HOUSE BILL 63

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

INTRODUCED BY

William "Bill" R. Rehm and Stefani Lord

AN ACT

RELATING TO MEDICAL MALPRACTICE; RESTORING DEFINITIONS OF "HEALTH CARE PROVIDERS"; REMOVING THE INDEPENDENT PROVIDER DESIGNATION; REMOVING PUNITIVE DAMAGES; PROVIDING PROCEDURES FOR CHALLENGING JUDGMENTS; PROVIDING LIMITATIONS OF CLAIMS; PROVIDING GUIDELINES FOR HEALTH CARE PROVIDERS' APPLICATIONS; REMOVING THE VIDEO CONFERENCE OPTION FOR HEARINGS OF THE NEW MEXICO MEDICAL REVIEW COMMISSION; PROVIDING HEARING PROCEDURES; REMOVING THE REQUIREMENT OF A THIRD-PARTY ADMINISTRATOR FOR THE PATIENT'S COMPENSATION FUND; REMOVING AN ANNUAL FUND AUDIT REQUIREMENT; REMOVING AN ANNUAL ACTUARIAL STUDY REQUIREMENT; REPEALING THE PATIENT'S COMPENSATION FUND ADVISORY BOARD; AMENDING, REPEALING AND ENACTING SECTIONS OF THE NMSA 1978; DECLARING AN EMERGENCY.

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

SECTION 1. A new section of the Medical Malpractice Act is enacted to read:

"[NEW MATERIAL] PATIENT--FUTURE EXAMINATIONS AND HEARINGS.--

A. Any health care provider shall be entitled to have a physical examination of a patient by a physician of the health care provider's choice from time to time for the purpose of determining the patient's continued need of medical care and related benefits, subject to the following requirements:

(1) notice in writing shall be delivered to or served upon the patient specifying the time and place where it is intended to conduct the examination. Such notice must be given at least ten days prior to the time stated in the notice. Delivery by certified mail is permitted;

(2) such examination shall be by a physician qualified to practice medicine under the law of this state or of the state or county wherein the patient resides;

(3) the place at which such examination is to be conducted shall not involve an unreasonable amount of travel for the patient considering all the circumstances. It shall not be necessary for a patient who resides outside this state to come into this state for such an examination unless so ordered by the court;

(4) within thirty days after the examination, the patient shall be compensated by the party requesting the

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examination for all necessary and reasonable expenses incidental to submitting to the examination, including the reasonable cost of travel, meals, lodging, loss of pay or other like direct expense;

(5) examinations may not be required more frequently than at six-month intervals; except that upon application to the court having jurisdiction of the claim and after reasonable cause shown therefor, examination within a shorter time interval may be ordered. In considering such application, the court shall exercise care to prevent harassment to the patient;

(6) the patient shall be entitled to have a physician or an attorney of the patient's own choice or both present at such examination. The patient shall pay such physician or attorney out of pocket; and

(7) the patient shall be promptly furnished with a copy of the report of the physical examination made by the physician making the examination on behalf of the health care provider.

B. If a patient fails or refuses to submit to examination in accordance with the notice and if the requirements of Subsection A of this section have been satisfied, the court may forfeit all medical care and related benefits that would accrue or become due to the patient except for such failure or refusal to submit to examination during the

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period that the patient willfully persists in such failure or refusal.

C. If any patient persists in any injurious practice that imperils, retards or impairs the patient's recovery or increases the patient's injury or refuses to submit to such medical or surgical treatment as is reasonably essential to promote the patient's recovery, the court may in its discretion reduce or suspend the patient's medical care and related benefits until the injurious practice is discontinued.

D. Any physician selected by a health care provider and paid by the health care provider who shall make or be present at an examination of a patient conducted in pursuance of this section may be required to testify as to the conduct thereof and the findings made. Communications made by the patient upon such examination to such physician or physicians shall not be considered privileged.

E. A health care provider or the custodian of the patient's compensation fund shall pay all reasonable legal fees, cost of medical examinations and the cost of the fees of medical expert witnesses in any proceeding in which a patient succeeds in raising the patient's medical care and related benefits or in any unsuccessful proceeding brought by the health care provider or the patient's compensation fund custodian to reduce medical care and related benefits."

