New Mexico
Public
Regulation
Commission

Report of the
Senate Memorial 7 Task Force on
Health Care Practitioner Liability Insurance

Submitted by:

The Insurance Division of the New Mexico Public Regulation Commission

and

The New Mexico Health Policy Commission

on

November 1, 2005

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STATE OF NEW MEXICO

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November 1, 2005

Governor Bill Richardson, The Honorable Danice Picraux, New Mexico House of Representatives, Chairperson and Members of Interim Legislative Health and Human Services Committee; The Honorable Luciano "Lucky" Varela, New Mexico House of Representatives, Chairperson and Members of the Legislative Finance Committee; and Secretary of Health Michelle Lujan Grisham

RE: Senate Memorial 7 Requesting the New Mexico Health Policy Commission and the Insurance Division of the Public Regulatory Commission to Convene a Task Force on Health Care Practitioner Liability Insurance

Dear Governor Richardson, Representatives Picraux and Varela, and Secretary Lujan Grisham:

On behalf of the New Mexico Health Policy Commission and the Insurance Division of the Public Regulation Commission, it is our pleasure to submit this Senate Memorial (SM)7 report. The SM 7 task force represented key health care interests from throughout the State.

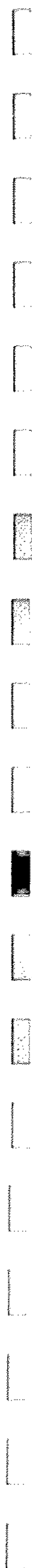
This challenging study addressed professional liability issues and the importance of these issues to the citizens of New Mexico. The report summarizes our findings and recommendations.

We appreciate the opportunity to present this report to the committee and would also like to thank the task force members and the many other people for all of the time and commitment that they have given to this study.

Sincerely,

Patricio C. Larragoite, DDS
Executive Director of the New Mexico Health Policy Commission

Eric P. Serna
Superintendent of Insurance



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HISTORICAL BACKGROUND

Medical malpractice received little public attention prior to 1970. Since then, however, there have been three periods of medical malpractice insurance dilemma in the nation: the mid-1970s, the mid-1980s, and the last several years. Each of these periods experienced widely publicized increases in medical malpractice insurance premiums, reports of the unavailability or unaffordability of coverage and threats by doctors and other practitioners to leave high-risk specialties or their professions.

With the exception of the mid-80s, these periods were accompanied by the exit of major insurers from the medical malpractice insurance market. It should also be noted that certain classes of health care providers, such as obstetricians, surgeons, emergency medicine practitioners, midwives, nursing homes and hospitals, have generally been more affected.

Various solutions that have been attempted within the nation include the following:

- ✓ Restrictions on plaintiffs' rights to file claims and receive damages, collectively referred to as "tort reform"
- ✓ State-sponsored insurance facilities, such as joint underwriting associations and patient compensation funds
- ✓ Insurance facilities created by and for doctors and other groups of health care providers, such as physician mutuals and risk retention groups
- ✓ Patient safety initiatives to reduce the incidence of medical injuries, such as the National Practitioner Data Bank and the Patient Safety and Quality Improvement Act
- ✓ "No-fault" alternatives to tort litigation, such as the Virginia and Florida birth-related neurological injury compensation programs

In addition, the insurance industry in the mid-1970s introduced an obscure type of policy form, called "claims-made" coverage[1], to its medical malpractice product line. This "claims-made" product, whose premiums are initially cheaper for policyholders and whose costs to insurers and reinsurers are more predictable, swept the marketplace and supplanted the previous "occurrence" coverage product.

The Task Force has considered the liability issues of governmental health care providers to be outside its scope of charge. This report therefore excludes these entities, which include university, state, federal and tribal hospitals, clinics and their staffs, from its statistics and findings.

1 "Claims-made" policies cover incidents that are reported during the year the policy is in effect, while "occurrence" policies cover incidents that occur during the year the policy is in effect even if those occurrences are not reported until years later.

