ch. 243, § 37; 2005, ch. 21, § 1; 2013, ch. 54, § 12; repealed by Laws 2013, ch. 54, § 15.

59A-56-5. Repealed.

History: Laws 1994, ch. 75, § 5; 1997, ch. 243, § 38; repealed by Laws 2013, ch. 54, § 15.

59A-56-6. Repealed.

History: Laws 1994, ch. 75, § 6; 1997, ch. 243, § 39; 2010, ch. 95, § 5; repealed by Laws 2013, ch. 54, § 15.

59A-56-7. Repealed.

History: Laws 1994, ch. 75, § 7; repealed by Laws 2013, ch. 54, § 15.

59A-56-8. Repealed.

History: Laws 1994, ch. 75, § 8; 1997, ch. 243, § 40; 2005, ch. 21, § 2; repealed by Laws 2013, ch. 54, § 15.

59A-56-9. Repealed.

History: Laws 1994, ch. 75, § 9; 1997, ch. 243, § 41; 2001, ch. 310, § 1; repealed by Laws 2013, ch. 54, § 15.

59A-56-10. Repealed.

History: Laws 1994, ch. 75, § 10; 1997, ch. 243, § 42; repealed by Laws 2013, ch. 54, § 15.

59A-56-11. Repealed.

History: Laws 1994, ch. 75, § 11; 1997, ch. 243, § 43; 1999, ch. 289, § 42; 2001, ch. 310, § 2; repealed by Laws 2013, ch. 54, § 15.

59A-56-12. Repealed.

History: Laws 1994, ch. 75, § 12; repealed by Laws 2013, ch. 54, § 15.

59A-56-13. Repealed.

History: Laws 1994, ch. 75, § 13; 1997, ch. 243, § 44; 2001, ch. 310, § 3; repealed by Laws 2013, ch. 54, § 15.

59A-56-14. Repealed.

History: Laws 1994, ch. 75, § 14; 1997, ch. 243, § 45; 2006, ch. 3, § 1; repealed by Laws 2013, ch. 54, § 15.

59A-56-15. Repealed.

History: Laws 1994, ch. 75, § 15; repealed by Laws 2013, ch. 54, § 15.

59A-56-16. Repealed.

History: Laws 1994, ch. 75, § 16; repealed by Laws 2013, ch. 54, § 15.

59A-56-17. Repealed.

History: Laws 1994, ch. 75, § 17; 1997, ch. 243, § 46; repealed by Laws 2013, ch. 54, § 15.

59A-56-18. Repealed.

History: Laws 1994, ch. 75, § 18; 1997, ch. 243, § 47; repealed by Laws 2013, ch. 54, § 15.

59A-56-19. Repealed.

History: Laws 1994, ch. 75, § 19; 1997, ch. 243, § 48; repealed by Laws 2013, ch. 54, § 15.

59A-56-20. Repealed.

History: Laws 1994, ch. 75, § 20; 1997, ch. 243, § 49; 1998, ch. 41, § 28; repealed by Laws 2013, ch. 54, § 15.

59A-56-21. Repealed.

History: Laws 1994, ch. 75, § 21; 1997, ch. 243, § 50; repealed by Laws 2013, ch. 54, § 15.

59A-56-22. Repealed.

History: Laws 1994, ch. 75, § 22; repealed by Laws 2013, ch. 54, § 15.

59A-56-23. Repealed.

History: Laws 1994, ch. 75, § 23; 1997, ch. 243, § 51; 2005, ch. 21, § 3; repealed by Laws 2013, ch. 54, § 15.

59A-56-24. Repealed.

History: Laws 1994, ch. 75, § 24; 1997, ch. 243, § 52; repealed by Laws 2013, ch. 54, § 15.

59A-56-25. Repealed.

History: Laws 1994, ch. 75, § 25; 2005, ch. 21, § 4; 2013, ch. 74, § 36; repealed by Laws 2013, ch. 54, § 15.

ARTICLE 57
Patient Protection

59A-57-1. Short title.

Chapter 59A, Article 57 NMSA 1978 may be cited as the "Patient Protection Act".

History: Laws 1998, ch. 107, § 1; 2003, ch. 327, § 1.

59A-57-2. Purpose of act.

The purpose of the Patient Protection Act is to regulate aspects of health insurance by specifying patient and provider rights and confirming and clarifying the authority of the department to adopt regulations to provide protections to persons enrolled in managed health care plans. The insurance protections should ensure that managed health care plans treat patients fairly and arrange for the delivery of good quality services.

History: Laws 1998, ch. 107, § 2.

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 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;

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

History: Laws 1998, ch. 107, § 3; 2017, ch. 130, § 18.

59A-57-4. Patient rights; disclosures; rights to basic and comprehensive health care services; grievance procedure; utilization review program; continuous quality program.

A. Each covered person enrolled in a managed health care plan has the right to be treated fairly. A managed health care plan shall arrange for the delivery of good quality and appropriate health care services to enrollees as defined in the particular subscriber agreement. The department shall adopt regulations to implement the provisions of the Patient Protection Act and shall monitor and oversee a managed health care plan to ensure that each covered person enrolled in a plan is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting regulations to implement the provisions of Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5) and (6) of Subsection B of this section regarding health care standards and specialists, utilization review programs and continuous quality improvement programs, the department shall cooperate with and seek advice from the department of health.

B. The regulations adopted by the department to protect patient rights shall provide at a minimum that:

(1) prior to or at the time of enrollment, a managed health care plan shall provide a summary of benefits and exclusions, premium information and a provider listing; within a reasonable time after enrollment and at subsequent periodic times as appropriate, a managed health care plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and the patients' rights generally available to all covered persons;

(2) a managed health care plan shall provide health care services that are reasonably accessible and available in a timely manner to each covered person;

(3) in providing reasonably accessible health care services that are available in a timely manner, a managed health care plan shall ensure that:

(a) the plan offers sufficient numbers and types of qualified and adequately staffed health care providers at reasonable hours of service to provide health care services to the plan's enrollees;

(b) health care providers that are specialists may act as primary care providers for patients with chronic medical conditions, provided the specialists offer all basic health care services that are required of them by a managed health care plan;

(c) reasonable access is provided to out-of-network health care providers if medically necessary covered services are not reasonably available through participating health care providers or if necessary to provide continuity of care during brief transition periods;

(d) emergency care is immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs; and

(e) the plan, through provider selection, provider education, the provision of additional resources or other means, reasonably addresses the cultural and linguistic diversity of its enrollee population;

(4) a managed health care plan shall adopt and implement a prompt and fair grievance procedure for resolving patient complaints and addressing patient questions and concerns regarding any aspect of the plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the plan's provider network. The grievance procedure shall notify patients of their right to obtain review by the plan, their right to obtain review by the superintendent, their right to expedited review of emergent utilization decisions and their rights under the Patient Protection Act;

(5) a managed health care plan shall adopt and implement a comprehensive utilization review program. The basis of a decision to deny care shall be disclosed to an affected enrollee. The decision to approve or deny care to an enrollee shall be made in a timely manner, and the final decision shall be made by a qualified health care professional. A plan's utilization review program shall ensure that enrollees have proper access to health care services, including referrals to necessary specialists. A decision made in a plan's utilization review program shall be subject to the plan's grievance procedure and appeal to the superintendent; and

(6) a managed health care plan shall adopt and implement a continuous quality improvement program that monitors the quality and appropriateness of the health care services provided by the plan.

History: Laws 1998, ch. 107, § 4.

59A-57-4.1. External grievance appeals; appointment; compensation.

A. The superintendent may appoint one or more qualified individuals to review external grievance appeals.

B. The superintendent shall fix the reasonable compensation of each appointee based upon, but not limited to, compensation amounts suggested by national or state legal or medical professional societies, organizations or associations.

C. Upon completion of the external grievance appeal review, the superintendent shall prepare a detailed statement of compensation due each appointee and shall present the statement to the enrollee's health insurer.

D. The enrollee's health insurer shall pay the compensation directly to each appointee who participated in the external grievance appeal review.

E. The superintendent shall promulgate rules to implement this section.

History: Laws 2003, ch. 327, § 2.

59A-57-5. Consumer assistance; consumer advisory boards; ombudsman office; reports to consumers; superintendent's orders to protect consumers.

A. Each managed health care plan shall establish and adequately staff a consumer assistance office. The purpose of the consumer assistance office is to respond to consumer questions and concerns and assist patients in exercising their rights and protecting their interests as consumers of health care.

B. Each managed health care plan shall establish a consumer advisory board. The board shall meet at least quarterly and shall advise the plan about the plan's general operations from the perspective of the enrollee as a consumer of health care. The board shall also review the operations of and be advisory to the plan's consumer assistance office.

D.[C.] The department shall prepare an annual report assessing the operations of managed health care plans subject to the department's oversight, including information about consumer complaints.

E.[D.] A person adversely affected may file a complaint with the superintendent regarding a violation of the Patient Protection Act. Prior to issuing any remedial order regarding violations of the Patient Protection Act or its regulations, the superintendent shall hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978. The superintendent may issue any order he deems necessary or appropriate, including ordering the delivery of appropriate care, to protect consumers and enforce the provisions of the Patient Protection Act. The superintendent shall adopt special procedures to govern the submission of emergency appeals to him in health emergencies.

History: Laws 1998, ch. 107, § 5.

59A-57-6. Fairness to health care providers; gag rules prohibited; grievance procedure for providers.

A. No managed health care plan may:

(1) adopt a gag rule or practice that prohibits a health care provider from discussing a treatment option with an enrollee even if the plan does not approve of the option;

(2) include in any of its contracts with health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to an enrollee; or

(3) require a health care provider to violate any recognized fiduciary duty of his profession or place his license in jeopardy.

B. A plan that proposes to terminate a health care provider from the managed health care plan shall explain in writing the rationale for its proposed termination and deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination.

C. A managed health care plan shall adopt and implement a process pursuant to which providers may raise with the plan concerns that they may have regarding operation of the plan, including concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the plan's provider network. The process shall include, at a minimum, the right of the provider to present the provider's concerns to a plan committee responsible for the substantive area addressed by the concern, and the assurance that the concern will be conveyed to the plan's governing body. In addition, a managed health care plan shall adopt and implement a fair hearing plan that permits a health care provider to dispute the existence of adequate cause to terminate the provider's participation with the plan to the extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism.

History: Laws 1998, ch. 107, § 6.

59A-57-7. Point-of-service option plan.

A. Except as otherwise provided in this section, the department may require a plan that offers a point-of-service plan or open plan to include in any managed health care plan it offers an option for a point-of-service plan or open plan to the extent that the department determines that the open plan option is financially sound.

B. No health care insurer may be required to offer a point-of-service plan or open plan as an option under a medicaid-funded managed health care plan unless the human services department [health care authority department] has established such a requirement as part of a procurement for managed health care under the medicaid program.

History: Laws 1998, ch. 107, § 7.

59A-57-8. Administrative costs and benefit costs disclosures.

The department shall adopt regulations to ensure that both the administrative costs and the direct costs of providing health care services of each managed health care plan are fully and fairly disclosed to consumers in a uniform manner that allows meaningful cost comparisons among plans.

History: Laws 1998, ch. 107, § 8.

59A-57-9. Private remedies to enforce patient and provider insurance rights; enrollee as third-party beneficiary to enforce rights.

A. A person who suffers a loss as a result of a violation of a right protected pursuant to the provisions of the Patient Protection Act, its regulations or a managed health care plan may bring an action to recover actual damages or the sum of one hundred dollars ($100), whichever is greater.

B. A person likely to be damaged by a denial of a right protected pursuant to the provisions of the Patient Protection Act or its regulations may be granted an injunction under the principles of equity and on terms that the court considers reasonable. Proof of monetary damage or intent to violate a right is not required.

C. To protect and enforce an enrollee's rights in a managed health care plan, an individual enrollee participating in or eligible to participate in a managed health care plan shall be treated as a third-party beneficiary of the managed health care plan contract between the plan and the party with which the plan directly contracts. An individual enrollee may sue to enforce the rights provided in the contract that governs the managed health care plan; provided, however, that the plan and the party to the contract may amend the terms of, or terminate the provisions of, the contract without the enrollee's consent.

D. The relief provided pursuant to this section is in addition to other remedies available against the same conduct under the common law or other statutes of this state.

E. In any class action filed pursuant to this section, the court may award damages to the named plaintiffs as provided in this section and may award members of the class the actual damages suffered by each member of the class as a result of the unlawful practice.

