AN ACT

RELATING TO MEDICAL MALPRACTICE; CLARIFYING AND MODERNIZING THE MEDICAL MALPRACTICE ACT; RAISING PERSONAL LIABILITY AND RECOVERY CAPS; LIMITING PARTICIPATION BY HOSPITALS AND OUTPATIENT HEALTH CARE FACILITIES; REQUIRING A THIRD-PARTY ADMINISTRATOR FOR THE PATIENT'S COMPENSATION FUND; REQUIRING ANNUAL FUND AUDITS; CREATING AN ADVISORY BOARD; REQUIRING ANNUAL ACTUARIAL STUDIES; REQUIRING SURCHARGES SUFFICIENT TO BRING THE FUND TO SOLVENCY BY DECEMBER 31, 2026; AMENDING, REPEALING AND ENACTING SECTIONS OF THE NMSA 1978.

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

C. "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, physician's

assistant, certified nurse practitioner, clinical nurse specialist or certified nurse-midwife or a business entity that is organized, incorporated or formed pursuant to the laws of New Mexico that provides health care services primarily through natural persons identified in this subsection;

D. "hospital" means a facility licensed as a hospital in this state that offers in-patient services, nursing or overnight care on a twenty-four-hour basis for diagnosing, treating and providing medical, psychological or surgical care for three or more separate persons who have a physical or mental illness, disease, injury or a 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;

E. "independent provider" means a doctor of medicine, doctor of osteopathy, chiropractor, podiatrist, nurse anesthetist, physician's assistant, certified nurse practitioner, clinical nurse specialist or certified nurse-midwife who is not an employee or not an agent of a hospital or outpatient health care facility. "Independent provider" includes a business entity that is not a hospital or

outpatient health care facility that employs or consists of members who are licensed or certified as doctors of medicine, doctors of osteopathy, chiropractors, podiatrists, nurse anesthetists, physician's assistants, certified nurse practitioners, clinical nurse specialists or certified nurse-midwives and the business entity's employees;

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

G. "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;

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

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

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

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

L. "superintendent" means the superintendent of insurance."

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

"41-5-5. QUALIFICATIONS.--

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

(1) establish its financial responsibility by filing proof with the superintendent that the health care provider is insured by a policy of malpractice liability

insurance issued by an authorized insurer in the amount of at least two hundred fifty thousand dollars ($250,000) 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 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. 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 fund. The superintendent shall arrange for an actuarial study before determining base coverage or deposit and surcharges.

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

SECTION 3. Section 41-5-6 NMSA 1978 (being Laws 1992, Chapter 33, Section 4) 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. The aggregate dollar amount includes 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. In jury cases, the jury shall not be given any instructions dealing with this limitation. Beginning January 1, 2023, the per occurrence limit on recovery shall be adjusted annually by the consumer price index for all urban consumers.

C. 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 an injury or death to a patient as a result of malpractice shall not exceed four million dollars ($4,000,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2022. The aggregate dollar amount includes 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. In jury cases, the jury shall not be given any instructions dealing with this limitation.

D. 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 an injury or death to a patient as a result of malpractice shall not exceed four million five hundred thousand dollars ($4,500,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2023. The aggregate dollar amount includes 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. In jury cases, the jury shall not be given any instructions dealing with this limitation.

E. 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 an injury or death to a patient as a result of malpractice shall not exceed five million dollars ($5,000,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2024. The aggregate dollar amount includes 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. In jury cases, the jury shall not be given any instructions dealing with this limitation.

F. 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 an injury or death to a patient as a result of malpractice shall not exceed five million five hundred thousand dollars ($5,500,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2025. The aggregate dollar amount includes 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. In jury cases, the jury shall not be given any instructions dealing with this limitation.

G. 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 an injury or death to a patient as a result of malpractice shall not exceed six million dollars ($6,000,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in 2026; provided that beginning January 1, 2027, the per occurrence limit shall be adjusted annually by the consumer price index for all urban consumers. The aggregate dollar amount includes 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. In jury cases, the jury shall not be given any instructions dealing with this limitation.

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

I. 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 Subsection K of this section.

J. The term "occurrence" shall not be construed in such a way as to limit recovery to only one maximum statutory payment if separate acts or omissions cause additional or enhanced injury or harm as a result of the separate acts or omissions. A patient who suffers two or more distinct injuries as a result of two or more different acts or omissions that occur at different times by one or more health care providers is entitled to up to the maximum statutory recovery for each injury.

