AN ACT

RELATING TO MEDICAL MALPRACTICE; CLARIFYING DEFINITIONS IN THE MEDICAL MALPRACTICE ACT; LIMITING PUNITIVE DAMAGES IN MEDICAL MALPRACTICE CASES; REQUIRING PAYMENTS FROM THE PATIENT'S COMPENSATION FUND TO BE MADE AS EXPENSES ARE INCURRED.

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

SECTION 1. Section 41-5-3 NMSA 1978 (being Laws 1976, 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. "control" means equity ownership in a business entity that:

(1) represents more than fifty percent of the total voting power of the business entity; or

(2) has a value of more than fifty percent of that business entity;

C. "fund" means the patient's compensation fund;

D. "health care provider" means a person, a corporation, an organization, a facility or an institution licensed or certified by this state to provide health care or professional services as a doctor of medicine, a hospital, an

outpatient health care facility, a doctor of osteopathy, a chiropractor, a podiatric physician, a nurse anesthetist, a physician's assistant, a certified nurse practitioner, a 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. "Health care provider" does not mean a person or an entity protected pursuant to the Tort Claims Act or the Federal Tort Claims Act;

E. "hospital" means a facility licensed as a hospital in this state that offers inpatient 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 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. "Hospital" does not mean a person or an entity protected pursuant to the Tort Claims Act or the Federal Tort Claims Act;

F. "hospital system" means a group of two or more

hospitals that are owned, operated or controlled by the same person or persons;

G. "independent outpatient health care facility" means a health care facility that is an ambulatory surgical center, an urgent care facility or a free-standing emergency room that is not, directly or indirectly through one or more intermediaries, controlled or under common control with a hospital. "Independent outpatient health care facility" includes a facility's employees, locum tenens providers and agency nurses providing services at the facility. "Independent outpatient health care facility" does not mean a person or an entity protected pursuant to the Tort Claims Act or the Federal Tort Claims Act;

H. "independent provider" means a doctor of medicine, doctor of osteopathy, chiropractor, podiatric physician, nurse anesthetist, physician's assistant, certified nurse practitioner, clinical nurse specialist or certified nurse-midwife who is not an employee of a hospital or an outpatient health care facility. "Independent provider" does not mean a person or an entity protected pursuant to the Tort Claims Act or the Federal Tort Claims Act. "Independent provider" includes:

(1) a health care facility that is:

(a) licensed pursuant to the Health Care Code as an outpatient facility;

(b) not an ambulatory surgical center, an urgent care facility or a free-standing emergency room; and

(c) not hospital-controlled; and

(2) a business entity that is not a hospital or an outpatient health care facility that employs or consists of members who are licensed or certified as doctors of medicine, doctors of osteopathy, chiropractors, podiatric physicians, nurse anesthetists, physician's assistants, certified nurse practitioners, clinical nurse specialists or certified nurse-midwives and the business entity's employees;

I. "insurer" means an insurance company engaged in writing health care provider malpractice liability insurance in this state;

J. "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, 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;

K. "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;

L. "occurrence" means a health care provider's or health care providers' acts or omissions in the course of medical treatment that created or combined to create an injury or injuries to a patient, regardless of the number of health care providers whose acts or omissions contributed to the injury or injuries; provided that "occurrence" shall not be construed to limit recovery to only one maximum statutory payment when independent medical acts or omissions cause separate injury or injuries to a patient in a course of medical treatment;

M. "outpatient health care facility" means an entity that is hospital-controlled and is licensed pursuant to the Health Care Code 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:

(1) independent providers;

(2) independent outpatient health care facilities; or

(3) individuals or entities protected pursuant to the Tort Claims Act or the Federal Tort Claims Act;

N. "patient" means a natural person who received or should have received health care from a health care provider, under a contract, express or implied;

O. "superintendent" means the superintendent of insurance; and

P. "value of accrued medical care and related benefits" means the actual amount paid or owed by a patient, or a third party on behalf of a patient, for medical care and related benefits. "Value of accrued medical care and related benefits" does not include any costs waived, written off or lowered by a health care provider."

SECTION 2. 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, except an independent outpatient health care facility, 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) per occurrence or by having continuously on deposit the sum of seven hundred fifty thousand dollars ($750,000) in cash with the superintendent or such other like deposit as the superintendent may allow by rule; provided that hospitals and hospital-controlled 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 NMSA 1978.

B. To be qualified under the provisions of the Medical Malpractice Act, an independent outpatient health care facility 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 five hundred thousand dollars ($500,000) per occurrence

or by having continuously on deposit the sum of one million five hundred thousand dollars ($1,500,000) in cash with the superintendent or other like deposit as the superintendent may allow by rule; provided that for independent outpatient health care facilities, 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 independent outpatient health care facilities by the superintendent pursuant to Section 41-5-25 NMSA 1978.

C. For hospitals or hospital-controlled 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 hospital-controlled outpatient health care facility, each hospital's or hospital-controlled outpatient health care facility's base coverage or deposit and additional charges for the fund. The superintendent shall arrange for an actuarial study before determining base coverage or deposit and surcharges.