SECTION 2. Section 41-5-3 NMSA 1978 (being Laws 1976,

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Chapter 2, Section 3, as amended) is amended to read:

"41-5-3. DEFINITIONS.--As used in the Medical Malpractice Act:

[~~A. "advisory board" means the patient's compensation fund advisory board;~~

~~B. "fund" means the patient's compensation fund;~~

~~C.~~] A. "health care provider" means a person, corporation, organization, facility or institution licensed or certified by this state to provide health care or professional services as a doctor of medicine, hospital, outpatient health care facility, doctor of osteopathy, chiropractor, podiatrist, nurse anesthetist or physician's assistant; [~~certified nurse practitioner, clinical nurse specialist or certified nurse-midwife or a business entity that is organized, incorporated or formed pursuant to the laws of New Mexico that provides health care services primarily through natural persons identified in this subsection;~~

~~D. "hospital" means a facility licensed as a hospital in this state that offers in-patient services, nursing or overnight care on a twenty-four-hour basis for diagnosing, treating and providing medical, psychological or surgical care for three or more separate persons who have a physical or mental illness, disease, injury or rehabilitative condition or are pregnant and may offer emergency services. "Hospital" includes a hospital's parent corporation, subsidiary~~

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~~corporations or affiliates if incorporated or registered in New Mexico; employees and locum tenens providing services at the hospital; and agency nurses providing services at the hospital;~~

~~E. "independent provider" means a doctor of medicine, doctor of osteopathy, chiropractor, podiatrist, nurse anesthetist, physician's assistant, certified nurse practitioner, clinical nurse specialist or certified nurse-midwife who is not an employee of a hospital or outpatient health care facility. "Independent provider" includes a business entity that is not a hospital or outpatient health care facility that employs or consists of members who are licensed or certified as doctors of medicine, doctors of osteopathy, chiropractors, podiatrists, nurse anesthetists, physician's assistants, certified nurse practitioners, clinical nurse specialists or certified nurse-midwives and the business entity's employees;~~

~~F.~~] B. "insurer" means an insurance company engaged in writing health care provider malpractice liability insurance in this state;

[~~G.~~] C. "malpractice claim" includes any cause of action arising in this state against a health care provider for medical treatment, lack of medical treatment or other claimed departure from accepted standards of health care that proximately results in injury to the patient, whether the patient's claim or cause of action sounds in tort or contract,

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and includes but is not limited to actions based on battery or wrongful death; "malpractice claim" does not include a cause of action arising out of the driving, flying or nonmedical acts involved in the operation, use or maintenance of a vehicular or aircraft ambulance;

[~~H.~~] D. "medical care and related benefits" means all reasonable medical, surgical, physical rehabilitation and custodial services and includes drugs, prosthetic devices and other similar materials reasonably necessary in the provision of such services;

[~~I. "occurrence" means all injuries to a patient caused by health care providers' successive acts or omissions that combined concurrently to create a malpractice claim;~~

~~J. "outpatient health care facility" means an entity that is licensed pursuant to the Public Health Act as an outpatient facility, including ambulatory surgical centers, free-standing emergency rooms, urgent care clinics, acute care centers and intermediate care facilities and includes a facility's employees, locum tenens providers and agency nurses providing services at the facility. "Outpatient health care facility" does not include independent providers;~~

~~K.~~] E. "patient" means a natural person who received or should have received health care from a licensed health care provider, under a contract, express or implied; and

[~~L.~~] F. "superintendent" means the superintendent

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of insurance."

SECTION 3. Section 41-5-5 NMSA 1978 (being Laws 1992, Chapter 33, Section 2, as amended) is amended to read:

"41-5-5. QUALIFICATIONS.--

A. To be qualified under the provisions of the Medical Malpractice Act, a health care provider shall:

(1) establish its financial responsibility by filing proof with the superintendent that the health care provider is insured by a policy of malpractice liability insurance issued by an authorized insurer in the amount of at least [~~two hundred fifty thousand dollars ($250,000)~~] two hundred thousand dollars ($200,000) per occurrence or by having continuously on deposit the sum of [~~seven hundred fifty thousand dollars ($750,000)~~] six hundred thousand dollars ($600,000) in cash with the superintendent or such other like deposit as the superintendent may allow by rule or regulation; provided that [~~hospitals and outpatient health care facilities that establish financial responsibility through a policy of malpractice liability insurance may use any form of malpractice insurance; and provided further that for independent providers~~] in the absence of an additional deposit or policy as required by this subsection, the deposit or policy shall provide coverage for not more than three separate occurrences; and

(2) pay the surcharge assessed on health care providers by the superintendent pursuant to Section 41-5-25

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NMSA 1978.

B. For hospitals or outpatient health care facilities electing to be covered under the Medical Malpractice Act, the superintendent shall determine, based on a risk assessment of each hospital or outpatient health care facility, each hospital's or outpatient health care facility's base coverage or deposit and additional charges for the patient's compensation fund. The superintendent shall arrange for an actuarial study [~~before determining base coverage or deposit and surcharges~~] as provided in Section 41-5-25 NMSA 1978.

