AN ACT

RELATING TO INSURANCE; IMPLEMENTING A CONSTITUTIONAL MANDATE TO TRANSFER INSURANCE REGULATORY POWER AWAY FROM THE PUBLIC REGULATION COMMISSION; PROVIDING FOR THE OFFICE OF SUPERINTENDENT OF INSURANCE; CREATING THE POSITION OF SUPERINTENDENT OF INSURANCE; CREATING THE INSURANCE NOMINATING COMMITTEE; ADDRESSING APPEALS FROM DECISIONS OF THE SUPERINTENDENT OF INSURANCE; AMENDING, REPEALING AND ENACTING SECTIONS OF THE NMSA 1978; PROVIDING A TEMPORARY PROVISION TRANSFERRING FUNCTIONS, PERSONNEL, APPROPRIATIONS, PROPERTY, RECORDS, CONTRACTS AND REFERENCES IN LAW; PROVIDING A TEMPORARY PROVISION ADDRESSING THE INITIAL INSURANCE NOMINATING COMMITTEE; DECLARING AN EMERGENCY.

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

SECTION 1. Section 8-8-5 NMSA 1978 (being Laws 1998, Chapter 108, Section 5, as amended) is amended to read:

"8-8-5. CHIEF OF STAFF--DIVISION DIRECTORS--OTHER STAFF.--

A. The commission shall appoint a "chief of staff" who is responsible for the day-to-day operations of the commission staff under the general direction of the commission. The chief of staff shall serve at the pleasure of the commission.

B. With the consent of the commission, the chief

of staff shall appoint division directors. Appointments shall be made without reference to party affiliation and solely on the ground of fitness to perform the duties of their offices.

C. Each director, with the consent of the chief of staff, shall employ such professional, technical and support staff as necessary to carry out the duties of the director's division. Employees shall be hired solely on the ground of their fitness to perform the job for which they are hired. Division staff are subject to the provisions of the Personnel Act."

SECTION 2. Section 8-8-6 NMSA 1978 (being Laws 1998, Chapter 108, Section 6, as amended) is amended to read:

"8-8-6. COMMISSION--DIVISIONS.--The commission shall include the following organizational units:

A. the administrative services division;

B. the consumer relations division;

C. the legal division;

D. the transportation division;

E. the utility division; and

F. the fire marshal division."

SECTION 3. Section 8-8-14 NMSA 1978 (being Laws 1998, Chapter 108, Section 14, as amended) is amended to read:

"8-8-14. HEARING EXAMINERS.--

A. The commission may appoint a commissioner or a hearing examiner to preside over any matter before the

commission, including rulemakings, adjudicatory hearings and administrative matters.

B. A hearing examiner shall provide the commission with a recommended decision on the matter assigned to the hearing examiner, including findings of fact and conclusions of law. The recommended decision shall be provided to the parties, and they may file exceptions to the decision prior to the final decision of the commission.

C. When the commission has appointed a hearing examiner to preside over a matter, at least one member of the commission shall, at the request of a party to the proceedings, attend oral argument."

SECTION 4. Section 9-7-11.3 NMSA 1978 (being Laws 2003, Chapter 235, Section 2) is amended to read:

"9-7-11.3. TASK FORCE CREATED--RESPONSIBILITIES--PARTICIPANTS--FUNDING.--

A. The "health care providers licensing and credentialing task force" is created under the direction of the New Mexico health policy commission to study and make recommendations for the consolidation and simplification of the health care licensure processes. The task force shall make recommendations for the establishment of a web site portal for licensure to facilitate and complement or replace the present system conducted by individual health care provider boards and for a central database for credentialing

information to simplify and eliminate duplication of effort.

B. The task force shall study and make recommendations to the superintendent of insurance on health care provider credentialing issues and obstacles to one-time efforts by providers to meet all necessary requirements to practice independently or as a provider for any appropriately licensed health care organization or facility. The task force shall study and recommend, if practicable, use of credentialing expertise developed by a statewide association of hospitals.

C. The task force shall include participation by the New Mexico health policy commission; the department of health; the New Mexico medical board; the board of nursing; other health care provider boards; the regulation and licensing department; the office of superintendent of insurance; the human services department; the office of the attorney general; other affected state agencies; members of the health care industry, including statewide associations and societies representing providers, hospitals and other affected facilities; insurers; other third-party payers; health care advocates; and members of the public.

D. The New Mexico health policy commission, together with the New Mexico medical board and the board of nursing, shall hire an information technology project manager to work under the commission to design, implement and maintain

a web site portal for licensure and a central database for credentialing of health care providers."

SECTION 5. Section 52-5-3 NMSA 1978 (being Laws 1986, Chapter 22, Section 29, as amended) is amended to read:

"52-5-3. REPORTS--DATA GATHERING.--

A. The intent of this section is to allow the director to gather data and conduct studies to evaluate the workers' compensation and occupational disease disablement system in New Mexico. This includes evaluating the benefits structure and the costs incurred under each version of the Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law. To this end, the director shall establish baseline data against which to assess the changes in the law.

B. The director shall independently evaluate insurance industry data pertaining to workers' compensation and occupational disease disablement claims and payments, as well as other information the director believes to be necessary and relevant to a thorough evaluation of the system's effectiveness. In addition to data generated by insurance industry representatives and organizations, the director shall collect data from employers, claimants and other relevant parties.

C. Unless otherwise provided by law, the director shall have access to insurance industry information that

contains workers' compensation and occupational disease disablement claim data as the director determines is necessary to carry out the provisions of this section.