F. Nothing in the Patient Protection Act is intended to make a plan vicariously liable for the actions of independent contractor health care providers.

History: Laws 1998, ch. 107, § 9.

59A-57-10. Application of act to medicaid program.

A. Except as otherwise provided in this section, the provisions of the Patient Protection Act apply to the medicaid program operation in the state. A managed health care plan offered through the medicaid program shall grant enrollees and providers the same rights and protections as are granted to enrollees and providers in any other managed health care plan subject to the provisions of the Patient Protection Act.

B. Nothing in the Patient Protection Act shall be construed to limit the authority of the human services department [health care authority department] to administer the medicaid program, as required by law. Consistent with applicable state and federal law, the human services department [health care authority department] shall have sole authority to determine, establish and enforce medicaid eligibility criteria, the scope, definitions and limitations of medicaid benefits and the minimum qualifications or standards for medicaid service providers.

C. Medicaid recipients and applicants retain their right to appeal decisions adversely affecting their medicaid benefits to the human services department [health care authority department], pursuant to the Public Assistance Appeals Act [Chapter 27, Article 3 NMSA 1978]. Notwithstanding other provisions of the Patient Protection Act, a medicaid recipient or applicant who files an appeal to the human services department [health care authority department] pursuant to the Public Assistance Appeals Act may not file an appeal on the same issue to the superintendent pursuant to the Patient Protection Act, unless the human services department [health care authority department] refuses to hear the appeal. The superintendent may refer to the human services department [health care authority department] any appeal filed with the superintendent pursuant to the Patient Protection Act if the complainant is a medicaid beneficiary and the matter in dispute is subject to the provisions of the Public Assistance Appeals Act.

D. Any managed health care plan participating in the medicaid managed care program as of the effective date of the Patient Protection Act and that is in compliance with contractual and regulatory requirements applicable to that program shall be deemed to comply with any requirements established in accordance with that act until July 1, 1999; provided that, from the effective date of that act, any rights established under that act beyond those under requirements of the human services department [health care authority department] shall apply to enrollees in medicaid managed health care plans.

History: Laws 1998, ch. 107, § 10.

59A-57-11. Penalty.

In addition to any other penalties provided by law, a civil administrative penalty of up to ten thousand dollars ($10,000) may be imposed for each violation of the Patient Protection Act. An administrative penalty shall be imposed by written order of the

superintendent made after holding a hearing as provided for in Chapter 59A, Article 4 NMSA 1978.

History: Laws 1998, ch. 107, § 11.

ARTICLE 57A
Surprise Billing Protection

59A-57A-1. Short title.

Sections 1 through 13 [59A-57A-1 to 59A-57A-13 NMSA 1978] of this act may be cited as the "Surprise Billing Protection Act".

History: Laws 2019, ch. 227, § 1.

59A-57A-2. Definitions.

As used in the Surprise Billing Protection Act:

A. "allowed amount" means the maximum portion of a billed charge that a health insurance carrier will pay, including any applicable covered person cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or by a nonparticipating provider;

B. "balance billing" means a nonparticipating provider's practice of issuing a bill to a covered person for the difference between the nonparticipating provider's billed charges on a claim and any amount paid by the health insurance carrier as reimbursement for that claim, excluding any cost-sharing amount due from the covered person;

C. "claim" means a request from a provider for payment for health care services rendered;

D. "co-insurance" means a cost-sharing method that requires a covered person to pay a stated percentage of medical expenses after any deductible amount is paid; provided that co-insurance rates may differ for different types of services under the same health benefits plan;

E. "copayment" means a cost-sharing method that requires a covered person to pay a fixed dollar amount when health care services are received, with the health insurance carrier paying the balance allowable amount; provided that there may be different copayment requirements for different types of services under the same health benefits plan;

F. "cost sharing" means a copayment, co-insurance, deductible or any other form of financial obligation of a covered person other than premium or share of premium, or any

combination of any of these financial obligations as defined by the terms of a health benefits plan;

G. "covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan;

H. "covered person" means:

(1) an enrollee, policyholder or subscriber;

(2) the enrolled dependent of an enrollee, policyholder or subscriber; or

(3) another individual participating in a health benefits plan;

I. "deductible" means a fixed dollar amount that a covered person may be required to pay during the benefit period before the health insurance carrier begins payment for covered benefits; provided that a health benefits plan may have both individual and family deductibles and separate deductibles for specific services;

J. "emergency care" means a health care procedure, treatment or service, excluding ambulance transportation service, which procedure, treatment or service is delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person;

K. "facility" means an entity providing a health care service, including:

(1) a general, special, psychiatric or rehabilitation hospital;

(2) an ambulatory surgical center;

(3) a cancer treatment center;

(4) a birth center;

(5) an inpatient, outpatient or residential drug and alcohol treatment center;

(6) a laboratory, diagnostic or other outpatient medical service or testing center;

(7) a health care provider's office or clinic;

(8) an urgent care center;

(9) a freestanding emergency room; or

(10) any other therapeutic health care setting;

L. "freestanding emergency room" means a facility licensed by the department of health that is separate from an acute care hospital and that provides twenty-four-hour emergency care to patients at the same level of care that a hospital-based emergency room delivers;

M. "health benefits plan" means a policy or agreement entered into or offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided that "health benefits plan" does not include any of the following:

(1) an accident-only policy;

(2) a credit-only policy;

(3) a long- or short-term care or disability income policy;

(4) a specified disease policy;

(5) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

(6) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act [27-2-1 to 27-2-34 NMSA 1978];

(7) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

(8) a fixed or hospital indemnity policy;

(9) a dental-only policy;

(10) a vision-only policy;

(11) a workers' compensation policy;

(12) an automobile medical payment policy; or

(13) any other policy specified in rules of the superintendent;

N. "health care services":

(1) means any service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or other disease, including physical or behavioral health services, to the extent offered by a health benefits plan; and

(2) does not mean ambulance transportation services;

O. "health insurance carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services or that provides, offers or administers a health benefit policy or managed health care plan in the state;

P. "hospital" means a facility offering inpatient health care services, nursing care and overnight care for three or more individuals on a twenty-four-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions;

Q. "inducement" means the act or process of enticing or persuading another person to take a certain course of action;

R. "network" means the group or groups of participating providers that have been contracted to provide health care services under a network plan;

S. "network plan" means a health benefits plan that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers and facilities managed, owned, under contract with or employed by the health insurance carrier offering the health benefits plan;

T. "nonparticipating provider" means a provider who is not a participating provider;

U. "participating provider" means a provider or facility that, under express contract with a health insurance carrier or with a health insurance carrier's contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost sharing;

V. "prior authorization" means a pre-service determination made by a health insurance carrier regarding a covered person's eligibility for services, medical necessity, benefit coverage and the location or appropriateness of services, pursuant to the terms of a health benefits plan that the health insurance carrier offers;

W. "provider" means a health care professional, hospital or other facility licensed to furnish health care services;

X. "stabilize" means to provide emergency care to a patient as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient to a facility or, with respect to emergency labor, to deliver, including the delivery of a placenta; and

Y. "surprise bill":

(1) means a bill that a nonparticipating provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider:

(a) emergency care provided by the nonparticipating provider; or

(b) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where: 1) a participating provider is unavailable; 2) a nonparticipating provider renders unforeseen services; or 3) a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render the particular services rendered; and

(2) does not mean a bill:

(a) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization; or

(b) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency care or for services rendered pursuant to Subparagraph (b) of Paragraph (1) of this subsection.

History: Laws 2019, ch. 227, § 2.

59A-57A-3. Emergency care; reimbursement; limitation on charges.

A. A health insurance carrier shall reimburse a nonparticipating provider for emergency care necessary to evaluate and stabilize a covered person if a prudent layperson would reasonably believe that emergency care is necessary, regardless of eventual diagnosis.

B. A health insurance carrier shall not require that prior authorization for emergency care be obtained by, or on behalf of, a covered person prior to the point of stabilization of that covered person if a prudent layperson would reasonably believe that the covered person requires emergency care.

C. A health insurance carrier may impose a cost-sharing or limitation of benefits requirement for emergency care performed by a nonparticipating provider only to the same extent that the copayment, co-insurance or limitation of benefits requirement applies for participating providers and is documented in the policy.

D. A health insurance carrier may require an emergency care provider to notify a health insurance carrier of a covered person's admission to the hospital within a reasonable time period after the covered person has been stabilized.

History: Laws 2019, ch. 227, § 3.

59A-57A-4. Non-emergency care; limitation on charges.

A. Other than applicable cost sharing that would apply if a participating provider had rendered the same services, a health insurance carrier shall provide reimbursement for and a covered person shall not be liable for charges and fees for covered non-emergency care rendered by a nonparticipating provider that are delivered when:

(1) the covered person at an in-network facility does not have the ability or opportunity to choose a participating provider who is available to provide the covered services; or

(2) medically necessary care is unavailable within a health benefits plan's network; provided that "medical necessity" shall be determined by a covered person's provider in conjunction with the covered person's health benefits plan and health insurance carrier.

B. Except as set forth in Subsection A of this section, nothing in this section shall preclude a nonparticipating provider from balance billing for non- emergency care provided by a nonparticipating provider to an individual who has knowingly chosen to receive services from that nonparticipating provider.

History: Laws 2019, ch. 227, § 4.

59A-57A-5. Credit against maximum out-of-pocket cost-sharing amount; communication by hospitals; advance notification of charges for health care services.

A. A nonparticipating provider shall not knowingly submit a surprise bill to a covered person.

B. In accordance with the hearing procedures established pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978], a covered person may appeal a health insurance carrier's determination made regarding a surprise bill.

C. By July 1, 2020, the department of health shall require each health facility licensed pursuant to the Public Health Act [Chapter 24, Article 1 NMSA 1978] to post the following on the health facility's website in a publicly accessible manner:

(1) the names and hyperlinks for direct access to the websites of all health insurance carriers with which the hospital has a contract for services;

(2) a statement that sets forth the following:

(a) services may be performed in the hospital by participating providers as well as nonparticipating providers who may separately bill the patient;

(b) providers that perform health care services in the hospital may or may not participate in the same health benefits plans as the hospital; and

(c) prospective patients should contact their health insurance carriers in advance of receiving services at that hospital to determine whether the scheduled health care services provided in that hospital will be covered at in-network rates;

(3) the rights of covered persons under the Surprise Billing Protection Act; and

(4) instructions for contacting the superintendent.

D. Any written communication, other than a receipt of payment, from a provider or health insurance carrier pertaining to a surprise bill, shall clearly state that the covered person is responsible only for payment of applicable in-network cost-sharing amounts under the covered person's health benefits plan. A collection agency collecting medical debt from New Mexico residents shall post a notice of consumer rights pursuant to the Surprise Billing Protection Act on its website.

E. When a nonparticipating provider under nonemergency circumstances has advance knowledge that the nonparticipating provider is not contracted with the covered person's health insurance carrier, the nonparticipating provider shall inform the covered person of the nonparticipating provider's nonparticipating status and advise the covered person to contact the covered person's health insurance carrier to discuss the covered person's options.

History: Laws 2019, ch. 227, § 5.

59A-57A-6. Covered persons; providers; overpayment.

A. If a covered person pays a nonparticipating provider more than the in-network cost-sharing amount for services provided under circumstances giving rise to a surprise bill, the nonparticipating provider shall refund to the covered person within forty-five

calendar days of receipt of payment from the health insurance carrier any amount paid in excess of the in-network cost-sharing amount.

B. If a nonparticipating provider has not made a full refund to the covered person of any amount paid in excess of the in-network cost-sharing amount to the covered person within forty-five calendar days of receipt, interest shall accrue at the rate set for payment of interest on a health plan's liability for clean claims submitted by eligible providers to a health plan pursuant to Chapter 59A, Article 16 NMSA 1978.

C. A covered person may seek recovery of the refund of the amount the covered person has paid in excess of the in-network cost-sharing amount that a nonparticipating provider owes, plus interest, pursuant to Subsection B of this section by filing an appeal with the office of superintendent of insurance. The superintendent of insurance shall develop an appeals process pursuant to this section.

History: Laws 2019, ch. 227, § 6.

59A-57A-7. Nonparticipating providers; rebates and inducements; prohibition.