C. A health care provider not qualifying under this section shall not have the benefit of any of the provisions of the Medical Malpractice Act in the event of a malpractice claim against it [~~provided that beginning July 1, 2021, hospitals and outpatient health care facilities shall not participate in the medical review process, and beginning January 1, 2027, hospitals and outpatient health care facilities shall have the benefits of the other provisions of the Medical Malpractice Act except participation in the fund~~]."

SECTION 4. Section 41-5-6 NMSA 1978 (being Laws 1992, Chapter 33, Section 4, as amended) is amended to read:

"41-5-6. LIMITATION OF RECOVERY.--

A. Except for punitive damages and [~~past and future~~] medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from any

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injury or death to a patient as a result of malpractice shall not exceed six hundred thousand dollars ($600,000) per occurrence [~~for malpractice claims brought against health care providers if the injury or death occurred prior to January 1, 2022~~]. In jury cases, the jury shall not be given any instructions dealing with this limitation.

[~~B. Except for punitive damages and past and future medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice shall not exceed seven hundred fifty thousand dollars ($750,000) per occurrence for malpractice claims against independent providers; provided that, beginning January 1, 2023, the per occurrence limit on recovery shall be adjusted annually by the consumer price index for all urban consumers.~~

~~C. In calendar year 2022 and subsequent calendar years, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice, except for punitive damages and past and future medical care and related benefits, shall not exceed the following amounts for claims brought against an outpatient health care facility that is not majority-owned and -controlled by a hospital:~~

~~(1) for an injury or death that occurred in calendar years 2022 and 2023, seven hundred fifty thousand~~

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~~dollars ($750,000) per occurrence;~~

~~(2) for an injury or death that occurred in calendar year 2024, five million dollars ($5,000,000) per occurrence;~~

~~(3) for an injury or death that occurred in calendar year 2025, five million five hundred thousand dollars ($5,500,000) per occurrence;~~

~~(4) for an injury or death that occurred in calendar year 2026, six million dollars ($6,000,000) per occurrence; and~~

~~(5) for an injury or death that occurred in calendar year 2027 and each calendar year thereafter, the amount provided in Paragraph (4) of this subsection, adjusted annually by the consumer price index for all urban consumers, per occurrence.~~

~~D. In calendar year 2022 and subsequent calendar years, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice, except for punitive damages and past and future medical care and related benefits, shall not exceed the following amounts for claims brought against a hospital or an outpatient health care facility that is majority-owned and -controlled by a hospital:~~

~~(1) for an injury or death that occurred in calendar year 2022, four million dollars ($4,000,000) per~~

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~~occurrence;~~

~~(2) for an injury or death that occurred in calendar year 2023, four million five hundred thousand dollars ($4,500,000) per occurrence;~~

~~(3) for an injury or death that occurred in calendar year 2024, five million dollars ($5,000,000) per occurrence;~~

~~(4) for an injury or death that occurred in calendar year 2025, five million five hundred thousand dollars ($5,500,000) per occurrence;~~

~~(5) for an injury or death that occurred in calendar year 2026, six million dollars ($6,000,000) per occurrence; and~~

~~(6) for an injury or death that occurred in calendar year 2027 and each calendar year thereafter, the amount provided in Paragraph (5) of this subsection, adjusted annually by the consumer price index for all urban consumers, per occurrence.~~

~~E. The aggregate dollar amounts provided in Subsections B through D of this section include payment to any person for any number of loss of consortium claims or other claims per occurrence that arise solely because of the injuries or death of the patient.~~

~~F. In jury cases, the jury shall not be given any instructions dealing with the limitations provided in this~~

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~~section.~~

~~G.~~] B. The value of accrued medical care and related benefits shall not be subject to [~~any~~] the six-hundred-thousand-dollar ($600,000) limitation.

C. Monetary damages shall not be awarded for future medical expenses in malpractice claims.

[~~H.~~] D. A health care provider's personal liability is limited to [~~two hundred fifty thousand dollars ($250,000)~~] two hundred thousand dollars ($200,000) for monetary damages and medical care and related benefits as provided in Section 41-5-7 NMSA 1978. Any amount due from a judgment or settlement in excess of [~~two hundred fifty thousand dollars ($250,000)~~] two hundred thousand dollars ($200,000) shall be paid from the patient's compensation fund, [~~except~~] as provided in [~~Subsection I of this~~] Section 41-5-25 NMSA 1978.

