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 – N/E, 3/01/2019; Rp, 13.21.2.1 NMAC, 4/30/2019]

13.21.2.2 SCOPE: The rules in this part govern the qualification and admission of health care providers to the PCF.
[13.21.2.2 NMAC – N/E, 3/01/2019; Rp, 13.21.2.2 NMAC, 4/30/2019]

13.21.2.3 STATUTORY AUTHORITY: Section 41-5-25 NMSA 1978.
[13.21.2.3 NMAC – N/E, 3/01/2019; Rp, 13.21.2.3 NMAC, 4/30/2019]

13.21.2.4 DURATION: Permanent.
[13.21.2.4 NMAC – N/E, 3/01/2019; Rp, 13.21.2.4 NMAC, 4/30/2019]

13.21.2.5 EFFECTIVE DATE: April 30, 2019, unless a later date is cited at the end of a section.
[13.21.2.5 NMAC – N/E, 3/01/2019; Rp, 13.21.2.5 NMAC, 4/30/2019]

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 PCF on a financially and actuarially sound basis.
[13.21.2.6 NMAC – N/E, 3/01/2019; Rp, 13.21.2.6 NMAC, 4/30/2019]

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 1.24.1.7 NMAC, and in 13.21.1.7 NMAC.
[13.21.2.7 NMAC – N/E, 3/01/2019; Rp, 13.21.2.7 NMAC, 4/30/2019]

13.21.2.8 BASIC QUALIFICATIONS FOR ADMISSION TO THE FUND: To be eligible for admission to the fund, a person shall:

A. 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;

B. 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;

C. apply for admission pursuant to these rules; and

D. pay the applicable surcharges to the fund.

[13.21.2.8 NMAC – N/E, 3/01/2019; Rp, 13.21.2.8 NMAC, 4/30/2019]

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 $200,000 per occurrence.

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

(1) shall be issued by an insurer:

(2) shall be on an occurrence coverage form approved by the superintendent;

(3) 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;

(4) shall, except for a hospital or outpatient health care facility, provide coverage for not more than three separate occurrences; and

(5) shall be nonassessable.

C. 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,

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.

D. Upon request, the superintendent shall advise applicants as to whether any specified policy form has been approved pursuant to this rule, or provide a list of all policy forms so approved.

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 – N/E, 3/01/2019; Rp, 13.21.2.9 NMAC, 4/30/2019]

13.21.2.10 FINANCIAL RESPONSIBILITY - SELF-INSURANCE: An individual health care provider, except for a hospital or outpatient health care facility, may qualify for admission to the fund by having continuously on deposit the sum of $600,000 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 $600,000. 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 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 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 PCF 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 executive director, 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 $200,000.

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

[13.21.2.10 NMAC – N/E, 3/01/2019; Rp, 13.21.2.10 NMAC, 4/30/2019]

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 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. Based on the risk assessment 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.

C. The risk assessment 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.

[13.21.2.11 NMAC – N/E, 3/01/2019; Rp, 13.21.2.11 NMAC, 4/30/2019]

13.21.2.12 CONFIDENTIAL INFORMATION: Any health care provider who seeks qualification and admission to the PCF may designate any information the applicant is required to submit to the superintendent as confidential. Any such information shall be submitted with a statement from the applicant setting forth the reasons the applicant desires the information to be deemed confidential, and citing any applicable statutory provisions or court rules supporting its claim of confidentiality. The superintendent shall make a determination whether to treat the information as confidential after a hearing pursuant to the procedures of 13.21.4 NMAC.

[13.21.2.12 NMAC – N/E, 3/01/2019; Rp, 13.21.2.12 NMAC, 4/30/2019]

13.21.2.13 ADMISSION PROCEDURE:

A. An application for admission to the fund shall be made through the PCF 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 may require.

B. The application shall be accompanied by evidence of financial responsibility in the form prescribed by these rules and in the case of a health care provider, other than a hospital or outpatient health care facility, the applicable surcharge. The applicable surcharge for a hospital or outpatient health care facility shall be determined by the superintendent on the basis of the application and risk assessment, as provided by these rules.

C. If the superintendent determines that an applicant does not meet the qualifications for admission to the fund set forth in the MMA and these rules, the superintendent shall issue an order 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 issuance of the order, appeal the determination to the superintendent by mailing a notice of appeal to the superintendent. The provisions of 13.21.4 NMAC shall apply to the appeal.

[13.21.2.13 NMAC – N/E, 3/01/2019; Rp, 13.21.2.13 NMAC, 4/30/2019]

13.21.2.14 ORDER OF ADMISSION:

A. Upon approval for admission into the fund, the superintendent shall issue and deliver to the health care provider an order of admission to the fund, which shall:

(1) identify the health care provider;

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

(3) specify the effective date and term of such 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 PCF website as soon as practicable. 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 mailing 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.

D. On the effective date of these rules, or as soon thereafter as practicable, the superintendent shall issue an order of admission (and if applicable a subsequent order of admission renewing the admission) pursuant to this rule for every qualified health care provider first admitted to the fund since January 1, 2017.

[13.21.2.14 NMAC – N/E, 3/01/2019; Rp, 13.21.2.14 NMAC, 4/30/2019]

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 – N/E, 3/01/2019; Rp, 13.21.2.15 NMAC, 4/30/2019]

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 occurrence 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 superintendent, 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 superintendent 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 superintendent 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 superintendent terminates a health care provider's admission to the fund, the superintendent 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 mailing a notice of appeal to the superintendent. The provisions of 13.21.4 NMAC shall apply to the appeal.

[13.21.2.16 NMAC – N/E, 3/01/2019; Rp, 13.21.2.16 NMAC, 4/30/2019]

13.21.2.17 PCF ACTUARY:

A. In accordance with the provisions of law applicable to contracting for personal, professional, or consulting services, the superintendent may employ or hire a qualified and competent actuary (the "superintendent's actuary") to advise and consult the superintendent on all aspects of the superintendent's administration, operation, and defense of the fund which require application of actuarial science.

B. The superintendent's 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 ~~several~~ 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 – N/E, 3/01/2019; Rp, 13.21.2.17 NMAC, 4/30/2019]

13.21.2.18 BI-ANNUAL ACTUARIAL STUDY:

A. At least bi-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 – N/E, 3/01/2019; Rp, 13.21.2.18 NMAC, 4/30/2019]

13.21.2.19 SURCHARGES:

A. For a health care provider other than a hospital or outpatient care facility, the superintendent 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 an actuarial study pursuant to this rule.

B. For a hospital or outpatient care facility, the superintendent shall determine surcharges considering the process or directions specified in an actuarial study, pursuant to this rule.

C. Surcharges, rates and classifications used, assessed, imposed or collected by the fund prior to the effective date of these rules shall remain valid and effective until superseded by order issued pursuant to 13.21.4 NMAC, or for 180 days after the effective date of these rules, whichever first occurs. Subsequent adoption or amendment of surcharges, rates and classifications shall be effective only upon issuance of an order pursuant to 13.21.4 NMAC.

[13.21.2.19 NMAC – N/E, 3/01/2019; Rp, 13.21.2.19 NMAC, 4/30/2019]

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 – N/E, 3/01/2019; Rp, 13.21.2.20 NMAC, 4/30/2019]

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.

[13.21.2.21 NMAC – N/E, 3/01/2019; Rp, 13.21.2.21 NMAC, 4/30/2019]

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.