NEW MEXICO'S MEDICAL MALPRACTICE ACT

In 1975, Travelers Insurance Company, the primary writer of medical malpractice for New Mexico's doctors, exited the state after citing the state's lack of tort reform and small market size. In response, the Legislature passed the Medical Malpractice Act of 1976 (hereafter referred to as "the Act") with the express purpose to "promote the health and welfare of the people of New Mexico by making available professional liability insurance for health care providers in New Mexico."

The Act contains the following benefits for qualifying health care providers:

- ✓ $600,000 cap on damages other than medical bills and punitive damages
- ✓ 3-year statute of limitations on the filing of a claim (subject to extension for minors)
- ✓ Mandatory review of claims by a medical/legal panel prior to the filing of lawsuits
- ✓ State participation in malpractice insurance coverage via a "patients compensation fund"

To be qualified under the Act, health care providers must either obtain base coverage from an admitted insurer on an "occurrence" policy form or else maintain a substantial cash deposit with the Superintendent of Insurance (few have done the latter). In addition to their base coverage premium payments, qualifying health care providers must also pay an annual surcharge to the patients compensation fund.

The list of health care providers that are eligible to be covered under the Act includes physicians, chiropractors, podiatrists, nurse anesthetists, physicians' assistants, hospitals and outpatient health care facilities. Any health care practitioners or facilities not on this list, such as midwives, nurse practitioners, dentists and nursing homes, are excluded from coverage under the Act.

The language of the Act requires the use of occurrence coverage. The Act's inability to predict the market dominance of the claims-made product has, over time, severely restricted the number of insurers providing access to the Act.

THE MEDICAL MALPRACTICE MARKET IN NEW MEXICO

The Insurance Division has begun to analyze the medical malpractice market in New Mexico over the past five years in order to understand the statewide impact of the current nationwide crisis. As stated earlier, the malpractice liability concerns of governmental providers, such as university, state, federal and tribal hospitals and clinics and their staffs, are outside the purview of our study.

Admitted Insurers and Alternative Markets

Our market analysis examined recent changes in the distribution of business among admitted (i.e. "licensed") insurers and alternative sources of coverage such as surplus lines (i.e. "unlicensed") insurers, risk retention groups and self-insurance. Admitted insurers have historically been the vendors of choice since their rates are usually substantially lower than those of surplus lines insurers and their claim obligations are backed by state guaranty funds.

Health care providers and other purchasers of insurance seek surplus lines insurers when insurance in the admitted market is not readily available. They either self-insure or insure through risk retention groups when the admitted and surplus lines markets are either unavailable or unaffordable. In either case, a movement of market share away from admitted insurers may be viewed as a sign of an unhealthy market.

While admitted insurers file rates with the Insurance Division, surplus lines insurers and risk retention groups do not. Hence, the Task Force's only avenue to track rates for providers such as hospitals, nursing homes and licensed midwives, where little if any coverage is written by admitted insurers, has been through member surveys.

Physicians

The American Medical Association has listed New Mexico as one of only six states that, from the viewpoint of physicians, are not in crisis. This is largely due to physicians' access to the Act, which is widely viewed as the main stabilizing influence on their malpractice premiums.

More than half the doctors in New Mexico are employed by private or governmental hospitals and clinics and have their malpractice exposures covered by their employers. Most of the approximately 2100 doctors who remain in need malpractice coverage purchase their insurance through one admitted insurer, American Physicians Assurance Corporation (commonly referred to as "AP Capital"). AP Capital is endorsed by the New Mexico Medical Society and writes physicians medical malpractice in a dozen states. In 1997, AP Capital assumed the book of business formerly written by the New Mexico Physicians Mutual Insurance Company, a physicians' mutual insurer created in New Mexico in 1976.

AP Capital is currently the only insurer actively writing (i.e. issuing new) occurrence policies for physicians in New Mexico. It has therefore become the *ipso facto* gatekeeper for physicians who want coverage under the Act. While AP Capital has a reputation for providing quality insurance services, the Insurance Division recognizes that it is unhealthy for any carrier to have a monopoly in any segment of the insurance market.

There have been several secondary writers of occurrence policies for physicians. In recent years these insurers have chosen to exit the New Mexico market, either abruptly by nonrenewing their book of policies, or gradually by not accepting new business.

