TITLE 13 INSURANCE
CHAPTER 21 PATIENT'S COMPENSATION FUND
PART 2 QUALIFICATIONS AND ADMISSIONS

13.21.2.1 ISSUING AGENCY: The New Mexico Superintendent of Insurance.
[13.21.2.1 NMAC –Rp, 13.21.2.1 NMAC, 01/01/2022]

13.21.2.2 SCOPE: The rules in this part govern the qualification and admission of health care providers to the Patient's Compensation Fund (the fund).
[13.21.2.2 NMAC – Rp,13.21.2.2 NMAC, 01/01/2022]

13.21.2.3 STATUTORY AUTHORITY: Section 41-5-25 NMSA 1978.
[13.21.2.3 NMAC – Rp,13.21.2.3 NMAC, 01/01/2022]

13.21.2.4 DURATION: Permanent.
[13.21.2.4 NMAC – Rp,13.21.2.4 NMAC, 01/01/2022]

13.21.2.5 EFFECTIVE DATE: January 1, 2022, unless a later date is cited at the end of a section.
[13.21.2.5 NMAC – Rp,13.21.2.5 NMAC, 01/01/2022]

13.21.2.6 OBJECTIVE: The rules in this part are intended to ensure that health care providers are qualified for and admitted to the fund on a financially and actuarially sound basis.
[13.21.2.6 NMAC – Rp,13.21.2.6 NMAC, 01/01/2022]

13.21.2.7 DEFINITIONS: This rule adopts the definitions found in Section 41-5-3 NMSA 1978, in Section 14-4-2 NMSA 1978, in Chapter 59A, Article 1 NMSA 1978, in 1.24.1.7 NMAC, and in 13.21.1.7 NMAC.
[13.21.2.7 NMAC – Rp,13.21.2.7 NMAC, 01/01/2022]

13.21.2.8 BASIC QUALIFICATIONS FOR ADMISSION TO THE FUND:

A. To be eligible for admission to the fund, a person shall:

(1) be a health care provider, as defined by the MMA or by these rules, who is engaged in the provision of health care services within the state of New Mexico, and is not organized solely or primarily for the purpose of qualifying for admission to the fund;

(2) demonstrate and maintain, to the satisfaction of and in the manner specified by the superintendent and in accordance with the standards prescribed by these rules, or as otherwise provided by law, financial responsibility for, and with respect to, malpractice or professional liability claims asserted against the person or institution;

(3) apply for admission pursuant to these rules; and

(4) pay the applicable surcharges and assessments to the fund.

B. Part-time health care providers and locum tenens may be enrolled individually in the fund, paying their class surcharge on a pro rata basis.

C. An independent provider that is a business entity, including solo corporations:

(1) must have at least one qualified health care provider as a member or employee of the entity;

(2) must have all qualifiable health care provider members or employees admitted to the fund to have the business entity eligible for fund coverage; and

(3) shall pay an applicable business entity surcharge to the fund.

D. Slot coverage is not permitted.

E. A health care provider who is a natural person may be qualified as a member or employee of more than one business entity, with the appropriate surcharges paid pro rata. The underlying medical malpractice liability insurance may be provided by different insurers.
[13.21.2.8 NMAC – Rp,13.21.2.8 NMAC, 01/01/2022]

13.21.2.9 FINANCIAL RESPONSIBILITY -- INSURANCE:

A. To establish and maintain financial responsibility using insurance, the health care provider, or authorized representative of the health care provider, shall submit proof that the health care provider is or will be insured under a policy of malpractice liability insurance with indemnity limits of $250,000 per occurrence.

B. To be acceptable as evidence of malpractice liability insurance, an insurance policy:

(1) shall be issued by an insurer licensed and admitted in New Mexico by the superintendent or by a licensed risk retention group;

(2) shall, except for a hospital or outpatient health care facility, be on an occurrence coverage form approved by the superintendent;

(3) if on a claims made form issued to a hospital or outpatient health care facility, shall be on a claims made form approved by the superintendent and must include an extended reporting endorsement or equivalent tail to maintain indefinite coverage;

(4) shall provide for the insurer's assumption of the defense of any covered claim, without limitation on the insurer's maximum obligation respecting the cost of defense;

(5) shall, for an independent provider, provide coverage for not more than three separate occurrences; and

(6) shall be nonassessable.

