

**STATE OF NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE**



**Medical Malpractice Act/Patient's Compensation Fund
Modification Report**

December 31, 2020

Russell Toal, Superintendent

Main Office: 1120 Paseo de Peralta, Room 428, Santa Fe, NM 87501
Satellite Office: 6200 Uptown Blvd NE, Suite 100, Albuquerque, NM 87110
Main Phone: (505) 827-4601 | Satellite Phone: (505) 322-2186 | Toll Free: (855) 4 - ASK - OSI
www.osi.state.nm.us

MEDICAL MALPRACTICE ACT/PATIENT'S COMPENSATION FUND
MODIFICATION REPORT

1. INTRODUCTION:

For 45 years the Patient's Compensation Fund ("PCF") and the New Mexico Medical Malpractice Act of 1976 ("MMA") have played important roles in ensuring that physicians have access to affordable malpractice coverage, and that patients who are injured by acts of medical malpractice are reasonably compensated for any resulting injuries and damages. In the 25 years since the MMA was last amended, significant change has occurred in the way health care providers are organized, the way care is delivered, and the cost of health care services. While the MMA has obviously served the state well, to ensure that the MMA and PCF continue to serve the interests of both patients and providers, the New Mexico Office of Superintendent of Insurance ("OSI") was asked early this year to examine the MMA to determine whether and how the Act should be revised to serve the current health care delivery landscape. To that end, the Superintendent of Insurance, as PCF Custodian, has undertaken a comprehensive assessment of the Act and concluded that indeed, the MMA needs revision.

The PCF Custodian respectfully offers this summary of issues with the MMA, derived from the insights of MMA stakeholders, independent actuaries¹ and OSI staff, and makes recommendations for modernization. The PCF Custodian thanks all stakeholders who have participated in MMA reform discussions in a meaningful manner.

2. SYNOPSIS:

The PCF, established by the MMA, ensures that funds are available to compensate patients injured by an act of medical malpractice committed by a member healthcare provider, including paying past and future medical care. Additionally, the benefits of the PCF enhance New Mexico's ability to recruit and retain physicians. The New Mexico Superintendent of Insurance is the PCF Custodian, and as such, has prime responsibility for ensuring compliance with the MMA and the solvency of the PCF.

In examining issues, recommendations, suggestions and options, the PCF Custodian has taken into full consideration the following:

- Impact on those harmed by malpractice;
- Impact on the availability and cost of healthcare and health insurance;
- Impact on the cost of malpractice liability insurance;
- Impact on the ability to recruit and retain physicians to and in New Mexico.

There are four basic requirements to get into the PCF: *See*, § 41-5-5(A) NMSA 1978.

- Practitioner must belong to a specialty that is eligible for coverage under the PCF.

¹ The PCF commissioned two actuarial studies to inform the decisions pertaining to the restructuring of the PCF. *See* Exhibit 1 for summary of reports.

- Practitioner must demonstrate and maintain financial responsibility by obtaining the primary layer of medical malpractice insurance from a participating insurance carrier, or through self-insurance.
 1. An acceptable underlying insurance policy must be on an **occurrence basis**, with indemnity limits of \$200,000 per occurrence and must provide coverage for three occurrences.
 2. In lieu of the primary layer of coverage, the practitioner may choose to continuously maintain \$600,000 on deposit with the Superintendent of Insurance.
- Practitioner must apply for admission to the PCF through their primary insurance carrier.
- Practitioner must pay the applicable PCF surcharge on a timely basis.

A hospital or outpatient care facility is admitted into the PCF in the following way: upon the application of the eligible entity to the PCF, the Superintendent performs a risk assessment which will determine that applicant's level of base coverage or self-insured deposit. After demonstrating the appropriate financial responsibility and paying the applicable surcharge, the entity is admitted into the PCF. *See*, 41-5-5(B) NMSA 1978.

An element of the PCF that warrants concern is its present financial deficit. (*See* Exhibit 1, Sheet 1 for the history of the PCF deficit growth). In order to address the deficit, the PCF needs to commit to the following:

- 1) Keeping rate adequacy up, by implementing regular increases to at least the “central” actuarial estimate, to ensure that rates are sufficient to cover future losses and avoid contributing to the deficit;
- 2) Implement rate increases at a higher actuarial confidence level whenever possible. This will result in more years with a “rate surplus” which will start to reduce the deficit; or
- 3) Start imposing a “deficit assessment”, a charge that would be additional to any rate increase to keep the rates at adequate levels, which will go towards reducing the deficit.

3. RECENT PCF ACTIVITY:

- a. The PCF implemented numerous changes to improve processes and transparency. The PCF also launched a new website with a newsletter function, and adopted rules to govern Qualified Health Care Provider (“QHP”) admissions, rulemaking and hearings.
- b. In the fall of 2019, the PCF published its biennial actuarial study and conducted its first public hearing in December to set surcharges for individual physicians and provider groups. The PCF also proposed adopting a rating plan to set surcharges for hospitals and outpatient facilities. On December 27, 2019, the PCF Custodian issued an Order setting provider surcharge rates and adopting the proposed hospital and outpatient facility rating plan.
- c. The new PCF Custodian commissioned a second-look actuarial study to determine the soundness of the actuarial analysis underlying the December 27, 2019 Order. This report was completed and made available on the OSI website in the spring of 2020.
- d. OSI has posted a position recruitment for a PCF attorney. Although OSI has conducted several interviews, as of this date, the position is unfilled.

- e. The PCF has engaged an insurance adjusting firm to evaluate medical malpractice claims that implicate the PCF and participate in mediations and other settlement efforts to resolve such claims.
- f. The OSI commissioned two additional actuarial studies in the summer of 2020. One study was to assess the rate adequacy and update the reserve estimate. The second study was to assess four structural questions on the PCF. Both reports were received early in November and posted on the OSI website. Please refer to Exhibit 1 for an additional discussion of the actuarial reports.
- g. The PCF Custodian organized and held multiple stakeholder meetings with each of the following groups: the NM Trial Lawyers Association, the NM Defense Lawyers Association, the NM Hospital Association, the NM Medical Society, representatives of the medical malpractice insurance industry, the Greater Albuquerque Medical Association, and other interested individuals. All of the organizations actively participated in the discussions and provided valuable insight to the PCF Custodian. In addition, some of the stakeholders submitted materials for the OSI staff to review (such as the Milliman actuarial report submitted by The Doctors Company, the largest insurer of physicians in the state). The OSI staff independently conducted research and analyzed actuarial reports and examined malpractice information on other states.
- h. The PCF Custodian issued two follow-up surveys to the organizations listed in the paragraph above to further refine issues that arose during stakeholder meetings.

4. SUMMARY OF RECOMMENDATIONS:

We discuss each of the issues considered in our examination in more detail in Section 5 below, including all of the issues that are addressed summarily in this section.

- a. The first and most important question was: **Should the MMA be revised in the upcoming legislative session**, and there was not a consensus answer to the question. In particular, several participants in the process recommended that due to the COVID-19 pandemic, there has been serious disruption to the health delivery system, and that a significant percentage of providers have experienced service and financial disruption. These stakeholders recommended that no legislative action be taken until the pandemic has been resolved. **The OSI agrees with this recommendation.**
- b. There were 7 items on which there was a consensus for the recommendations proposed herein, namely:
 - **Item C:** that participation in the PCF should remain voluntary;
 - **Item D:** there was consensus that the MMA damages cap should be increased, but there was NO consensus on what the new cap should be, nor on when a new cap should take effect;
 - **Item F:** that no change was required to better define what the PCF Custodian must consider to determine the base coverage and surcharge;
 - **Item I:** that the MMA should maintain the requirement for occurrence-based coverage for physicians to protect both the need for patients to obtain recovery and the need for individual providers to be covered;
 - **Item J:** that no change to the MMA should be made to change how economic damages should be treated with respect to the damages cap;