New Mexico has shared in the nationwide trend for doctors, particularly those in high-risk specialties, to leave private practice and seek facility-based employment, partly to avoid having to purchase their own malpractice insurance.

Other Health Care Professionals

Non-physician health care professionals play an integral role in New Mexico's health care delivery system. Compared to much of the nation, New Mexico is large, rural, poor and thinly populated. All but three of the state's 33 counties have far fewer doctors per capita than the national average. New Mexico also has one of the nation's highest percentages of citizens on Medicaid. Within this challenging environment midwives, nurse anesthetists, nurse practitioners and other non-physician health care professionals serve the medical needs of many New Mexicans.

The volume of coverage written by admitted insurers has diminished over the last five years with a corresponding growth in surplus lines writings. Most non-physician practitioners cannot find occurrence coverage and can obtain only claims-made policies. There are only two insurers writing a few non-physician practitioners on occurrence forms. The vast majority of non-physician practitioners, even those on the Act's qualifying list, have no access to the Act.

Midwives

Almost a third of all babies born in New Mexico are delivered by midwives. This is by far the highest midwife-attended birthrate in the nation. Midwives, who tend to service low-income families, receive most of their revenues from Medicaid reimbursement. Approximately three-quarters of New Mexico's midwives are certified nurse midwives and the remaining quarter are licensed midwives. Certified nurse midwives usually deliver in hospitals while licensed midwives usually deliver in homes and birthing clinics.

Malpractice insurance remains available for certified nurse midwives but at premiums that have increased by approximately 30% per year for the past several years. Since malpractice insurance is not available for home births, the vast majority of licensed midwives have no malpractice coverage. The decision of the Human Services Department to withhold Medicaid reimbursement from licensed midwives who do not have malpractice coverage has further compounded their predicament. Only those licensed midwives who deliver in birthing centers are able to obtain insurance, at rates that are triple those of a year ago and that now equal approximately half their income.
The New Mexico Trial Lawyers Association and the New Mexico Medical Society believe that home births are medically risky and that home deliveries and the use of midwives should be severely curtailed.

Nurse Anesthetists

Nurse anesthetists provide most of the anesthesia delivered in New Mexico and are the sole anesthesia providers in the majority of hospitals in the state. While nurse anesthetists are on the Act's list of qualifying providers, only the relatively small number who are employed by anesthesiologists insured by AP Capital have access, however indirect, to the Act.

Hospitals

While doctors and other health care professionals usually purchase stand-alone malpractice policies, hospitals and other health care facilities routinely obtain their professional liability coverage bundled with their premises liability coverage through what are termed "GL/PL" policies. The issues and concerns of the GL/PL policies of hospitals and other health care facilities reflect those of the medical malpractice policies that practitioners buy.

According to the New Mexico Hospitals and Health Systems Association, which represents all of the general acute non-governmental hospitals in the state, the GL/PL premiums of their insured members have

risen on average about 30% per year during the last five years. These increases have driven most of the state's hospitals completely out of the GL/PL marketplace and into self-insurance.

Prior to 2003, roughly half the hospital market was insured by one admitted carrier, Truck Insurance Exchange, whose abrupt exit in 2003 shifted the market further to self-insurance as well as to surplus lines insurers and risk retention groups. Today, only 1% of the hospital market is insured through admitted insurers compared to 92% five years ago.

There are currently no hospitals covered under the Act and no available avenue (other than posting a large cash deposit with the Superintendent) for them to enter the Act, despite their inclusion in the Act's list of qualifying providers.

Nursing Homes and Other Health Care Facilities

This category includes long-term care, intermediate care, outpatient and all other health care facilities that are not classified as hospitals. As with hospitals, there are no insurers writing occurrence policies and hence no insurance avenues for entrance into the Act. Furthermore, all facilities other than hospitals and outpatient facilities are excluded from the Act's list of qualifying providers.

Since 2001, GL/PL rates for nursing homes in New Mexico have increased on average over 20% a year while the levels of coverage provided have simultaneously declined. These increases in rates and reductions in coverage are driven by a doubling of the frequency and a tripling of the severity of nationwide nursing facility liability claims over the last eight years. This has occurred at a time when Medicaid reimbursement to nursing facilities continues to fall below their associated operating expenses.