D. The director shall have access to files and records of:

(1) the workforce solutions department that pertain to:

(a) the name and number of employees reported by employers;

(b) employers' mailing addresses;

(c) federal identification numbers; and

(d) general wage information;

(2) the office of superintendent of insurance that pertain to:

(a) historical insurance classification rates and total premiums paid during given periods of time;

(b) insurers licensed to underwrite casualty insurance; and

(c) records of group self-insurers;

(3) the human services department that include names, addresses and other identifying information of recipients of benefits and services pertaining to income support;

(4) the taxation and revenue department that identify employers paying workers' compensation assessments in

accordance with Section 52-5-19 NMSA 1978; and

(5) the motor vehicle division of the taxation and revenue department that pertain to the identity of licensed drivers and the ownership of motor vehicles.

E. Information that is confidential under state law shall be accessible to the director and shall remain confidential.

F. The director shall prepare an annual report. The director shall publish in that report and in other reports as the director deems appropriate such statistical and informational reports and analyses based on reports and records available as, in the director's opinion, will be useful in increasing public understanding of the purposes, effectiveness, costs, coverage and administrative procedures of workers' compensation and in providing basic information regarding the occurrence and sources of work injuries or disablements to public and private agencies engaged in industrial injury prevention activities. The reports shall include information concerning the nature and frequency of injuries and occupational diseases sustained and the resulting benefits, costs and other factors that are important to furthering the intent of this section."

SECTION 6. Section 52-6-2 NMSA 1978 (being Laws 1986, Chapter 22, Section 76, as amended) is amended to read:

"52-6-2. DEFINITIONS.--As used in the Group Self-

Insurance Act:

A. "administrator" means an individual, partnership or corporation engaged by a group's board of trustees to carry out the policies established by that board and to provide day-to-day management of the group;

B. "group" means a not-for-profit unincorporated association consisting of two or more public hospital employers or private employers that are engaged in the same or similar type of business, are members of the same bona fide trade or professional association that has been in existence for not less than five years and that enter into agreements to pool their liabilities for workers' compensation benefits; except that public hospital employers shall segregate their accounting records and investment accounts from those of private employers in accordance with applicable state law;

C. "insolvent" means that a group is unable to pay its outstanding lawful obligations as they mature in the regular course of business, as shown both by having an excess of required reserves and other liabilities over assets and by not having sufficient assets to reinsure all outstanding liabilities after paying all accrued claims owed;

D. "net premium" means premium derived from standard premium adjusted by any advance premium discounts;

E. "private employer" means every employer that is not a public employer or a public hospital employer;

F. "public employer" means the state of New Mexico or any of its branches, agencies, departments, boards, instrumentalities or institutions and all school districts and all political subdivisions of the state or any of their agencies, instrumentalities or institutions. "Public employer" does not include a public hospital employer;

G. "public hospital employer" means any local, county, district, city-county or other public hospital or health-related facility, whether operating in wholly or partially owned or leased premises;

H. "service company" means a person or entity that provides services not provided by the administrator, including claims adjustment; safety engineering; compilation of statistics and the preparation of premium, loss and tax reports; preparation of other required self-insurance reports; development of members' assessments and fees; and administration of a claim fund;

I. "standard premium" means the premium derived from the manual rates adjusted by experience modification factors but before advance premium discounts;

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

K. "workers' compensation benefits" means benefits pursuant to the Workers' Compensation Act or the New Mexico Occupational Disease Disablement Law."

SECTION 7. Section 58-19-7 NMSA 1978 (being Laws 1959, Chapter 204, Section 7, as amended) is amended to read:

"58-19-7. RETAIL INSTALLMENT CONTRACTS--REQUIREMENTS--PROHIBITIONS.--

A. A retail installment contract shall be in writing and shall be signed by both the buyer and the seller; it shall be completed as to all essential provisions prior to its signing by the buyer.

B. The printed portion of the contract, other than instructions for completion, shall be in at least eight-point type. The contract shall contain in a size equal to at least ten-point bold type the following notice: "Notice to the Buyer: 1. Do not sign this contract before you read it or if it contains any blank spaces. 2. You are entitled to an exact copy of the contract you sign.".

C. The seller shall deliver to the buyer or mail to the buyer at the buyer's address shown on the contract a copy of the contract signed by the seller. Until the seller does so, a buyer who has not received delivery of the motor vehicle shall have the right to rescind the buyer's agreement and to receive a refund of all payments made and return of all goods traded in to the seller on account of or in contemplation of the contract; if such goods cannot be returned, the value thereof shall be paid by the seller. Any acknowledgment by the buyer or delivery of a copy of the

contract shall be in a size equal to at least ten-point bold type and, if contained in the contract, shall appear directly above the buyer's signature.

D. Any such agreement shall contain immediately before the buyer's signature substantially the following notice printed or typed in a size equal to at least twelve-point bold type as follows:

"NOTICE TO BUYER

LIABILITY INSURANCE FOR BODILY INJURY CAUSED TO YOURSELF OR TO OTHERS OR PROPERTY DAMAGE CAUSED TO OTHERS IS NOT PROVIDED WITH THIS AGREEMENT. IF YOU DESIRE LIABILITY INSURANCE COVERAGE, YOU SHOULD OBTAIN SUCH COVERAGE FROM AN AGENT OF YOUR CHOICE.".