- **Item M:** that the MMA should be revised to expressly authorize the PCF Custodian to continue the conventional practice of evaluating and approving all proposed settlements when the case implicates the PCF;
 - **Item O:** that the MMA should not be changed to adjust the statute of limitations related to acts of malpractice committed against a minor.
- c. There were many differing positions on the other items, but on each the PCF Custodian has made a recommendation after taking into consideration the arguments and views of the differing parties and the consideration factors listed in the Synopsis above. On each item, the Current Law, Proposals, Assessment and Recommendation are provided.
- d. Our recommendations on the most contested issues are:
- **Item A:** We recommend that hospitals and other health facilities remain in the PCF, but per the recommendation of the NM Trial Lawyers Association, OSI should revise its processes for admission of a hospital to the PCF;
 - **Item D:** We recommend that the MMA damages cap be increased to \$750,000 per occurrence;
 - **Item E:** We recommend that the base coverage be increased to \$250,000 per occurrence (from the current \$200,000), and there be no distinction by QHP type;
 - **Item G:** We recommend that clarification be provided to ensure the current three occurrence limit applies only to individual providers. There should be no limit on occurrences for hospitals, outpatient health care facilities and entities;
 - **Item H:** We recommend that “malpractice claim” and “occurrence” be synonymously defined in such a way that a single, individual injury event be treated as a single malpractice claim or occurrence, regardless of the number of contributing providers or acts;
 - **Item K:** We believe changes are appropriate to strengthen the current MMA provisions regarding ensuring coverage of ongoing medical needs of an injured patient;
 - **Item L:** We recommend that punitive damages should only be allowed in the most egregious of cases, and a patient should not be allowed to assert a claim for such damages without first obtaining leave of court;
 - **Item N:** We recommend that the MMA should clarify that the PCF Custodian is entitled to classify information submitted to the PCF as confidential;
 - **Item P:** We believe that consideration should be given to removing the current statutory provisions related to the NM Medical Review Commission and substituting an Alternative Dispute Resolution process prior to court action; and
 - **Item Q:** We recommend that consideration be given to including a venue provision which requires that medical malpractice actions be brought in the county where the medical care occurred or in the county where the patient resided at the time of the alleged malpractice.

The Superintendent recognizes that the ultimate decision on how or whether to update the MMA belongs with the Legislature and Governor. These are matters of critical public policy importance which will have broad impact on New Mexicans. We hope that the recommendations herein will inform policymakers in their deliberations on the MMA.

The Superintendent commends to the Legislature the considerations found in the Synopsis above as it deliberates on the MMA. In particular, we urge that due attention be given to the impact of any MMA changes to the state's ability to recruit and retain physicians. New Mexico has a very fragile health delivery system which is anchored by an aging physician workforce and a paucity of doctors in certain parts of the state. OSI heard many complaints about the difficulties of recruiting physicians to New Mexico because of malpractice premiums that already are higher than surrounding states, as well as other factors (e.g., personal income tax, GRT). For some physicians, particularly for those just starting a practice, the cost of malpractice coverage can be a significant barrier. We urge both caution and assessment of MMA changes to the medical practice community.

5. ISSUES AND CONCERNS RAISED:

A. Whether the MMA should expand the types of providers that can participate in the PCF.

- **Current Law:** §41-5-3(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.
- **Proposals:** Some stakeholders suggest that the definition of health care provider should be expanded to include all persons licensed in the state to provide health care services. This would include nurses, technicians, etc. Other stakeholders suggest that the list should be limited to doctors. Some stakeholders suggest that the definition should include all hospital and entity employees acting within the scope of their employment. Other stakeholders suggest that hospitals should be removed from the definition of "Health Care Provider" in the MMA.
- **Assessment:** Information received from practicing physicians and hospitals indicates that an increasing amount of direct patient care is provided by ancillary providers or advanced practice providers that are not included in the MMA's definition of health care provider. Many of these ancillary or advanced practice providers do not carry medical malpractice liability insurance. Proponents argue that expanding the definition to include these ancillary or advanced practice providers would provide injured patients access to a larger pool of providers with PCF protections, enhancing the likelihood that these patients are provided benefits up to the liability cap and payment of their past and future medical costs. Opponents argue that having more providers under a liability cap restricts the injured patients' ability to recover damages commensurate with their injuries. Stakeholders who advocate for removing hospitals from the PCF are concerned that claims against the hospitals will deplete the fund. Other stakeholders assert that having the hospitals in the fund is beneficial to the financial health of the fund.

- **Recommendation:** Revise definition in §41-5-3(A) to:
"health care provider" means a person as defined in 12-2A-3(E) licensed or certified by this state to provide health care or professional services as a hospital, outpatient health care facility, or person identified in Subsections B (2) through (9) of §59A-22-32 NMSA 1978.

(Note: Subsections B (2) through (9) of §59A-22-32 states: "practitioner of the healing arts" means a person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition pursuant to:

- (a) the Chiropractic Physician Practice Act [61-4-1 NMSA 1978];*
- (b) the Dental Health Care Act [61-5A-1 NMSA 1978];*
- (c) the Medical Practice Act [61-6-1 NMSA 1978];*
- (d) Chapter 61, Article 10 NMSA 1978; and*
- (e) the Acupuncture and Oriental Medicine Practice Act [61-14A-1 NMSA 1978];*
- (3) "optometrist" means a person holding a license provided for in the Optometry Act [61-2-1 NMSA 1978];*
- (4) "podiatrist" means a person holding a license provided for in the Podiatry Act [61-8-1 NMSA 1978];*
- (5) "psychologist" means a person who is duly licensed or certified in the state where the service is rendered and has a doctoral degree in psychology and has had at least two years of clinical experience in a recognized health setting or has met the standards of the national register of health service providers in psychology;*
- (6) "physician assistant" means a person who is licensed by the New Mexico medical board to practice as a physician assistant and who provides services to patients under the supervision and direction of a licensed physician;*
- (7) "certified nurse-midwife" means a person licensed by the board of nursing as a registered nurse and who is registered with the public health division of the department of health as a certified nurse-midwife;*
- (8) "registered lay midwife" means a person who practices lay midwifery and is registered as a registered lay midwife by the public health division of the department of health;*
- (9) "registered nurse in expanded practice" means a person licensed by the board of nursing as a registered nurse approved for expanded practice pursuant to the Nursing Practice Act [61-3-1 NMSA 1978] as a certified nurse practitioner, certified registered nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or clinical nurse specialist in private practice and who has a master's degree or doctorate in a defined clinical nursing specialty and is certified by a national nursing organization.*

Hospitals should remain in the definition of “Health Care Provider” and remain participants in the PCF to prevent adverse impacts on PCF solvency. (Please refer to the actuarial appendix in Exhibit 1, Paragraph II for an expanded discussion and demonstration of the impact of removing hospitals from the Fund.) In addition, there is the reality that a very large percentage of physicians practicing in the state are employed by hospitals, so if the hospitals are not allowed to participate in the Fund, the PCF would lose their employed physicians as well, further shrinking the insured pool and leaving the Fund in a precarious condition with a risk of insolvency and inability to fully cover future claims. OSI acknowledges that per the recommendation of select stakeholders, more robust actuarial studies and data collection from hospitals are warranted.

B. Whether the MMA should specify that a non-QHP employee of a QHP is not personally liable for medical malpractice if the employer QHP is liable for that employee’s conduct under master of the ship, vicarious liability or a negligent hiring/supervision theory.

- **Current Law:** §41-5-3(A) states that "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.
- **Proposals:** Some stakeholders state that, in order to be entitled to the protections offered by the MMA, an individual or entity must be a “health care provider” who meets the qualification requirements necessary to participate in the MMA, and argue that the Superintendent should not permit damages to be awarded from the PCF for the alleged malpractice of a non-qualified employee based solely on the fact that they are employed by a qualified health care provider. These stakeholders cite *Baker v. Hedstrom*, 2013-NMSC-043, 309 P.3d 1047, opining that the NM Supreme Court recognized the following regarding the operation of respondeat superior claims under the Act: “Since the MMA only covers the acts of medical malpractice committed by an individual who must be licensed or certified as a doctor of medicine, doctor of osteopathy, chiropractor, podiatrist, nurse anesthetist, or physician’s assistant, any claim for malpractice brought against a legal organization can only be brought under the doctrine of respondeat superior for the alleged malpractice of the licensed or certified medical professional listed in Section 41-5-3(A).” These stakeholders go on to opine that the *Baker* opinion would be applicable even if the definition “health care provider” is expanded in an amendment to the MMA. Some stakeholders state that the MMA should not be revised to specify that non-qualified health care providers are entitled to the protection of the Act based on their employer-employee relationship with a qualified health care provider and that paying claims on behalf of unqualified health care providers will quickly deplete the Fund. Proponents argue that the definition of “health care provider” and the necessary surcharge requirements for qualification should be amended to include employees because, in doing so, the protections of the MMA will be extended to employees, patients will have meaningful recourse against employees, and the PCF will remain solvent because proper surcharges will be collected based on the risk posed by the employees brought under the MMA.