[~~I. Until January 1, 2027, amounts due from a judgment or settlement against a hospital or outpatient health care facility in excess of seven hundred fifty thousand dollars ($750,000), excluding past and future medical expenses, shall be paid by the hospital or outpatient health care facility and not by the fund. Beginning January 1, 2027, amounts due from a judgment or settlement against a hospital or outpatient health care facility shall not be paid from the fund.~~

~~J. The term "occurrence" shall not be construed in such a way as to limit recovery to only one maximum statutory~~

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~~payment if separate acts or omissions cause additional or enhanced injury or harm as a result of the separate acts or omissions. A patient who suffers two or more distinct injuries as a result of two or more different acts or omissions that occur at different times by one or more health care providers is entitled to up to the maximum statutory recovery for each injury.~~]

E. For the purposes of Subsections A and B of this section, the six-hundred-thousand-dollar ($600,000) aggregate amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice shall apply only to malpractice occurring on or after July 1, 2023."

SECTION 5. Section 41-5-7 NMSA 1978 (being Laws 1992, Chapter 33, Section 5, as amended) is amended to read:

"41-5-7. FUTURE MEDICAL EXPENSES [~~AND PUNITIVE DAMAGES~~].--

A. In all malpractice claims where liability is established, the jury shall be given a special interrogatory asking if the patient is in need of future medical care and related benefits. No inquiry shall be made concerning the value of future medical care and related benefits, and evidence relating to the value of future medical care shall not be admissible. In actions upon malpractice claims tried to the court, where liability is found, the court's findings shall include a recitation that the patient is or is not in need of

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future medical care and related benefits.

B. Except as provided in Section 1 of this 2023 act, once a judgment is entered in favor of a patient who is found to be in need of future medical care and related benefits or a settlement is reached between a patient and health care provider in which the provision of medical care and related benefits is agreed upon, and continuing as long as medical or surgical attention is reasonably necessary, the patient shall be furnished with all medical care and related benefits directly or indirectly made necessary by the health care provider's malpractice, subject to a semiprivate room limitation in the event of hospitalization, unless the patient refuses to allow them to be so furnished.

[~~A.~~] C. Awards of [~~past and~~] future medical care and related benefits shall not be subject to the [~~limitations of recovery~~] six-hundred-thousand-dollar ($600,000) limitation imposed in Section 41-5-6 NMSA 1978.

D. Payment for medical care and related benefits shall be made as expenses are incurred.

[~~B.~~] E. The health care provider shall be liable for all medical care and related benefit payments until the total payments made by or on behalf of it for monetary damages and medical care and related benefits combined equals [~~the health care provider's personal liability limit as provided in Subsection I of Section 41-5-6 NMSA 1978~~] two hundred thousand

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dollars ($200,000), after which the payments shall be made by the patient's compensation fund.

[~~C. Beginning January 1, 2027, any amounts due from a judgment or settlement against a hospital or outpatient health care facility shall not be paid from the fund if the injury or death occurred after December 31, 2026.~~

~~D.~~] F. This section shall not be construed to prevent a patient and a health care provider from entering into a settlement agreement whereby medical care and related benefits shall be provided for a limited period of time only or to a limited degree.

G. The court in a supplemental proceeding shall estimate the value of the future medical care and related benefits reasonably due to the patient on the basis of evidence presented to the court. That figure shall not be included in any award or judgment but shall be included in the record as a separate court finding.

[~~E.~~] H. A judgment of punitive damages against a health care provider shall be the personal liability of the health care provider. Punitive damages shall not be paid from the patient's compensation fund or from the proceeds of the health care provider's insurance contract unless the contract expressly provides coverage. Nothing in Section 41-5-6 NMSA 1978 precludes the award of punitive damages to a patient. Nothing in this subsection authorizes the imposition of

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liability for punitive damages on a derivative basis where that imposition would not be otherwise authorized by law."

SECTION 6. Section 41-5-9 NMSA 1978 (being Laws 1976, Chapter 2, Section 9, as amended) is amended to read:

"41-5-9. DISTRICT COURT--CONTINUING JURISDICTION.--

A. The district court from which final judgment [~~issued~~] issues shall have continuing jurisdiction in cases where [~~future~~] medical care and related benefits [~~were~~] are awarded pursuant to Section 41-5-7 NMSA 1978 [~~for malpractice claims arising from occurrences prior to July 1, 2021~~].

B. In all cases where the patient's continued need of such benefits or the degree to which such benefits are needed is challenged at a point in time after a judgment is entered, the court, sitting without a jury, shall determine whether such need continues to exist and the extent of such need.

C. Whenever a patient petitions the district court for an increase in medical care and related benefits, the petition shall be set down for hearing at the earliest possible time and take precedence over all matters except older matters of the same character and motions for preliminary injunctions filed pursuant to Rules 1-065, 1-066 NMRA.