E. The contract shall contain the following items:

(1) the names of the seller and the buyer, the place of business of the seller, the residence or place of business of the buyer as specified by the buyer and a description of the motor vehicle, including its make, year model, model and identification numbers or marks;

(2) the cash sale price of the motor vehicle;

(3) the amount of the buyer's down payment and whether made in money or goods;

(4) the difference between items in Paragraphs (2) and (3) of this subsection;

(5) the amount, if any, included for insurance and other benefits, specifying the types of coverage and benefits, and if it is the case, including as a benefit amounts paid or to be paid by the seller pursuant to agreement with the buyer to discharge a security interest, lien or lease interest on property traded in;

(6) the amount of official fees;

(7) the principal balance, which is the sum of items in Paragraphs (4), (5) and (6) of this subsection;

(8) the amount of the finance charge; and

(9) the time balance, which is the sum of items in Paragraphs (7) and (8) of this subsection, payable in installments by the buyer to the seller, the number of installments, the amount of each installment and the due date or term thereof.

The above items need not be stated in the sequence or order set forth, and additional items may be included to explain the calculations involved in determining the stated time balance to be paid by the buyer.

F. The amount, if any, included for insurance, which may be purchased by the holder of the retail installment contract, shall not exceed the applicable premiums chargeable in accordance with the rates filed with the office of superintendent of insurance. If dual interest insurance on the motor vehicle is purchased by the holder, it shall, within

thirty days after execution of the retail installment contract, send or cause to be sent to the buyer a policy or policies or certificate of insurance written by an insurance company authorized to do business in this state, clearly setting forth the amount of the premium, the kind or kinds of insurance, the coverages and all the terms, exceptions, limitations, restrictions and conditions of the contract or contracts of insurance. The buyer shall have the privilege of purchasing such insurance from an agent or broker of the buyer's own selection and of selecting an insurance company acceptable to the holder, and in such case, the inclusion of the insurance premium in the retail installment contract shall be optional with the seller.

G. If any insurance is canceled or the premium adjusted, any refund of the insurance premium received by the holder shall be credited to the final maturing installments of the contract except to the extent applied toward payment for similar insurance protecting the interests of the buyer and the holder or either of them.

H. The holder may, if the contract or refinancing agreement so provides, collect a delinquency and collection charge on each installment in default for a period not less than ten days, in an amount not in excess of five percent of each installment or fifteen dollars ($15.00), whichever is less. In addition to such delinquency and collection charge,

the contract may provide for the payment of attorney fees not exceeding fifteen percent of the amount due and payable under such contract, where such contract is referred for collection to any attorney not a salaried employee of the holder of the contract, plus the court costs.

I. A buyer may transfer the buyer's equity in the motor vehicle at any time to another person upon agreement by the holder, but in such event, the holder of the contract shall be entitled to a transfer of equity fee, which shall not exceed twenty-five dollars ($25.00).

J. No retail installment contract shall be signed by any party thereto when it contains blank spaces to be filled in after execution, except that if delivery of the motor vehicle is not made at the time of the execution of the contract, the identifying numbers or marks of the motor vehicle or similar information and the due date of the first installment may be inserted in the contract after its execution. The buyer's written acknowledgement, conforming to the requirements of Subsection C of this section, of delivery of a copy of a contract shall be conclusive proof of such delivery, that the contract when signed did not contain any blank spaces except as herein provided and of compliance with this section in any action or proceeding by or against the holder of the contract.

K. Upon written request from the buyer, the holder

of a retail installment contract shall give or forward to the buyer a written statement of the dates and amounts of payments made and the total amount unpaid under such contract. A buyer shall be given a written receipt for any payment when made in cash.

L. No provision in a retail installment contract relieving the seller from liability under any legal remedies that the buyer may have against the seller under the contract, or any separate instrument of similar import executed in connection therewith, shall be enforceable.

M. In the event that the seller or the holder of the retail installment contract repossesses a motor vehicle, the buyer shall be responsible and liable for any deficiency in accordance with Section 55-9-608 NMSA 1978."

SECTION 8. Section 59A-1-7 NMSA 1978 (being Laws 1984, Chapter 127, Section 7, as amended) is amended to read:

"59A-1-7. INSURANCE DEPARTMENT.--"Insurance department", "insurance division" or "division" means the office of superintendent of insurance."

SECTION 9. Section 59A-2-1 NMSA 1978 (being Laws 1984, Chapter 127, Section 19, as amended) is amended to read:

"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."

SECTION 10. Section 59A-2-2 NMSA 1978 (being Laws 1984, Chapter 127, Section 20, as amended) is amended to read:

"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. If the position of superintendent becomes vacant, the successor shall serve for the remainder of the term vacated. An incumbent superintendent may apply to the insurance nominating committee for appointment to additional terms.

D. The superintendent's annual compensation shall be established by the legislature in an appropriations act and 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 first providing the superintendent with notice and a hearing."

SECTION 11. Section 59A-2-3 NMSA 1978 (being Laws 1984, Chapter 127, Section 21) is amended to read:

"59A-2-3. SUPERINTENDENT--QUALIFICATIONS AND BOND.--The superintendent shall:

A. have been a resident of New Mexico for at least one year before appointment;

B. be bonded as provided in the Surety Bond Act; and

C. 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."

SECTION 12. Section 59A-2-4 NMSA 1978 (being Laws 1984, Chapter 127, Section 22, as amended) is amended to read:

"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; 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."

