F I S C A L I M P A C T R E P O R T

SPONSOR Stefanics **ORIGINAL DATE** 02/05/21 **LAST UPDATED** 03/01/21 **HB**

SHORT TITLE Healthcare Provider in Medical Malpractice **SB** 239/aSHPAC

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY21	FY22	FY23	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	NFI	NFI	NFI			

(Parenthesis ( ) Indicate Expenditure Decreases)

Conflicts with House Bill 75

SOURCES OF INFORMATION
LFC Files

Responses Received From
Office of the Superintendent of Insurance (OSI)
General Services Department (GSD)
Attorney General (NMAG)

No Response Received
Administrative Office of the Courts (AOC)

SUMMARY

Synopsis of SHPAC Amendment

The Senate Health and Public Affairs Committee amendment exempts business entities (corporations, limited liability companies, joint ventures or legal or commercial entities according to the definition in the original bill) from the requirement that they must maintain a policy not limited to three occurrences of malpractice, while hospitals and outpatient health care facilities would continue to be required to have policies not limited to three occurrences.

Synopsis of Original Bill

Senate Bill 239 makes extensive changes in the Medical Malpractice Act (Section 41-5 NMSA 1978). Some of the more salient changes include

1. Creating a medical malpractice advisory committee, which would review proposed surcharges on malpractice insurance policies used to add to the patient's compensation fund and review actuarial reports on the patient compensation fund;
2. Raising the recoverable limits for occurrences alleged against individual practitioners and, thus, the amount of medical malpractice insurance required;
3. Requiring hospitals, outpatient clinics, and other business entities desiring to be covered under the Medical Malpractice Act to undergo actuarial study through OSI;
4. Assuring the confidentiality of information regarding individual cases by prohibiting its release to the public or to the advisory committee;
5. Requiring criteria for the assessment of punitive damages before inclusion in a claim, including a finding of "a reckless and wanton indifference to the value of human life";
6. Codifying an alternative dispute resolution process, with regulations specified.

A more detailed description of these and other changes in the bill is available in the table below:

Section of this bill	Provisions	Sections in NMSA 1978 modified
1	Adds definitions of the "advisory committee" established in Sec. 16; and "business entity'; and changes definition of "health care provider", "malpractice claim, "occurrence," and "qualified health care provider."	Sec. 41-5-3
2	Raises required malpractice insurance from $200 thousand to $250 thousand per occurrence for individuals. OSI would determine, based on past actuarial experience, the amount required for a hospital, outpatient facility or business entity. Hospitals may purchase a claims-made policy and may also need prior acts coverage if there have been gaps.	Sec. 41-5-5
3	The aggregate amount that could be recovered by a patient is increased from $600 thousand to $750 thousand, with an individual practitioner's liability rising from the current $300 thousand to $250 thousand.	Sec. 41-5-6
4	If an entity's employee is not a healthcare provider, a vicarious liability claim could be brought against a hospital, outpatient facility, or business entity employing that person. If an individual healthcare provider is sued on the basis of vicarious liability for a non-healthcare provider's actions, that would be covered by the Medical Malpractice Act.	New Sec. 41-5-6.2
5	Awards for future medical expenses as a result of an act of malpractice would not be subject to the $750 thousand limit and would place in a medical savings trust if there were an approved settlement. The section removes a requirement that punitive damages be paid by the individual, but it is added back in later (Section 13).	Sec. 41-5-7
6	The medical review commission considers only malpractice claims against individuals qualified as healthcare providers, not unqualified individuals, hospitals, outpatient facilities, or business entities. Parties to a case may agree to opt out	Sec. 41-5-14

	of the medical review commission-operated panel review, which is otherwise mandated before any claim can go to trial.	
7	Except in cases where litigants agree to bypass the panel, court filings cannot be filed before panel hearing occurs, in the case of individuals liable for their own or their employees' actions (under the theory of *respondeat superior*."	Sec. 41-5-15
8	Removes a subsection requiring the medical review commissioner's director to forward information about malpractice actions to an individual provider's medical society or board.	Sec. 41-5-16
9	Removes a subsection dealing with *respondeat superior*. Adds the proviso that panel members will be given per diem and mileage, but not paid for their service but given a discharge on the surcharge he/she would have paid to the patient compensation fund.	Sec. 41-5-17
10	Increases the maximum allowable time between transmittal of a complaint to the panel and a hearing from 60 to 120 days.	Sec. 41-5-18
11	Regarding the patient's compensation fund, adds the provision that the Superintendent of Insurance must approve any settlement of a claim for more than $250 thousand. Requires OSI to give notice to providers of the amount of surcharge they will have to pay into the fund. Describes mechanisms for payment of claims, with new limit of $250 thousand. Requires an actuarial study of the fund's balance, which will require confidentiality.	Sec. 41-5-25
12	Removes an annual limit on commission expenses but requires submission of an annual budget.	Sec. 41-5-28
13	Defines instances when punitive damages can be assessed, requiring evidence of "wanton disregard of the value of human life" on the part of an individual practitioner in the case of a *respondeat superior* filing. Punitive damages are the responsibility of the health care provider.	New section
14	Describes an alternative dispute resolution process for claims against hospitals, outpatient facilities, or business entities. Specifies procedures for intent to file suit against such entities at the same time as requesting alternative dispute resolution, with notice to all parties.	New section
15	Venue for a medical malpractice suit may only be one of three counties: 1. The county where the treatment occurred, 2. The county that is the principal place of business of one or more of the defendants, 3. The county of the patient's residence.	New section
16	Creates the Medical Malpractice Act advisory committee, specifies its composition and describes its duties, including	New section

	reporting to the chief justice of the New Mexico Supreme Court. Per diem and mileage are provided, but no other recompense.	