A nonparticipating provider shall not, either directly or indirectly, knowingly waive, rebate, give, pay or offer to waive, rebate, give or pay all or part of a cost-sharing amount owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek a health care service from that nonparticipating provider. The superintendent may impose fines on providers for unlawful rebates and inducements; provided that a provider on which the superintendent intends to impose a fine shall be entitled to a hearing in accordance with the provisions of Section 59A-4-15 NMSA 1978.

History: Laws 2019, ch. 227, § 7.

59A-57A-8. Health care provider reimbursement rates; surprise billing.

A. The superintendent shall convene appropriate stakeholders, including rural providers, insurers and consumer advocates, and review the reimbursement rate for surprise bills annually to ensure fairness to providers and to evaluate the impact on health insurance premiums and health benefits plan networks.

B. Calculation of the date of health insurance carrier receipt of a claim shall align with requirements for prompt payment established pursuant to Section 59A-16-21.1 NMSA 1978.

C. A health insurance carrier shall make available to providers access to claims status information.

History: Laws 2019, ch. 227, § 8.

59A-57A-9. Reasonable health care cost management permitted.

Nothing in the Surprise Billing Protection Act shall be construed to prohibit a health insurance carrier from appropriately using reasonable health care cost management techniques.

History: Laws 2019, ch. 227, § 9.

59A-57A-10. Private cause of action.

Except as provided in Subsection C of Section 6 [59A-57A-6 NMSA 1978] of the Surprise Billing Protection Act, nothing in that act shall be construed to create or imply a private cause of action for a violation of that act.

History: Laws 2019, ch. 227, § 10.

59A-57A-11. Information from provider networks.

The superintendent:

A. may require that health insurance carriers report the annual percentage of claims and expenditures paid to nonparticipating providers for health care services; and

B. may require by rule a report on changes to the percent of claims paid as an emergency claim.

History: Laws 2019, ch. 227, § 11.

59A-57A-12. Applicability.

The provisions of the Surprise Billing Protection Act apply to the following types of health coverage delivered or issued for delivery in this state:

A. group health coverage governed by the provisions of the Health Care Purchasing Act [Chapter 13, Article 7 NMSA 1978];

B. individual health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 22 NMSA 1978;

C. multiple-employer welfare arrangements governed by the provisions of Section 59A-15-20 NMSA 1978;

D. group and blanket health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978;

E. individual and group health maintenance organization contracts governed by the provisions of the Health Maintenance Organization Law; and

F. individual and group nonprofit health benefits plans governed by the provisions of the Nonprofit Health Care Plan Law [Chapter 59A, Article 47 NMSA 1978].

History: Laws 2019, ch. 227, § 12.

59A-57A-13. Providers; reimbursement for a surprise bill. (Repealed effective July 1, 2028.)

A. For services provided pursuant to Section 3 [59A-57A-3 NMSA 1978] or 4 [59A-57A-4 NMSA 1978] of the Surprise Billing Protection Act, a health insurance carrier shall directly reimburse a nonparticipating provider for care rendered the surprise bill reimbursement rate for services.

B. The surprise bill reimbursement rate shall be calculated using claims data reflecting the allowed amounts paid for claims paid in the 2017 plan year.

C. As used in this section, "surprise bill reimbursement rate" means the sixtieth percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent after consultation with health care sector stakeholders; provided that no surprise bill reimbursement rate shall be paid at less than one hundred fifty percent of the 2017 medicare reimbursement rate for the applicable health care service provided.

D. The nonprofit organization shall be conflict-free and unaffiliated with any stakeholder in the health care sector.

History: Laws 2019, ch. 227, § 13.

ARTICLE 58
Service Contract Regulation

59A-58-1. Short title.

Chapter 59A, Article 58 NMSA 1978 may be cited as the "Service Contract Regulation Act".

History: Laws 2001, ch. 206, § 1; 2017, ch. 125, § 1.

59A-58-2. Definitions.

As used in the Service Contract Regulation Act:

A. "administrator" means a person who is responsible for administering a service contract that is issued, sold or offered for sale by a provider or sold by a seller;

B. "automatic renewal provision" means a provision within a service contract that acts to automatically renew the service contract after the end of the original term for a renewal term greater than two months, and such renewal is effective unless the holder gives notice to the provider or administrator of the holder's intention to terminate the service contract;

C. "consumer" means a person who purchases, other than for resale, property used primarily for personal, family or household purposes and not for business or research purposes;

D. "holder" means a resident of this state who:

(1) purchases a service contract; or

(2) is legally in possession of a service contract and is entitled to enforce the rights of the original purchaser of the service contract;

E. "incidental costs" means expenses specified in a warranty that are incurred by the warranty holder due to the failure of the product to perform as provided in the contract. Incidental costs may include, without limitation, insurance policy deductibles, rental vehicle charges, the difference between the actual value of a motor vehicle at the time of failure and the cost of a replacement vehicle, gross receipts taxes, registration fees, transaction fees and mechanical inspection fees. Incidental costs may be reimbursed in either a fixed amount specified in the warranty or by use of a formula itemizing specific incidental costs incurred by the warranty holder;

F. "maintenance agreement" means a contract for a limited period that provides only for scheduled maintenance;

G. "major manufacturing company" means a person who:

(1) manufactures or produces and sells products under its own name or label or is a wholly owned subsidiary or affiliate of the person who manufactures or produces products; and

(2) maintains, or its parent company maintains, a net worth or stockholders' equity of at least one hundred million dollars ($100,000,000);

H. "property" means all property, whether movable at the time of purchase or a fixture, that is used primarily for personal, family or household purposes;

I. "provider" means a person who is contractually obligated to a holder or to indemnify the holder for the costs of repairing, replacing or performing maintenance on property;

J. "reimbursement insurance policy" means a policy of insurance issued to a provider to either provide reimbursement to the provider under the terms of the insured service contracts issued or sold by the provider or, in the event of the provider's non-performance, to pay on behalf of the provider all covered contractual obligations incurred by the provider under the terms of the insured service contracts issued or sold by the provider;

K. "road hazard" means a hazard that is encountered while driving a motor vehicle and that may include potholes, rocks, wood debris, metal parts, glass, plastic, curbs or composite scraps;

L. "seller" means a person who sells service contracts that contractually obligate another party or parties;

M. "service contract" means a contract pursuant to which a provider, in exchange for separately stated consideration, is obligated for a specified period to a holder to repair, replace or perform maintenance on, or indemnify or reimburse the holder for the costs of repairing, replacing or performing maintenance on, property that is described in the service contract and that has an operational or structural failure as a result of a defect in materials, workmanship or normal wear and tear, including a contract that provides or includes one or more of the following:

(1) incidental payment of indemnity under limited circumstances, including towing, rental and emergency road service and food spoilage;

(2) the repair, replacement or maintenance of property for damages that result from power surges or accidental damage from handling;

(3) the repair or replacement of tires and wheels on a motor vehicle damaged as a result of coming into contact with road hazards;

(4) the removal of dents, dings or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding or painting;

(5) the repair of chips or cracks in motor vehicle windshields or the replacement of motor vehicle windshields as a result of damage caused by road hazards;

(6) the replacement of a motor vehicle key or key fob in the event the key or key fob becomes inoperable or is lost or stolen; and

(7) other services approved by the superintendent if not inconsistent with other provisions of the Service Contract Regulation Act; and

N. "warranty" means a warranty provided solely by a manufacturer, importer or seller of property for which the manufacturer, importer or seller did not receive separate consideration and that:

(1) is not negotiated or separated from the sale of the property;

(2) is incidental to the sale of the property; and

(3) guarantees to indemnify the consumer for defective parts, mechanical or electrical failure, labor or other remedial measures required to repair or replace the property and may provide specified incidental costs.

History: Laws 2001, ch. 206, § 2; 2013, ch. 74, § 37; 2017, ch. 125, § 2; 2019, ch. 254, § 1.

59A-58-3. Exclusions from act.

The provisions of the Service Contract Regulation Act do not apply to:

A. a warranty;

B. a maintenance agreement;

C. a service contract provided by a public utility on its transmission device if the service contract is regulated by the public regulation commission;

D. a service contract sold or offered for sale to a person who is not a consumer; or

E. a service contract for property if the purchase price of the property is less than two hundred fifty dollars ($250) and the consideration for the service contract is less than twenty-five dollars ($25.00).

History: Laws 2001, ch. 206, § 3.

59A-58-4. Prohibition of sale of service contract unless registered.

A provider shall not issue, sell or offer for sale service contracts in this state unless the provider has been registered with the superintendent pursuant to the provisions of the Service Contract Regulation Act. However, an administrator or seller of a service

contract is not required to be registered. The provisions of this section shall not apply to major manufacturing companies' service contracts.

History: Laws 2001, ch. 206, § 4; 2017, ch. 125, § 3.

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.

History: Laws 2001, ch. 206, § 5; 2017, ch. 125, § 4; 2021, ch. 108, § 36.

59A-58-6. Security required for registration of provider.

A. To ensure the faithful performance of a provider's obligations to the provider's service contract holders, a provider shall comply with the requirements of one of the following:

(1) maintain a deposit with the superintendent as provided in this paragraph:

(a) a provider of a service contract shall deposit fifty thousand dollars ($50,000) unless the contract covers the following, in which case the provider shall deposit one hundred thousand dollars ($100,000): 1) a motor vehicle; and 2) mechanical, plumbing and electrical systems and appliances at a residential dwelling when the service contract was sold in conjunction with the sale of the residential dwelling;

(b) deposits required pursuant to Subparagraph (a) of this paragraph shall be: 1) a surety bond issued by a surety company authorized to do business in New Mexico on a form acceptable to the superintendent; 2) securities of the type eligible for deposit by an insurance company; or 3) a clean and irrevocable letter of credit issued by a financial institution acceptable to the superintendent; and

(c) additional deposits may be required of any provider when it is determined by the superintendent that an additional deposit is necessary for the protection of the public; or

(2) insure all service contracts under a reimbursement insurance policy issued by an insurer licensed, registered or otherwise authorized to do business in this state, and who either:

(a) at the time the policy is filed with the superintendent, and continuously thereafter: 1) maintains a surplus as to policyholders and paid-in capital of at least fifteen million dollars ($15,000,000); and 2) annually files copies of the insurer's financial statements, its national association of insurance commissioners annual statement and the actuarial certification required by and filed in the insurer's state of domicile; or

(b) at the time the policy is filed with the superintendent, and continuously thereafter: 1) maintains a surplus as to policyholders and paid-in capital of less than fifteen million dollars ($15,000,000) but at least equal to ten million dollars ($10,000,000); 2) demonstrates to the satisfaction of the superintendent that the company maintains a ratio of net written premiums, wherever written, to surplus as to policyholders and paid-in capital of not greater than three to one; and 3) annually files copies of the insurer's audited financial statements, its national association of insurance commissioners annual statement and the actuarial certification required by and filed in the insurer's state of domicile.

B. Except for the requirements specified in this section, no other financial security requirements shall be required by the superintendent.

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

History: Laws 2001, ch. 206, § 6; 2007, ch. 282, § 13; 2017, ch. 125, § 5.

59A-58-7. Transactions exempt from premium tax.

The premium tax imposed pursuant to Chapter 59A, Article 6 NMSA 1978 does not apply to any business transacted pursuant to the provisions of the Service Contract Regulation Act.

History: Laws 2001, ch. 206, § 7.

59A-58-8. Transactions not subject to New Mexico Insurance Code; exceptions.

A. Except as otherwise provided in the Service Contract Regulation Act, the marketing, issuance, sale, offering for sale, making, proposing to make and administration of service contracts are not subject to the provisions of the New Mexico Insurance Code [Chapter 59A NMSA 1978], except, when applicable, the provisions of Chapter 59A, Article 16 NMSA 1978.

B. A provider, person who sells service contracts, administrator or any other person is not required to obtain a certificate of authority or license from the superintendent to issue, sell, offer for sale or administer service contracts.

History: Laws 2001, ch. 206, § 8.

59A-58-9. Right of holder to return service contract for refund.

A. A service contract is void and a provider shall refund to the holder the purchase price of the service contract if the holder has not made a claim under the service contract and the holder returns the service contract to the provider:

(1) within twenty days after the date the provider mails a copy of the service contract to the holder;

(2) within ten days after the purchaser receives a copy of the service contract if the provider furnishes the holder with the copy at the time the contract is purchased; or

(3) within a longer period specified in the service contract.

B. The right of a holder to return a service contract pursuant to Subsection A of this section applies only to the original purchaser of the service contract.