SECTION 13. Section 59A-2-8 NMSA 1978 (being Laws 1984, Chapter 127, Section 26) is amended to read:

"59A-2-8. GENERAL POWERS AND DUTIES OF SUPERINTENDENT.--The superintendent shall:

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

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

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

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

E. conduct such examinations and investigations of insurance matters, in addition to those expressly authorized, as the superintendent may deem proper upon reasonable and

probable cause to determine whether a person has violated a provision of the Insurance Code or to secure information useful in the lawful enforcement or administration of the provision;

F. have the power to sue or be sued;

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

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

I. have the right to require performance bonds of employees as the superintendent deems necessary pursuant to the Surety Bond Act. The office of superintendent of insurance shall pay the cost of required bonds;

J. comply with the provisions of the Administrative Procedures Act; and

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

SECTION 14. A new section of the New Mexico Insurance Code is enacted to read:

"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."

SECTION 15. A new section of the New Mexico Insurance Code is enacted to read:

"INSURANCE NOMINATING COMMITTEE.--

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 vote 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 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 reimbursed for expenses incurred in pursuit of the member's duties on the committee pursuant to the Per Diem and Mileage Act.

C. The committee and individual members shall be subject to the Governmental Conduct Act, the Inspection of Public Records Act, the Financial Disclosure Act and the Open Meetings Act.

D. A regular session of the committee shall convene ninety days prior to the date of the initial term of the superintendent and thereafter ninety days prior to the date on which the term of a superintendent ends and shall conclude on the date that the initial superintendent or next superintendent takes office. The committee shall select a superintendent within sixty days of convening.

E. Upon the occurrence of a vacancy in the superintendent position, the committee shall convene within thirty days of the date of the beginning of the vacancy for a special session and shall appoint a successor to fill the remainder of the superintendent's term within sixty days of convening.

F. If a position on the committee becomes vacant during a term, a successor shall be selected in the same manner as the original appointment for that position and shall

serve for the remainder of the term of the position vacated.

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 select the applicant that, in the committee's judgment, is best qualified to serve as superintendent.

I. A majority vote of all members of the committee in favor of an applicant is required for that applicant to be appointed superintendent."

SECTION 16. Section 59A-2-12 NMSA 1978 (being Laws 1984, Chapter 127, Section 30) is amended to read:

"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."

SECTION 17. Section 59A-2-13 NMSA 1978 (being Laws 1984, Chapter 127, Section 31) is amended to read:

"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."

SECTION 18. Section 59A-12-10 NMSA 1978 (being Laws 1997, Chapter 48, Section 1, as amended) is amended to read:

"59A-12-10. LICENSING OF LENDING INSTITUTION--DEFINITIONS AND EXCEPTIONS.--

A. As used in this section:

(1) "lending institution" means an institution, including its holding company, subsidiary or insurance agent, solicitor or broker affiliate, whose business includes accepting deposits or lending money in New Mexico, including banks, savings and loan associations and credit unions; "lending institution" does not include insurance companies;

(2) "holding company", "subsidiary" and "affiliate" mean those terms as defined in regulations adopted by the superintendent; except "bank holding company" means that term as defined in Section 2 of the federal Bank Holding Company Act of 1956;

(3) "public utility" means a private employer subject to the jurisdiction of the public regulation commission that is engaged in the business of providing telecommunications, electric, gas, water or steam heat services to the public;

(4) "sell" means to engage in the solicitation, sale and placement of insurance and such other related activities conducted by an agent, solicitor or broker pursuant to the Insurance Code;

(5) "service contract" means a contract issued on consumer products pursuant to which the vendor or manufacturer bears the cost of the repair or replacement of the consumer product;

(6) "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

(7) "loan transaction" and any other reference to lending or extension of credit does not include loans made by broker-dealers registered in accordance with applicable state and federal securities laws that are wholly collateralized by securities.

B. A lending institution:

(1) that is a subsidiary or an affiliate of a state or federally chartered bank may be licensed to sell:

(a) any insurance in accordance with the Insurance Code and to the extent authorized by federal and state lending institution regulators; and

(b) annuities to the extent authorized by law and federal and state lending institution regulators; but nothing in this subparagraph shall affect the rights and obligations of nationally chartered lending institutions; and

(2) other than one described in Paragraph (1) of this subsection, may be licensed to sell:

(a) any insurance except title insurance in accordance with the Insurance Code and to the

extent authorized by federal and state lending institution regulators; and

(b) annuities to the extent authorized by law and federal and state lending institution regulators; but nothing in this subparagraph shall affect the rights and obligations of nationally chartered lending institutions.

C. A public utility or its holding company, subsidiary or affiliate shall not be licensed to sell insurance or act as a broker for insurance in New Mexico.

D. As used in Subsections E through Y of this section, "insurance" means all products defined or regulated as insurance under the Insurance Code except:

(1) credit life, credit accident and health, credit involuntary unemployment, credit casualty and credit property insurance, and when providing insurance coverage to a borrower or co-borrower or both, the following insurance products: accidental death and dismemberment, accidental disability and any other accidental casualty insurance product;

(2) insurance placed by a lending institution on the collateral pledged as security for a loan when the debtor breaches the contractual obligation to provide that insurance;

(3) private mortgage insurance and financial guarantee insurance;

(4) annuities;

(5) service contracts;

(6) insurance premium finance agreements; and

(7) travel accident or baggage insurance.

E. A lending institution shall not require as a condition precedent to the extension of credit, or any subsequent renewal thereof, or the procurement of other bank services that the customer purchase insurance through a particular insurer, agent, solicitor or broker.

