LFC Requestor: KLUNDT, Kelly

2025 LEGISLATIVE SESSION
AGENCY BILL ANALYSIS

Section I: General

Chamber: Senate

Category: Bill

Number: 449

Type: Introduced

Date (of **THIS** analysis)**:** 02/20/2025

Sponsor(s): Larry R. Scott, James G. Townsend, and Candy Spence Ezzell

Short Title: Medical Malpractice Changes

Reviewing Agency: Agency 665 - Department of Health

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Section II: Fiscal Impact

APPROPRIATION (dollars in thousands)

Appropriation Contained		Recurring or Nonrecurring	Fund Affected
FY 25	**FY 26**		
$ 0.00	*Variable	*Variable	Patient safety Improvement Act

*SB449 would create a Patient safety Improvement Fund in the State Treasury to be administered by the Department of Health (DOH). The fund would include appropriations and other sources (e.g. gifts, grants, punitive damage wards from medical malpractice claims), and would be appropriated to NMDOH by the legislature. SB449 does not provide for a specific dollar amount for appropriations.

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY 25	**FY 26**	**FY 27**		
$ 0.00	*Variable	*Variable	N/A	Patient Safety Improvement Fund

*SB449 would create a Patient Safety Improvement Fund in the State Treasury to be administered by the DOH. Revenue for the fund will consist of distributions, appropriations, gifts, grants, donations, and receipts of punitive damage awards

from medical malpractice claims. As a result, revenue will vary depending on the above sources.

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY 25	FY 26	FY 27	3 Year Total Cost	Recurring or Non-recurring	Fund Affected
Total	$ 0.00	$ 356.49	$ 352.58	$ 709.07	Recurring	Patient Safety Improvement Fund

The budget required to operate the NMDOH administration of the Patient Safety Improvement Fund will depend on the administrative and programmatic effort required, as well as the initiatives selected to improve patient safety, and the revenue generated. As a result, it is difficult to estimate the overall annual operating budget beyond base costs.

To cover base operational costs, starting in FY26, a proposal would be to establish a program with:

Program Coordinator:
To plan, coordinate, and evaluate operational, fiscal, and administrative activities, including program marketing, logistics, and reporting. Given the complexity of the program, including the potential need to identify and implement evidence-based approaches to improving patient safety, a Program Coordinator II (Class Code B90402 – Pay band 75 – range: $61,531-$98,449/year) at 1.0 FTE would be needed for a program with potentially statewide reach.

- Annual cost = 1.0 FTE * $79,990/year (midpoint) * 1.40 (benefits) = $111,986/year

Business Operations Specialist:
To provide program guidance and direction, as well as reporting and analysis of costs of operations. Given the likely need for some latitude for independent judgement and the need for various work methods, procedures, and setting priorities, a Business Operations Specialist II (Class Code C11990 – Pay Band 50 – range: $37,422-$58,003/year) at 0.25 FTE would be needed.

- Annual cost = 0.25 FTE *$47,713/year (midpoint) * 1.40 (benefits) = $16,700/year

Budget Analyst:
To help allocate program resources, including developing, analyzing, and executing budgets, and estimating financial needs. Given the potential need for independent judgement, a Budget Analyst II (Class Code C2031O – Pay Band 60 – range: $41,218-$65,949/year) would be necessary – time requirements would depend on complexity of the initiatives but may be sufficient at 0.1 FTE for tracking program expenditures and support activities.

- Annual cost = 0.1 FTE * $53,584/year (midpoint) * 1.40 (benefits) = $75,018/year

Programmatic Physician:
To help with the identification, evaluation, development, implementation, and assessment of patient health programs in hospital and non-hospital environments. Given the need for more advanced evaluation skills and experience in working in a wide range of patient care environments, a Programmatic Physician I (Class Code HPR035 – Pay Band XA – range: $136,446-$1981,025/year) at 1.0 FTE would be needed. Note that this effort could also be fulfilled through a contract physician.