Five years ago, 65% of New Mexico's GL/PL premiums for non-hospital health care facilities were written by admitted insurers. That admitted insurer market share has now dropped to 5%, with the remaining 95% written by surplus lines insurers.

The Trial Bar and the Medical Society believe that the insurance problems faced by nursing homes result from chronic understaffing and mismanagement. They also believe that nursing homes should be required to post $5,000,000 cash bonds per facility with the State as well as purchase GL/PL policies with no aggregate coverage limits.

IMPACT ON PATIENTS

While the medical malpractice insurance debate usually focuses on the impact to providers, the impact on patients is equally important. These impacts include:

- ✓ Failures of the current system in improving patient safety
- ✓ Increased healthcare costs due to defensive medicine and to malpractice claims
- ✓ Access to health care providers in impacted specialties

Patient Safety

According to "To Err Is Human: Building a Safer Health System," a landmark study published in 1999 by the Institute of Medicine, roughly 45,000 to 100,000 Americans die each year from medical errors which, if accurate, exceeds the number that die from traffic accidents. The causes cited for this epidemic of medical errors include the fragmentation of health care delivery systems and the failure of medical licensing boards to educate and discipline their membership regarding medical errors. The study concludes that most medical errors result from faulty systems, processes and conditions rather than from individual acts of negligence. This finding, along with the widespread continuance of medical injuries despite decades of tort litigation, challenges the notion that the current system provides an effective deterrent to medical injuries.

The findings and recommendations of "To Err Is Human" have led to the passage of the federal Patient Safety and Quality Improvement Act of 2005, which allows and encourages doctors and other health care providers to confidentially report mistakes and hazards to certified patient safety organizations, which will then analyze these reports to identify patterns of safety problems. Such reporting systems have been successful in reducing the frequency of accidents in the fields of anesthesiology and aviation.

Impact of Defensive Medicine and Malpractice Claims on Health Care Costs

"Defensive medicine" refers to the widespread practice of physicians to order excessive tests, treatments and referrals in order to reduce their exposure to potential lawsuits rather than to medically benefit their patients. The monetary costs of defensive medicine, however, remain difficult to measure, with estimates ranging from 5% to 9% of total health care costs (U.S. Department of Health and Human Services) to "small" (Congressional Budget Office).

The impact of malpractice premiums is much easier to quantify. According to *Health Affairs'* latest annual report on health care spending among industrialized nations, malpractice claims account for only 1% of total health care costs in this country. It is therefore likely that the costs of defensive medicine exceed, perhaps by several times, the direct costs of malpractice claims on the overall cost of health care.

Access to Health Care Providers

While New Mexico has a shortage of physicians and most other classes of health care professionals, this is more likely caused by limited income opportunities than by malpractice concerns. We do, however, have testimonial evidence that licensed midwives may curtail practice due to the combined effect of the unavailability or unaffordability of malpractice insurance coupled with the abovementioned restrictions on Medicaid reimbursement. We also have testimony that some of the state's nursing homes may face insolvency due to the high self-insured retentions now required under their GL/PL policies.

NO-FAULT ALTERNATIVES

The right to trial by jury is engrained in our legal system and is guaranteed by the New Mexico Constitution. Nonetheless, courts have occasionally allowed this right to be abridged, an example being the workers compensation system wherein injured workers forego their right to sue their employers in exchange for the guarantee of fair and adequate compensation for their work-related injuries.

Virginia and Florida's Birth Injury Compensation Programs

During the mid-1980s, many of Virginia's obstetricians were poised to leave the state. In response, Virginia developed a novel program that compensates, without litigation or findings of fault, children who are neurologically injured at birth for all economic losses not covered by other sources. Florida enacted a similar program soon thereafter.

These programs offer an exclusive remedy to tort liability for voluntarily participating providers of obstetrical services. Both programs have achieved their founding objectives, have low overhead and have remained fiscally self-sufficient, with the majority of their funding derived from fees and assessments on participating and non-participating providers.