F. A lending institution shall not extend credit, lease or sell property or furnish any other service or fix or vary the consideration for any of the foregoing on the condition or requirement that the customer obtain insurance from that lending institution or from a particular insurer, agent, solicitor or broker.

G. A lending institution shall not impose a requirement on an insurance agent, solicitor or broker who is not associated with the lending institution that is not imposed on an insurance agent, solicitor or broker who is associated with that institution or, unless otherwise authorized by applicable federal or state law, require a debtor, insurer, agent, solicitor or broker to pay a separate charge in connection with the handling of insurance that is required under a contract.

H. A lending institution, except an institution that does not accept deposits that are federally insured, that sells insurance on its premises shall:

(1) conspicuously post a notice that is clearly visible to anyone who may purchase insurance that insurance is not a deposit account insured by a federal deposit insuring agency;

(2) orally inform a prospective purchaser of insurance that insurance is not a deposit account insured by a federal deposit insuring agency; and

(3) provide a written disclosure to the customer containing the following statements before the sale of insurance is complete:

(a) insurance is not a lending institution deposit account and is not insured by its federal deposit insuring agency;

(b) insurance is not an obligation of or guaranteed by the lending institution;

(c) the customer is not required to obtain insurance from a particular lending institution, agent, solicitor or broker; and

(d) where applicable, insurance involves investment risk, including potential loss of principal.

I. The sale of insurance by a lending institution,

except an institution that does not accept deposits that are federally insured, shall be effectuated in such a manner so as to avoid confusion between federally insured deposit products offered by a lending institution and the nonfederally insured insurance sold. Insurance advertisements and other sales material shall be accurate and not misleading or deceptive. Insurance advertising and other sales materials regarding insurance shall include disclosures that contain language that is the same or substantially similar to the following:

(1) insurance is not a lending institution deposit and is not insured by its federal deposit insuring agency;

(2) insurance is not an obligation of or guaranteed by the lending institution; and

(3) where applicable, insurance involves investment risk, including potential loss of principal.

J. Insurance operations may be conducted by the lending institution, its holding company, an affiliate or subsidiary of either or through a separate corporate entity or partnership.

K. A lending institution shall not provide nonpublic customer information to a third party for the purpose of another's sale of insurance without written authorization from the customer. As used in this subsection, "nonpublic customer information" means information regarding a

person that has been derived from a record of a financial institution. "Nonpublic customer information" does not include customer names and addresses and telephone numbers or information about an individual that could be obtained from an unaffiliated credit bureau that is subject to the federal Fair Credit Reporting Act by a third party that is not entering into a credit relationship with the individual but has a legitimate need for the information in connection with a business transaction with the individual; except that "nonpublic customer information" includes information concerning insurance premiums, the terms and conditions of insurance coverage, insurance expirations, insurance claims and insurance history of an individual. Notwithstanding any provision in this section to the contrary, compliance with Section 603 of the federal Fair Credit Reporting Act by a lending institution shall be deemed to be full compliance with this subsection. "Nonpublic customer information" does not include material excluded from the definition of "consumer report" by Section 603(d)(2)(A) of the federal Fair Credit Reporting Act.

L. Records relating to the insurance sales of a lending institution, including files relating to and reflecting customer complaints, shall be kept separate and apart from all records relating to the banking transactions of the lending institution. Records pertaining to insurance

activities of the lending institution or copies of those records shall be subject to the inspection and audit by the office of superintendent of insurance. If the office determines to inspect and audit the records relating to the insurance activities of a lending institution, that institution shall make available to the office, at a location in New Mexico, the lending institution's records and knowledgeable personnel to assist in the interpretation of the lending institution's records.

M. A lending institution, or officer, director or employee acting on behalf of the institution, who qualifies for issuance of an agent's, solicitor's or broker's license pursuant to the Insurance Code may be issued an agent or broker license authorizing the sale of insurance.

N. A lending institution shall not pay a commission or other valuable consideration to a person for services of an insurance agent, solicitor or broker unless the person performing the service holds a valid insurance license for the class of insurance for which the service is rendered or performed at the time the service is performed. No person, other than a person properly licensed in accordance with the Insurance Code, shall accept any commission or valuable consideration for those services.

O. A lending institution shall not offer an inducement to a customer to purchase insurance from the

institution other than as plainly expressed in the insurance policy. Investment programs, memberships or other programs designed or represented to waive, reduce, pay, produce or provide funds to pay all or part of the cost on insurance are an illegal inducement.

P. A lending institution may not in the same transaction solicit the purchase of insurance from a customer who has applied for a loan from the institution before the time the customer has received a written commitment from the lending institution with respect to that loan, or, in the event that no written commitment has been or will be issued in connection with the loan, a lending institution shall not solicit the purchase of insurance before the time the customer receives notification of approval of the loan by the lending institution and the institution creates a written record of the loan approval. This subsection shall not apply when a lending institution contacts a customer in the course of direct or mass marketing to a group of persons in a manner that bears no relation to the customer's loan application or credit decision.

Q. The sale of insurance by a lending institution, credit union, sales finance company, insurance company, insurance agent, an institution that grants or arranges consumer credit or an institution that solicits or makes loans in New Mexico may be conducted by a person whose

responsibilities include loan transactions or other transactions involving the extension of credit so long as the person who is primarily responsible for making the specific loan or extension of credit is not the same person engaged in the sale of insurance for that same transaction; provided, however, that the provisions of this subsection shall not apply to:

(1) a broker or dealer registered under the federal Securities Exchange Act of 1934; or

(2) a lending institution location that has three or fewer persons with lending authority.