- **Assessment:** §41-5-16(C) acknowledges potential allegations of respondeat superior in MMA cases by stating: “In instances where applications [to the Medical Review Commission] 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 health care provider whose alleged malpractice caused the application to be filed, and the health care provider named a respondent as employer, master or principal.” Arguably, however, the law limits the application of the legal theory only as between” health care providers,” which, in the MMA, are only the 8 specifically named provider types listed in §41-5-3(A). The lack of clarity creates significant debate at mediations and is a subject of litigation. Amendment of the MMA to clarify the issue is needed.
- **Recommendation:** Amend the §41-5-3(C) definition of “malpractice claim” to include the following: “When a QHP delivers healthcare to a patient through an employee or agent who cannot qualify as a QHP, and the patient is injured in the provision of the healthcare, any resulting malpractice claim may only be brought against the QHP. When a QHP delivers healthcare to a patient through an employee or agent who is eligible to be a QHP but chooses not to qualify as a QHP, that employee or agent is not entitled to the protections of the MMA.

As an example, when a QHP hospital delivers health care to a patient through an employed radiology tech, whose position cannot qualify as a QHP, and the patient is injured in the provision of care by that radiology tech, any resulting malpractice claim may be brought only against the hospital. When a QHP hospital delivers health care to a patient through an advanced practice nurse (“APN”), who IS eligible to be a QHP but chooses not to so qualify and a patient is injured by the APN, the APN is not entitled to the protections of the MMA.

C. Whether PCF participation should be a condition of licensure as a health care provider in NM.

- **Current Law:** Neither the MMA nor provider licensing laws require PCF participation as a condition of licensure. Participation in the PCF is voluntary.
- **Proposals:** Several stakeholders oppose mandating participation, citing that likelihood of suit is unequal and risk is not comparable. Additional arguments state that health care providers who may present significant risk based on loss experience should not be included. Proponents of the idea argue that mandating participation and increasing the exposure base better spreads the risk for the PCF and stabilizes pricing.
- **Assessment:** The law of large numbers in insurance suggests that as the number of policyholders increases, the probability that the actual loss per policyholder will equal the expected loss per policyholder is higher. In practical terms, this means that it is easier to establish the correct base coverage and surcharge and thereby reduce risk exposure for the Fund as more policyholders enter the Fund. However, there is a reasonable basis for arguing that not all providers should be in the PCF.
- **Recommendation:** Participation in the PCF should remain voluntary. Adopting the proposed §41-5-3(A) definition of "health care provider" will increase the number of

participants in the PCF, thereby spreading risk amongst a larger pool and providing greater financial protections for injured patients.

D. Whether the MMA damages cap should be increased.

- **Current Law:** §41-5-6(A) “Except for punitive damages and 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.”
- **Proposals:** Some stakeholders suggest that raising the cap may drive physicians from the state and hinder physician recruitment because of the associated additional premium costs and the potential increase in malpractice litigation due to availability of higher awards. Some stakeholders cited the financial hardship that COVID has caused, and suggested that any increase in the cap should be delayed until health care providers are able to recover financially from the economic effects of the pandemic. Some stakeholders argued that raising the cap to \$1 million may significantly increase medical liability costs to physicians, which will have a negative impact on the access to healthcare for patients in New Mexico, and that these additional costs will have a disproportionate impact on physicians who are serving rural and underserved communities. Some stakeholders suggested that it is possible to mitigate the cost of raising the non-medical cap by adding a \$250,000 cap on non-economic damages (a cap within the cap). Proponents for raising the cap argue that the MMA damages cap has not been increased since 1995 and a failure to adjust the cap consistent with the Consumer Price Index results in a liability cap that does not properly compensate patients injured through no fault of their own.
- **Assessment:** The MMA damages cap has not been increased since 1995, yet, the New Mexico MMA cap is higher than the liability caps in some other states. (*See* Exhibit 1, Sheet 2 and the RRC actuarial review²). There is consensus that the cap should be raised, but the recommended increase varies widely among stakeholders. Actuarial analysis suggests that any increase to the cap be accompanied by adjustments to base coverages to limit the negative impact on surcharges and premiums.
- **Recommendation:** Amend §41-5-6(A) to increase the MMA damages cap to \$750,000 per occurrence. This increase reflects a reasonable adjustment to the most recently established cap, and will not do unwarranted harm to the viability of the PCF.

The PCF has struggled to reach adequate surcharge rates under the current structure, so a larger jump in the cap amount should not be approved. With a 42% cumulative rate increase to Physicians’ surcharges over the past five (5) years (including the upcoming March 1, 2021 rate increase) the rates are still below the actuarially indicated levels, resulting in continuing growth of the deficit.

Raising the damages cap significantly without a sub-cap on non-economic damages will increase costs beyond a reasonable level. (*See* Table 3 in the TDC/Milliman actuarial

² The full RRC actuarial review is posted on OSI’s website: <https://pcf.osi.state.nm.us/wp-content/uploads/2020/11/PCF-RRC-Final-Report.pdf>.

report³). Such an increase, coupled with the rate increase to bring rates to adequacy, will be unmanageable for the medical providers. Continuing to delay PCF rate increases or amortizing them over future years will result in deficit growth that will soon become overwhelming and impossible to reverse and may result in the Fund's inability to pay out claims.

E. Whether the base coverage requirement (\$200,000) should be increased.

- **Current Law:** (Regarding individual health care providers) §41-5-5(A) “To be qualified under the provisions of the Medical Malpractice Act, a health care provider shall 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 thousand dollars (\$200,000) per occurrence. *See also*, §41-5-6(D) “A health care provider's personal liability is limited to two hundred thousand dollars (\$200,000) for monetary damages and medical care and related benefits.”
- **Current Law:** (Regarding hospitals and outpatient health care facilities) §41-5-5(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”.
- **Proposals:** Opponents of an increase to the base coverage argue that any increase in the \$200,000 coverage requirement would result in substantial premium increases, which would drive providers out of the state and further inhibit the state's ability to bring new providers into the state. Stakeholders further argue that an increase of the required base coverage and the associated premium increases will ultimately be passed on to consumers through increased health care costs. Proponents of an increase suggested it is necessary to keep the fund economically sound.
- **Assessment:** There is no consensus that the base coverage should be raised. The proposals range from no increase to an increase to \$500,000. An actuarial analysis will be required to determine the exact impact of any base coverage increases on PCF surcharges and the financial effect on the PCF. However, it is important to keep in mind that unlike changes to the damages cap, changes to the base coverage limit only shift the distribution of premium between the primary carrier and the PCF, and will not significantly impact the total premium paid by the insured provider. Any increase to the aggregate premiums due to base coverage changes will be immaterial compared to the impact of raising the damages cap. On the other hand, raising the amount of base coverage would benefit the PCF by shifting some of the exposure risk to the primary carriers, as sudden large increases in exposure are a known solvency risk.
- **Recommendation:** Amend §41-5-5(A) to increase the base coverage to two hundred fifty thousand dollars (\$250,000) per occurrence.

F. Whether the MMA should better define what the PCF Custodian must consider to determine the base coverage and surcharge.

³ The full TDC/Milliman actuarial report is posted on OSI's website: <https://pcf.osi.state.nm.us/wp-content/uploads/2020/11/Milliman-TDC-PCF-Cap-Analysis-Report-.pdf>.

- **Current Law:** §41-5-5(B) requires that, 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, as provided in Section 41-5-25 NMSA 1978. §41-5-25(B) provides, "To create the patient's compensation fund, an annual surcharge shall be levied on all health care providers qualifying under Paragraph (1) of Subsection A of Section 41-5-5 NMSA 1978 in New Mexico. The surcharge shall be determined by the superintendent based upon sound actuarial principles, using data obtained from New Mexico experience if available." §41-5-25(H) states that "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."
- **Proposals:** Some stakeholders supported the MMA language that requires an actuarial risk analysis, but they suggested that the analysis should be performed annually instead of every two years. No stakeholders indicated opposition to the current language.
- **Assessment:** The PCF recently issued rules that provide specific requirements associated with the statutorily required risk analysis. The additional requirements are intended to result in more substantial and more accurate risk analyses and, therefore, more accurate assessments for PCF participation.
- **Recommendation:** The Superintendent recommends no change to the statute.

G. Whether there should be a distinction between individual physician and entity requirements related to the damages cap, base coverage, and occurrence limits.