LEGISLATIVE PROPOSALS

Despite much effort, the Task Force failed to achieve full consensus on any legislative proposals. The various legislative initiatives that were discussed include:

- ✓ Creating a state-sponsored Joint Underwriting Association
- ✓ Amending the Medical Malpractice Act of 1976
- ✓ Creating a parallel Medical Malpractice Act
- ✓ No-fault carve-outs for providers of obstetric services

These initiatives are described below.

Joint Underwriting Association

The entire Task Force was favorably inclined toward the creation of a state-sponsored insurance facility called a Joint Underwriting Association (JUA) that would provide malpractice coverage to classes of health care providers that cannot find coverage elsewhere. All agreed that such a JUA should be self-supporting with rates that are actuarially sound, should exercise normal underwriting authority, including the right to deny coverage to health care providers who have an adverse claims history, and should adjust individual policyholders' premiums to reflect their claim experience.

Divisions arose regarding whether the JUA should have caps and whether it should be open to providers who are not "in crisis." The majority supported a JUA that would be open to all classes of providers, that would offer both occurrence and claims-made products, that would qualify as a base coverage insurer under the Act, and that would have relatively high caps on non-economic damages for providers not under the Act.

The provision for caps was opposed by the New Mexico Trial Lawyers Association. The Medical Society and the Trial Bar oppose the creation of a JUA that would insure providers who can find coverage elsewhere and thereby to compete with AP Capital and other private insurers.

Amending the Medical Malpractice Act of 1976

The majority of Task Force members believe that amending the 1976 Medical Malpractice Act to (1) allow the use of claims-made policies for the required base coverage and (2) expand the list of eligible health care providers, would ameliorate New Mexico's medical malpractice dilemma and promote the stated purpose of the Act. These efforts to amend the Act were opposed by the Medical Society, which fears that the introduction of other health care providers may financially endanger the fund, and by the Trial Bar.

Creating a "Mirror" Medical Malpractice Act

In view of the effectiveness of the Act for physicians and of the opposition to its amendment, the Task Force discussed the creation of a "mirror" act with its own patients compensation fund that would be open to all health care providers. This was not pursued due to anticipated difficulties in obtaining appropriate medical/legal review panels and caps on non-economic damages.

No-Fault Carve-Outs for Providers of Obstetric Services

Many on the Task Force were intrigued with the concept of an alternative, non-judicial compensation system that would serve as an excusive remedy for obstetric injuries. Such a system could resemble those

in Virginia and Florida or could extend further and include all obstetric injuries, either on a voluntary or a mandatory basis. The Task Force ran out of time to explore this option further.

RECOMMENDATIONS

The Task Force did agree on the two recommendations described below.

Increased Medicaid Reimbursement to Providers of Obstetric Services

The Task Force has recommended that Medicaid reimbursements to midwives and obstetricians be increased and that the maintenance of malpractice coverage not be a condition for reimbursement. A copy of our letter to Secretary Hyde containing this recommendation is attached.

New Mexico Patient Safety Organization

The federal Patient Safety and Quality Improvement Act of 2005 encourages individual states to create Patient Service Organizations (PSOs) for certification by the U.S. Department of Health and Human Services. The purpose of these PSOs is to collect confidential reports of medical errors from local health care providers and share them with the Department of Health and Human Services for analysis of patterns of unsafe medical practices that can then be addressed in a systematic way. The Task Force recommends that interested parties consider forming a PSO in our state.

CONDUCT OF THE TASK FORCE

The Task Force met monthly from May through October. The Task Force devoted its first several meetings to relevant expert presentations, including presentations on Joint Underwriting Associations, Alternatives to Traditional Tort Liability, Hospital Risk Retention Groups, Vicarious Liability Exposures of Midwives, New Mexico's Medical Malpractice Act, Perspectives of New Mexico Plaintiffs' Bar, and the Virginia and Florida Birth-Related Neurological Injury Compensation Programs.

At the recommendation of Task Force members who represented facilities and non-physician providers, the Task Force created a subcommittee to meet separately and recommend initiatives to the full Task Force. That subcommittee recommended the pursuit of a JUA. The Task Force then created a second subcommittee to determine the details of the JUA.