R. If insurance is required as a condition of obtaining a loan, the credit and insurance transactions shall be completed independently and through separate documents.

S. A loan for premiums on required insurance shall not be included in the primary credit without the written consent of the customer, which may be evidenced by compliance with the federal Truth in Lending Act.

T. A person who engages in loan transactions at any office of, or on behalf of, a lending institution or any other agent, employee, director or officer of the lending institution may refer a customer who seeks to purchase, or seeks an opinion or advice on, any insurance product to a person, or may give the phone number of a person, who sells or provides opinions or advice on such products only if the

customer expressly requests the referral; the person who engages in loan transactions does not solicit the customer request; and the person who engages in the loan transaction does not receive any compensation for the referral.

U. The location for the sale of insurance on the premises of a lending institution, except an institution that does not accept deposits that are federally insured, to the extent practicable shall be:

(1) physically located to be distinct from the lending activities of the institution; and

(2) clearly and conspicuously signed to be easily distinguishable by the public as separate and distinct from the lending activities of the institution.

V. Signs and other informational material concerning the availability of insurance products from the lending institution or third party soliciting the purchase of or selling insurance on the premises of the lending institution shall not be displayed to the extent practicable in an area where application for loans or other extensions of credit are being taken or closed.

W. Nothing in this section grants a lending institution, including its holding company, subsidiary or affiliate, except those enumerated in this section, the power to sell insurance that was not allowed prior to July 1, 1997.

X. Nothing in this section precludes the

superintendent from adopting reasonable rules and regulations for the purposes of the administration of the provisions of this section, including rules and regulations for written disclosures.

Y. If any of the provisions of this section are preempted by federal law, then those preempted provisions shall not apply to any person or lending institution subject to the provisions of this section."

SECTION 19. Section 59A-16-21.1 NMSA 1978 (being Laws 2000, Chapter 58, Section 1) is amended to read:

"59A-16-21.1. HEALTH PLAN REQUIREMENTS.--

A. As used in this section:

(1) "clean claim" means a manually or electronically submitted claim from a participating 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 thirty days of the

date of receipt if submitted electronically or forty-five days if submitted manually; and

(2) "health plan" means health maintenance organizations, provider service networks or third-party payers or their agents.

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 participating provider and not paid within thirty days of the date of receipt; and

(2) the amount of a clean claim manually submitted by the participating 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 a participating provider within the times specified in Subsection B of this section, the health plan shall make a good-faith effort to notify the participating provider by fax, electronic or other written communication within thirty days of receipt of the claim if submitted electronically 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. By December 1, 2000, the office of superintendent of insurance, with input from interested parties, including health plans and participating providers, shall promulgate rules to require health plans to provide:

(1) timely participating 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."

SECTION 20. Section 59A-17-34 NMSA 1978 (being Laws 1984, Chapter 127, Section 329, as amended) is amended to read:

"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."

SECTION 21. Section 59A-17-35 NMSA 1978 (being Laws 1984, Chapter 127, Section 330, as amended) is amended to read:

"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."

SECTION 22. Section 59A-17A-3 NMSA 1978 (being Laws 2005, Chapter 275, Section 3) is amended to read:

"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."

SECTION 23. Section 59A-18-13.3 NMSA 1978 (being Laws 2011, Chapter 144, Section 6) is amended to read:

"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 or 59A-47-46 NMSA 1978;

(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."

SECTION 24. Section 59A-18-13.5 NMSA 1978 (being Laws 2011, Chapter 144, Section 8) is amended to read:

"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."

SECTION 25. Section 59A-21-9 NMSA 1978 (being Laws 1984, Chapter 127, Section 406a) is amended to read:

"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."

SECTION 26. Section 59A-22-50 NMSA 1978 (being Laws 2010, Chapter 94, Section 1) is amended to read:

"59A-22-50. 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, except individually underwritten health insurance policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law. Reimbursement shall be made for direct 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. 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. 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.

C. 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 assure 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.

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

E. 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 or the Health Insurance Alliance Act;

provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

(2) "health insurer" means a person duly authorized to transact the business of health insurance in the state pursuant to the Insurance Code 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 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."

SECTION 27. Section 59A-23-6 NMSA 1978 (being Laws 1983, Chapter 64, Section 1, as amended) is amended to read:

"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 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."

SECTION 28. Section 59A-23C-10 NMSA 1978 (being Laws 2010, Chapter 94, Section 2) is amended to read:

"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 or the Health Insurance Alliance Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

(2) "health insurer" means a person duly authorized to transact the business of health insurance in the state pursuant to the Insurance Code 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 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."

SECTION 29. Section 59A-23D-2 NMSA 1978 (being Laws 1995, Chapter 93, Section 2, as amended) is amended to read:

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

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

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

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

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

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

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

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

D. "dependent" means:

(1) a spouse;

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

(a) a natural child;

(b) a legally adopted child;

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

(d) a child for whom the employee is the legal guardian and who is primarily dependent on the employee for maintenance and support, as long as evidence of

the guardianship is evidenced in a court order or decree; or

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

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

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

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

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

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

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

(b) provides coverage for a benefit that is covered under the qualified higher deductible health plan; and

(3) is covered by a qualified higher

deductible health plan that is established and maintained by the employer of the individual or of the spouse of the individual;

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

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

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

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

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

(a) unless it is in cash; or

(b) to the extent the contribution, when added to previous contributions to the trust for the calendar year, exceeds seventy-five percent of the highest annual limit deductible permitted pursuant to the Medical Care Savings Account Act;

(2) no part of the trust assets will be

invested in life insurance contracts;

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

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

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

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

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

(2) family coverage with an annual deductible of not less than three thousand dollars ($3,000) or more than four thousand five hundred dollars ($4,500) and a maximum annual out-of-pocket expense requirement of five thousand five hundred dollars ($5,500), not including

premiums; and

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

SECTION 30. Section 59A-30-4.1 NMSA 1978 (being Laws 2009, Chapter 80, Section 13) is amended to read:

"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."