C. Subsequent to the time period specified in Subsection A of this section, or if a claim was made during that time period, a holder may cancel a service contract and the provider shall refund to the contract holder one hundred percent of the unearned pro rata provider fee, less any claims paid. If the service contract is canceled by the holder, a reasonable administrative fee may be charged by the provider, not to exceed ten percent of the purchase price of the service contract. A provider who cancels a service contract may not impose an administrative fee.

D. A service contract must include a provision that clearly states the right of a holder to return a service contract pursuant to this section. Notwithstanding Subsection C of this section, a provider is not required to deduct the amount of any claims paid under a service contract from the amount of a refund a holder is entitled to.

E. The provider shall refund to the holder or credit to the account of the holder the purchase price of the service contract within sixty days after a service contract is returned pursuant to Subsection A of this section. If the provider fails to refund the purchase price or credit the account of the holder within that time, the provider shall pay the holder a penalty of ten percent of the purchase price for each thirty-day period or portion thereof that the refund and any accrued penalties remain unpaid.

History: Laws 2001, ch. 206, § 9; 2019, ch. 254, § 2.

59A-58-10. Information required in service contract.

A. A service contract shall:

(1) be written in language that is understandable and printed in a typeface that is easy to read;

(2) include the amount, if applicable, of any deductible that the holder is required to pay;

(3) include the name, address and telephone number of the provider and, if applicable:

(a) the name, address and telephone number of the administrator;

(b) the name of the holder, if provided by the holder; and

(c) the name, address and telephone number of the seller; however, the names and addresses of the foregoing persons are not required to be preprinted on the service contract and may be added to the service contract at the time of the sale;

(4) include the purchase price of the service contract; however, the purchase price of the service contract is not required to be preprinted on the service contract and may be added to the service contract at the time of the sale;

(5) include a description of the property covered by the service contract;

(6) specify the duties of the provider and any limitations, exceptions or exclusions;

(7) if the service contract covers a motor vehicle, indicate whether replacement parts that are not made for or by the original manufacturer of the motor vehicle may be used to comply with the terms of the service contract;

(8) include, if applicable, any restrictions on transferring or renewing the service contract;

(9) include the terms, restrictions or conditions for canceling the service contract before it expires and the procedure for canceling the service contract. The conditions for canceling the service contract shall include the provisions of Section 59A-58-12 NMSA 1978;

(10) include the duties of the holder under the contract, including the duty to protect against damage to the property covered by the service contract or to comply with any instructions included in the owner's manual for the property;

(11) indicate whether the service contract authorizes the holder to recover consequential damages; and

(12) indicate whether any defect in the property covered by the service contract existing on the date the contract is purchased is not covered under the service contract.

B. A provider shall not allow, make or cause to be made a false or misleading statement in any of the provider's service contracts or intentionally omit a material statement that causes a service contract to be misleading. The superintendent may require the provider to amend any service contract that the superintendent determines is false or misleading.

History: Laws 2001, ch. 206, § 10; 2017, ch. 125, § 6.

59A-58-10.1. Automatic renewal; notice.

A. A provider shall not include an automatic renewal provision within a service contract offered in this state unless the provider discloses the terms of the automatic renewal provision in a clear and conspicuous manner, or in the case of an offer conveyed by voice, in temporal proximity, to the request for consent to the offer and the consumer consents to the terms of the automatic renewal provision.

B. A provider shall provide notice to a holder specifying, in a clear and conspicuous manner, the procedure by which the holder may cancel the service contract, and such notice shall be provided at least thirty days before the last day on which the holder may

give notice of the holder's intention not to renew the service contract but not sooner than sixty days before the last day on which the holder may give notice of the holder's intention not to renew.

C. The notice required by Subsection B of this section may be provided by United States mail, postage prepaid, or electronic mail if the consumer consents to receive notice via electronic mail at the inception of the service contract.

History: Laws 2019, ch. 254, § 3.

59A-58-11. Receipt for and copy of service contract required.

A. A provider shall provide a receipt for, or other written evidence of, the purchase of a service contract.

B. The provider shall furnish a copy of the service contract to the holder within a reasonable time after the contract is purchased.

History: Laws 2001, ch. 206, § 11.

59A-58-12. Cancellation of service contract.

A. No service contract that has been in effect for at least seventy days may be canceled by the provider before the expiration of the agreed term or one year after the effective date of the service contract, whichever occurs first, except on any of the following grounds:

(1) failure by the holder to pay an amount when due;

(2) conviction of the holder of a crime that results in an increase in the service required under the service contract;

(3) discovery of fraud or material misrepresentation by the holder in obtaining the service contract or in presenting a claim for service thereunder; or

(4) discovery of either of the following if it occurred after the effective date of the service contract and substantially and materially increased the service required under the service contract:

(a) an act or omission by the holder; or

(b) a violation by the holder of any condition of the service contract.

B. No cancellation of a service contract may become effective until at least fifteen days after the notice of cancellation is mailed to the holder.

History: Laws 2001, ch. 206, § 12.

59A-58-13. Business name restrictions.

A. Except as otherwise provided in this section, a provider shall not include in the name of his business:

(1) the words "insurance", "casualty", "surety", "mutual" or any other word or term that implies that he is engaged in the business of transacting insurance or is a surety company; or

(2) a name that is deceptively similar to the name or description of an insurer or surety company or the name of another provider.

B. A provider may include the word "guaranty" or a similar word in the name of his business.

C. This section does not apply to a provider who, before January 1, 2002, includes in the name of his business a name that does not comply with the provisions of Subsection A of this section. Such a provider shall include in each service contract he issues, sells or offers for sale a statement that the service contract is not a contract of insurance.

History: Laws 2001, ch. 206, § 13.

59A-58-14. Prohibition of requiring purchase of service contract as a condition of loan approval or purchase of property.

No person may require the purchase of a service contract as a condition for the approval of a loan or the purchasing of property.

History: Laws 2001, ch. 206, § 14.

59A-58-15. Records requirements.

A. A provider shall maintain records of the transactions governed by the Service Contract Regulation Act. The records of a provider shall include:

(1) a copy of each type of service contract that the provider issues, sells or offers for sale;

(2) the name and address of each holder who possesses a service contract under which the provider has a duty to perform, to the extent that the provider knows the name and address of each holder;

(3) a list that includes each location where the provider issues, sells or offers for sale service contracts; and

(4) the date and a description of each claim made by a holder under a service contract.

B. Except as otherwise provided in this subsection, a provider shall retain all records relating to a service contract for at least one year after the contract has expired. A provider who intends to discontinue doing business in this state shall provide the superintendent with satisfactory proof that he has discharged his duties to the holders in this state and shall not destroy his records without the prior approval of the superintendent.

C. The records required to be maintained pursuant to this section may be stored on a computer disk or other storage device for a computer from which the records can be readily printed.

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

History: Laws 2001, ch. 206, § 15.

59A-58-16. Examinations and inspection of books by superintendent.

A. The superintendent may conduct examinations to enforce the provisions of the Service Contract Regulation Act pursuant to Chapter 59A, Article 4 NMSA 1978 at such times as he deems necessary.

B. A provider shall, upon the request of the superintendent, make available to the superintendent for inspection any accounts, books and records concerning any service contract issued, sold or offered for sale by the provider that are reasonably necessary to enable the superintendent to determine whether the provider is in compliance with the provisions of the Service Contract Regulation Act.

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

History: Laws 2001, ch. 206, § 16.

59A-58-17. Civil penalty for violation.

A person who violates any provision of the Service Contract Regulation Act or an order or rule of the superintendent issued or adopted pursuant thereto may be assessed a civil penalty by the superintendent of not more than five thousand dollars ($5,000) for each act or violation, not to exceed an aggregate amount of one hundred thousand

dollars ($100,000) for violations of a similar nature. For the purposes of this section, violations shall be deemed to be of a similar nature if the violations consist of the same or similar conduct, regardless of the number of times the conduct occurred.

History: Laws 2001, ch. 206, § 17.

59A-58-18. Rulemaking.

The superintendent may adopt rules necessary to carry out the provisions of the Service Contract Regulation Act.

History: Laws 2001, ch. 206, § 18.

ARTICLE 59
Prescription Drug Uniform Information Card

59A-59-1. Short title.

This act [59A-59-1 to 59A-59-4 NMSA 1978] may be cited as the "Prescription Drug Uniform Information Card Act".

History: Laws 2003, ch. 373, § 1.

59A-59-2. Intent of legislature.

It is the intent of the legislature to improve care for patients by enacting the Prescription Drug Uniform Information Card Act to minimize confusion, eliminate unnecessary paperwork, decrease administrative burdens and streamline dispensing of prescription products paid for by third party payors.

History: Laws 2003, ch. 373, § 2.

59A-59-3. Prescription drug information card required.

A. A health benefit plan that provides coverage for prescription drugs and that issues, uses or requires a card for prescription claims submission and adjudication, and third-party administrators for self-insured plans and state-administered plans, or the plan's agents or contractors that issue such cards, shall issue for the plan's insureds, enrollees or participants a uniform prescription drug information card that conforms to the standards of the national council for prescription drug programs' current implementation guide for such cards.

B. The uniform prescription drug information card required in Subsection A of this section shall include all of the national council for prescription drug programs' standard

information adopted by the current implementation guide or at a minimum contain the following labeled information:

(1) the card issuer name or logo on the front of the card;

(2) the cardholder's name and identification number, which shall be displayed on the front side of the card;

(3) complete information for electronic transaction claims routing, including:

(a) the international identification number labeled as RxBin;

(b) the processor control number labeled as RxPCN if required for proper routing of electronic claim transactions for prescription benefits; and

(c) the group number labeled as RxGrp if required for proper routing of electronic claim transactions for prescription benefits; and

(4) a telephone number that pharmacy providers may call for pharmacy benefit claims assistance.

C. All information required in Subsection B of this section shall be included in a clear, readable and understandable manner on the card issued by the plan, its administrators or its agents or contractors. The content and format of all information shall be in the current content and format required by the plan for electronic claims routing.

D. The uniform prescription drug information card required by this section shall be issued by a health benefit plan or by the plan's administrators, agents or contractors upon enrollment and reissued within a reasonable time upon any change in the information required under Subsection B or C of this section; provided, however, the plan, its administrators or its agents or contractors shall not be required to issue a new card more often than once in a calendar year; and further provided that nothing shall prevent the plan, its administrators or its agents or contractors from issuing stickers or other methodologies to the insureds, enrollees or participants to update the cards temporarily until the cards are reissued, or from reissuing updated new cards on a more frequent basis.

E. The uniform prescription drug information card required by the Prescription Drug Uniform Information Card Act may be used for any and all health insurance coverage. Nothing in this section requires any person issuing, using or requiring the card to issue, use or require a separate card for prescription coverage; provided that the card can accommodate the information necessary to process the claim as required in this section.

F. The superintendent of insurance shall adopt such rules as he deems necessary to implement and ensure full compliance with the provisions of the Prescription Drug Uniform Information Card Act. If rules are deemed necessary, they shall be prepared not later than six months after July 1, 2003.

G. As used in this section, "health benefit plan" means an accident and health insurance policy, plan or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement to the extent permitted by the employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not include any of the following types of insurance:

(1) accident;

(2) credit;

(3) disability income;

(4) specified disease;

(5) dental or vision;

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

(7) medical payments under automobile or homeowners;

(8) insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance; and

(9) hospital income or indemnity.

History: Laws 2003, ch. 373, § 3.

59A-59-4. Applicability.

A. All health benefit plans issued or renewed on or after July 1, 2003 shall comply with the Prescription Drug Uniform Information Card Act no later than two years after July 1, 2003. For purposes of that act, renewal of a health benefit policy, contract or plan is presumed to occur on each anniversary of the date on which coverage was first effective for the persons covered by the health benefit plan.

B. The Prescription Drug Uniform Information Card Act shall not apply to the medicaid fee-for-service prescription drug program.

History: Laws 2003, ch. 373, § 4.

ARTICLE 59A
Prescription Drug Price Transparency

59A-59A-1. Short title.

This act [59A-59A-1 to 59A-59A-8 NMSA 1978] may be cited as the "Prescription Drug Price Transparency Act".

History: Laws 2024, ch. 33, § 1.

59A-59A-2. Definitions.