- Annual cost = 1.0 FTE * $163,735/year (midpoint) * 1.40 (benefits) = $229,229/year

Total annual personnel costs for the 2.35 FTE would therefore be:
FY26: $111,986 + $16,700 + $75,018 + $229,229 = $332,993/year
Including a 3% cost-of-living adjustment:

- FY27: $332,993*1.03 = $342,983

Additional costs related to space, computer/IT costs for 2.35 FTE:
Year 1: $4,000/FTE plus $6,000/FTE start up (computer, chair, screens, cell phone, etc.) = 2.35 * $4,000 + 2.35 * $6,000 = $23,500
Year 2+: $4,000/FTE maintenance (software licenses, supplies) = 2.35 * $4,000 = $9,600

Additional costs for trainings, programs, incentives, or other activities would use remaining funding, dependent on fund availability and legislature appropriation, and are not included in the program cost at this time.

Section III: Relationship to other legislation

Duplicates:

Conflicts with: None

Companion to: None

Relates to: HB374, HB378, HB379, SB176

Duplicates/Relates to an Appropriation in the General Appropriation Act: None

Section IV: Narrative

1. BILL SUMMARY

a) Synopsis

Senate Bill 449 (SB449) proposes to amend Section 38-3-1 NMSA 1978
Subsection B would change language to address the county in which civil actions in district court may be commenced. Language is amended to read, “when the defendant has rendered himself liable to a civil action…” to “when the defendant is liable to a civil action…”.
Subsection D amends “are” to “is” and “where” to “if”.
Subsection F would be amended from “non-residents” to “nonresidents” and “which” to “that”.
Subsection “H” is added and would specify that the residence of a conservator or guardian would not be considered in determining the venue for any civil action.
Subsection “I” would be added related to venue, where subject to subsection “H”, it would limit the action to the county in which the patient received medical treatment that is the basis of the lawsuit. This subsection would also include definitions for “medical malpractice lawsuit” and “patient.”

Section 41-5-3 NMSA 1978 definitions are amended:

- “health care provider” and “independent provider”
- “podiatrist” is changed to “podiatric physician”.
- “occurrence” the definition is amended to read, “claims for damages from all persons arising from harm to a single patient, no matter how many health care providers, errors or omissions contributed to the harm.”

Amend Section 41-5-4 NMSA 1978 related to venue:

- Subsection A would re-arrange wording related to the ability to demand right of trial by jury and add “where venue is proper.”
- Add a new subsection, now B, defining the proper venue in a malpractice claim to be when filed in the county in which the patient received the medical treatment that is the basis for the malpractice claim.

Amend Section 41-5-6 NMSA 1978 related to limitations of recovery as:

- Changing subsection B related to adjustments from reading "beginning January 1, 2023" to "on the first day of each calendar year" and specifying with the addition that it is adjusted by the "prior three-year average" of the consumer price index for all urban consumers. It also would include new language that "an adjustment shall not result in a percentage increase in the per occurrence limit on recovery greater than three percent."
- Changing subsection D, related to claims in calendar year 2025 or later, adds new language that "an adjustment shall not result in a percentage increase in the per occurrence limit on recovery greater than three percent."
- Changing subsection E. (6), related to claims in calendar year 2027 or later, specifying with the addition that it is adjusted by the "prior three-year average" of the consumer price index for all urban consumers per occurrence. It would also add new language that "an adjustment shall not result in a percentage increase in the per occurrence limit on recovery greater than three percent."
- Changing subsection K to remove the clause that beginning January 1, 2027, amounts due from a judgement or settlement against a hospital or hospital-controlled outpatient health care facility shall not be paid from Patient's Compensation Fund.
- Removing subsection L related to defining the term "occurrence" (as a new definition would be added to Section 41-5-3 NMSA 1978 as noted above).
- Adding a new subsection L that would define the "consumer price index".

Amend Section 41-5-7 NMSA 1978 related to medical expenses and punitive damages to:

- Add subsection C that would state that awards of past or future medical care and related benefits would not be paid from the Patient's Compensation Fund unless the amount of the award was actually paid by or on behalf of an injured person and accepted by a healthcare provider as payment for services rendered.
- Add subsection D that would state that awards of future medical care and related health benefits shall only be paid from the Patient's Compensation Fund as the expenses are incurred, and not as a lump-sum payment.
- Add subsection G that would address the division of punitive damages, such that 25% would go to the prevailing party, and 75% would be awarded to the state to be remitted to the State Treasurer for deposit into the Patient Safety Improvement Fund.
- Renumber subsections, with new subsection H that would add wording that punitive damages may only be awarded if the prevailing party provides clear and convincing evidence that the acts of the healthcare provider were made with deliberate disregard for the rights or safety of others.
- Add a new section I that would cap punitive damage awards to no more than three times the compensatory damage award.