- **Current Law:** (Regarding damages cap) §41-5-6(A) "Except for punitive damages and 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."
 (Regarding base coverage) §41-5-5(A) requires that an individual physician must be insured by a policy of malpractice liability insurance issued by an authorized insurer in the amount of at least two hundred thousand dollars (\$200,000) per occurrence. §41-5-5(B) requires that, 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.
 (Regarding occurrence limits) §41-5-5(A) states that, "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 thousand dollars (\$200,000) per occurrence or for an individual health care provider, excluding hospitals and outpatient health care facilities, by having continuously on deposit the sum of 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 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.

- **Proposals:** Some stakeholders suggest that the base coverage and cap should be the same for individual providers, hospitals and outpatient care facilities. Others argue there should be a distinction between individual providers and entities. Some stakeholders propose that the three occurrence limit should apply to individual providers, hospitals and outpatient care facilities equally, while others suggest that because hospitals employ thousands of people and have significantly more encounters with patients than individual health care providers, it is inappropriate to set a limit on the number of occurrences for hospitals. All stakeholders agree that each of these determinations must be based on sound actuarial analyses.
- **Assessment:** There is currently no distinction between an individual physician and an entity with regard to the damages cap. The current cap is \$600,000 for all health care providers. While some stakeholders assert that hospitals should be subject to a higher liability cap, others argue that such a distinction will cause plaintiffs to sue hospitals more often in attempts to reach the higher cap. There IS a distinction between an individual physician's and an entity's base coverage requirements. For an individual physician, the base coverage is a policy in the amount of at least two hundred thousand dollars (\$200,000) per occurrence; and for an entity, the superintendent shall determine each hospital's or outpatient health care facility's base coverage based on a risk assessment of each hospital or outpatient health care facility. It is controverted whether there is a distinction between the occurrence limits applicable to an individual physician and an entity. Some stakeholders assert that the three occurrence limit applies to all healthcare providers, including hospitals, and that PCF coverage for a hospital is therefore extinguished after a hospital's third occurrence. Other stakeholders assert that hospitals are not subject to the three occurrence limit because that limit resides in §41-5-5(A) following the language "excluding hospitals and outpatient health care facilities."
- **Recommendation:** There should be no distinction between damages caps by status of QHP. The current statute creates a three occurrence limit for individual providers and business entities but no occurrence limit for hospitals and outpatient health care facilities. Consideration should be given to clarifying the statute to keep the three limit occurrence for individual providers and maintaining no limit on occurrences for hospitals, outpatient health care facilities, and business entities. Additionally, there should not be a separate liability cap for hospitals because of rating difficulties arising from the historical claim administration practices that did not track or segregate claims based on direct negligence as opposed to vicarious liability. Nevertheless, if a separate hospital liability cap is considered, it should be for direct negligence to avoid constitutional issues.

H. Whether the MMA should better define "malpractice claim" and "occurrence."

- **Current Law:** §41-5-3(C) provides that "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 which

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... "Occurrence" is not defined in the MMA.

- **Proposals:** Some stakeholders propose that any clarification of the terms "malpractice claim", "occurrence" and "acts of malpractice" should reinforce the principle that it is the resulting injury(ies) that defines an occurrence and not the number of practitioners named in a lawsuit or alleged acts, citing that the MMA already includes within the definition of "malpractice claim" the requirement that the breach of the standard of care must "proximately result in injury to the patient" at §41-5-3(C). Other stakeholders opine that if additional language is added to the statute to better define these terms, then the language should clearly set out that there is one occurrence per patient, stating that this clarification is consistent with New Mexico's liability construct which is pure comparative fault. In other words, the damages that flow from the injury(ies) allegedly caused by more than one provider or act should only result in a single recovery per patient, with fault for that injury meted out consistent with a jury's finding of comparative fault. One stakeholder proposed that the MMA should define an "occurrence" as actual or alleged malpractice in the provision of medical treatment, or failure to provide medical treatment, causing harm to a patient and includes all related acts, errors, or omissions by providers involved in the patient's care that resulted in the harm to the patient, and includes all claims by any number of persons arising out of the harm to the patient. Another stakeholder suggested that the agreed upon definition of "malpractice claim" in the vetoed 2011 MMA amendments should be implemented, which reads, "malpractice claim" includes any cause of action arising in this state against a health care provider for medical treatment, lack of medical treatment, negligent hiring, supervision, training or deficient credentials 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 action 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.
- **Assessment:** The lack of a clear definition of "occurrence" creates significant debate in mediations and is a subject of litigation. A significant number of stakeholders suggest that clarity is needed.
- **Recommendation:** "Malpractice claim" and "occurrence" need to be synonymously defined in such a way that all harm to a single patient, no matter how many QHPs or errors or omissions contributed to the harm, is treated as a single malpractice claim or occurrence.

I. Whether the MMA should allow claims-made or modified claims-made coverage instead of only allowing occurrence coverage.

- **Current Law:** §41-5-5(A) provides that, to be qualified under the provisions of the Medical Malpractice Act, a health care provider shall 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 thousand dollars (\$200,000) *per occurrence*. (Emphasis added).

- **Proposals:** Some stakeholders propose that modified claims-made coverage should be permitted under the MMA, as long as all such professional liability policies are covered under the Guaranty Fund and all include tail coverage. Some stakeholders also opine that hospitals should be permitted to have claims-made or modified claims-made policies as long as proper tail coverage exists under the policy. Some argue that more medical malpractice insurers will enter the New Mexico market if they are allowed to write claims-made coverage for the PCF. Opponents argue that the initial appeal of seemingly lower-priced claims-made coverage will be blunted by the inclusion of a cost load for prepaid tail coverage. Additionally, some argue that tail coverage is not unlimited, and they provide as an example that a pediatrician or OB/GYN who tails out his or her coverage could face claims for the better part of two decades, yet he or she could exhaust the tail coverage in the first few years of that time.
- **Assessment:** An occurrence policy will pay a claim based on when a potential malpractice incident occurred, even if the physician no longer carries the coverage when a suit or complaint is filed. As an example, if the physician paid premium on an occurrence policy between 2010 and 2015 and then cancelled the coverage, and a former patient charges the physician with malpractice for treatment received in 2014, the occurrence policy will protect the physician from the claim even though the physician no longer carries the policy. Conversely, a claims made policy only provides coverage for as long as premiums are paid. The physician must be covered by the policy both at the time of an incident and at the time a claim of malpractice is made. In the hypothetical example above, a claims made policy would not cover any losses because the physician would no longer be covered by the malpractice insurance. A physician covered by a claims made policy who then cancels or terminates it may purchase “tail” coverage to protect him or her against future claims resulting from past incidents. Generally, occurrence-based coverage initially is more expensive than, but preferable to, claims-made coverage because of its “unlimited” coverage during the term of the policy. Depending on the length of the tail, tail coverage can basically convert a claims-made policy into an occurrence policy – but the cost of extended tail coverage can be very significant.
- **Recommendation:** The MMA should maintain the requirement for individual QHPs to have occurrence-based coverage to protect both the need for patients to obtain a recovery and the need for providers to be covered. A number of hospitals requested an option to use claims-made coverage to insure the primary layer. The PCF Custodian appreciates the challenges of obtaining occurrence-based coverage for the medical malpractice exposures of hospitals. Nevertheless, because a lapse in claims-made coverage could result in an uninsured primary layer exposure, the PCF Custodian recommends retaining the occurrence form coverage requirement.

J. How economic damages such as lost earnings or earning capacity should be treated with respect to the damages cap.

- **Current Law:** §41-5-6(A) provides that, “Except for punitive damages and 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.” §41-5-3(D) states that "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. §41-5-6(B) states that “The value of accrued medical care and related benefits shall not be subject to the six hundred thousand dollar (\$600,000) limitation. §41-5-6(D) states that “A health care provider's personal liability is limited to two hundred thousand dollars (\$200,000) for monetary damages and medical care and related benefits as provided in § 41-5-7 NMSA 1978.

- **Proposals:** Generally, stakeholders agreed that all compensatory damages except medical and related expenses should be subject to the cap.
- **Assessment:** The stakeholders’ position is supported by the MMA’s existing language.
- **Recommendation:** No change to the statute should be made.

K. Whether anything should be done to strengthen the current MMA provisions regarding ongoing coverage of medical needs of an injured patient.

- **Current law:** §41-5-6(B) “The value of accrued medical care and related benefits shall not be subject to the six hundred thousand dollar (\$600,000) limitation.” §41-5-6(C) “Monetary damages shall not be awarded for future medical expenses in malpractice claims.”

§41-5-7

(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 future medical care and related benefits.’

(B). ‘Except as provided in Section 41-5-10 NMSA 1978, 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 semi-private room limitation in the event of hospitalization, unless the patient refuses to allow them to be so furnished.’