As used in the Prescription Drug Price Transparency Act:

A. "authorized health insurer" means an entity holding a valid certificate of authority issued pursuant to the insurance laws of this state, including a health insurance company, health maintenance organization, hospital or health care services corporation, provider service network, nonprofit health care plan or any other entity that:

(1) contracts, offers to contract or enters into agreements to pay for or reimburse any costs of health care services; or

(2) provides, offers or administers health benefits plans or managed health care plans in this state;

B. "biosimilar product" means a prescription drug product that, in reference to a biological product that the federal food and drug administration has licensed:

(1) is highly similar to the single biological product against which the biosimilar product was evaluated in the biosimilar product's marketing application to the federal food and drug administration; and

(2) displays no clinically meaningful differences between the biosimilar product and the single biological product against which the biosimilar product was evaluated in the biosimilar product's marketing application to the federal food and drug administration in terms of the safety, purity and potency of the product;

C. "brand name drug" means a prescription drug that is marketed or distributed in accordance with:

(1) an original new drug application, except for a generic drug; or

(2) a biologics license application approved by the federal food and drug administration;

D. "confidential information" means information obtained by the superintendent pursuant to the Prescription Drug Price Transparency Act that has not become public information and that, if released prematurely or in non-aggregate or non-summary form, may provide unfair economic advantage or adversely affect the competitive position of any entity that reports to the superintendent pursuant to the Prescription Drug Price Transparency Act. "Confidential information" includes proprietary information and trade secrets;

E. "generic drug" means a prescription drug that is:

(1) marketed or distributed in accordance with an abbreviated new drug application approved by the federal food and drug administration;

(2) an authorized generic drug approved by the federal food and drug administration; or

(3) a prescription drug that entered the market before 1962 that was not originally marketed under a new drug application;

F. "manufacturer" means an entity licensed to manufacture or distribute prescription drugs pursuant to the Pharmacy Act [Chapter 61, Article 11 NMSA 1978] that:

(1) owns the patent to a prescription drug product;

(2) enters into a lease with another manufacturer to market and distribute a brand name drug under the entity's own name; or

(3) sets or changes the wholesale acquisition cost of a prescription drug product that the entity manufactures or markets;

G. "medicare part D specialty-tier cost threshold" means the cost threshold set by the federal centers for medicare and medicaid services to determine which prescription drugs are in the specialty tier of the prescription drug benefit plan provided under part D of Title 18 of the federal Social Security Act;

H. "pharmacy benefits manager" means an entity licensed as a pharmacy benefits manager pursuant to the Pharmacy Benefits Manager Regulation Act [Chapter 59A, Article 61 NMSA 1978];

I. "pharmacy services administrative organization" means an entity registered with the superintendent as a pharmacy services administrative organization pursuant to the Pharmacy Benefits Manager Regulation Act;

J. "prescription drug product" means any of the following products:

(1) a biologic product produced or distributed in accordance with a biologics license application approved by the federal food and drug administration;

(2) a biosimilar product;

(3) a brand name drug; or

(4) a generic drug;

K. "rebate" means a price concession paid by a manufacturer to a pharmacy benefits manager or authorized health insurer that is based on the:

(1) actual or estimated use of a prescription drug; or

(2) effectiveness of a prescription drug pursuant to the terms of a value-based or performance-based contract; and

L. "wholesale acquisition cost" means the manufacturer's list price for a prescription drug sold to wholesalers in the United States, not including discounts, rebates or reductions in price.

History: Laws 2024, ch. 33, § 2.

59A-59A-3. Prescription drug manufacturer price and price increase reporting requirements.

A. By May 1, 2025, and annually thereafter, each manufacturer shall submit data to the superintendent, in a form and manner prescribed by the superintendent, that includes the name and national drug code for each prescription drug product that has a wholesale acquisition cost of four hundred dollars ($400) or more for a thirty-day supply or for a course of treatment that is less than thirty days and is a:

(1) brand name drug that has increased in wholesale acquisition cost by ten percent or more in the previous calendar year;

(2) brand name drug that has increased in wholesale acquisition cost by sixteen percent or more over the course of the previous two calendar years; or

(3) generic drug or biosimilar product that has increased in wholesale acquisition cost by thirty percent or more in the previous calendar year.

B. For each prescription drug product that is reported to the superintendent, the manufacturer shall provide the following information that shall be verified, whenever possible, by the superintendent through the use of independent third-party resources:

(1) the introductory wholesale acquisition cost of the prescription drug product when the prescription drug product was approved for marketing by the federal food and drug administration;

(2) the annual increase in the prescription drug product's wholesale acquisition cost over the previous five calendar years;

(3) the direct costs associated with manufacturing, marketing and distributing the prescription drug product;

(4) the total revenue from the prescription drug product over the previous calendar year;

(5) the net profit attributable to the prescription drug product over the previous calendar year;

(6) the patent expiration date for the prescription drug product;

(7) the ten highest government-negotiated prices of the prescription drug product in European Union countries and the United Kingdom;

(8) any agreement between the manufacturer and another entity that involves a delay in marketing a generic version of the prescription drug product;

(9) the names and prices of any generic equivalents of the prescription drug product;

(10) the total amount of manufacturer-supported financial assistance provided to consumers of the prescription drug product; and

(11) other information requested by the superintendent.

C. When a new brand name drug is introduced in the United States and has a price that is higher than the medicare part D specialty-tier threshold, the manufacturer of the brand name drug shall report the name of the drug to the superintendent within three days of the brand name drug's introduction.

D. When a new generic drug or biosimilar product is introduced in the United States with a price that is higher than the medicare part D specialty-tier threshold and a price that is not at least fifteen percent lower than the price of the brand name drug or biological product that the generic drug or biosimilar product is based on, the manufacturer of the generic drug or biosimilar product shall report the name of the generic drug or biosimilar product to the superintendent within three days of the generic drug or biosimilar product's introduction.

E. A manufacturer of a prescription drug product that is increasing in price enough to meet the reporting requirements of Subsection A of this section shall notify the superintendent on the price increase in writing no later than the date that the price increase becomes effective. The notice shall include:

(1) the date of the price increase;

(2) the current wholesale acquisition cost of the prescription drug product;

(3) the dollar amount of any known future increase of the wholesale acquisition cost of the prescription drug product; and

(4) a statement regarding whether a change or improvement in the prescription drug product necessitates the price increase, and if so, the manufacturer shall describe the change or improvement.

F. Except for the superintendent's reporting requirements in Section 7 [59A-59A-7 NMSA 1978] of the Prescription Drug Price Transparency Act, the superintendent and a person acting on behalf of the superintendent, including staff and third-party contractors, shall keep confidential all of the information provided pursuant to this section, and the information shall not be subject to the requirements of the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. The superintendent shall include in every contract for services related to the Prescription Drug Price Transparency Act a requirement that contractors and subcontractors do not disclose confidential information to any persons other than the superintendent or a person acting on behalf of the superintendent.

History: Laws 2024, ch. 33, § 3.

59A-59A-4. Pharmacy services administrative organization reporting requirements.

A. By June 30, 2025, and annually thereafter, except as provided by Subsection B of this section, each pharmacy services administrative organization that represents a pharmacy or chain of pharmacies that do business in this state shall submit data to the superintendent, in a form and manner prescribed by the superintendent, that includes a list of the:

(1) negotiated reimbursement rate of the twenty-five prescription drug products with the highest reimbursement rate;

(2) twenty-five prescription drug products with the highest year-to-year percentage change in reimbursement rate;

(3) twenty-five prescription drug products with the highest year-to-year change in reimbursement rate based on the total dollar amount of change; and

(4) schedule of fees charged to pharmacies for the services provided by the pharmacy services administrative organization.

B. A pharmacy services administrative organization that solely generates revenue from charging flat service fees to pharmacies and does not charge pharmacies for services based on prescription drug product prices or volume shall be exempt from the reporting requirements of this section.

C. Except for the superintendent's reporting requirements in Section 7 [59A-59A-7 NMSA 1978] of the Prescription Drug Price Transparency Act, the superintendent and a person acting on behalf of the superintendent, including staff and third-party contractors, shall keep confidential all of the information provided pursuant to this section, and the information shall not be subject to the requirements of the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. The superintendent shall include in every contract for services related to the Prescription Drug Price Transparency Act a requirement that contractors and subcontractors do not disclose confidential information to any persons other than the superintendent or a person acting on behalf of the superintendent.

History: Laws 2024, ch. 33, § 4.

59A-59A-5. Authorized health insurer reporting requirements.

A. By May 1, 2025, and annually thereafter, each authorized health insurer shall submit data to the superintendent, in a form and manner prescribed by the superintendent, that includes:

(1) a list of the twenty-five most frequently prescribed prescription drug products;

(2) a list of the twenty-five most costly prescription drug products by total annual plan spending;

(3) a list of the twenty-five prescription drug products with the highest increase in total annual spending compared to the previous calendar year; and

(4) an evaluation on the effect that the cost of prescription drug products has on health care premiums.

B. Except for the superintendent's reporting requirements in Section 7 [59A-59A-7 NMSA 1978] of the Prescription Drug Price Transparency Act, the superintendent and a person acting on behalf of the superintendent, including staff and third-party contractors, shall keep confidential all of the information provided pursuant to this section, and the information shall not be subject to the requirements of the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. The superintendent shall include in every contract for services related to the Prescription Drug Price Transparency Act a

requirement that contractors and subcontractors do not disclose confidential information to any persons other than the superintendent or a person acting on behalf of the superintendent.

History: Laws 2024, ch. 33, § 5.

59A-59A-6. Pharmacy benefits manager reporting requirements.

A. By May 1, 2025, and annually thereafter, each pharmacy benefits manager shall provide data to the superintendent that includes the following information for the previous calendar year that is attributable to patient utilization of prescription drug products covered by authorized health insurers:

(1) the aggregate rebates and fees collected from manufacturers; and

(2) the aggregate dollar amount of rebates and fees collected from manufacturers that were:

(a) passed on to: 1) authorized health insurers; and 2) consumers at the point of sale of a prescription drug product; or

(b) retained by the pharmacy benefits manager.

B. A report submitted by a pharmacy benefits manager shall not disclose the identity of a specific authorized health insurer or consumer, the price charged for a specific prescription drug product or class of prescription drug products or the amount of any rebate or fee provided for a specific prescription drug product or class of prescription drug products.

C. Information provided to the superintendent pursuant to this section shall be kept confidential by the superintendent and any person acting on behalf of the superintendent, including staff and third-party contractors, and shall not be subject to the requirements of the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978], except to the extent that the information is used on an aggregate basis across all pharmacy benefits managers, in accordance with the superintendent's reporting requirements in Section 7 [59A-59A-7 NMSA 1978] of the Prescription Drug Price Transparency Act. The superintendent shall include in every contract for services related to the Prescription Drug Price Transparency Act a requirement that contractors and subcontractors do not disclose confidential information to any persons other than the superintendent or a person acting on behalf of the superintendent.

History: Laws 2024, ch. 33, § 6.

59A-59A-7. Superintendent of insurance legislative reports.

A. By December 31, 2025, and annually thereafter, the superintendent shall submit to the legislative finance committee and the legislative health and human services committee a report that includes:

(1) aggregate market trends for prescription drug products across the state and country;

(2) the impact of prescription drug product prices in the state, including the overall impact of prescription drug product costs on health care premiums;

(3) the geographic and demographic populations in the state most affected by high prescription drug product costs; and

(4) any recommendations the superintendent has on further action or legislation needed to make prescription drug products more affordable and reduce overall patient cost in the state.

B. By December 31, 2025, and annually thereafter, the superintendent shall aggregate the information collected from manufacturers, pharmacy services administrative organizations, authorized health insurers and pharmacy benefits managers and submit a report on the aggregate data to the legislative finance committee and the legislative health and human services committee. The superintendent shall hold an annual public meeting that is focused on discussing the contents of the report.

C. The superintendent shall make the reports required by this section available to the public on the superintendent's website.

D. The aggregate data included in the reports shall not disclose or tend to disclose proprietary or confidential information on any specific or individual manufacturer, pharmacy services administrative organization, authorized health insurer, pharmacy benefits manager or consumer.

History: Laws 2024, ch. 33, § 7.

59A-59A-8. Enforcement and penalties.

A. A manufacturer, pharmacy services administrative organization, authorized health insurer or pharmacy benefits manager may be subject to a penalty imposed by the superintendent in accordance with Section 59A-1-18 NMSA 1978 for:

(1) failing to submit information or data;

(2) failing to submit information or data on time; or

(3) providing inaccurate or incomplete information or data.