D. The health care provider shall have the burden of proving that the patient's need for benefits has subsided or abated, or that medical care and related benefits are not

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reasonably necessary, which the health care provider shall establish by clear and convincing evidence. The patient shall have the burden of proving that the patient's need for medical care and related benefits has increased, which the patient shall establish by a preponderance of the evidence."

SECTION 7. Section 41-5-13 NMSA 1978 (being Laws 1976, Chapter 2, Section 13, as amended) is amended to read:

"41-5-13. LIMITATIONS.--No claim for malpractice arising out of an act of malpractice that occurred subsequent to the effective date of the Medical Malpractice Act may be brought against a health care provider unless filed within three years after the date that the act of malpractice occurred, except that [~~the times limited for the bringing of actions by minors and incapacitated persons shall be extended so that they shall have one year from and after the age of majority or termination of incapacity within which to commence the actions~~] a minor under the full age of six years shall have until the minor's ninth birthday in which to file. This section applies to all persons regardless of minority or other legal disability."

SECTION 8. Section 41-5-14 NMSA 1978 (being Laws 1976, Chapter 2, Section 14, as amended) is amended to read:

"41-5-14. MEDICAL REVIEW COMMISSION [~~INDEPENDENT PROVIDERS~~].--

A. The "New Mexico medical review commission" is created. The function of the New Mexico medical review

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commission is to provide panels to review all malpractice claims against [~~independent~~] health care providers [~~who are natural persons~~] covered by the Medical Malpractice Act.

B. Those eligible to sit on a panel shall consist of health care providers licensed pursuant to New Mexico law and residing in New Mexico and members of the state bar.

C. The [~~only cases that a~~] panel will consider [~~are~~] cases involving [~~an~~] any alleged act of malpractice occurring in New Mexico by [~~an independent provider~~] a health care provider qualified under the Medical Malpractice Act. [~~Beginning July 1, 2021, cases involving an alleged act of malpractice by a hospital or outpatient health care facility shall not be considered and such claims shall not be filed with the New Mexico medical review commission.~~]

D. An attorney shall submit a case for the consideration of a panel, prior to filing a complaint in any district court or other court sitting in New Mexico, by addressing an application, in writing, signed by the patient or the patient's attorney, to the director of the New Mexico medical review commission.

E. The director of the New Mexico medical review commission shall be an attorney appointed by and serving at the pleasure of the chief justice of the New Mexico supreme court.

F. The chief justice shall set the director's salary and report the salary to the superintendent in the

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superintendent's capacity as custodian of the patient's compensation fund."

SECTION 9. Section 41-5-15 NMSA 1978 (being Laws 1976, Chapter 2, Section 15, as amended) is amended to read:

"41-5-15. COMMISSION DECISION REQUIRED--APPLICATION.--

A. No malpractice action may be filed in any court against a qualifying [~~independent~~] health care provider [~~or the independent provider's employer, master or principal based on a theory of respondeat superior or any other derivative theory of recovery~~] before application is made to the New Mexico medical review commission and its decision is rendered [~~provided, however, that an independent provider and the patient may stipulate to forego the panel process~~].

B. This application shall contain the following:

[~~(1) the name of the health care provider against which the claims are asserted;~~

~~(2) a short and plain statement of the grounds as to why the New Mexico medical review commission has jurisdiction over the claims being asserted;~~

~~(3) the specific date or date range when the malpractice allegedly occurred;~~

~~(4) so far as known, a brief statement of the facts supporting the patient's malpractice claim; and~~

~~(5) a statement authorizing the panel to obtain access to all medical and hospital records and~~

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~~information pertaining to the matter giving rise to the application and, for the purposes of its consideration of the matter only, waiving any claim of privilege as to the contents of those records. Nothing in that statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.~~]

(1) a brief statement of the facts of the case, naming the persons involved, the dates and the circumstances, so far as they are known, of the alleged act or acts of malpractice; and

(2) a statement authorizing the panel to obtain access to all medical and hospital records and information pertaining to the matter giving rise to the application, and, for the purposes of its consideration of the matter only, waiving any claim of privilege as to the contents of those records. Nothing in that statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court."

SECTION 10. Section 41-5-16 NMSA 1978 (being Laws 1976, Chapter 2, Section 16, as amended) is amended to read:

"41-5-16. APPLICATION PROCEDURE.--

A. Upon receipt of an application for review, the [~~New Mexico medical review~~] commission's director or the director's designee shall cause to be served a true copy of the application on the [~~independent~~] health care providers [~~against~~

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~~which claims are asserted~~]. Service shall be effected pursuant to New Mexico law. If the [~~independent~~] health care provider involved chooses to retain legal counsel, the [~~independent~~] health care provider's attorney shall informally enter an appearance with the director.