C. Admitted carriers and risk retention groups desiring to provide malpractice liability insurance policies for the qualification of health care providers under the MMA must apply for approval from the superintendent by submitting a copy of the proposed policy forms and proposed rates to the superintendent.

D. The proof required by Subsection A of this section shall be issued and executed by an officer or authorized agent of the applicant health care provider's insurer and shall specifically identify the policyholder, the named insureds under such policy, the policy period, and the limits of coverage. Upon request by the superintendent or the TPA, such certification shall be accompanied by a certified true copy of the policy, or identification of the SERFF numbers of the specific policy form(s) previously filed with and approved by the superintendent.

E. The occurrence coverage required by this rule to demonstrate the requisite financial responsibility for qualification with the fund shall be deemed to be continuing without a lapse in coverage by the fund, provided that the health care provider meets the premium payment conditions of the underlying coverage and timely meets the surcharge payment conditions of these rules, as applicable.

[13.21.2.9 NMAC – Rp,13.21.2.9 NMAC, 01/01/2022]

13.21.2.10 FINANCIAL RESPONSIBILITY -- SELF-INSURANCE: An independent provider may qualify for admission to the fund by having continuously on deposit the sum of $750,000 in cash, as long as the following conditions are met:

A. The deposit shall be conditioned only for, dedicated exclusively to, and held in trust for the benefit and protection of and as security for the prompt payment of all medical malpractice claims arising or asserted against the health care provider.

B. A self-insured health care provider shall be required to execute a pledge agreement for the money on deposit prescribed and supplied by the superintendent.

C. Sums on deposit with the superintendent pursuant to this rule shall not be assigned, transferred, mortgaged, pledged, hypothecated, or otherwise encumbered by the health care provider nor shall any such deposit be subject to writ of attachment, sequestration, or execution except pursuant to a final judgment or court-approved settlement issued or made in connection with and arising out of a malpractice claim against the health care provider.

D. To maintain financial responsibility for continuing qualification with the fund, a self-insured health care provider shall at all times maintain the sum on deposit provided for by this rule at not less than $750,000. The value of the health care provider's deposit shall be deemed impaired when any portion is seized or released pursuant to judicial process.

E. In the event that a self-insured health care provider's deposit provided for by this rule becomes impaired, the superintendent shall give written notice of such impairment to the self-insured health care provider, and the self-insured health care provider shall, unless a longer period is provided for by the superintendent, have five days from receipt of such notice to make such additional deposit as will restore the minimum deposit value prescribed by this rule. A self-insured health care provider's qualification with the fund shall terminate on and as of the later of the last day set by these rules or, if applicable, by the superintendent, if the self-insured health care provider has not on or prior to such date restored the minimum deposit value prescribed by this rule. In the case of multiple self-insured health care providers approved by the superintendent to post one deposit, as set forth in Subsection B of this section, the admission to the fund of each member of the group or each related entity shall terminate on and as of the last day set by these rules or, if applicable, by the superintendent, if the self-insured health care provider has not on or prior to such date restored the minimum deposit value prescribed by this rule.

F. A self-insured health care provider shall, within 120 days of receiving notice of a request for review of a malpractice claim, submit a report to the superintendent and the TPA of the anticipated exposure to the fund and

the self-insured health care provider and containing sufficient details supporting the anticipated exposure. In addition, said self-insured heath care provider shall provide updates to the superintendent and the TPA when significant changes in anticipated exposure occur.

G. A self-insured health care provider who has evidenced financial responsibility pursuant to this rule may withdraw the deposit prescribed by this rule upon authorization of the superintendent. All money shall remain on deposit and pledged to the fund during the term of the health care provider's admission as a self-insured health care provider with the fund and for the longer of a three-year period following termination of such admission or as long as any medical malpractice claim is pending, whether with the medical review commission or in a court of competent jurisdiction. After this time period, authorization may be given when the health care provider files with the superintendent and the TPA, not less than 30 days prior to the date such withdrawal is to be effected, a certificate signed by the health care provider, certifying:

(1) the date the health care provider terminated admission to the fund as a self-insured health care provider;

(2) that there are no medical malpractice claims pending with the medical review commission or in a court of competent jurisdiction;

(3) that there are no unpaid final judgments or settlements against or made by the health care provider in connection with or arising out of a malpractice claim; and

(4) that there are no unasserted medical malpractice claims which are probable of assertion against the health care provider.