B. The superintendent may audit the data submitted to the superintendent by a manufacturer, pharmacy services administrative organization, authorized health insurer or pharmacy benefits manager in a form and manner specified by the superintendent. The entity that submitted the data shall pay all costs associated with the audit.

History: Laws 2024, ch. 33, § 8.

ARTICLE 60
Portable Electronics Insurance

59A-60-1. Short title.

Sections 4 through 10 [59A-60-1 to 59A-60-7 NMSA 1978] of this act may be cited as the "Portable Electronics Insurance Act".

History: Laws 2013, ch. 140, § 4.

59A-60-2. Definitions.

As used in the Portable Electronics Insurance Act:

A. "customer" means a person who purchases portable electronics or services;

B. "enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics;

C. "location" means any physical location in the state of New Mexico or any web site, call center site or similar location directed to residents of the state of New Mexico;

D. "portable electronics" means electronic devices that are portable in nature and their accessories;

E. "portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics that may provide coverage for portable electronics against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss. "Portable electronics insurance" also includes any agreement whereby a person or any legal entity, in exchange for consideration paid, agrees to provide for the future repair, replacement or provision of portable electronics. "Portable electronics insurance" does not include:

(1) a service contract governed by the Service Contract Regulation Act [Chapter 59A, Article 58 NMSA 1978];

(2) a policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

(3) a homeowner's, renter's, private passenger automobile, commercial multiperil or similar policy;

F. "portable electronics transaction" means:

(1) the sale or lease of portable electronics by a vendor to a customer; or

(2) the sale of a service related to the use of portable electronics by a vendor to a customer;

G. "superintendent" means the superintendent of insurance;

H. "supervising entity" means a business entity that is a licensed insurer or insurance producer that is appointed by an insurer to supervise the administration of a portable electronics insurance program; and

I. "vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

History: Laws 2013, ch. 140, § 5.

59A-60-3. Licensure of vendors.

A. A vendor is required to hold a limited agent's license pursuant to Section 59A-12-18 NMSA 1978 to sell or offer coverage under a policy of portable electronics insurance.

B. A limited agent's license issued to a vendor shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

C. The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the superintendent and with reasonable notice to the supervising entity, the registry shall be open to inspection and examination by the superintendent during regular business hours of the supervising entity.

D. Notwithstanding any other provision of law, a limited agent's license issued to a vendor shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted by the Portable Electronics Insurance Act.

History: Laws 2013, ch. 140, § 6.

59A-60-4. Requirements for sale of portable electronics insurance.

A. At every location where portable electronics insurance is offered to customers, brochures or other written materials shall be made available to a prospective customer that:

(1) disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of coverage;

(2) state that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(3) summarize the material terms of the insurance coverage, including:

(a) the identity of the insurer;

(b) the identity of the supervising entity;

(c) the amount of any applicable deductible and how it is to be paid;

(d) benefits of the coverage; and

(e) key terms and conditions of coverage, including whether portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment;

(4) summarize the process for filing a claim, including a description of how to return portable electronics, and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(5) state that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

B. The written materials required by this section shall not be subject to filing or approval requirements with the superintendent.

C. Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor for its enrolled customers.

D. Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

History: Laws 2013, ch. 140, § 7.

59A-60-5. Authority of vendors of portable electronics.

A. The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as insurance agents under any other provision of the Insurance Code, provided that:

(1) the vendor obtains a limited agent's license to authorize its employees or authorized representatives to sell or offer portable electronics insurance and complies with the provisions of the Portable Electronics Insurance Act;

(2) the insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the program, including development of a training program for employees and authorized representatives of the vendors. The training:

(a) shall be delivered to employees and authorized representatives of vendors who are directly engaged in the activity of selling or offering portable electronics insurance;

(b) may be provided in electronic form, provided that the supervising entity implements a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by licensed employees of the supervising entity; and

(c) shall provide to each employee and authorized representative of a vendor basic instruction about the portable electronics insurance offered to customers and the disclosures required by the Portable Electronics Insurance Act; and

(3) employees or authorized representatives of a vendor of portable electronics shall not advertise, represent or otherwise hold themselves out as nonlimited lines licensed insurance producers.

B. Notwithstanding any other provision of law, employees or authorized representatives of a vendor shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage but may receive compensation for activities under the limited agent's license that is incidental to their overall compensation.

C. The charges for portable electronics insurance coverage may be billed and collected by the vendor. Any charge to an enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously

disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account; provided that the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within sixty days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

History: Laws 2013, ch. 140, § 8.

59A-60-6. Penalties; suspension or revocation of license.

A person who violates any provision of the Portable Electronics Insurance Act may, after notice and hearing, be subject to:

A. fines not to exceed one thousand dollars ($1,000) per violation and not to exceed a total of ten thousand dollars ($10,000); or

B. as the superintendent deems necessary:

(1) suspension of the privilege of transacting portable electronics insurance at specific locations where violations have occurred; or

(2) suspension or revocation of the ability of individual employees or authorized representatives of a vendor to act under the license.

History: Laws 2013, ch. 140, § 9.

59A-60-7. Termination of portable electronics insurance.

Notwithstanding any other provision of law:

A. an insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty days' notice;

B. if the insurer changes the terms and conditions of a policy, the insurer shall provide the vendor with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure or other evidence indicating that a change in the terms and conditions has occurred and shall provide a summary of material changes;

C. notwithstanding the provisions of Subsection A of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance

policy upon fifteen days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder;

D. notwithstanding the provisions of Subsection A of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy without prior notice:

(1) for nonpayment of premium;

(2) if the enrolled customer ceases to have an active service with the vendor; or

(3) if an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer;

E. if a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty days prior to the termination;

F. if notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this section or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this subsection. If the notice or correspondence is mailed, it shall be sent to the vendor at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer. The insurer or vendor shall maintain proof of mailing in a form authorized or accepted by the United States postal service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor at the vendor's electronic mail address specified for such purpose and to its affected enrolled customers' last known electronic mail addresses as provided by each enrolled customer to the insurer or vendor. For purposes of this subsection, an enrolled customer's provision of an electronic mail address to the insurer or vendor shall be deemed consent to receive notices and correspondence by electronic means. The insurer or vendor shall maintain proof that the notice or correspondence was sent; and

G. notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor by the supervising entity.

History: Laws 2013, ch. 140, § 10.

ARTICLE 61
Pharmacy Benefits Manager Regulation

59A-61-1. Short title.

Chapter 59A, Article 61 NMSA 1978 may be cited as the "Pharmacy Benefits Manager Regulation Act".

History: Laws 2014, ch. 14, § 1; 2017, ch. 16, § 1.

59A-61-2. Definitions.

As used in the Pharmacy Benefits Manager Regulation Act:

A. "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug;

B. "maximum allowable cost list" means a searchable, electronic and internet-based listing of drugs used by a pharmacy benefits manager setting the maximum allowable cost on which reimbursement to a pharmacy or pharmacist is made;

C. "obsolete" means a product that is listed in national drug pricing compendia but is no longer available to be dispensed based on the expiration date of the last lot manufactured;

D. "pharmacist" means an individual licensed as a pharmacist by the board of pharmacy;

E. "pharmacy" means a licensed place of business where drugs are compounded or dispensed and pharmacist services are provided;

F. "pharmacy benefits management" means a service provided to or conducted by a health plan as defined in Section 59A-16-21.1 NMSA 1978 or health insurer that involves:

(1) prescription drug claim administration;

(2) pharmacy network management;

(3) negotiation and administration of prescription drug discounts, rebates and other benefits;

(4) design, administration or management of prescription drug benefits;

(5) formulary management;

(6) payment of claims to pharmacies for dispensing prescription drugs;

(7) negotiation or administration of contracts relating to pharmacy operations or prescription benefits; or

(8) any other service determined by the superintendent as specified by rule to be a pharmacy benefits management activity;

G. "pharmacy benefits manager" means an entity that provides pharmacy benefits management services;

H. "pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by or is under common ownership or control with a pharmacy benefits manager;

I. "pharmacy services administrative organization" means an entity that contracts with a pharmacy or pharmacist to act as the pharmacy or pharmacist's agent with respect to matters involving a pharmacy benefits manager or third-party payor, including negotiating, executing or administering contracts with the pharmacy benefits manager or third-party payor; and

J. "superintendent" means the superintendent of insurance.

History: Laws 2014, ch. 14, § 2; 2019, ch. 269, § 1.

59A-61-3. Licensure; initial application; annual renewal required; revocation.

A. A person shall not operate as a pharmacy benefits manager unless licensed by the superintendent in accordance with the Pharmacy Benefits Manager Regulation Act and applicable federal and state laws. A licensee shall renew the licensee's pharmacy benefits manager license annually.

B. An initial application and a renewal application for licensure as a pharmacy benefits manager shall be made on a form and in a manner provided for by the superintendent, but at a minimum shall require:

(1) the identity of the pharmacy benefits manager;

(2) the name and business address of the contact person for the pharmacy benefits manager;

(3) where applicable, the federal employer identification number for the pharmacy benefits manager; and

(4) any other information specified in rules promulgated by the superintendent.

C. The superintendent shall enforce and promulgate rules to implement the provisions of the Pharmacy Benefits Manager Regulation Act and may suspend or revoke a license issued to a pharmacy benefits manager or deny an application for a license or renewal of a license if:

(1) the pharmacy benefits manager is operating in contravention of its application;

(2) the pharmacy benefits manager has failed to continuously meet or comply with the requirements for issuance or maintenance of a license; or

(3) the pharmacy benefits manager has failed to comply with applicable state or federal laws or rules.

D. If the license of a pharmacy benefits manager is revoked, the manager shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs, notify each pharmacy in its network and conduct no further pharmacy benefits management services in the state, except as may be essential to the orderly conclusion of its affairs. The superintendent may permit further operation of the pharmacy benefits manager if the superintendent finds it to be in the best interest of patients.

E. A person whose pharmacy benefits manager license has been denied, suspended or revoked may seek review of the denial, suspension or revocation pursuant to the provisions of Chapter 59A, Article 4 NMSA 1978.

F. Nothing in the Pharmacy Benefits Manager Regulation Act shall be construed to authorize a pharmacy benefits manager to transact the business of insurance.

History: Laws 2014, ch. 14, § 3; 2019, ch. 269, § 2.

59A-61-4. Pharmacy reimbursement practices for generic drugs; appeals process required.

A. A pharmacy benefits manager shall determine a reimbursement amount for a generic drug based on objective and verifiable sources.

B. A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service.

C. A pharmacy benefits manager using maximum allowable cost pricing may place a drug on a maximum allowable cost list if the drug:

(1) is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book", or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference;

(2) is available for purchase by pharmacies in the state at the time of claim submission from national or regional wholesalers and is not obsolete; and

(3) is a drug with not fewer than two "A" or "B" rated therapeutically equivalent drugs in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book".

D. A pharmacy benefits manager using maximum allowable cost pricing shall:

(1) upon a network pharmacy's request, provide that network pharmacy with the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(2) review and update maximum allowable cost price information at least once every seven business days to reflect any modification of maximum allowable cost pricing;

(3) establish and maintain a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in at least seven business days to remain consistent with pricing changes and product availability in the marketplace;

(4) provide a procedure that allows a pharmacy to choose the entity to which it will appeal reimbursement for generic drugs. A pharmacy may appeal:

(a) directly to the pharmacy benefits manager; or

(b) through a pharmacy services administrative organization;

(5) provide an appeals process that, at a minimum, includes the following:

(a) a dedicated telephone number and electronic mail address or website for the purpose of submitting appeals;

(b) the ability to submit an appeal directly to the pharmacy benefits manager; and

(c) the allowance of at least twenty-one business days to file an appeal after the date a pharmacy receives notice of the reimbursement amount;

(6) grant an appeal if the pharmacy benefits manager fails to respond to a complete submission as defined by rules promulgated by the superintendent of the appealing party in writing within fourteen business days after the pharmacy benefits manager receives the appeal;

(7) if an appeal is granted, notify the challenging pharmacy and its pharmacy services administrative organization, if any, that the appeal is granted and make the change in the maximum allowable cost effective for the appealing pharmacy and for each other pharmacy in its network and permit the appealing pharmacy to reverse and bill again the claim or claims that formed the basis of the appeal;

(8) when an appeal is denied, provide the challenging pharmacy and its pharmacy services administrative organization, if any, the national drug code number and supplier that has the product available for purchase in New Mexico at or below the maximum allowable cost;

(9) within one business day of granting or denying a network pharmacy's appeal, notify all network pharmacies of the decision;

(10) upon granting an appeal, allow other similarly situated network pharmacies to reverse and bill again for like claims that formed the basis of the granted appeal; and

(11) provide for each of its network pharmacy providers and the superintendent a process and mechanism to readily access the maximum allowable cost list specific to that provider.