B. The [~~independent~~] health care provider shall answer the application for review and in addition shall submit a statement authorizing the panel to obtain access to all medical and hospital records and information pertaining to the matter giving rise to the application and, for the purposes of its consideration of the matter only, waiving any claim of privilege as to the contents of those records. Nothing in that statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

C. In instances where applications are received employing the theory of respondeat superior or some other derivative theory of recovery, the director shall forward such applications to the state professional societies, associations or licensing boards of both the individual [~~independent~~] health care provider whose alleged malpractice caused the application to be filed and the [~~independent~~] health care provider named a respondent as employer, master or principal."

SECTION 11. Section 41-5-17 NMSA 1978 (being Laws 1976, Chapter 2, Section 17, as amended) is amended to read:

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"41-5-17. PANEL SELECTION.--

A. Applications for review shall be promptly transmitted by the director [~~of the New Mexico medical review commission~~] to the directors of the [~~independent~~] health care provider's state professional society or association and the state bar association, who shall each select three panelists within thirty days from the date of transmittal of the application.

B. If no state professional society or association exists or if the [~~independent~~] health care provider does not belong to a society or association, the director shall transmit the application to the [~~independent~~] health care provider's state licensing board, which shall in turn select three persons from the [~~independent~~] health care provider's profession and, where applicable, two persons specializing in the same field or discipline as the [~~independent~~] health care provider.

C. In cases where there are multiple defendants, the case against each health care provider may be reviewed by a separate panel, or a single combined panel [~~shall~~] may review the [~~claims~~] claim against all [~~party defendants. At the discretion of the panel chair, a hearing involving multiple defendants may include fewer than three panelists from the independent provider's profession and fewer than three lawyer panel members per defendant~~] parties defendant, at the discretion of the director.

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D. [~~Except for cases involving multiple defendants~~] Three panel members from the [~~independent~~] health care provider's profession and three panel members from the state bar association shall sit in review in each case.

E. In those cases where the theory of respondeat superior or some other derivative theory of recovery is employed, two of the panel members shall be chosen from the individual health care provider's profession and one panel member shall be chosen from the profession of the health care provider named a respondent employer, master or principal.

[~~E.~~] F. The director of the [~~medical review~~] commission or the director's delegate, who shall be an attorney, shall sit on each panel and serve as chair.

[~~F. A~~] G. Any member shall disqualify the member's self from consideration of [~~a~~] any case in which, by virtue of circumstances, the member feels the member's presence on the panel would be inappropriate, considering the purpose of the panel. The director may excuse a proposed panelist from serving.

[~~G.~~] H. Whenever a party [~~makes and files~~] shall make and file an affidavit that a panel member selected pursuant to this section cannot, according to the belief of the party making the affidavit, sit in review of the application with impartiality, that panel member shall proceed no further. Another panel member shall be selected by the [~~independent~~]

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health care provider's professional association, state licensing board or the state bar association, as the case may be. A party may not disqualify more than three proposed panel members in this manner in any single malpractice claim."

SECTION 12. Section 41-5-18 NMSA 1978 (being Laws 1976, Chapter 2, Section 18, as amended) is amended to read:

"41-5-18. TIME AND PLACE OF HEARING.--A date, time and place for hearing shall be fixed by the director [~~of the New Mexico medical review commission~~] and prompt notice [~~of the hearing~~] thereof shall be given to the parties involved, their attorneys and the members of the panel. In no instance shall the date set be more than sixty days after the transmittal by the director of the application for review, unless good cause exists for extending the period. Hearings may be held anywhere in the state, and the director shall give due regard to the convenience of the parties in determining the place of hearing. [~~Upon the request of one party, within ten days of the answer filed by the respondent, the hearing shall be conducted via video conference, including attorneys, witnesses and panel members appearing remotely.~~]"

SECTION 13. Section 41-5-19 NMSA 1978 (being Laws 1976, Chapter 2, Section 19, as amended) is amended to read:

"41-5-19. HEARING PROCEDURES.--

A. At the time set for hearing, the attorney submitting the case for review shall be present and shall make

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a brief introduction of the case, including a resume of the facts constituting alleged professional malpractice, which the health care provider's attorney is prepared to prove. The [~~independent~~] health care provider against whom the claim is brought and the [~~independent~~] health care provider's attorney may be present and may make an introductory statement of the [~~independent~~] health care provider's case.

B. Both parties may call witnesses to testify before the panel, which witnesses shall be sworn. Medical texts, journals, studies and other documentary evidence relied upon by either party may be offered and admitted if relevant. Written statements of fact of treating [~~independent~~] health care providers may be reviewed. The monetary damages in any case shall not be a subject of inquiry or discussion.