The effective date of this bill is July 1, 2021 (Section 17).

FISCAL IMPLICATIONS

There is no appropriation in Senate Bill 239. OSI states that there is no anticipated fiscal impact on state funds because the patient compensation fund is self-funded.

GSD points out, "The Tort Claims Act, not the Medical Malpractice Act, governs medical malpractice claims against state entities. Therefore, SB239 should not have any direct fiscal impact on the General Services Department's Risk Management Division."

SIGNIFICANT ISSUES

There have been a number of legislative efforts to revise the Medical Malpractice Act over the last several legislative sessions, among them

- 2015 HB395, to change the definition of medical malpractice venues;
- 2015 HB542, which would have changed the limits in malpractice awards;
- 2017 SB295, which would have required healthcare providers, including institutions to disclose any malpractice claims against them;
- 2019 Senate Memorial 108, which would have set up a task force to study and recommend amendments to the Medical Malpractice Act.
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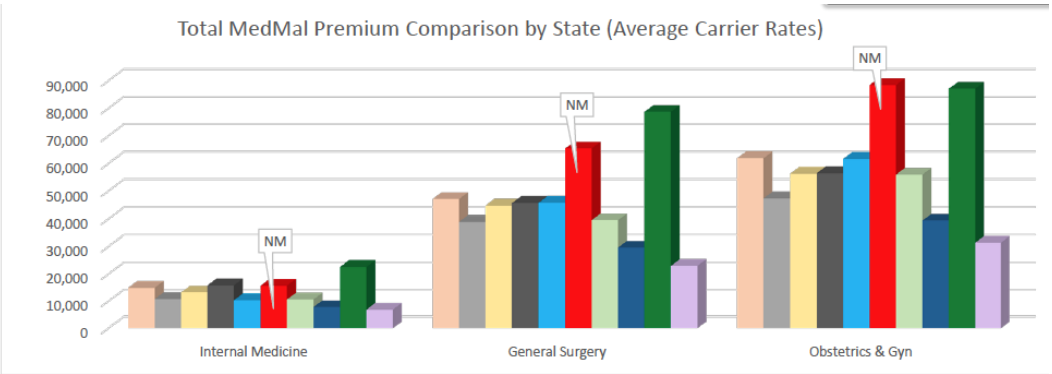
None of these legislative measures passed.

In December 2020, the Office of the Superintendent published an extensive analysis of changes recommended in the Medical Malpractice Act (available at www.osi.state.nm.us/wp-content/uploads/2020/02). This report, in turn, was partly predicated on two external audits of the patient compensation fund accomplished earlier in 2020. These audits confirmed a growing deficit in the patient compensation fund (PCF), progressing from a deficit of $1.1 million at the end of 2009 to $65.2 million 10 years later, despite a 42 percent increase in the surcharge that providers must pay into the fund over the past five years. These facts and this report contributed to the changes enshrined in Senate Bill 239.

OSI takes note of the high rates New Mexico physicians pay for malpractice insurance. In 2019, physicians across the country paid an average of $12 thousand per year for primary care physicians and $21 thousand per year for specialists, ranging up to $46 thousand per year for obstetricians/gynecologists (www.medscape.com). New Mexico's malpractice rate per capita was lower than in 32 other states, but the payout rate was high, totaling $50.8 million in 2019, which represented a 41.8 percent rise since 2014. (www.beckerhospitalreview.com). The following graph from the 2020 OSI report indicates the medical malpractice rate paid by three types of physicians in New Mexico compared with other states in the region:



Note 1: States selected for the comparison include those with a PCF, and those close to NM geographically.
Note 2: All states but LA have higher limits and caps than NM. NM premiums at comparable limits would show an even greater divergence.
Note 3: LA rates appear very similar to NM, but the LA PCF Fund has a surplus of $1,160,493,736 (as of 10/31/20).

OSI and others express concern about high malpractice rates limiting the willingness of medical practitioners to enter New Mexico or to remain here. As Note 2 to the graph indicates, other states have higher malpractice award limits, but increasing the New Mexico limit would also be likely to increase malpractice premiums.

OSI notes, "SB239 allows hospitals to remain in the PCF which will benefit the Fund by expanding the pool of insureds, and will greatly help other Fund participants (primarily individual physicians) to reduce the current Fund deficit over time."

The Attorney General's office indicates concern that aspects of the bill might conflict with the Supreme Court's charge to regulate procedure in lower courts:

> If the statute creates a conflict with an existing court rule or encroaches on an exclusive power vested [in] the courts, the statute may face a constitutional challenge. Several SB 239 provisions, including the new pre-suit process, the new procedure for making a punitive damages claim, the new venue clause and the alternative dispute requirements could face scrutiny under such challenge.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Conflicts with House Bill 75, which removes hospitals from the list of entities covered by the medical malpractice act.

TECHNICAL ISSUES

NMAG suggests two changes: "The "affidavit" referenced in Section 14. Subsection B does not specify the nature or content requirements of the "affidavit" nor its purpose. In addition, the specific duties and responsibilities of the "Medical Malpractice Act Advisory Committee" in Section 1 Subsection C. (1) and (2) should be more clearly delineated."

ALTERNATIVES

As suggested by NMAG, "A formal request may be made to the New Mexico Supreme Court for new rule-making or revisions to current rules of procedure to augment or incorporate some or all of the procedural changes contained within SB239."

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

The patient compensation fund might continue to experience increasing deficits.

LAC/al/rl/al