E. A maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefits manager is confidential.

F. Pursuant to Section 59A-4-3 NMSA 1978, a pharmacy benefits manager shall provide information contained in a maximum allowable cost list to the superintendent upon request by the superintendent.

History: Laws 2014, ch. 14, § 4; 2019, ch. 269, § 3.

59A-61-5. Pharmacy benefits manager contracts; certain practices prohibited; certain disclosures required upon request.

A. A pharmacy benefits manager shall not require that a pharmacy participate in one contract in order to participate in another contract.

B. A pharmacy benefits manager shall provide to a pharmacy by electronic mail, facsimile or certified mail, at least thirty calendar days prior to its execution, a contract written in plain English.

C. A contract between a pharmacy benefits manager and a pharmacy shall identify the industry standard reimbursement practice that the pharmacy benefits manager will use to determine a reimbursement amount, unless the contract is modified in writing to specify another industry standard practice.

D. The provisions of the Pharmacy Benefits Manager Regulation Act shall not be waived, voided or nullified by contract.

E. A pharmacy benefits manager shall not:

(1) cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;

(2) require pharmacy validation and revalidation standards inconsistent with, more stringent than or in addition to federal and state requirements for licensure and operation as a pharmacy in this state;

(3) prohibit a pharmacy or pharmacist from:

(a) mailing or delivering drugs to a patient as an ancillary service;

(b) providing a patient information regarding the patient's total cost for pharmacist services for a prescription drug; or

(c) discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available;

(4) require or prefer a generic drug over its generic therapeutic equivalent;

(5) prohibit, restrict or limit disclosure of information by a pharmacist or pharmacy to the superintendent; or

(6) prohibit, restrict or limit pharmacies or pharmacists from providing to state or federal government officials general information for public policy purposes.

F. A pharmacy benefits manager or health benefit plan shall not impose a fee on a pharmacy for scores or metrics or both scores and metrics. Nothing in this subsection prohibits a pharmacy benefits manager or health benefit plan from offering incentives to a pharmacy based on a score or metric; provided that the incentive is equally available to all in-network pharmacies.

G. Within seven business days of a request by the superintendent or a contracted pharmacy or pharmacist, a pharmacy benefits manager or pharmacy services administrative organization shall provide as appropriate:

(1) a contract;

(2) an agreement;

(3) a claim appeal document;

(4) a disputed claim transaction document or price list; or

(5) any other information specified by law.

H. In a time and manner required by rules promulgated by the superintendent, a pharmacy benefits manager shall issue to the superintendent a network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility to insureds statewide.

I. Pursuant to the provisions of Section 59A-4-3 NMSA 1978, the superintendent, or the superintendent's designee, may examine the books, documents, policies, procedures and records of a pharmacy benefits manager to determine compliance with applicable law. The pharmacy benefits manager shall pay the costs of the examination. At the request of a person who provides information in response to a complaint, investigation or examination, the superintendent may deem the information confidential.

History: Laws 2014, ch. 14, § 5; 2019, ch. 269, § 4.

59A-61-6. Audit; pharmacy benefits manager.

A pharmacy benefits manager licensed pursuant to the Pharmacy Benefits Manager Regulation Act shall be subject to Section 61-11-18.2 NMSA 1978. A pharmacy benefits manager shall not reduce or eliminate payment on an adjudicated claim except as permitted by Section 61-11-18.2 NMSA 1978.

History: Laws 2014, ch. 14, § 6; 2019, ch. 269, § 5.

59A-61-7. Pharmacy benefits managers; prohibited pharmacy fees.

A. A pharmacy benefits manager shall not charge a pharmacy a fee related to the adjudication of a claim, including:

(1) the receipt and processing of a pharmacy claim;

(2) the development or management of a claim processing or adjudication network; or

(3) participation in a claim processing or claim adjudication network.

B. A pharmacy benefits manager shall not charge a pharmacy a fee for a service unless the fee for service is itemized in the pharmacy benefits management contract.

History: Laws 2017, ch. 16, § 2; 2019, ch. 269, § 6.

59A-61-8. Registration of pharmacy services administrative organizations required.

A pharmacy services administrative organization shall register with the superintendent on a form and in a time frame and method of submission specified by the superintendent.

History: Laws 2019, ch. 269, § 7.

59A-61-9. Prohibition on discrimination against a covered entity.

A. As used in this section:

(1) "340B drug" means a drug that is purchased at a discount in accordance with the 340B program requirements;

(2) "340B program" means the federal drug pricing program created pursuant to 42 U.S.C. Section 256b;

(3) "covered entity" means an entity participating in the 340B program; and

(4) "pharmacy benefits manager" means an entity that provides pharmacy benefits management services.

B. A pharmacy benefits manager or a third party shall not discriminate against a covered entity on the basis of its participation in the 340B program by:

(1) reimbursing a covered entity for a 340B drug at a rate lower than that paid for the same drug to pharmacies, similar in prescription volume, that are non-covered entities;

(2) assessing a fee, chargeback or other adjustment to the covered entity that is not assessed to non-covered entities;

(3) imposing a provision that prevents or interferes with a person's choice to receive 340B drugs from a covered entity; or

(4) imposing terms or conditions that differ from terms or conditions imposed on a non-covered entity, including:

(a) restricting or requiring participation in a pharmacy network;

(b) requiring more frequent auditing or a broader scope of audit for inventory management systems using generally accepted accounting principles;

(c) requiring a covered entity to reverse, resubmit or clarify a claim after the initial adjudication, unless these actions are in the normal course of pharmacy business and not related to the 340B program; or

(d) charging an additional fee or provision that prevents or interferes with an individual's choice to receive a 340B drug from a covered entity.

History: Laws 2023, ch. 206, § 7.

ARTICLE 62
Self-Service Storage Insurance License

59A-62-1. Short title.

Sections 1 through 11 [59A-62-1 to 59A-62-11 NMSA 1978] of this act may be cited as the "Self-Service Storage Insurance License Act".

History: Laws 2019, ch. 219, § 1.

59A-62-2. Definitions.

As used in the Self-Service Storage Insurance License Act:

A. "occupant" means a person who is entitled to the use of storage space at a self-service storage facility, to the exclusion of others, under terms of a rental agreement, including a sublessee, successor or assignee;

B. "owner" means the owner, operator, franchisee, lessor or sublessor of a self-service storage facility, agent or any person authorized to manage the facility or to receive rent from an occupant under a rental agreement;

C. "personal property" means movable property not affixed to land, and includes goods, merchandise and household items;

D. "rental agreement" means any written agreement or lease between the owner and the occupant that establishes or modifies the terms, conditions or rules or any other provisions concerning the use and occupancy of storage space at a self-service storage facility;

E. "self-service storage facility" means any real property designed and used in the business of providing leased or rented storage space to occupants who have access to such facility for the purpose of storing and removing personal property;

F. "self-service storage insurance" means personal or commercial property insurance offered to an occupant in connection with and incidental to the rental of storage space at a self-service storage facility and that provides coverage for the loss of or damage to the occupant's personal property that occurs at the self-service storage facility or when such property is in transit to or from the facility during the period of the rental agreement;

G. "self-service storage insurance producer" means a business entity licensed only to offer insurance in connection with, and incidental to, rental agreements on behalf of an insurer authorized to write self-service storage insurance; and

H. "supervising entity" means an insurer issuing self-service storage insurance or a licensed insurance producer licensed pursuant to Article 11 of the Insurance Code that is authorized by an insurer to supervise the administration of a self-service storage insurance program.

History: Laws 2019, ch. 219, § 2.

59A-62-3. Self-service storage insurance producer license.

A. The superintendent may issue a self-service storage insurance producer license to an applicant who is qualified to solicit or sell self-service storage insurance.

B. An owner shall not sell, solicit or offer self-service storage insurance unless the owner has complied with the requirements of the Self-Service Storage Insurance License Act and has been issued a self-service storage insurance producer license by the superintendent.

C. A self-service storage insurance producer license authorizes the licensee and its employees and authorized representatives to sell, solicit and offer self-service storage insurance to occupants at any self-service storage facility at which the owner conducts business.

D. Self-service storage insurance producers shall be licensed pursuant to Article 11 of the Insurance Code.

E. An owner is not required to be licensed as a self-service storage insurance producer solely to display and make available to occupants and prospective occupants brochures and other promotional materials created by or on behalf of an insurer, if the owner and its unlicensed employees and authorized representatives do not sell, solicit or offer self-service storage insurance.

F. A licensee pursuant to this section may provide self-service storage insurance under an individual policy or under a commercial, corporate, group or master policy.

G. An owner shall not:

(1) require an occupant to purchase insurance offered by the owner as a requirement to lease storage space at a self-service storage facility; or

(2) advertise, represent or otherwise hold the owner's self out as a self-service storage insurance producer unless licensed pursuant to the Self-Service Storage Insurance License Act.

History: Laws 2019, ch. 219, § 3.

59A-62-4. Registry of authorized locations.

A. Before offering self-service storage insurance at a location, a self-service storage insurance producer shall provide the superintendent with a complete list of each location where the self-service storage insurance producer will offer self-service storage insurance. The supervising entity shall maintain a registry of each location at which a self-service storage insurance producer is authorized to sell, solicit or offer self-service storage insurance in this state.

B. The registry shall be made available for inspection by the superintendent upon reasonable request.

C. A self-service storage insurance producer shall notify the superintendent within thirty days after:

(1) engaging in the sale or solicitation of self-service storage insurance at any additional location in the state; or

(2) ceasing to sell, solicit or offer self-service storage insurance.

History: Laws 2019, ch. 219, § 4.

59A-62-5. Disclosure of terms.

A. A self-service storage insurance producer shall not sell, solicit or offer self-service storage insurance to occupants at any location unless the licensee makes available a brochure or other written or electronic material that:

(1) discloses that self-service storage insurance may provide a duplication of coverage already provided by an occupant's homeowner's insurance policy, renter's insurance policy, vehicle insurance policy, watercraft insurance policy or other property insurance coverage;

(2) states that the purchase by the occupant of the self-service storage insurance offered by the owner is not required in order to lease storage space at the self-service storage facility;

(3) provides the actual terms of the self-service storage insurance coverage or summarizes the material terms of the self-service storage insurance coverage, including:

(a) the identity of the insurer;

(b) the price of coverage and how payment shall be made;

(c) the identity of the supervising entity;

(d) deductibles, exclusions and conditions;

(e) benefits of the coverage; and

(f) key terms and conditions of coverage;

(4) summarizes the process for filing a claim; and

(5) states that an occupant that purchases self-service storage insurance may cancel the insurance at any time by notifying the insurer or the supervising entity in writing and shall receive a refund of any unearned premium within twenty days of cancellation.

B. The written or electronic material required pursuant to this section shall be submitted to the superintendent for approval upon request.

History: Laws 2019, ch. 219, § 5.

59A-62-6. Authorized employees and representatives.

A. At the time of filing a self-service storage insurance producer license application, the applicant shall establish a list of the names of all employees and authorized representatives whose duties may include offering and selling self-service storage insurance. The list shall be:

(1) maintained by the licensee in a form prescribed by the superintendent;

(2) updated annually; and

(3) retained by the self-service storage facility for three years and made available to the superintendent for review and inspection upon request.

B. An employee or authorized representative of a self-service storage insurance producer who is at least eighteen years of age and has been trained pursuant to Section 8 [59A-62-8 NMSA 1978] of the Self-Service Storage Insurance Act may act on behalf and under the supervision of the self-service storage insurance producer in matters relating to the conduct of business under that producer's license.

C. An employee or authorized representative of a self-service storage insurance producer may sell, solicit and offer self-service storage insurance to occupants and shall not be subject to licensure as an insurance producer.

History: Laws 2019, ch. 219, § 6.

59A-62-7. Commissions.

A self-service storage insurance producer shall not compensate an employee or authorized representative based primarily on the number of occupants that purchase self-service storage insurance from the self-service storage insurance producer unless that compensation is incidental to the employee's or authorized representative's overall compensation.

