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

SPONSOR Ely **ORIGINAL DATE** 01/31/21 **LAST UPDATED** 03/18/21 **HB** 75/aHJC/aSJC/aSFl#1

SHORT TITLE Medical Malpractice Definitions **SB**

ANALYST Glenn/Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY21	FY22	FY23	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	Indeterminate but Minimal				Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Related to Senate Bill 239

SOURCES OF INFORMATION
LFC Files

Responses Received From Regarding the Original Bill
Office of the Superintendent of Insurance (OSI)
Medical Board (MB)
Department of Health (DOH)
Administrative Office of the Courts (AOC)

SUMMARY

Synopsis of SFl#1

Senate Floor amendment #1 to House Bill 75 adds four words to the definition of "independent provider" in Section 1 of the bill to the effect that employees or agents of healthcare entities are not independent providers.

Synopsis of SJC Amendment

The Senate Judiciary Committee amendment to House Bill 75 puts forward an entirely new bill, scrapping all of the previous House Bill 75, Sections 1, 2, and 3, and substituting seventeen new sections, making a number of new provisions regarding medical malpractice not included in the previously once-amended bill. Much of the bill has to do with the previously established patient compensation fund. An entirely new title, reflecting the increased scope of the bill, replaces the previous title. Here are some of its chief provisions:

1. Raising the recoverable limits for occurrences alleged against individual practitioners and, thus, the amount of medical malpractice insurance required. These limits exclude punitive damages and medical expenses.
2. Requiring hospitals, outpatient clinics, and other business entities desiring to be covered under the Medical Malpractice Act to undergo actuarial study through OSI and ending their participation in the patient compensation fund after December 31, 2026.
3. Establishing a patient compensation fund advisory committee, specifying its composition (to include representatives of trial lawyers, health care providers, and hospitals) and its duties.
4. Requires the hiring of a qualified third party administrator for the fund.
5. Defines "independent provider," newly including certified nurse practitioners, clinical nurse specialists, certified nurse midwives and health care business entities.
6. Determines annual surcharges for participating in the PCF will be set with the intention of bringing the fund to solvency – with no projected deficit – by December 31, 2026.

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

Section of this amended 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" to include "malpractice claim," and "occurrence." Also adds a definition of "hospital" to include hospitals' parent corporations and other subsidiaries if located within New Mexico, and employees and locum tenens providers and nurses at those hospitals. "Independent provider" is newly defined to include allopathic and osteopathic physicians, chiropractors, nurse practitioners, physician assistants, podiatrists, nurse anesthetists, clinical nurse specialists and certified nurse-midwives and their business office associates.	Sec. 41-5-3
2	Raises required malpractice insurance from $200 thousand to $250 thousand per occurrence for individuals. OSI would determine, based on a new actuarial evaluation of previous malpractice experience, the amount required for a hospital, outpatient facility or business entity. Hospitals would not participate in the medical review process after July 1, 2022, and would not participate in the fund after January 1, 2027.	Sec. 41-5-5
3	The aggregate amount that could be recovered by a patient is increased from $600 thousand to $750 thousand per occurrence, with an individual practitioner's liability rising from the current $200 thousand to $250 thousand. Hospitals and outpatient facilities would see a limit of $4 million per occurrence in calendar year 2022, $4.5 million	Sec. 41-5-6

	in 2023, $5 million in 2024, $5.5 million in 2025, and $6 million in 2026. Juries would receive instruction as to these limits. These limits do not apply to punitive damages nor to the value of medical care needed as a result of the malpractice committed.	
4	Awards for future medical expenses as a result of an act of malpractice would not be subject to the limits specified in Section 3 and would place in a medical savings trust if there were an approved settlement. Events involving hospitals and outpatient facilities occurring beginning January 1, 2027 would not be paid from the fund.	Sec. 41-5-7
5	(Simplifies previous statute) The district court that decided damages on an act occurring before January 1. 2022 would continue to have jurisdiction if needed after that date.	Sec. 4-5-9
6	A statute of limitations of three years after act of alleged malpractice obtains, except for children and incapacitated persons, where the statute of limitations extends to one year after the child no longer is a minor, or an incapacitated person is no longer incapacitated.	
7	Establishes a medical review commission that 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 of the medical review commission-operated panel review, which is otherwise mandated before any claim can go to trial.	Sec. 41-5-14
8	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
9	Leaves this section relatively untouched except to substitute "independent provider (as defined in section 1)" for "provider."	Sec. 41-5-16
10	Regards panel selection. 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
11	Newly allows panel hearings to occur by video conference.	Sec. 41-5-18
12	Leaves this section untouched except to substitute "independent provider (as defined in section 1)" for "provider."	Sec. 4-15-19
13	Regarding the patient's compensation fund (a nonreverting fund in the state treasury), adds the provision that the Superintendent of Insurance must approve any settlement of a claim for more than $250 thousand ($200 thousand before January 1, 2022). Requires OSI to appoint a qualified third-	Sec. 41-5-25