K. Until January 1, 2027, amounts due from a judgment or settlement against a hospital or outpatient health care facility in excess of seven hundred fifty thousand dollars ($750,000), excluding past and future

medical expenses, shall be paid by the hospital or outpatient health care facility and not by the fund. Beginning January 1, 2027, amounts due from a judgment or settlement against a hospital or outpatient health care facility shall not be paid from the fund."

SECTION 4. Section 41-5-7 NMSA 1978 (being Laws 1992, Chapter 33, Section 5, as amended by Laws 1992, Chapter 33, Section 6) is amended to read:

"41-5-7. MEDICAL EXPENSES AND PUNITIVE DAMAGES.--

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

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

D. 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.

E. 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 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 where that imposition would not be otherwise authorized by law."

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

"41-5-9. DISTRICT COURT--CONTINUING JURISDICTION.--The district court from which final judgment issued shall have continuing jurisdiction in cases where future medical care and related benefits were awarded pursuant to Section 41-5-7 NMSA 1978 for malpractice claims arising from occurrences prior to July 1, 2021."

SECTION 6. Section 41-5-13 NMSA 1978 (being Laws 1976, Chapter 2, Section 13) is amended to read:

"41-5-13. LIMITATIONS.--No claim for malpractice may be brought against a health care provider unless filed within

three years after the date that the act of malpractice occurred, except that the times limited for the bringing of actions by minors and incapacitated persons shall be extended so that they shall have one year from and after the age of majority or termination of incapacity within which to commence the actions."

SECTION 7. Section 41-5-14 NMSA 1978 (being Laws 1976, Chapter 2, Section 14) is amended to read:

"41-5-14. MEDICAL REVIEW COMMISSION--INDEPENDENT PROVIDERS.--

A. The "New Mexico medical review commission" is created. The function of the New Mexico medical review commission is to provide panels to review all malpractice claims against independent providers who are natural persons covered by the Medical Malpractice Act.

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

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

review commission.

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

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

F. The chief justice shall set the director's salary and report the salary to the superintendent in the superintendent's capacity as custodian of the fund."

SECTION 8. Section 41-5-15 NMSA 1978 (being Laws 1976, Chapter 2, Section 15) is amended to read:

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

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

B. This application shall contain the following:

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

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

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

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

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

SECTION 9. Section 41-5-16 NMSA 1978 (being Laws 1976, Chapter 2, Section 16) is amended to read:

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

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

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

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

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

SECTION 10. Section 41-5-17 NMSA 1978 (being Laws 1976, Chapter 2, Section 17) is amended to read:

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

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

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

C. In cases where there are multiple defendants, a single combined panel shall review the claims against all party defendants. At the discretion of the panel chair, a hearing involving multiple defendants may include fewer than three panelists from the independent provider's profession and fewer than three lawyer panel members per defendant.

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

E. The director of the medical review commission

or the director's delegate, who shall be an attorney, shall sit on each panel and serve as chair.

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

G. Whenever a party makes and files an affidavit that a panel member selected pursuant to this section cannot, according to the belief of the party making the affidavit, sit in review of the application with impartiality, that panel member shall proceed no further. Another panel member shall be selected by the independent provider's professional association, state licensing board or the state bar association, as the case may be. A party may not disqualify more than three proposed panel members in this manner in any single malpractice claim."

SECTION 11. Section 41-5-18 NMSA 1978 (being Laws 1976, Chapter 2, Section 18) is amended to read:

"41-5-18. TIME AND PLACE OF HEARING.--A date, time and place for hearing shall be fixed by the director of the New Mexico medical review commission and prompt notice of the hearing shall be given to the parties involved, their attorneys and the members of the panel. In no instance shall

the date set be more than sixty days after the transmittal by the director of the application for review, unless good cause exists for extending the period. Hearings may be held anywhere in the state, and the director shall give due regard to the convenience of the parties in determining the place of hearing. Upon the request of one party, within ten days of the answer filed by the respondent, the hearing shall be conducted via video conference, including attorneys, witnesses and panel members appearing remotely."

SECTION 12. Section 41-5-19 NMSA 1978 (being Laws 1976, Chapter 2, Section 19) is amended to read:

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

A. At the time set for hearing, the attorney submitting the case for review shall be present and shall make a brief introduction of the case, including a resume of the facts constituting alleged professional malpractice. The independent provider against whom the claim is brought and the independent provider's attorney may be present and may make an introductory statement of the independent provider's case.