H. Effective as of the date on which a self-insured health care provider's deposit is withdrawn pursuant to this rule, the health care provider's admission to and qualification with the fund shall be terminated.

I. The deposit with the superintendent shall provide coverage for not more than three separate occurrences, and the limit that shall be paid from the deposit for each occurrence is $250,000.

J. The acceptance by the superintendent of the self-insurance deposit described in this rule does not create in the superintendent, the TPA, or the fund a duty to defend any health care provider making a deposit under this rule.

[13.21.2.10 NMAC – Rp,13.21.2.10 NMAC, 01/01/2022]

13.21.2.11 ADDITIONAL QUALIFICATIONS FOR HOSPITALS AND OUTPATIENT HEALTH CARE FACILITIES:

A. The superintendent shall perform a risk assessment for each applicant hospital or outpatient health care facility. If the hospital or outpatient care facility will establish and maintain financial responsibility with medical malpractice liability insurance, the superintendent may consider as the risk assessment the information and documents that the applicant submitted to its insurer, all of which shall be provided to the superintendent by, or on behalf of, the applicant, along with all other information that the superintendent has or requests of the applicant. If the hospital or outpatient care facility will be self-insured, the risk assessment shall be based on information requested by the superintendent upon forms prescribed and supplied by the superintendent. The superintendent may request and consider any additional information pertinent to a risk assessment.

B. The superintendent shall arrange for an actuarial study before determining base coverage or deposit and surcharges. If the data available for a hospital or outpatient health care facility is insufficient for actuarial analysis, due to sample size or similar inadequacies, the actuarial study may aggregate data among similar hospitals or outpatient health care facilities to achieve actuarial significance.

C. Based on the risk assessment and actuarial study the superintendent shall determine each hospital’s or outpatient health care facility’s base coverage and coverage terms, or, if self-insured, the required deposit, pursuant to the procedures of this section.

D. The risk assessment and actuarial study for each hospital or outpatient health care facility shall be required when the hospital or outpatient health care facility applies the first time for admission to the fund, and may be required at any other time the superintendent deems it necessary or advisable.

E. A hospital or outpatient health care facility seeking admission to the fund must apply by April 1 of the year prior to their first admission to the fund.

[13.21.2.11 NMAC – Rp,13.21.2.11 NMAC, 01/01/2022]

13.21.2.12 CONFIDENTIAL INFORMATION: Information from any health care provider who seeks qualification and admission to the fund shall be kept confidential pursuant to the requirements of Subsection D of Section 41-5-25 NMSA 1978.

[13.21.2.12 NMAC – Rp,13.21.2.12 NMAC, 01/01/2022]

13.21.2.13 ADMISSION PROCEDURE:

A. An application for admission to the fund shall be made to the third-party administrator through the patient's compensation fund website, which shall require the applicant to provide a legal name; professional license, certification, or registration number; information relating to the nature and scope of the applicant's practice sufficient to identify the class or category of the practitioner; information on malpractice claims previously concluded or then pending against the applicant; and such other information as the superintendent or the TPA may require.

B. The application shall be accompanied by evidence of financial responsibility in the form prescribed by these rules and the applicable surcharge as determined by the superintendent with the advice of the advisory board.

C. The advisory board will provide advice to the superintendent and carry out its additional obligations as set forth in Subsection E of Section 41-5-25.1 NMSA 1978.

D. If the third-party administrator determines that an applicant does not meet the qualifications for admission to the fund set forth in the MMA and these rules, the third-party administrator shall issue a notice to that effect and notify the applicant within 15 days of receipt of the completed application. The applicant may within 15 days of receipt of the notice, appeal the determination to the superintendent by delivering a notice of appeal to the superintendent. The provisions of 13.21.4 NMAC shall apply to the appeal.