	party administrator of the fund and give notice to providers of the amount of surcharge they will have to pay into the fund. Describes mechanisms for payment of claims, with the new limit of $250 thousand. Requires an actuarial study of the fund's balance, which will require confidentiality. Surcharges on hospitals, outpatient facilities and business entities would be determined using actuarial data.	
14	Creates a nine-member patient's compensation fund advisory board and defines its members' qualifications and duties.	New section
15	Increases the annual limit on commission expenses to $500 thousand.	Sec. 41-5-28
16	Requires an annual report by OSI to "interested parties" regarding balances in the fund, closed claims, and accounts of contributions to the fund.	Sec. 4-5-29
17	Repeals Sections 41-5-2, which established the purpose of the act, and 41-5-10 NMSA 1978, which made requirements of the patient to have an examination done at the request of the provider who was alleged to have committed malpractice.	Sections 4-5-2 and 4-5-10.
18	Effective dates: • Sections 7, 13, and 14: July 1, 2021. • All other sections: January 1, 2022.	New section

Synopsis of HJC Amendment

The House Judiciary Committee amendment to House Bill 75 adds an effective date of December 31, 2021.

Synopsis of Original Bill

House Bill 75 amends the Medical Malpractice Act, Chapter 41, Article 5 NMSA 1978, to remove hospitals from the definition of "healthcare provider." As a result, hospitals would no longer qualify for coverage under the Medical Malpractice Act, including the act's cap on nonmedical damages in malpractice claims (there is no cap on damages related to accrued medical care) and provisions governing insurance coverage and payments to the patient's compensation fund.

There is no effective date of this bill. It is assumed the effective date is 90 days following adjournment of the Legislature.

FISCAL IMPLICATIONS

According to OSI, the patient's compensation fund (PCF) is self-funded, so changes resulting from HB75 would not affect the general fund.

AOC states that there will be a minimal administrative cost for statewide update, distribution,

and documentation of statutory changes. Any additional fiscal impact on the judiciary would be proportional to the enforcement of the bill, medical malpractice actions commenced against hospitals and appeals resulting from such actions, and awards for damages. New laws, amendments to existing laws and new hearings have the potential to increase caseloads in the courts, thus requiring additional resources to handle the increase.

SIGNIFICANT ISSUES

Section 41-5-25 of the Medical Practice Act provides that the PCF is created in the state treasury and administered by the Superintendent of Insurance. The PCF is funded with annual premium surcharges imposed on qualified healthcare providers. Amounts from the PCF are used to pay the amount of monetary damages in a malpractice claim in excess of the $200 thousand for which a healthcare provider is personally liable, subject to a $600 thousand cap on nonmedical damages.

Hospitals have made significant contributions to the PCF since joining in 2015. Removing hospitals from the act would result in higher surcharges for the remaining participants.

OSI provided the following information regarding the potential effect of HB75 on the PCF:

PCF Balance and Deficit Summary

	Fund Balance	Fund Deficit = Fund Balance–Estimated Total Liabilities
12/31/2015 (before hospitals joined the PCF)	$33.4 million	$39.9 million
12/31/2019	$109.4 million	$65.2 million

The PCF deficit increased from $40 million in 2015 to $65 million as of 12/31/2019. However, since hospitals were included in the PCF, the deficit, as a percentage of annual surcharges, has decreased to 155 percent in 2019. This shows that the financial condition of the PCF improved by having the hospitals included.

Reduction of the deficit requires assessment increases calculated as percentage increases of the current PCF surcharge. OSI estimates the PCF will lose about half of its total surcharge revenue if the hospitals are no longer included, which will cause the deficit to surge above 300 percent. The burden of reducing the deficit will fall on the remaining participants in the PCF, who will be subjected to substantial increases in surcharges.

In addition to carrying the burden of making up the PCF deficit, the remaining participants will bear the risk of all future claims, including those involving hospitals that previously participated in the PCF. If actual claims involving hospitals exceed the amount of the surcharges collected from those hospitals, the shortfall will be borne by the remaining participants.

The increase in surcharges if hospitals are removed from participation in the PCF may result in rates that are unaffordable for many of the remaining participants. If the

surcharges increase enough to be comparable to or exceed the cost of medical malpractice insurance coverage in the private market, the remaining participants may choose to drop out of the PCF. This will further shrink the number of participating health care providers and surcharge revenues available to pay malpractice claims.

DOH states that HB75 would open the possibility for greater damage awards against hospitals in malpractice claims due to the removal of the protective cap on nonmedical damages afforded healthcare providers under the act.

AOC notes that if damages awarded in malpractice claims against hospitals are no longer covered by the Medical Malpractice Act's liability cap, it may be more difficult for hospitals to obtain professional liability insurance. This could result in fewer hospitals operating in New Mexico, lower quality healthcare available to New Mexicans, and higher-cost hospital services.

TECHNICAL ISSUES

In Section 1, line 23, AOC points out that the deletion of the word "hospital" in Section 41-5-3(A) does not include the comma that exists in the current provision.

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