SECTION 31. Section 59A-35-12 NMSA 1978 (being Laws 1984, Chapter 127, Section 601, as amended) is amended to read:

"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."

SECTION 32. Section 59A-46-51 NMSA 1978 (being Laws 2010, Chapter 94, Section 3) is amended to read:

"59A-46-51. HEALTH MAINTENANCE ORGANIZATIONS--DIRECT SERVICES.--

A. A health maintenance organization shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, except individually underwritten health insurance policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law. Reimbursement shall be made for direct 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. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health maintenance organization 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. 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 or health maintenance organization writing these policies, plans or contracts 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 or health maintenance organization that requires a higher amount of premiums paid to be used for reimbursement for direct services.

C. A health maintenance organization that fails to

comply with the reimbursement requirements pursuant to this section shall issue a dividend or credit against future premiums to all policy or contract holders in an amount sufficient to assure 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.

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

E. For the purposes of this section:

(1) "direct services" means services rendered to an individual by a health maintenance organization 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 or the Health Insurance Alliance Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

(2) "health maintenance organization" means any person who 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, but does not include a person that only issues a limited-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 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 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."

SECTION 33. Section 59A-47-46 NMSA 1978 (being Laws 2010, Chapter 94, Section 4) is amended to read:

"59A-47-46. HEALTH INSURERS--DIRECT SERVICES.--

A. A health care plan shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, except individually underwritten health care policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law. Reimbursement shall be made for direct 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. 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. 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 as a percent of premiums. Additional 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, plans or contracts 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.

C. A health care plan 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 assure 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.

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

E. For the purposes of this section:

(1) "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 or the Health Insurance Alliance Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

(2) "health 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 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 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."

SECTION 34. Section 59A-53-19 NMSA 1978 (being Laws 2006, Chapter 103, Section 8, as amended) is amended to read:

"59A-53-19. FIRE PROTECTION GRANT COUNCIL--DUTIES.--

A. The "fire protection grant council" is created. Subject to the requirements of Subsection B of this section, the council shall consist 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 public regulation commission who shall serve at the pleasure of the commission;

(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. No appointee to the council shall be a member or employee of the public regulation commission or the office of superintendent of insurance.

C. The public members are entitled to receive per diem and mileage as provided in the Per Diem and Mileage Act and shall receive no other compensation, perquisite or allowance.

D. 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; and

(6) stipends for volunteer firefighters in underserved areas.

E. 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.

F. In awarding grant assistance, the council may require conditions and procedures necessary to ensure that the money is expended in the most prudent manner.

G. When considering applications for grant assistance to pay stipends to volunteer firefighters in underserved areas, the council shall:

(1) define "underserved area";

(2) 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;

(3) require a basic level of training before

a volunteer may receive a stipend;

(4) consider whether the fire district requires a service commitment from its volunteer firefighters in exchange for stipends; and

(5) weight the applications against other criteria or requirements determined by the council."

SECTION 35. Section 59A-56-3 NMSA 1978 (being Laws 1994, Chapter 75, Section 3, as amended) is amended to read:

"59A-56-3. DEFINITIONS.--As used in the Health Insurance Alliance Act:

A. "alliance" means the New Mexico health insurance alliance;

B. "approved health plan" means any arrangement for the provisions of health insurance offered through and approved by the alliance;

C. "board" means the board of directors of the alliance;

D. "child" means a dependent unmarried individual who is less than twenty-five years of age;

E. "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 federal Social Security Act;

(4) Title 19 of the federal 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;

(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;

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

G. "director" means an individual who serves on the board;

H. "earned premiums" means premiums paid or due during a calendar year for coverage under an approved health plan less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

I. "eligible expenses" means the allowable charges for a health care service covered under an approved health plan;

J. "eligible individual":

(1) means an individual who:

(a) as of the date of the individual's application for coverage under an approved health plan, has 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 those plans are defined in Subsections P, N and D of Section 59A-23E-2 NMSA 1978, respectively, or health insurance offered in connection with any of those plans; but 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 an approved health plan if, after that period and before the enrollment date, there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

(b) is entitled to continuation coverage pursuant to Section 59A-56-20 or 59A-23E-19 NMSA 1978; and

(2) does not include an individual who:

(a) has or is eligible for coverage under a group health plan;

(b) is eligible for coverage under medicare or a state plan under Title 19 of the federal Social Security Act or any successor program;

(c) has health insurance coverage as defined in Subsection R of Section 59A-23E-2 NMSA 1978;

(d) during the most recent coverage within the coverage period described in Subparagraph (a) of Paragraph (1) of this subsection was terminated from coverage as a result of nonpayment of premium or fraud; or

(e) has been offered the option of coverage under a COBRA continuation provision as that term is defined in Subsection F of Section 59A-23E-2 NMSA 1978, or under a similar state program, except for continuation coverage under Section 59A-56-20 NMSA 1978, and did not exhaust the coverage available under the offered program;