(C). ‘Awards of future medical care and related benefits shall not be subject to the 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.’

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

(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 the patient on the basis of evidence presented to it. That figure shall not be included in any award or judgment but shall be included in the record as a separate court finding.’ *See also*, §41-5-9(B) which provides “In all cases where the patient’s continued need of such benefits [medical care and related 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.

- **Proposals:** Stakeholder responses range from “leaving the language as-is,” to “significant amendments should be made to the provisions regarding future medical expenses.” Generally, proponents of leaving the language as-is suggest that the current language is appropriate to address the issue of future medical needs and as a practical matter, because most are settled and are settled in their totality, including a lump-sum for future medical needs. A proponent of changing the language suggests that all patients who are entitled to future medical care should be enrolled in the New Mexico Medical Insurance Pool (“NMMIP”). All premiums and any other associated costs with the patient’s participation in the NMMIP could be covered by the PCF paid in accordance with the principles set forth in NMSA 1978, § 41-5-7(D). Another stakeholder offered that, given the anecdotal evidence that some patients who choose to settle with a lump sum that includes future medicals run out of funds but still need medical care, perhaps the statute should require that all or a portion of the settlement funds attributable to future medical care be put into a medical trust or other financial vehicle that limits use of the funds to the patient’s future medical and related expenses. Another stakeholder noted that limiting medical expense recovery to amounts for which the plaintiff patient is actually responsible would reduce an unnecessary drain on PCF resources and further ensure monies will be available to pay actual costs incurred going forward. Allowing recovery of damages charged but not paid is detrimental to the viability of the PCF.
- **Assessment:** An important charge of the MMA and benefit of the PCF is the assurance that patients injured through no fault of their own have their future medical and related benefits covered for the rest of their life. Some stakeholders argue that a patient who receives a lump-sum payment for future medicals but exhausts that sum while medical expenses are still arising puts an additional strain on the overall health care system. Others argue that it is unclear whether the current process is flawed and that a re-write of the provisions could result in substantial unintended consequences.
- **Recommendation:** A lump sum settlement that includes future medical expenses may leave a patient without adequate funding for required future services. This may cause a patient to forego needed services, or to receive the services at the expense of a private health insurer or the public. To ensure that future medical services are received and paid for with PCF funds, current law should be changed to ensure that future medical expenses are either paid by the PCF as incurred, or that the plaintiff’s share of any lump sum

settlement allocable to future medical expenses be judicially approved and placed in an appropriate medical savings trust.

L. Whether the MMA should limit punitive damages and other non-economic damages awards.

- **Current Law:** §41-5-7(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 liability for punitive damages on a derivative basis where that imposition would not be otherwise authorized by law.”
- **Proposals:** Many stakeholders opined that punitive damages in medical malpractice cases should be limited or removed entirely. Proponents of limiting the award suggest that doing so will not only promote the public policy of New Mexico with regard to making access to healthcare more readily available, but also could have a positive impact on the viability of the PCF. An example provided suggests that a cap of \$250,000 or three times economic damages would codify what many courts have already considered to be appropriate. Further, a provision providing that any punitive damages awarded, or a portion thereof, would be paid into the PCF, as opposed to a private party, would further the purposes of the Medical Malpractice Act by contributing to the on-going viability of the PCF and limit the windfall nature of punitive damages when actually awarded and collected. A stakeholder also suggested that because punitive damages are quasi-criminal in their nature and intent, the burden of proof to recover punitive damages should be elevated to “clear and convincing evidence.” Some stakeholders opine that punitive damages, which are the personal liability of the health care provider, are commonly used as a tool to threaten New Mexico health care providers with economic ruin, and are generally utilized by claimants as leverage to increase settlement amounts and then are dismissed once a settlement is reached in order to avoid the excess taxes.
- **Assessment:** Medical malpractice lawsuits increase the costs of malpractice insurance for doctors and hospitals. That in turn increases the costs of health care and health insurance for consumers. Opponents of punitive damages argue that other means exist to satisfy the goals of punitive damages, including regulatory action by medical licensing boards and governmental agencies. Furthermore, opponents contend that punitive damages make little sense because a patient who has already been made whole with compensatory damages receives a windfall when punitive damages are awarded in addition to compensatory damages. Proponents of punitive damages argue that in cases in which a health care provider has done something deplorable, intentionally or recklessly, that any resolution must go beyond compensation and require punitive damages, and the provider deserves to be penalized for their terrible conduct by being made to pay punitive damages for what they have done.
- **Recommendation:** We recommend that the MMA contain a provision that punitive damages should only be allowed on a showing of clear and convincing evidence of a reckless and wanton indifference to the value of human life, and a patient should not be

allowed to assert a claim for such damages without first obtaining leave of court based on a submission of prima facie evidence of such conduct.

M. The role of the PCF Custodian in approving settlements of MMA claims.

- **Current Law:** §41-5-25(A) provides, “The fund and any income from it *shall be held in trust* ...[.] “The fund and any income from the fund shall only be expended for the purposes of and to the extent provided in the Medical Malpractice Act.” “The superintendent, *as custodian of the patient's compensation fund*...[.] §41-5-25(E) provides, “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.” (emphases added). *But see*, §41-5-25(G) which provides, The only claim against the patient's compensation fund shall be a voucher or other appropriate request by the superintendent after he receives: (1) a certified copy of a final judgment in excess of two hundred thousand dollars (\$200,000) against a health care provider; (2) 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) 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 E of Section 41-5-7 NMSA 1978, combined with the monetary recovery, exceed two hundred thousand dollars (\$200,000). *See also*, §41-5-7(B), relating to payment of future medical expenses, which states, “[o]nce 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*...” (emphasis added); or §41-5-7(F) which states, “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.” (emphasis added).
- **Proposals:** Some stakeholders believe that the PCF custodian’s role in case settlement should be limited to sending back settlements that exceed the cap. Others suggest that the underlying carrier should continue as it does now to settle claims up to its limits and only after that should the PCF Custodian be engaged. Some stakeholders opine that the Superintendent, as the PCF’s Custodian, has a fiduciary duty to ensure that PCF funds are only expended to settle claims that involve medical malpractice by qualified health care providers. In other words, the Superintendent should never permit the use of PCF funds to a settle claim against an unqualified health care provider. Furthermore, PCF funds should only be used to settle medical malpractice claims as defined by the MMA. In addition to requiring confirmation that a settlement is based only on the alleged medical malpractice of a qualified health care provider, the MMA should also require the PCF Custodian to assess the fairness and reasonableness of all settlements proposed before approving them. One stakeholder proposed the creation of a Medical Malpractice Advisory Committee to be comprised of three licensed New Mexico attorneys and three physicians or other medical professionals. The Committee would be chaired by the Superintendent and would have the duty to confirm that any settlements paid from the PCF involved medical malpractice claims against a qualified health care provider and are reasonable. Another proposal

suggested that the State Risk Management Division (“RMD”) could oversee active litigation cases and settlements arising under the MMA.

- **Assessment:** The MMA confers upon the Superintendent, as PCF Custodian, fiduciary responsibility to the PCF, but does not outline specific responsibilities in case mediations or settlement negotiations. Most cases settle. And, as a matter of practice, the PCF Custodian and his contracted adjusters play an active role in the settlement of cases that may impose liability on the PCF. This position in settlement has not been challenged, and statutory changes may not be necessary. If, however, this role is deemed appropriate, yet is not articulated well in the statute, clarifying language in the MMA may be warranted.
- **Recommendation:** The MMA should be revised to expressly authorize the PCF Custodian to continue the conventional practice of evaluating and approving all proposed settlements when the case implicates the PCF.