D. 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 hospital-controlled outpatient health

care facilities shall not participate in the medical review process."

SECTION 3. 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 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. 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 seven hundred fifty thousand dollars ($750,000) for claims brought against an independent outpatient health care facility; for an injury or death that occurred in calendar years 2022 and 2023.

D. In calendar year 2024 and subsequent years, the aggregate dollar amount recoverable by all persons for or arising from an 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 independent outpatient health care facility:

(1) for an injury or death that occurred in calendar year 2024, one million dollars ($1,000,000) per occurrence; and

(2) for an injury or death that occurred in calendar year 2025 and thereafter, the amount provided in Paragraph (1) of this subsection, adjusted annually by the prior three-year average consumer price index for all urban consumers, per occurrence.

E. 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 a hospital-controlled outpatient health care facility:

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

F. The aggregate dollar amounts provided in

Subsections B through E 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.

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

H. The value of accrued medical care and related benefits shall not be subject to any limitation.

I. Except for an independent outpatient health care facility, a health care provider's personal liability is limited to two hundred fifty thousand dollars ($250,000) 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) shall be paid from the fund, except as provided in Subsections J and K of this section.

J. An independent outpatient health care facility's personal liability is limited to five hundred thousand dollars ($500,000) 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 five hundred thousand dollars ($500,000) shall be paid from the fund.

K. Amounts due from a judgment or settlement

against a hospital or hospital-controlled 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 hospital-controlled outpatient health care facility and not by the fund."

SECTION 4. Section 41-5-7 NMSA 1978 (being Laws 1992, Chapter 33, Section 5, as amended) is amended to read:

"41-5-7. MEDICAL EXPENSES.--

A. Awards of past and future medical care and related benefits shall not be subject to the limitations of recovery imposed in Section 41-5-6 NMSA 1978.

B. 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 Section 41-5-6 NMSA 1978, after which the payments shall be made by the fund.

C. Payments made from the fund for the cost of medical care and related benefits shall be made as expenses are incurred."

SECTION 5. A new section of the Medical Malpractice Act, Section 41-5-7.1 NMSA 1978, is enacted to read:

"41-5-7.1. PUNITIVE DAMAGES.--

A. Punitive damages may only be awarded in a malpractice claim if the prevailing party provides clear and convincing evidence demonstrating that the acts of the health care provider were malicious, willful, wanton, reckless, fraudulent or in bad faith.

B. A judgment of punitive damages against any of the following persons shall not be in an amount greater than the applicable limitation on monetary damages provided in Section 41-5-6 NMSA 1978:

(1) an independent provider;

(2) an independent outpatient health care facility and the facility's employees, locum tenens providers and agency nurses;

(3) a hospital operated by a New Mexico resident or domestic corporation that is not part of a hospital system and the hospital's employees, locum tenens providers and agency nurses; and

(4) employees, locum tenens providers and agency nurses of a hospital or a hospital-controlled outpatient health care facility.

C. Except as provided in Subsection B of this section, a judgment of punitive damages against a hospital or hospital-controlled outpatient health care facility shall not be in an amount greater than two and one-half times the applicable limitation on monetary damages provided in Section

41-5-6 NMSA 1978.

D. A judgment of punitive damages against a health care provider shall not be paid from the fund.

E. The initial claim for relief in a malpractice claim shall not include punitive damages. A claim for punitive damages may be asserted by amendment to the pleadings only after the plaintiff has presented sufficient evidence to the court that it is more likely than not that the claim has a triable issue after substantial completion of discovery. If the court allows amendment to the complaint pursuant to this subsection, the court, in its discretion, may permit additional discovery on the question of punitive damages."

SECTION 6. 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 "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. The fund shall be held in trust, deposited in a segregated account in the state treasury and invested by the investment office and shall not become a part of or revert to the

general fund or any other fund of the state. Money from the fund shall be expended only for the purposes of and to the extent provided in the Medical Malpractice Act. All approved expenses of collecting, 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, as custodian of the 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 an annual surcharge on all New Mexico health care providers qualifying under Section 41-5-5 NMSA 1978. The surcharge for health care providers shall be based on sound actuarial principles, using data obtained from New Mexico claims and loss experience. The surcharges for independent providers and independent outpatient health care facilities 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 surcharge for hospitals and outpatient health care facilities shall be no less than the actuary's recommended surcharges based on an expected value basis to fully fund the current and projected claims obligations of the hospitals and outpatient health care facilities. 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. The surcharge shall be collected on the same basis as premiums by each insurer from the health care provider. The surcharge 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. If the surcharge is collected but not paid timely, the superintendent may suspend the certificate of authority of the insurer 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.

G. If the 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.

H. 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 and made a part of its final judgment. The only claim against the 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 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)."

SECTION 7. SEVERABILITY.--If a provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this act that can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

SECTION 8. APPLICABILITY.--The provisions of this act apply to all claims for medical malpractice that arise on or after the effective date of this act.