Amends Section 41-5-25 NMSA 1978 related to the Patient's Compensation Fund to add a new subsection (now D) that would specify that the superintendent of insurance, or designee, shall evaluate and approve a proposed settlement if any amount of the proposed settlement is to be paid from the fund.

- In addition, after renumbering of subsections, new subsection G related to surcharges would remove language related to surcharges being set with the intention of bringing the fund to solvency with no projected deficit by December 31, 2026.

Enacts a new section of the Medical Malpractice Act to limit attorney fees by requiring that:

- An attorney shall not contract for or collect a contingency fee for representing a malpractice claim in an amount that exceeds:
- 25% of the dollar amount recovered, if the recovery is pursuant to a settlement agreement and release of all claims prior to the start of a trial or arbitration proceeding; or,
- 33% of the dollar amount recovered if the recovery is pursuant to settlement, arbitration, or judgment after a trial or arbitration begins.

Enacts a new section of the Medical Malpractice Act related to creating a Patient Safety Improvement Fund that would:

- Created in the state treasury and administered by DOH;
- Consist of distributions, appropriations, gifts, grants, donations, and receipts of punitive damage awards from medical malpractice claims;
- Be invested by the state treasurer, with income credited to the fund;
- Be appropriated by legislature to DOH for the purposes of improving patient safety and healthcare outcomes; and,
- Any unexpended or unencumbered balance remaining at the end of the fiscal year shall not revert but shall remain to the credit of the fund.

Is this an amendment or substitution? ☐ Yes ☒ No

Is there an emergency clause? ☐ Yes ☒ No

b) Significant Issues

Medical malpractice is one of the determining factors that medical providers look at when choosing to work in a state. Currently, New Mexico is ranked 13th for Medical Malpractice issues in the U.S. (https://www.forbes.com/advisor/legal/medical-malpractice/medical-malpractice-cases-by-state/). As a result, efforts to address medical malpractice costs, and thereby improve the ability to attract and retain providers to New Mexico, are of significant interest.

Many states "cap" (or limit) the amount of damages that can be awarded in medical malpractice cases. Most states' damage caps apply only to compensation for "noneconomic" losses, which can include such intangible injuries as pain and suffering or loss of enjoyment of life. New Mexico's damage caps, however, apply to total damages, **except for** awards for:

- past and future medical care (and related benefits), and
- punitive damages, which are intended to punish particularly bad conduct and deter similar conduct in the future.

In addition, New Mexico law provides different damages caps on health care facilities, depending on whether they are majority-owned and -controlled by a hospital. New Mexico Medical Malpractice Laws & Statutory Rules

The proposed bill could help New Mexican healthcare providers stay in New Mexico, especially those in rural hospitals or rural clinics, without the fear of increased medical practice suits or high malpractice insurance rates.

SB449 attempts to address some significant issues:

- Specifying the venue – this may be related to venue shopping, as well as reducing the burden on providers in participating in the lawsuit by limiting the venue to the county in which care was provided;
- Amending the meaning of an "occurrence" – this may be related to better preventing lawyers from filing multiple lawsuits arising from a single malpractice incident;
- Limiting the annual adjustment to the limit of malpractice claims to no more than 3% for independent providers, independent outpatient facilities, hospital or hospital-controlled outpatient health care facility - this may help to keep increases predictable should prior three-year average consumer price indexes for all urban consumers increase substantially;
- Removing the distinction that after January 1, 2027, amounts due from hospitals or hospital-controlled outpatient health care facilities shall not be paid from the Patient's Compensation Fund – as a result, the fund will only be responsible for payments up to $750,000 until January 1, 2027. This may help to improve the Patient's Compensation Fund solvency, although it may reduce some protections for some facilities with limited resources.
- Preventing lump-sum payments from the Patient's Compensation Fund and only paying for expenses as they are incurred. This may improve the solvency of the fund, as well as ensure that injured individuals have long-term resources available.
- Defining (raising) the threshold for awarding punitive damages, and dividing punitive damages between the injured party (25%) and the state (75%) – as punitive damages are intended to punish behavior and ensure the rights or safety or others, this division may better align with the intent of the award to punish bad conduct, and where the state can use the funds to improve patient safety;
- Cap punitive damages to no greater than three times the compensatory damage award – this may help to limit excessive claims or the perception by providers of high risk in the state (especially as some malpractice insurance policies do not cover punitive damages, leaving providers to pay – and where the potential for high damages may be a disincentive to practice in a location). This is a clear cap on the amount that can be awarded for punitive damages in any case. This could benefit rural healthcare providers by preventing excessively large punitive damage awards.
- Remove the requirement for surcharges for the Patient's Compensation Fund to be set in order to achieve solvency by 2026 – this may be due to the current high deficit, and the potential significant increase in surcharges that would be needed to achieve solvency, further discouraging providers from practicing in the state;
- Limiting attorney fees to 25% of a recovery for damages before trial and to 33% of a recovery after a trial – this limits fees to attempt ensuring that more of the award goes to the injured patient, while the increase is related to covering the increased resources and effort required for cases that go to trial; and,
- Creation of a Patient Safety Improvement Fund that would be intended to use punitive damages and other sources to improve patient safety and health care outcomes.

Of note, the need for this may be limited, as the United States Supreme Court has stated that more than a single digit multiplier on actual damages when awarding punitive damages constitutes "cruel and unusual punishment" in violation of the 8th Amendment. Generally,

more than 2-3x is considered potentially in violation of Campbell. (State Farm Mut. Automobile Ins. Co. v. Campbell, 538 U.S. 408 (2003))

SB449 proposes the prevailing party be required to provide clear and convincing evidence that the health care provider acted with deliberate disregard for the rights or safety of others. In rural areas, healthcare providers are often less numerous, and the workforce is smaller. If rural health facilities are involved in incidents requiring settlement or judgments, they may face financial difficulties without the support of the state fund. This could lead to increased risk of rural health facilities closing or reducing services unless alternative insurance mechanisms are put in place. The risk of punitive damages may discourage healthcare professionals from practicing in rural areas due to increased exposure to potential lawsuits. This could reduce the availability of care in already underserved rural regions.

Many states have sought changes to their medical malpractice laws to reduce the cost of malpractice insurance in their state. Medical malpractice rates are not often affected by changes in laws related to medical malpractice (https://centerjd.org/content/fact-sheet-caps-do-not-lower-insurance-premiums-doctors-and-insurance-insiders-admit-it). The potential rate hikes or inaccessibility to medical malpractice only impacts smaller, independent medical providers (https://www.kob.com/new-mexico/4-investigates-doctors-warn-malpractice-changes-could-drive-providers-out-of-new-mexico/). Many times, these are the very medical providers who serve rural communities. This often leaves these practices with no option but to close or to merge with a larger healthcare business, which can mean closure if the practice is not deemed to be economically sustainable.

SB449 would establish the “Patient Safety and Improvement Fund,” allowing the legislature to appropriate funds to DOH to support initiatives aimed at improving patient safety and healthcare outcomes. The bill's broad language suggests that funds could be allocated for a wide range of activities, depending on the specific appropriation language used by the legislature.

The potential uses of the fund could vary, supporting initiatives in areas such as quality improvement programs, healthcare workforce training, data analysis, or patient care enhancements. The impact of the bill would depend on the amount appropriated, and the scope of activities authorized under future legislative action. Depending on the scale of appropriations and the complexity of initiatives funded, additional staff or administrative resources may be needed within DOH to oversee related activities.

2. PERFORMANCE IMPLICATIONS

- Does this bill impact the current delivery of NMDOH services or operations?

  ☒ Yes ☐ No

- Is this proposal related to the NMDOH Strategic Plan? ☒ Yes ☐ No

☐ **Goal 1**: We expand equitable access to services for all New Mexicans

☒ **Goal 2**: We ensure safety in New Mexico healthcare environments

☒ **Goal 3**: We improve health status for all New Mexicans

☐ **Goal 4**: We support each other by promoting an environment of mutual respect, trust, open communication, and needed resources for staff to serve New Mexicans and to grow and reach their professional goals

SB 449 would create a Patient Safety improvement Fund. If funds are allocated by the legislature the fund would provide money to the DOH to improve patient safety and improving patient health care outcomes. This could impact a wide range of programs.