N. Whether the MMA should better define the confidential or public status of documents submitted to the PCF Custodian.

- **Current Law:** §59A-2-12(B) provides that, “The superintendent may classify as confidential certain records and information obtained from another governmental agency or other source upon the express condition that they remain confidential or are deemed confidential by the superintendent, and such records and information shall not be subject to public inspection while confidentiality exists; except that no filing required to be made with the superintendent under the Insurance Code shall be deemed confidential unless expressly so provided by law.” There is no separate condition in the MMA.
- **Proposals:** Most stakeholders opine that un-aggregated, provider specific, claims data submitted to the PCF Custodian for purposes of actuarial analysis should be deemed confidential, and that any data released by the Superintendent should only be released in an aggregated format with necessary redactions made in order to prevent the claims experience of an individual provider or entity from being discovered. Some stakeholders also opine that holding un-aggregated claims data in confidence will promote the free exchange of information that is integral to the completion of accurate and reliable actuarial studies of the PCF. Additionally, some stakeholders opine that such information provides insight to competitors and trial attorneys regarding how a provider evaluates and handles claims. The information could be used improperly to attempt to influence the settlement of other claims or even to improperly influence juries at trial if the information is made public. Stakeholders that oppose holding documents submitted to the PCF Custodian as confidential argue that the MMA is not part of the Insurance Code, the Code’s confidentiality provisions do not apply, and all such documents are public documents subject to disclosure under the Inspection of Public Records Act.
- **Assessment:** The issue of the PCF Custodian’s authority and responsibility with regard to holding certain documents confidential is currently the subject of litigation. It is controverted whether the Courts should decide the issue or whether the Legislature should decide the issue. Inserting clarifying language into the MMA may serve to resolve the question.
- **Recommendation:** To properly conduct the mandated actuarial studies and set surcharges, the PCF Custodian requires PCF participants to disclose potentially sensitive information,

proprietary materials and trade secrets. To protect the personal and business interests of the PCF participants, and ensure full disclosures, the MMA should clarify that the PCF Custodian is entitled to classify information submitted to the PCF as confidential.

O. Whether the MMA should adjust the statute of limitations related to acts of malpractice committed against a minor.

- **Current Law:** §41-5-13 provides, No claim for malpractice arising out of an act of malpractice which 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 a minor under the full age of six years shall have until his ninth birthday in which to file. This section applies to all persons regardless of minority or other legal disability.
- **Proposals:** Some stakeholders do not oppose the removal of the provisions in §41-5-13, which were determined to be unconstitutional by the Court of Appeals in *Jaramillo v. Heaton*. However, because the Court in *Jaramillo* did not provide clear guidance as to how the statute of limitations set forth in §41-5-13 should operate in the case of a minor, those stakeholders suggest the MMA will have to be revised to ensure that the constitutional rights of minors are protected. Other stakeholders believe the MMA should not be changed unless the issue is decided by the NM Supreme Court. Still other stakeholders believe that allowing a minor's claim to be deferred until one year after reaching age 18 unfairly prejudices all parties. These stakeholders also believe that if a minor has a Personal Representative appointed, the statute of repose should run for one year from appointment or three years from the date of treatment, whichever is longer.
- **Assessment:** Under the *Jaramillo* decision, the question of whether the existing statute of limitations applies to the claim of a particular minor depends on the circumstances of the case.
- **Recommendation:** Because there are circumstances where the existing statute of limitations will bar a claim by a minor, the existing statute should not be changed.

P. Whether the MMA should adjust any of the provisions related to the NM Medical Review Commission.

- **Current Law:** §§41-5-14 through 24 and §41-5-28
- **Proposals:** Some stakeholders think the MRC has little value, while other stakeholders think that the MRC plays an important role in the system and should be continued, although it should be updated. Proponents of updating the MRC process suggest modernization of conduct of panel hearings to include available technology; updates to address recent participation of hospitals and outpatient health care facilities in the process; and revisions to prohibit the calling of participants in the panel hearing, whether witnesses, panel members, or others, to testify in depositions or at trial, or provide information in any other format, regarding what transpired during the panel hearing. Other stakeholders suggest that the section of the MMA governing the MRC should be revised to narrow the scope of the MRC's jurisdiction to only hear matters involving medical malpractice claims where the active tortfeasor is a natural person licensed to practice medicine or otherwise provide health care services as a health care provider as defined in the MMA. These advocates

believe that the MRC should, therefore, not hear cases against entities or providers not included in the list of enumerated providers in the MMA. Others have noted that with the increased number of cases presented to the MRC for review, the sixty-day deadline is unrealistic, and that accordingly, §41-5-18 should be revised to require cases to be heard in a reasonable period of time after receipt, not to exceed 120 days, unless the director finds that there is good cause to extend the timeframe to hear a case. Due to the substantial increase in the number of cases being heard by the MRC, an increase in funding is necessary if it is to continue in its current role. Funding could be based on a budget that would be prepared annually by the Director and approved by the chief justice of the Supreme Court, or it could operate on a fixed percentage of the funds available in the PCF on an annual basis. In any event, the current budget of \$350,000 is insufficient to cover the costs associated with running the MRC. Some suggested that the MMA should include a “Medical Malpractice Act Advisory Committee” to review policies, administrative actions, statutes, court opinions, and all other matters relating to the Medical Malpractice Act and other applicable law, to evaluate the performance of panel chairs, and to review and provide written comments on the PCF to the Superintendent.

- **Assessment:** The Superintendent is aware of allegations related to abuse of the MRC process for discovery purposes. Additionally, the Superintendent is aware of allegations that the MRC process has limited value, as some attorneys simply go through the motions at the MRC because they have predetermined that they are filing a malpractice case, regardless of the MRC panel’s determination. One stakeholder suggested that the panel review process should be given more authority. Currently, the provisions only reward the claimant (with the provision of an expert) but do not provide any protection to the hospital or provider against unsupported claims. Some stakeholders state unequivocally the MRC and its processes serve no useful purpose other than to delay justice and resolution of the malpractice action. Others suggested adopting a provision that if the hospital or provider prevails at a MRC panel hearing, the claimant must post a cost bond when filing their complaint in order to ensure that the defendant’s costs will be paid should the plaintiff bring a failed claim and lose in litigation. A large number of complaints were made by multiple stakeholders on the futility of the current MRC process.
- **Recommendation:** Consideration should be given to either removing the current statutory provisions related to the NMMRC, or significantly tightening the provisions to address the concerns expressed above. Another option to be considered is a substitution of an Alternative Dispute Resolution process prior to court action. (*See Exhibit 2 for ADR process proposal*).

Q. Venue:

- **Current Law:** There are no venue provisions in the MMA.
- **Proposals:** Some stakeholders believe there should be a venue provision to avoid forum shopping and the resulting unequal treatment of medical malpractice victims. Other stakeholders believe that the existing statutory venue provisions are adequate and not a matter to be addressed in the MMA.
- **Assessment:** A venue located near where alleged malpractice occurred is more convenient for witnesses and providers, and ensures that providers are judged in accordance with the

standards of the community in which they practice. It is more equitable for venue to have a closer nexus to the location of the malpractice. Additionally, limiting the venue may allow the PCF to introduce territory rating, which may lead to lower surcharges for rural area providers.

- **Recommendation:** We recommend inclusion of a venue provision in the MMA which requires that medical malpractice actions be brought in the county where the medical care occurred or in the county where the patient resided at the time of the alleged malpractice.

Conclusion:

The MMA requires revision, however, given the reality of COVID-19 and the uncertainty of its lasting impacts, moving forward with amendments to the MMA during the 2021 legislative session is not recommended. Healthcare providers and state agencies are overwhelmed with managing the pandemic. Proceeding with reform legislation without an actuarial assessment of the changes that are recommended herein will result in an uninformed product. Given the precarious financial condition of the PCF, the appropriate step to take is to secure a complete actuarial assessment of the recommendations, seek input from stakeholder groups, and then consider a legislative product. For these reasons, the OSI recommends against considering MMA amendments in the upcoming legislative session.

The OSI will proceed with securing actuarial assistance, taking action on the administrative actions described in this report, and respond to any legislative or stakeholder inquiries on our recommendations.

Exhibit 1

PCF Actuarial Reports Summary and Discussion

The PCF has commissioned two actuarial studies to inform the decisions pertaining to the restructuring of the PCF:

- 1) The Merlinos report is a review of the latest available PCF experience with the goal of updating the reserve/liabilities estimate and the required change to bring rates to an adequate level.
- 2) The RRC study was initiated to address the questions about the impact on the Fund of changing the eligibility criteria and the levels of the cap and underlying limit.

In addition, The Doctors Company (TDC) has shared with us a report that they had employed Milliman, a consulting actuarial firm, to produce using TDC's data. The importance and great value of the TDC/Milliman report stems from the fact that it is based on detailed claims data applicable specifically to the NM PCF, which makes this report highly relevant.

The following are important takeaways from these reports for consideration in the revision of the MMA.

- I. The Merlinos report confirms the findings from the past PCF actuarial reports, reiterating that the current rates are not adequate.

The conclusions of the TDC/Milliman report, considered in conjunction with the Merlinos report, present a grave concern about affordability of PCF coverage if, in addition to the current inadequate rates and the existing deficit, the cap on claims is raised to a higher level. The TDC/Milliman report indicates an increase of 35.9% in the overall cost of coverage if the cap is raised to \$1M, which means an even higher increase as a percentage of the PCF surcharge.