B. Both parties may call witnesses to testify before the panel, which witnesses shall be sworn. Medical texts, journals, studies and other documentary evidence relied upon by either party may be offered and admitted if relevant. Written statements of fact of treating independent

providers may be reviewed. The monetary damages in any case shall not be a subject of inquiry or discussion.

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

D. At the conclusion of the hearing, the panel shall deliberate and reach a decision."

SECTION 13. 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 state 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 shall be determined by the superintendent with the advice of the advisory board and based on the annual independent actuarial study of the fund. The surcharges for health care providers, including hospitals and outpatient health care facilities whose qualifications for the fund end on January 1, 2027, shall be based on sound actuarial principles, using data obtained from New Mexico claims and loss experience. A hospital or outpatient health care facility seeking participation in the fund during the remaining qualifying

years shall provide, at a minimum, the hospital's or outpatient health care facility's direct and indirect cost information as reported to the federal centers for medicare and medicaid services for all self-insured malpractice claims, including claims and paid loss detail, and the claims and paid loss detail from any professional liability insurance carriers for each hospital or outpatient health care facility and each employed health care provider for the past eight years to the third-party actuary. The same information shall be available to the advisory board for review, including financial information and data, and excluding individually identifying case information, which information shall not be subject to the Inspection of Public Records Act. The superintendent, the third-party actuary or the advisory board shall not use or disclose the information for any purpose other than to fulfill the duties pursuant to this subsection.

E. 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 14. A new section of the Medical Malpractice Act, Section 41-5-25.1 NMSA 1978, is enacted to read:

"41-5-25.1. PATIENT'S COMPENSATION FUND ADVISORY BOARD--CREATED--MEMBERSHIP--POWERS AND DUTIES.--

A. The "patient's compensation fund advisory

board" is created to advise the superintendent and the third-party administrator. The office of superintendent of insurance shall provide staff services to the advisory board. The advisory board shall be established by July 2, 2021.

B. The nine-member advisory board shall consist of:

(1) two representatives from the New Mexico trial lawyers association;

(2) two representatives of a statewide association representing hospitals;

(3) two representatives of a statewide association representing physicians;

(4) two patient or patient advocate representatives; and

(5) one representative of a statewide association representing certified nurse practitioners.

C. Members of the advisory board shall be chosen annually by their organizations, as applicable, and the patient or patient advocate representatives shall be chosen by the chief justice of the supreme court from nominations made by the New Mexico trial lawyers association. Members of the advisory board are entitled to receive per diem and mileage pursuant to the Per Diem and Mileage Act, but shall receive no other compensation, perquisite or allowance.

D. The advisory board shall elect a chair and a

vice chair. A majority of the members constitutes a quorum for the transaction of business. All decisions of the advisory board shall be by majority vote of the members present.

E. The advisory board shall convene at least twice a year or at the request of the superintendent to:

(1) review the process and data for the setting of the surcharges for all qualified health care providers pursuant to the Medical Malpractice Act;

(2) advise the superintendent concerning surcharge data accumulation and results;

(3) advise the superintendent on the surcharges to be set by the superintendent; and

(4) prepare an annual report to the legislature on the operations and financial condition of the fund no later than the first day of each year's legislative session."

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

"41-5-28. PAYMENT OF MEDICAL REVIEW COMMISSION EXPENSES.--Unless otherwise provided by law, expenses incurred in carrying out the powers, duties and functions of the New Mexico medical review commission, including the salary of the director of the commission, shall be paid by the fund. The superintendent, in the superintendent's

capacity as custodian of the fund, shall disburse fund money to the director upon receipt of vouchers itemizing expenses incurred by the commission. The director shall supply the chief justice of the New Mexico supreme court with duplicates of all vouchers submitted to the superintendent. Expenses of the commission paid by the fund shall not exceed five hundred thousand dollars ($500,000) in any single calendar year; provided, however, that expenses incurred in defending the commission shall not be subject to that maximum amount."

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

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

A. the beginning and ending calendar year balances in the fund;

B. an itemized accounting of the total amount of contributions to the fund;

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

D. any other information regarding the fund that the superintendent or the legislature considers to be important."

SECTION 17. REPEAL.--Sections 41-5-2 and 41-5-10 NMSA 1978 (being Laws 1976, Chapter 2, Sections 2 and 10) are repealed.

SECTION 18. EFFECTIVE DATES.--

A. The effective date of the provisions of Sections 7, 13 and 14 of this act is July 1, 2021.

B. The effective date of the provisions of Sections 1 through 6, 8 through 12 and 15 through 17 of this act is January 1, 2022.