[13.21.2.13 NMAC – Rp,13.21.2.13 NMAC, 01/01/2022]

13.21.2.14 ORDER OF ADMISSION:

A. Periodically, after health care providers have been approved for admission into the fund, the TPA shall notify the superintendent, who shall issue an order of admission to the fund, which shall:

(1) identify the health care providers who have been admitted;

(2) state that the health care providers have qualified for admission to the fund pursuant to Section 41-5-5 NMSA 1978;

(3) specify the effective date and term of each admission; and

(4) for a hospital or outpatient health care facility for whom a base coverage or surcharge has been set, the amount of the base coverage or surcharge.

B. Duplicate or additional orders of admission shall be available to and upon the request of a qualified health care provider or the qualified health care provider's attorney, or professional liability insurance underwriter, when such certification is required to evidence admission to or qualification with the fund in connection with an actual or proposed malpractice claim against the health care provider.

C. A copy of each order of admission shall be available for public inspection at the main office of the superintendent on the day it is issued, and a copy of the order shall be posted on the patient's compensation fund website as soon as practicable. Posting the order on the patient's compensation fund website shall constitute delivery to the health care provider and any other interested person. Any person aggrieved by the admission of any qualified health care provider to the fund or by the conditions of the health care provider's admission may, within 15 days of issuance of the order, appeal the admission to the superintendent by delivering a notice of appeal to the superintendent. The filing of an appeal shall not operate to stay the order of admission or suspend the conditions of admission. The provisions of 13.21.4 NMAC shall apply to the appeal.

[13.21.2.14 NMAC – Rp,13.21.2.14 NMAC, 01/01/2022]

13.21.2.15 EXPIRATION OF ADMISSION AND RENEWAL OF ADMISSION:

A. Admission to the fund expires:

(1) as to a health care provider evidencing financial responsibility other than by self-insurance, on and as of:

(a) the effective date and time of termination or cancellation of the policy of the health care provider's malpractice liability coverage; or

(b) the last day of the applicable period for which the prior annual surcharge applied in the event that the annual surcharge for renewal coverage is not paid by the health care provider to the insurer on or before 30 days following the expiration of the prior admission period.

(2) as to a self-insured health care provider on and as of:

(a) the effective date and time of termination, cancellation or impairment of the health care provider's financial responsibility; or

(b) the last day of the applicable period for which the prior surcharge applied in the event that the surcharge for renewal coverage is not paid by the health care provider to the superintendent on or before 30 days following the expiration of the prior admission period.

B. Admission to the fund must be renewed by each qualified health care provider on or before expiration of the admission period in accordance with these rules.
[13.21.2.15 NMAC – Rp,13.21.2.15 NMAC, 01/01/2022]

13.21.2.16 TERMINATION OF ADMISSION:

A. A health care provider's admission to the fund shall terminate:

(1) as to a health care provider evidencing financial responsibility by proof of insurance pursuant to these rules, on and as of the effective date of cancellation of the health care provider's insurance coverage;

(2) as to a self-insured health care provider on and as of any date on which:

(a) the health care provider ceases to maintain financial responsibility in the amount and form prescribed by these rules; or

(b) the health care provider fails, within the allowed time after notice by the TPA, to provide additional security for financial responsibility when existing financial responsibility security is impaired as provided in these rules.

(3) on any date that the health care provider's professional or institutional license, certification, or registration is suspended or revoked or that the health care provider ceases to be a health care provider as defined by the MMA or these rules or otherwise ceases to be eligible for admission to the fund.

B. Upon written notice to a health care provider, or such provider's authorized representative, the TPA may terminate a health care provider's admission to the fund, effective 30 days following the mailing by registered or certified mail, return receipt requested, or giving of such notice in the event that a qualified health care provider has failed or refused to timely provide any reports or submit any information or data required to be reported or submitted by these rules. If, within 30 days of receipt of such a notice, a health care provider furnishes to the TPA any and all delinquent reports, information, and data, as specified by such notice, the health care provider's admission to the fund may be continued in effect, provided that the health care provider remains otherwise qualified for admission to the fund.

C. If the TPA terminates a health care provider’s admission to the fund, the TPA shall notify the provider within 15 days of receipt of the cancellation or termination. The health care provider may, within 15 days of receipt of the notice, appeal the determination by delivering a notice of appeal to the superintendent. The provisions of 13.21.4 NMAC shall apply to the appeal.
[13.21.2.16 NMAC – Rp,13.21.2.16 NMAC, 01/01/2022]

13.21.2.17 PATIENT’S COMPENSATION FUND ACTUARY:

A. In accordance with the provisions of law applicable to contracting for personal, professional, or consulting services, the superintendent, in consultation with the advisory board, may employ or hire one or more qualified and competent actuaries to advise and consult the superintendent, the advisory board, and the TPA on all aspects of the administration, operation, and defense of the fund which require application of actuarial science.