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 that enrollment;

L. "gross earned premiums" means premiums paid or due during a calendar year for all health insurance written in the state less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

M. "group health plan" means an employee welfare benefit plan to the extent the plan provides hospital, surgical or medical expenses benefits to employees or their

dependents, as defined by the terms of the plan, directly through insurance, reimbursement or otherwise;

N. "health care service" means a service or product furnished an individual for the purpose of preventing, alleviating, curing or healing human illness or injury and includes services and products incidental to furnishing the described services or products;

O. "health insurance" means "health" insurance as defined in Section 59A-7-3 NMSA 1978; any hospital and medical expense-incurred policy; nonprofit health care plan service contract; health maintenance organization subscriber contract; short-term, accident, fixed-indemnity, specified-disease policy or disability income insurance contracts and limited health benefit or credit health insurance; coverage for health care services 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 for health care services 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; or coverage by medicare or other governmental programs providing health care services; but "health insurance" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or similar law, automobile medical payment

insurance or provisions by which benefits are payable with or without regard to fault and are required by law to be contained in any liability insurance policy;

P. "health maintenance organization" means a health maintenance organization as defined by Subsection M of Section 59A-46-2 NMSA 1978;

Q. "incurred claims" means claims paid during a calendar year plus claims incurred in the calendar year and paid prior to April 1 of the succeeding year, less claims incurred previous to the current calendar year and paid prior to April 1 of the current year;

R. "insured" means a small employer or its employee and an individual covered by an approved health plan, a former employee of a small employer who is covered by an approved health plan through conversion or an individual covered by an approved health plan that allows individual enrollment;

S. "medicare" means coverage under both Parts A and B of Title 18 of the federal Social Security Act;

T. "member" means a member of the alliance;

U. "nonprofit health care plan" means a health care plan as defined in Subsection K of Section 59A-47-3 NMSA 1978;

V. "premiums" means the premiums received for coverage under an approved health plan during a calendar year;

W. "small employer" means a person that is a resident of this state, that has employees at least fifty percent of whom are residents of this state, that is actively engaged in business and that, on at least fifty percent of its working days during either of the two preceding calendar years, employed no fewer 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;

X. "total premiums" means the total premiums for business written in the state received during a calendar year; and

Y. "unearned premiums" means the portion of a premium previously paid for which the coverage period is in

the future."

SECTION 36. Section 59A-56-25 NMSA 1978 (being Laws 1994, Chapter 75, Section 25, as amended) is amended to read:

"59A-56-25. EXPANDED SERVICE DEVELOPMENT.--The office of superintendent of insurance, in cooperation with the alliance, shall develop a plan to provide health insurance coverage for uninsured children, individuals and other employers, including outreach and technical assistance activities conducted by the alliance to increase employer, employee and public awareness of available health insurance coverage options and to assist employers in securing or retaining health insurance coverage for employees and their dependents."

SECTION 37. Section 59A-58-2 NMSA 1978 (being Laws 2001, Chapter 206, Section 2) is amended to read:

"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;

B. "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;

C. "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;

D. "maintenance agreement" means a contract for a limited period that provides only for scheduled maintenance;

E. "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 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);

F. "property" means all property, whether movable at the time of purchase or a fixture, that is used primarily for personal, family or household purposes;

G. "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;

H. "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:

(1) a contract that includes a provision for incidental payment of indemnity under limited circumstances, including towing, rental and emergency road service and food spoilage; and

(2) a contract that provides for the repair, replacement or maintenance of property for damages that result from power surges or accidental damage from handling; and

. "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."

SECTION 38. TEMPORARY PROVISION--TRANSFER OF FUNCTIONS,

PERSONNEL, APPROPRIATIONS, PROPERTY, RECORDS, CONTRACTS AND REFERENCES IN LAW.--On the effective date of this act, all:

A. staff positions and all money, appropriations, records, furniture, equipment, supplies and other property belonging to the insurance division of the public regulation commission are transferred to the office of superintendent of insurance;

B. existing contracts, agreements and other obligations in effect for the insurance division of the public regulation commission shall be binding on the office of superintendent of insurance;

C. pending cases, legal actions, appeals and other legal proceedings and all pending administrative proceedings that involve the insurance division of the public regulation commission shall be unaffected and shall continue in the name of the office of superintendent of insurance;

D. rules, orders and other official acts of the insurance division of the public regulation commission shall continue in effect until amended, replaced or repealed by the office of superintendent of insurance; and

E. references in law, rules, orders and other official acts to the insurance department or the insurance division of the public regulation commission shall be deemed to be references to the office of superintendent of insurance.

SECTION 39. TEMPORARY PROVISION--APPOINTMENTS TO

INSURANCE NOMINATING COMMITTEE--SUPERINTENDENT SELECTION.--

A. Within fifteen days of the effective date of this act, if it is adopted with an emergency clause, or as soon as practicable otherwise, the governor and the New Mexico legislative council shall appoint their members to the insurance nominating committee.

B. The insurance nominating committee shall pursue its duties on a foreshortened schedule as necessary to select a superintendent of insurance by July 1, 2013.

SECTION 40. REPEAL.--Sections 8-8-9, 59A-1-4 and 59A-18-13.4 NMSA 1978 (being Laws 1998, Chapter 108, Section 9, Laws 1984, Chapter 127, Section 4 and Laws 2011, Chapter 144, Section 7, as amended) are repealed.

SECTION 41. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.