3. FISCAL IMPLICATIONS

- If there is an appropriation, is it included in the Executive Budget Request?

  ☐ Yes ☐ No ☒ N/A

- If there is an appropriation, is it included in the LFC Budget Request?

  ☐ Yes ☐ No ☒ N/A

- Does this bill have a fiscal impact on NMDOH? ☒ Yes ☐ No

4. ADMINISTRATIVE IMPLICATIONS

Will this bill have an administrative impact on NMDOH? ☒ Yes ☐ No

If the legislature allocated funding, the DOH would be responsible for using the funds to improve patient safety and health care outcomes.

5. DUPLICATION, CONFLICT, COMPANIONSHIP OR RELATIONSHIP

- SB449 relates to SB176 which also addresses medical malpractice by limiting compensation to attorneys, requires payouts from the patient compensation fund be paid out as expenses are incurred, eliminates lump sum payouts for future treatments.
- SB449 relates to HB374, which covers the Medical Malpractice Occurrence Definition to claims for damages from all persons arising from harm to a single patient, no matter how many health care providers, errors or omissions contributed to the harm.
- SB449 relates to HB378, which covers the Medical Malpractice Act Changes to omit and add new guidance on the following
  - Sections B through F (pages 6-9), and sections J through L (pages 9-10), were removed.
  - The recovery amounts were lowered from $250,000 to $200,000 (page 9, lines 20-21).
- SB449 relates to HB 379, which covers Punitive Damages in Medical Malpractice Claim.
  - Section E to include text, "Punitive damages may only be awarded if the prevailing party provides clear and convincing evidence demonstrating that the acts of the health care provider were made with deliberate disregard for the rights or safety of others" (page 2, lines 14-18).
  - Section F (new section) to read, "The amount of a punitive damage award shall not be greater than thirty times the state median annual household income at the time the award is made" (page 2 line 25 through and page 3 line 2).

6. TECHNICAL ISSUES

Are there technical issues with the bill? ☐ Yes ☒ No

7. LEGAL/REGULATORY ISSUES (OTHER SUBSTANTIVE ISSUES)

- Will administrative rules need to be updated or new rules written? ☐ Yes ☒ No

- Have there been changes in federal/state/local laws and regulations that make this legislation necessary (or unnecessary)? ☐ Yes ☒ No
- Does this bill conflict with federal grant requirements or associated regulations? ☐ Yes ☒ No
- Are there any legal problems or conflicts with existing laws, regulations, policies, or programs? ☐ Yes ☒ No

8. DISPARITIES ISSUES

There are several considerations for providing healthcare in rural communities across the country, particularly in the West. Factors such as aging populations, hospital closures or downsizing (https://pubmed.ncbi.nlm.nih.gov/33011448/), the aging out of local healthcare providers (https://pubmed.ncbi.nlm.nih.gov/36205415/), and population declines among younger residents contribute to ongoing challenges in maintaining healthcare access.

The potential risk of punitive damages may further discourage healthcare professionals from practicing in rural areas due to concerns about increased exposure to malpractice lawsuits. This could further limit the availability of care in already underserved rural regions.

9. HEALTH IMPACT(S)

The fiscal impact of malpractice cases can be significant for healthcare providers and institutions. Not all institutions, particularly those in rural areas, may have the resources to absorb multimillion-dollar malpractice settlements. Rural healthcare facilities face challenges in attracting and retaining providers due to factors such as high medical malpractice insurance costs, limited career advancement opportunities, lower reimbursement rates, and insufficient infrastructure (https://pubmed.ncbi.nlm.nih.gov/35760437/).

HB449 aims to support both current and future healthcare practitioners in New Mexico's rural and medically underserved areas. By strengthening workforce stability, the bill could contribute to improved healthcare access, potentially reducing wait times and increasing provider availability in these communities.

10. ALTERNATIVES

None.

11. WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL?

If SB449 is not enacted, language will not be added or omitted from the Medical Malpractice Act to implement the proposed changes.

12. AMENDMENTS

None.