For example, if a physician pays \$30 for the underlying coverage and \$70 for the PCF coverage for a total of \$100, a 35% increase in overall costs would mean \$135 in total premium, with all \$35 of the increase being attributed to the PCF coverage layer. The PCF surcharge would therefore increase from \$70 to \$105, which is a 50% increase.

Raising the underlying coverage limit would alleviate this issue to some extent, but it's important to note that the total insurance cost from the point of view of the medical provider will still increase as estimated (i.e., changing the level of the underlying limit will shift premium distribution between the underlying carrier and the PCF, but it will not decrease the costs for the insured provider.)

Based on these two reports, increasing rates to an adequate level while simultaneously raising the cap to \$1M would mean at least a 60% increase in PCF rates for the physicians (the 60% is arrived at by combining the 17.4% increase from the Merlinos report and the

35.9% from the TDC/Milliman report.) But because the true impact on PCF surcharges of raising the cap is larger than 35.9%, as explained above, the PCF surcharge increase would actually be much higher than 60%.

Furthermore, the estimates used to arrive at this number are “central” estimates, or about a 50% confidence level, which means that there’s a significant risk that even this drastic rate increase will not be sufficient and the deficit will continue to grow.

Fortunately, the TDC/Milliman report also suggests a solution (a sub-cap on non-economic damages) that could allow injured patients to be fairly indemnified, while also keeping PCF surcharges reasonably affordable for the healthcare providers of NM.

- II. An issue studied within the RRC report that is highly relevant to the revision of the MMA is the subject of QHP eligibility for the PCF.

The RRC report makes it clear that expanding the pool of participants in the Fund, keeping hospitals and allowing in ancillary providers, will be a benefit to the PCF. The PCF has already seen that benefit with the entrance of Hospitals into the Fund, which has roughly doubled the surcharge volume and significantly increased the Fund balance. While the deficit, in dollar terms, has continued to grow after Hospitals joined the PCF, the deficit *as a percentage of the annual surcharge volume or of the fund balance* has improved dramatically. Please refer to Exhibit 1, Sheet 1 for the development of the PCF Deficit. This supports the argument that if at some point the PCF is forced to charge an assessment on the participants to reduce or eliminate the deficit, having more participants in the Fund would make that assessment a lot more manageable.

One stakeholder concern about allowing (or keeping) the Hospitals in the Fund has been the worry that Hospitals will bring a lot of claims which will draw down the Fund and/or increase the surcharges paid by the Physicians. It is important to keep in mind that the Hospitals’ rate adequacy is evaluated separately from that of the Physicians, so claims attributable to the Hospitals will be reflected in the Hospitals’ rates but not the Physicians’, and vice versa. Increased number of claims from either side (Hospitals or Physicians) will not adversely affect the other side, and will not be detrimental to the long-term health of the Fund, as long as surcharge rates do not deviate significantly from the actuarial recommendations.

In contrast to rating the two groups separately, the greatest benefit and protection to the NM consumers will come from having a combined fund/capital for both Hospitals and Physicians. The benefit of a single fund is a result of pooling and diversification of risk, which can be illustrated by the following example:

Consider two separate funds with a balance of \$10M each. If Group 1 has some catastrophic claims amounting to \$15M (similar to the two batch claims that were paid out by the PCF on behalf of two physicians around 2015), Group 1’s fund balance

will become overdrawn and their fund will become insolvent. Alternatively, consider merging the two funds for a total balance of \$20M. This merged fund will now have enough money to pay out the claims and remain solvent, while allowing time for the fund balance to be replenished in subsequent years through increased rates to Group 1.

In short, the larger pool better protects consumers without disproportionately burdening hospitals or individual providers.

The Hypothetical illustration on the bottom of the Historical Deficit exhibit (Exhibit 1, Sheet 1) estimates what the Fund Balance and Fund Deficit would have been if the larger group of Hospitals had not joined the PCF. The deficit as a percentage of annual surcharge and the deficit as a percentage of the Fund balance would both be about double of what they currently are.

Removing the Hospitals out of the Fund now would not only double the burden on Physicians when it comes to making up the current Fund deficit, but also would place any potential risk of having underpriced the Hospitals on the Physicians. To elaborate on the latter risk – if experience proves that the Hospital claims for past years exceed the corresponding premiums, the PCF will not be able to compensate for this shortage by increasing the Hospitals' surcharges (as in the example above) since they will no longer be in the Fund. If the Hospitals are removed from the Fund, this shortage would contribute to the Fund deficit and would eventually have to be made up entirely by the Physicians.

The remaining sheets in Exhibit 1 help illustrate some relevant concepts and concerns that have been brought up by the stakeholders.

- Sheet 2: Shows a comparison of Medical Malpractice insurance rates between NM and other states. The comparison includes the neighboring states, and other states with Patient Compensation Funds. It is clear that NM rates are significantly higher than almost any other state in the comparison, even though the limits corresponding to the rates shown for other states are often much higher. NM rates at comparable limits would show an even greater divergence. While the Louisiana rates are comparable and in some cases higher than NM rates, it's important to note that the Louisiana PCF has a surplus of \$1.1B.
- Sheet 3: Some stakeholders had significant concerns about raising the underlying coverage limit due to the increase in the underlying coverage premiums. It is correct that the primary coverage premiums would increase, but this would be mostly offset by the decrease to the PCF rates, since the PCF would no longer cover that layer. A much bigger impact to the overall MedMal premiums (i.e. primary coverage plus PCF) would

come from raising the MMA cap, so any premium increase due to shifting a layer of coverage from the PCF to the primary carrier would be insignificant in comparison. More importantly, raising the underlying coverage level would allow the PCF to transfer some of the risk to the primary carrier and limit the sudden large growth in exposure resulting from the raised MMA cap. As with all insurance companies, rapid growth in exposure is considered a significant risk to solvency.



Anna Krylova, FCAS, MAAA
Chief Actuary
New Mexico Office of Superintendent of Insurance

History of the PCF Deficit

----- in Millions -----

As of:	Nominal Reserves	Fund Balance	Fund Deficit
12/31/2004	\$40.30	\$36.10	(\$4.20)
12/31/2007	\$49.30	\$47.70	(\$1.60)
12/31/2009	\$52.20	\$54.20	\$2.00
12/31/2011	\$59.40	\$58.30	(\$1.10)
12/31/2013	\$61.80	\$56.50	(\$5.30)
12/31/2015	\$73.30	\$33.40	(\$39.90)
12/31/2017	\$100.90	\$64.30	(\$36.60)
12/31/2018	\$131.50	\$87.10	(\$44.40)
12/31/2019	\$174.60	\$109.40	(\$65.20)

* Before 2017 Actuarial Reviews were only done every other year, so Reserve estimates are not available for the years when there was no review.

Calendar Year	Surcharge Revenue	Fund Balance	Fund Deficit	Deficit as % of Annual Surcharge	Deficit as % of Fund Balance
2015	11,886,745	33,389,231	39,900,000	336%	119%
2016	21,225,230	43,455,311	N/A	N/A	N/A
2017	38,377,990	64,285,006	36,600,000	95%	57%
2018	43,027,702	87,104,681	44,400,000	103%	51%
2019	42,042,473	109,398,646	65,160,000	155%	60%
Nov 2020	46,155,048	102,262,819	56,362,181		

* Nov 2020 values shown above are estimates.