History: Laws 2019, ch. 219, § 7.

59A-62-8. Required training programs.

A. The supervising entity shall supervise the administration of the self-service storage insurance program, including development of a training program approved by the superintendent for employees and authorized representatives of the self-service storage insurance producer.

B. The training program shall be provided to an employee or authorized representative of a self-service storage insurance producer prior to that person engaging in the activity of selling, soliciting or offering self-service storage insurance.

C. The training shall inform employees and authorized representatives:

(1) that employees and authorized representatives of an owner are prohibited from advertising, representing or otherwise holding themselves out as insurance producers;

(2) about ethical sales practices; and

(3) about the self-service storage insurance offered to occupants and regarding the disclosures required pursuant to the Self-Service Storage Insurance License Act.

D. The training materials used by or on behalf of the self-service storage facility to train employees and authorized representatives shall be submitted to the superintendent at the time the owner applies for a self-service storage insurance producer license and whenever modified. Any changes to those training materials shall be submitted to the superintendent prior to their use by the licensee and in a form prescribed by the superintendent.

E. Training materials and changes to those materials that are submitted to the superintendent in accordance with this section shall be deemed approved for use by the supervising entity unless the superintendent notifies the supervising entity otherwise.

F. Failure by a self-service storage facility to submit training materials or changes for the superintendent's review, or use of disapproved training materials, shall constitute grounds for the denial of an application for license, nonrenewal of a license or a suspension of a license.

History: Laws 2019, ch. 219, § 8.

59A-62-9. Collection of fees.

A. Charges for self-service storage insurance coverage may be billed and collected by a self-service storage insurance producer.

B. A charge to an occupant for coverage that is not included in the cost associated with the rental of storage space shall be separately itemized on the occupant's bill.

C. If self-service storage insurance coverage is included with the rental of storage space, the self-service storage insurance producer shall clearly and conspicuously disclose to the occupant in the rental invoice or otherwise that the self-service storage insurance coverage is included with charges for the rental of storage space.

D. An occupant that purchases self-service storage insurance may cancel the insurance at any time by notifying the insurer or the supervising entity in writing and shall receive a refund of any unearned premium within twenty days of cancellation.

History: Laws 2019, ch. 219, § 9.

59A-62-10. Fiduciary funds.

A. Self-service storage insurance producers billing and collecting charges shall comply with the fiduciary requirements set forth in Section 59A-12-22 NMSA 1978, except that, pursuant to Paragraph (1) of Subsection B of Section 59A-12-22 NMSA 1978, the self-service storage insurance producer may remit received premiums, less applicable commissions, if any, and return premiums to the insurer or supervising entity within a time established by contract with the insurer or supervising entity, not to exceed sixty days after such receipt.

B. All money received by a self-service storage insurance producer or its employees or authorized representatives from an occupant for the sale of self-service storage insurance shall be held by the self-service storage insurance producer in a fiduciary capacity for the benefit of the insurer. A self-service storage insurance producer may receive compensation for billing and collection services, as established by contract with the insurer or supervising entity.

History: Laws 2019, ch. 219, § 10.

59A-62-11. Penalties.

After notice and hearing by the superintendent, the superintendent may impose by administrative penalty upon a person who violates a provision of the Self-Service Storage Insurance License Act the following:

A. a fine not to exceed one thousand dollars ($1,000) per violation and not to exceed a total of ten thousand dollars ($10,000);

B. suspension of transacting self-service storage insurance at specific locations where violations have occurred;

C. suspension or revocation of the rights of individual employees or authorized representatives of a self-service storage insurance producer to act under the license; or

D. suspension or revocation of the self-service storage insurance producer's or supervising entity's license to transact insurance in this state.

History: Laws 2019, ch. 219, § 11.

ARTICLE 63
Health Care Consolidation Oversight

59A-63-1. Short title. (Repealed effective July 1, 2025.)

This act [59A-63-1 to 59A-63-8 NMSA 1978] may be cited as the "Health Care Consolidation Oversight Act".

History: Laws 2024, ch. 40, § 1.

59A-63-2. Definitions. (Repealed effective July 1, 2025.)

As used in the Health Care Consolidation Oversight Act:

A. "acquisition" means an agreement or activity the consummation of which results in a person acquiring, directly or indirectly, the control of a hospital in New Mexico and

includes the acquisition of voting securities, membership interests, equity interests or assets;

B. "affiliation" means a business arrangement in which one person directly or indirectly is controlled by, is under common control with or controls another person;

C. "authority" means the health care authority department;

D. "control" means the power to direct or cause the direction of the management and policies of a hospital, whether directly or indirectly, including through the ownership of voting securities, through licensing or franchise agreements or by contract other than a commercial contract for goods or nonmanagement services, unless the power is the result of an official position with or corporate office held by an individual;

E. "essential services" means health care services covered by the state medicaid program, health care services that are required to be included in health plans pursuant to state or federal law and health care services that are required to be included in qualified health plans offered through the New Mexico health insurance exchange;

F. "health care provider" means a person qualified or licensed under state law to perform or provide health care services;

G. "health insurer" means a person required to be licensed or subject to the Insurance Code in connection with the business of health insurance or health care;

H. "hospital" means a hospital licensed by the department of health or its successor health facility licensing agency, but "hospital" does not include a state university teaching hospital or a state-owned special hospital;

I. "management services organization" means a person that provides all or substantially all of the administrative or management services under contract with a hospital, including administering contracts with health plans, third-party administrators and pharmacy benefit managers, on behalf of the hospital;

J. "office" means the office of superintendent of insurance;

K. "party" means a person taking part in a transaction subject to the Health Care Consolidation Oversight Act;

L. "person" means an individual, association, organization, partnership, firm, syndicate, trust, corporation or other legal entity;

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

N. "transaction" means any of the following:

(1) a merger of a hospital in New Mexico with another hospital;

(2) an acquisition of one or more hospitals in New Mexico;

(3) any affiliation or contract or other agreement that results in a change of control of a hospital in New Mexico, including with a management services organization or health insurer;

(4) a formation of a new corporation, partnership, joint venture, trust, parent organization or management services organization that results in a change of control of an existing hospital in New Mexico; and

(5) a sale, purchase, lease, new affiliation or any agreement that results in control of a hospital in New Mexico.

History: Laws 2024, ch. 40, § 2.

59A-63-3. Applicability; provisions additional; control presumptions. (Repealed effective July 1, 2025.)

A. The oversight power of the office pursuant to the Health Care Consolidation Oversight Act applies to proposed transactions that involve a New Mexico hospital.

B. Being subject to the Health Care Consolidation Oversight Act does not preclude or negate any person regulated pursuant to the Insurance Holding Company Law.

C. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds fifteen percent or more of the power to vote or holds proxies representing fifteen percent or more of the voting securities of any other person. The presumption may be rebutted by a showing in the manner provided by Section 59A-37-19 NMSA 1978 that control does not in fact exist.

History: Laws 2024, ch. 40, § 3.

59A-63-4. Confidentiality. (Repealed effective July 1, 2025.)

All documents, materials or other information in the possession or control of the office that are obtained by or disclosed to the office or the authority in the course of a review under the Health Care Consolidation Oversight Act are confidential.

History: Laws 2024, ch. 40, § 4.

59A-63-5. Timing of review of notice and tolling. (Repealed effective July 1, 2025.)

A. A notice of a proposed transaction shall be deemed complete by the office on the date when all the information required by the Health Care Consolidation Oversight Act or requested by the office is submitted by all the parties to the transaction, as applicable.

B. Should the scope of the proposed transaction be significantly modified from that outlined in the initial notice, the time periods set out in the Health Care Consolidation Oversight Act shall be restarted by the office.

C. The time periods shall be tolled during any time in which the office has requested and is awaiting further information from the parties to a transaction necessary to complete its review.

History: Laws 2024, ch. 40, § 5.

59A-63-6. Notice of proposed transaction; general provisions; requirements; consultations; experts; payment of costs. (Repealed effective July 1, 2025.)

A. At least one person that is a party to a proposed transaction shall submit to the office a written notice of the proposed transaction in the form and manner prescribed by the office. The parties shall pay the reasonable costs and expenses incurred by the office in the performance of the office's or authority's duties pursuant to the Health Care Consolidation Oversight Act for costs associated with the office's contracts with experts, unless determined otherwise by the superintendent. The office shall notify parties before any costs are incurred when a transaction review requires the use of outside experts, including the estimated cost of their services.

B. Upon receipt of a complete notice of a proposed transaction, the office shall determine if the transaction is urgently necessary to maintain the solvency of a hospital or if there is an emergency that threatens the continued provision of immediate health care services. In such circumstances, the office may agree to an immediate approval of a transaction with or without conditions.

C. Entry into a binding agreement before a transaction is effectuated is not a violation of the Health Care Consolidation Oversight Act if the transaction remains subject to regulatory review and approval.

D. If a party to the proposed transaction is a health insurer, the notice shall be submitted as an addendum to any filing required by Sections 59A-37-4 through 59A-37-10 NMSA 1978.

E. The notice of the proposed transaction shall include:

(1) a list of the parties, the terms of the proposed transaction and copies of all transaction agreements between any of the parties;

(2) a statement describing the goals of the proposed transaction and whether and how the proposed transaction affects health care services in New Mexico;

(3) the geographic service area of any hospital affected by the proposed transaction;

(4) a description of the groups or individuals likely to be affected by the transaction; and

(5) a summary of the health care services currently provided by any of the parties and any health care services that will be added, reduced or eliminated, including an explanation of why any services will be reduced or eliminated in the service area in which they are currently provided.

F. The office shall consult with the authority about the potential effect of the proposed transaction and incorporate the authority's recommendations into the office's final determination.

G. The office may retain actuaries, accountants, attorneys or other professionals who are qualified and have expertise in the type of transaction under review as necessary to assist the office in conducting its review of the proposed transaction.

H. The parties shall not effectuate a transaction without the written approval of the superintendent. The submitting party shall notify the office in a form and manner prescribed by the office when the transaction has been effectuated.

I. Parties to a proposed transaction may request a pre-notice conference to determine if they are required to file a notice or to discuss the potential extent of the review.

History: Laws 2024, ch. 40, § 6.

59A-63-7. Review of proposed transaction. (Repealed effective July 1, 2025.)

A. Within one hundred twenty days of receiving a complete notice of a proposed transaction, the office shall complete a review, confer with the authority and either:

(1) approve the proposed transaction;

(2) approve the proposed transaction with conditions; or

(3) disapprove the proposed transaction.

B. The superintendent shall notify the submitting party in writing of the office's determination and the reasons for the determination.

C. The review period may be extended if the parties agree to an extension.

D. In conducting a review of a proposed transaction, the office may consider the likely effect in New Mexico of the proposed transaction on:

(1) the potential reduction or elimination in access to essential services;

(2) the availability, accessibility and quality of health care services to any community affected by the transaction;

(3) the health care market share of a party and whether the transaction may foreclose competitors of a party from a segment of the market or otherwise increase barriers to entry in a health care market;

(4) changes in practice restrictions for licensed health care providers who work at the hospital;

(5) patient costs, including premiums and out-of-pocket costs;

(6) health care provider networks; and

(7) the potential for the proposed transaction to affect health outcomes for New Mexico residents.

E. The office shall approve the proposed transaction after the comprehensive review if the office determines that:

(1) the parties to the proposed transaction have demonstrated that the transaction will benefit the public by:

(a) reducing the growth in patient costs, including premiums and out-of-pocket costs; or

(b) maintaining or increasing access to services, especially in medically underserved areas;

(2) the proposed transaction will improve health outcomes for New Mexico residents; and

(3) there is no substantial likelihood of:

(a) a significant reduction in the availability, accessibility, affordability or quality of care for patients and consumers of health care services; or

(b) anti-competitive effects from the proposed transaction that outweigh the benefits of the transaction.

History: Laws 2024, ch. 40, § 7.

59A-63-8. Post-transaction oversight.

A. The person that acquired control over the hospital through an approved or conditionally approved transaction shall submit reports to the office and the authority in the form and manner prescribed by the office annually for three years after approval or conditional approval.

B. Reports shall:

(1) describe compliance with conditions placed on the transaction, if any;

(2) describe the growth, decline and other changes in services provided by the person; and

(3) provide analyses of cost trends and cost growth trends of the hospital.

History: Laws 2024, ch. 40, § 8.