C. The hearing shall be informal, and no official transcript shall be made. Nothing contained in this subsection shall preclude the [~~recording or transcribing~~] taking of the testimony by the parties at their own expense.

D. At the conclusion of the hearing, the panel shall [~~deliberate and reach a decision~~] take the case under advisement or may request that additional facts, records, witnesses or other information be obtained and presented at a supplemental hearing, which shall be set for a date and time certain, not longer than thirty days from the date of the original hearing unless the attorney bringing the matter for

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review shall in writing consent to a longer period.

E. Any supplemental hearing shall be held in the same manner as the original hearing, and the parties concerned and their attorneys may be present."

SECTION 14. Section 41-5-25 NMSA 1978 (being Laws 1992, Chapter 33, Section 9, as amended) is amended to read:

"41-5-25. PATIENT'S COMPENSATION FUND [~~THIRD-PARTY ADMINISTRATOR--ACTUARIAL STUDIES--SURCHARGES--CLAIMS--PRORATION--PROOFS OF AUTHENTICITY~~].--

A. [~~The~~] There is created in the state treasury a "patient's compensation fund" [~~is created as a nonreverting fund in the state treasury. The fund consists of money from surcharges, income from investment of the fund and any other money deposited to the credit of the fund~~] to be collected and received by the superintendent for exclusive use for the purposes stated in the Medical Malpractice Act. The fund and any income from the fund shall be held in trust, deposited in a segregated account, [~~in the state treasury and~~] invested [~~by the state investment office~~] and reinvested by the superintendent with the prior approval of the state board of finance and shall not become a part of or revert to the general fund [~~or any other fund~~] of the state. [~~Money~~] The fund and any income from the fund shall only be expended [~~only~~] for the purposes of and to the extent provided in the Medical Malpractice Act. [~~All approved expenses of collecting,~~

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~~protecting and administering the fund, including purchasing insurance for the fund, shall be paid from the fund.~~

~~B. The superintendent shall contract for the administration and operation of the fund with a qualified, licensed third-party administrator, selected in consultation with the advisory board, no later than January 1, 2022. The third-party administrator shall provide an annual audit of the fund to the superintendent.~~

~~C.~~] The superintendent shall have the authority to use fund money to purchase insurance for the fund and its obligations. The superintendent, as custodian of the patient's compensation fund, [~~and the third-party administrator~~] shall be notified by the health care provider or the health care provider's insurer within thirty days of service on the health care provider of a complaint asserting a malpractice claim brought in a court in this state against the health care provider.

[~~D. The superintendent shall levy~~] B. To create the patient's compensation fund, an annual surcharge shall be levied on all [~~New Mexico~~] health care providers qualifying under Paragraph (1) of Subsection A of Section 41-5-5 NMSA 1978. The surcharge shall be determined by the superintendent, [~~with the advice of the advisory board and based on the annual independent actuarial study of the fund. The surcharges for health care providers, including hospitals and outpatient~~

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~~health care facilities whose qualifications for the fund end on January 1, 2027, shall be based on sound actuarial principles, using data obtained from New Mexico claims and loss experience. A hospital or outpatient health care facility seeking participation in the fund during the remaining qualifying years shall provide, at a minimum, the hospital's or outpatient health care facility's direct and indirect cost information as reported to the federal centers for medicare and medicaid services for all self-insured malpractice claims, including claims and paid loss detail, and the claims and paid loss detail from any professional liability insurance carriers for each hospital or outpatient health care facility and each employed health care provider for the past eight years to the third-party actuary. The same information shall be available to the advisory board for review, including financial information and data, and excluding individually identifying case information, which information shall not be subject to the Inspection of Public Records Act. The superintendent, the third-party actuary or the advisory board shall not use or disclose the information for any purpose other than to fulfill the duties pursuant to this subsection.~~

~~E.~~] based upon sound actuarial principles, using data obtained from New Mexico experience if available. The surcharge shall be collected on the same basis as premiums by each insurer from the health care provider.

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C. The surcharge with accrued interest shall be due and payable within thirty days after the premiums for malpractice liability insurance have been received by the insurer from the health care provider in New Mexico.

D. If the annual premium surcharge is collected but not paid [~~timely~~] within the time limit specified in Subsection C of this section, the [~~superintendent may suspend the~~] certificate of authority of the insurer may be suspended until the annual premium surcharge is paid.