B. An actuary may be asked to evaluate or recommend:

(1) the claims experience data required for risk assessments;

(2) the establishment, maintenance, and adjustment of reserves on individual claims against the fund and the establishment, maintenance, and adjustment of reserves for incurred but not reported claims;

(3) surcharges, rated and classified according to the classes or risks against which the fund provides compensation, that shall reasonably ensure that the fund is sufficiently funded so as to be and remain financially and actuarially capable of providing the compensation for which it is organized;

(4) each hospital’s or outpatient health care facility’s base coverage and coverage terms upon initial admission into the fund, and whether additional charges need to be made for initial admission to the fund; and

(5) any other actuarial questions affecting the administration, operation, and defense of the fund.
[13.21.2.17 NMAC – Rp,13.21.2.17 NMAC, 01/01/2022]

13.21.2.18 ANNUAL ACTUARIAL STUDY:

A. Annually, as required by Section 41-5-25 NMSA 1978, the superintendent shall cause an independent actuary to perform an actuarial study of the fund, and of the surcharges necessary and appropriate to ensure that it is and remains financially and actuarially sound.

B. In the performance of the actuarial study, the independent actuary shall employ sound actuarial principles.
[13.21.2.18 NMAC – Rp,13.21.2.18 NMAC, 01/01/2022]

13.21.2.19 SURCHARGES:

A. For a health care provider other than a hospital or outpatient care facility, the superintendent, with the advice of the advisory board, shall determine surcharges based on classifications and categories of medical malpractice liability risks underwritten by the fund with respect to practice type or specialties as determined and specified in the annual actuarial study pursuant to this rule.

B. For a hospital or outpatient care facility, the superintendent, with the advice of the advisory board, shall determine surcharges based on the annual actuarial study using the information specified in Subsection D of Section 41-5-25 NMSA 1978.

[13.21.2.19 NMAC – Rp,13.21.2.19 NMAC, 01/01/2022]

13.21.2.20 PAYMENT OF SURCHARGES:

A. An insured health care provider must pay the applicable surcharge to the medical malpractice liability insurer within 30 days of the inception of coverage, and within 30 days of the inception of each period of renewal coverage.

B. A self-insured health care provider must pay the applicable surcharge within 30 days of the requested date for admission into the fund, and within 30 days of the inception of each renewal period.

[13.21.2.20 NMAC – Rp,13.21.2.20 NMAC, 01/01/2022]

13.21.2.21 ADMISSION DATE:

A. A health care provider who applied for admission to the fund prior to the effective date of these rules, and who was approved for admission prior to the effective date of these rules, shall be admitted to the fund as of the date of the prior application.

B. A health care provider whose first application for admission to the fund is made after the effective date of these rules, and who is approved for admission pursuant to these rules, will be admitted to the fund as of the date of initial application.

C. Under Sections A and B of this section, the admission date for an insured health care provider who applies to participate in the fund, and who pays all applicable surcharges to the fund, within 60 days of the inception of the base coverage, shall relate back to the inception date of the base coverage.

D. The admission of all health care providers in the fund as of December 31, 2021 shall expire at the end of December 31, 2021. The admission of any health care provider renewed or admitted to the fund on or after January 1, 2022 shall expire at the end of December 31 of the year of renewal or admission.

[13.21.2.21 NMAC – Rp,13.21.2.21 NMAC, 01/01/2022]

History of 13.21.2 NMAC:

13.21.2 NMAC, Qualifications and Admissions, effective 3/1/2019.

History of Repealed Material:

13.21.2 NMAC, Qualifications and Admissions, filed 3/1/2019 was repealed and replaced by 13.21.2 NMAC, Qualifications and Admissions, effective 4/30/2019.

13.21.2 NMAC, Qualifications and Admissions, filed 4/30/2019 was repealed and replaced by 13.21.2 NMAC, Qualifications and Admissions, effective 01/01/2022.