Hypothetical Illustration of Fund Balance and Deficit as if the Hospitals never entered the Fund

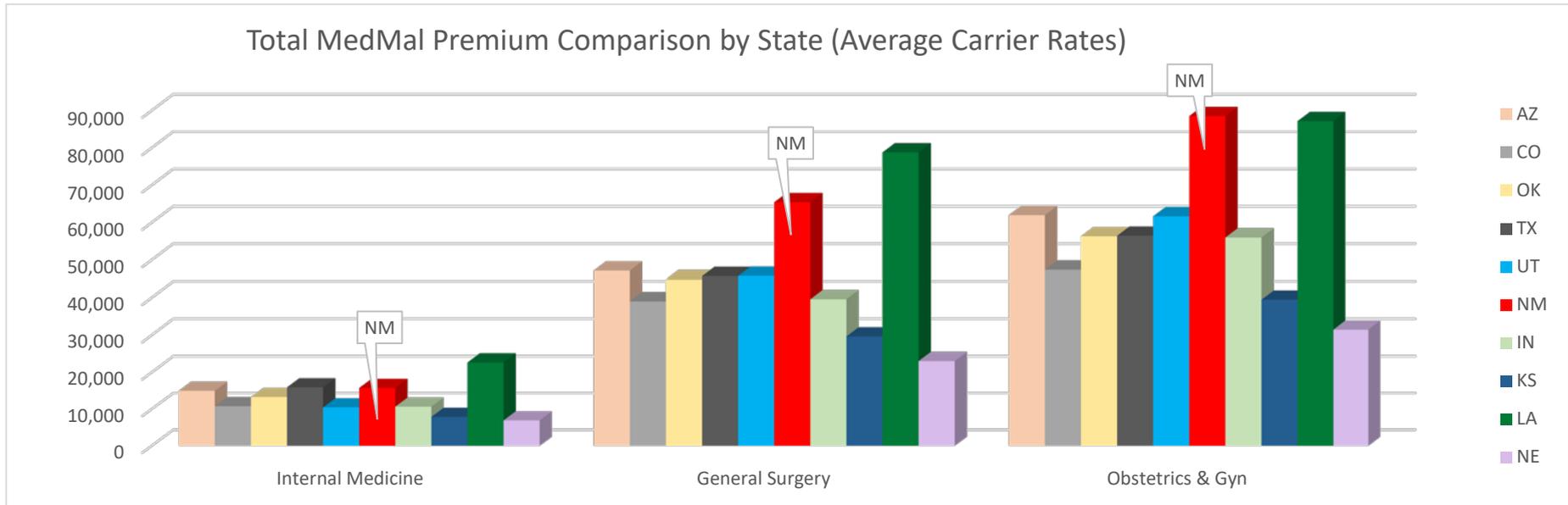
Calendar Year	Physician & Surgeon Surcharge Revenue	Fund Balance	Fund Deficit	Deficit as % of Annual Surcharge	Deficit as % of Fund Balance
2018	21,435,425	37,712,362	43,737,416	204%	116%
2019	20,518,662	38,276,510	60,174,722	293%	157%

* MRC expenses and Reinsurance costs would be slightly lower without the Hospitals in the Fund, but so would investment income. In the Illustration above these can be considered to offset each other.

** Christus St Vincent surcharges and claims were not split out along with the larger group of Hospitals because CSVH has been in the Fund since 2009 and expense information is not available that far back, which limits the ability to restate the Fund balance without CSVH.

Rate Comparison to other PCF and Non-PCF states

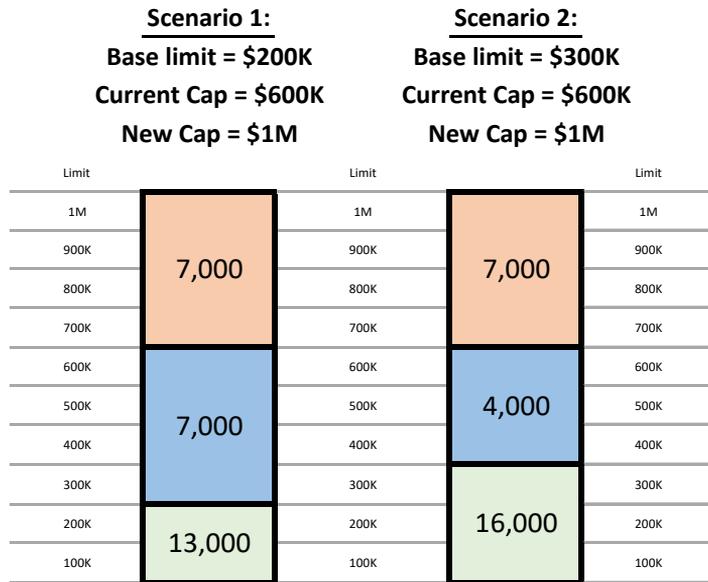
Policy Limit/Cap	NO PCF					\$200K/\$600K Base; \$600K Cap	PCF STATES			
	\$1M/\$3M	\$1M/\$3M	\$1M/\$3M	\$1M/\$3M \$250K NonEcon cap	\$1M/\$3M		\$250K/\$750K Base; \$1.25M Cap	\$200K/\$600K Base; \$1M Cap	\$100K/\$300K Base; \$500K Cap	\$500K/\$1M Base; \$1.75M Cap
	AZ	CO	OK	TX	UT	NM	IN	KS	LA	NE
Internal Medicine	14,981	10,792	13,290	15,935	10,465	15,759	10,667	7,880	22,686	6,933
General Surgery	47,169	39,027	44,830	45,697	45,755	65,456	39,595	29,647	78,791	23,051
Obstetrics & Gyn	61,991	47,399	56,331	56,468	61,679	88,514	55,995	39,468	87,162	31,460



Note 1: States selected for the comparison include those with a PCF, and those close to NM geographically.

Note 2: All states but LA have higher limits and caps than NM. NM premiums at comparable limits would show an even greater divergence.

Note 3: LA rates appear very similar to NM, but the LA PCF Fund has a surplus of \$1,160,493,736 (as of 10/31/20).



This illustration addresses the concern that an increase in the base coverage level will significantly affect the premiums paid by medical providers for the underlying MedMal coverage. There is no doubt that increasing the base coverage level from \$200K to \$300K will increase the premiums for the base coverage, however, that increase will be mostly offset by a decrease in PCF surcharges because the PCF will no longer be covering that layer. Unfortunately, this decrease to the PCF surcharge will be masked by the large increase due to raising the MMA Cap.

To illustrate this, consider the following simplified example:

Under the current structure, with a \$200K base limit and the PCF providing coverage for the next \$400K, a provider might pay \$13,000 for base coverage and \$7,000 for the PCF coverage, for a total of \$20,000.

Increasing the cap to \$1M might add another \$7,000 to the surcharge, for a total premium of \$27,000. (See illustration for Scenario 1)

In Scenario 2, if the base limit is raised to \$300K, with the same overall cap of \$600K, the premium distribution will shift such that the premium for the base layer may now be \$16,000, but the PCF surcharge would decrease to \$4,000.

The extra layer of coverage up to the new cap of \$1M remains the same, from \$600K to \$1M, with the same premium of \$7,000.

Note that the aggregate premium remains the same in both scenarios.

In reality, the aggregate premium for the coverage up to \$600K would likely increase slightly above \$20,000 as a result of changing the base limit to \$300K, due to the fact that the PCF administrative expenses are really low and therefore the coverage can be provided at a lower cost. However, this difference, compared to the premium increase due to the change in the cap, will be immaterial.

The purpose and benefit of raising the base coverage level is to limit the exposure of the PCF, as the rapid growth in exposure due to the change in the Cap can be a solvency hazard for the Fund.

Exhibit 2

ADR Process Proposal

1. Plaintiff files malpractice action in district court
2. Each defendant has 30 days after service of the complaint to move court for court annexed arbitration.
3. If moving defendant provides prima facie evidence that claim is subject to the MMA, court shall order court annexed arbitration, and PCF Custodian shall be served with a copy of the order.
4. Upon receiving copy of order compelling arbitration, PCF Custodian will randomly select the names of five arbitrators from an approved arbitrator list, and send that list of names to the parties.¹
5. Each party may strike up to three proposed arbitrators from the list. If, after the strikes, the parties would agree on one or more of the proposed arbitrators, the PCF custodian shall appoint an agreed arbitrator to conduct the arbitration. If none of the proposed arbitrators is acceptable to all parties, the SOI will randomly select and appoint a sixth arbitrator from the pool of qualified arbitrators.
6. The sole arbitrator shall conduct the arbitration according to the PCF arbitration rules.
7. The arbitrator shall make an award that conforms to MMA limits.
8. Either party may ask the district court to conform the award as a judgment, or to strike the award and order a trial de novo in the district court.
9. If a party requests a trial de novo, and the outcome of that trial is more favorable to that party than the arbitration award, that party shall be allowed to recover the attorney fees and costs incurred in the district court proceedings (excluding any fees or costs relating to the arbitration. If a plaintiff requests a trial de novo, and the outcome is not as favorable as the arbitration award, the applicable damages caps, and future medicals, are reduced by 25%. A plaintiff who requests a trial de novo shall post a bond, in the amount specified by the district court, to cover a potential award of attorney fees to the defendant. The primary insurer for a defendant who requests a trial de novo shall be liable for any attorney fees awarded against that defendant.

¹ Any New Mexico licensed attorney or health care provider can apply to the PCF Custodian to be added to the pool of potential arbitrators. The PCF Custodian will promulgate rules to specify arbitrator qualifications, compensation and arbitration procedures. Any applicant who qualifies will be added to the pool of potential arbitrators.