[~~F. Surcharges shall be set by October 31 of each year for the next calendar year. Beginning in 2021, the surcharges shall be set with the intention of bringing the fund to solvency with no projected deficit by December 31, 2026. All qualified and participating hospitals and outpatient health care facilities shall cure any fund deficit attributable to hospitals and outpatient health care facilities by December 31, 2026.~~]

E. All expenses of collecting, protecting and administering the patient's compensation fund or of purchasing insurance for the fund shall be paid from the fund.

F. Claims payable pursuant to Laws 1976, Chapter 2, Section 30 shall be paid in accordance with the payment schedule constructed by the court. If the patient's compensation fund would be exhausted by payment of all claims allowed during a particular calendar year, then the amounts

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paid to each patient and other parties obtaining judgments shall be prorated, with each such party receiving an amount equal to the percentage the party's own payment schedule bears to the total of payment schedules outstanding and payable by the fund. Any amounts due and unpaid as a result of such proration shall be paid in the following calendar years. However, payments for medical care and related benefits shall be made before any payment made under Laws 1976, Chapter 2, Section 30.

[~~G.~~] If the patient's compensation fund would be exhausted by payment of all claims allowed during a particular calendar year, then the amounts paid to each patient and other parties obtaining judgments shall be prorated, with each such party receiving an amount equal to the percentage the party's own payment schedule bears to the total of payment schedules outstanding and payable by the fund. Any amounts due and unpaid as a result of such proration shall be paid in the following calendar years. However, payments for medical care and related benefits shall be made before any payment made under Laws 1976, Chapter 2, Section 30.

[~~H.~~] G. Upon receipt of one of the proofs of authenticity listed in this subsection, reflecting a judgment for damages rendered pursuant to the Medical Malpractice Act, the superintendent shall issue or have issued warrants in accordance with the payment schedule constructed by the court

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and made a part of its final judgment. The only claim against the patient's compensation fund shall be a voucher or other appropriate request by the superintendent after the superintendent receives:

(1) [~~until January 1, 2022~~] a certified copy of a final judgment in excess of two hundred thousand dollars ($200,000) against a health care provider;

(2) [~~until January 1, 2022~~] a certified copy of a court-approved settlement or certification of settlement made prior to initiating suit, signed by both parties, in excess of two hundred thousand dollars ($200,000) against a health care provider; or

(3) [~~until January 1, 2022~~] a certified copy of a final judgment less than two hundred thousand dollars ($200,000) and an affidavit of a health care provider or its insurer attesting that payments made pursuant to Subsection [~~B~~] E of Section 41-5-7 NMSA 1978, combined with the monetary recovery, exceed two hundred thousand dollars ($200,000).

[~~I. On or after January 1, 2022, the amounts specified in Paragraphs (1) through (3) of Subsection H of this section shall be two hundred fifty thousand dollars ($250,000).~~]

H. The superintendent shall contract for an independent actuarial study of the patient's compensation fund to be performed not less than once every two years."

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SECTION 15. Section 41-5-28 NMSA 1978 (being Laws 1976, Chapter 2, Section 29, as amended) is amended to read:

"41-5-28. PAYMENT OF MEDICAL REVIEW COMMISSION EXPENSES.--Unless otherwise provided by law, expenses incurred in carrying out the powers, duties and functions of the New Mexico medical review commission, including the salary of the director [~~of the commission~~], shall be paid by the patient's compensation fund. The superintendent, in the superintendent's capacity as custodian of the fund, shall disburse fund money to the director upon receipt of vouchers itemizing expenses incurred by the New Mexico medical review commission. The director shall supply the chief justice of the New Mexico supreme court with duplicates of all vouchers submitted to the superintendent. Expenses [~~of the commission~~] paid by the fund shall not exceed [~~five hundred thousand dollars ($500,000)~~] three hundred fifty thousand dollars ($350,000) in any single calendar year; provided, however, that expenses incurred in defending the commission shall not be subject to that maximum amount."

SECTION 16. Section 41-5-29 NMSA 1978 (being Laws 1992, Chapter 33, Section 10, as amended) is amended to read:

"41-5-29. [~~FUND~~] REPORTS.--On January 31 of each year, the superintendent shall, upon request, provide a written report to all interested persons of the following information:

A. the beginning and ending calendar year balances

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in the patient's compensation fund;

B. [~~an itemized accounting of~~] the total amount of contributions to the patient's compensation fund; and

[~~C. All information regarding closed claims files, including an itemized accounting of all payments paid out; and~~

~~D.~~] C. any other information regarding the patient's compensation fund that the superintendent [~~or the legislature~~] considers to be important."

SECTION 17. REPEAL.--Section 41-5-25.1 NMSA 1978 (being Laws 2021, Chapter 16, Section 14) is repealed.

SECTION 18. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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