The JUA subcommittee developed two basic models. One was an "emergency-enabled JUA" that granted admittance only to those classes of health care providers for whom a malpractice emergency had been formally determined by the Department of Health. The other was a "continuous JUA" open to all health care providers and containing caps. The divisions on the details of the JUA, as discussed earlier, became apparent during the subcommittee meetings.

During the August Task Force meeting the Trial Bar requested that the Task Force obtain data to determine whether there is indeed a malpractice crisis in New Mexico. The Task Force and the Insurance Division subsequently commenced to compile such data, portions of which are attached to this Report.

Attachments

Text of Senate Memorial 7

Roster of Task Force Members

Correspondence

- Letter from Task Force Co-Chairs to Human Services Department re Medicaid
- Letter from Trial Bar and Medical Society to Task Force Co-Chairs
    - Response from Co-Chairs

Market Data

- From Insurance Division
    - Trends in Admitted Insurers vs. Alternative Markets
    - Recent Rate Changes for Select Classes and Carriers
- From Task Force Members
    - Beth Enson of New Mexico Midwives Association
        - Letter from Dean Insurance Agency
        - Analysis of Liability Insurance Trend for Licensed Midwives
    - Suzanne Stalls of American College of Nurse Midwives
    - Sharon Hensley of New Mexico Association of Nurse Anesthetists
    - Jeff Dye of New Mexico Hospitals & Health Systems Association
    - Linda Sechovec of New Mexico Health Care Association

A MEMORIAL

REQUESTING THE NEW MEXICO HEALTH POLICY COMMISSION AND THE INSURANCE DIVISION OF THE PUBLIC REGULATION COMMISSION TO CONVENE A TASK FORCE ON HEALTH CARE PRACTITIONER LIABILITY INSURANCE.

WHEREAS, there is an escalating crisis in health care access because malpractice premiums for all types of health care providers are skyrocketing; and

WHEREAS, declining reimbursement rates for medicare and medicaid affect every type of provider and practitioner, including physicians, advance practice nurses, hospitals, nursing homes, clinics and others; and

WHEREAS, medical malpractice liability is capped at six hundred thousand dollars ($600,000) for health care providers who qualify by contributing to the patient's compensation fund; and

WHEREAS, certain practitioners, such as nurse midwives, nurse practitioners, dentists and others, are required to carry three million dollars ($3,000,000) in malpractice coverage; and

WHEREAS, some health care providers are not included under the Medical Malpractice Act and thus do not qualify under its provisions; and

WHEREAS, insurance coverage is not available for certain

types of practitioners and certain types of services, including home births; and

WHEREAS, options may be available to address this escalating crisis, including amending the Medical Malpractice Act, creating a joint underwriting association, purchasing coverage through the risk management division of the general services department, creating a separate liability act or self-insuring;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the New Mexico health policy commission and the insurance division of the public regulation commission be requested to convene a task force of representatives from statewide health care practitioner groups, including the New Mexico medical society, the American college of nurse-midwives, the New Mexico nurse anesthetist association, the New Mexico midwives association, the New Mexico dental association, the New Mexico hospital and health systems association, the New Mexico health care association, the New Mexico trial lawyers association and foundation, the office of the governor and others, to examine the malpractice insurance dilemma and its impact on providers and patients; and

BE IT FURTHER RESOLVED that the task force examine the statutes, constitutional provisions, regulations and court decisions governing medical malpractice; and

BE IT FURTHER RESOLVED that the task force submit its findings and recommendations, including legislative initiatives for malpractice insurance reform for health care providers, by November 1, 2005 to the legislative health and human services committee, the legislative finance committee, the department of health and the office of the governor; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the New Mexico health policy commission and the insurance division of the public regulation commission.

Task Force Members

Member	Organization
Patricio Larragoite, Co-Chair	New Mexico Health Policy Commission
Eric Serna, Co-Chair	Insurance Division of New Mexico Public Regulation Commission
Suzanne Stalls	American College of Nurse Midwives
Beth Enson	New Mexico Midwives Association
Sharon Hensley	New Mexico Association of Nurse Anesthetists
Edwin Esquibel	New Mexico Nurse Practitioner Council
Kathleen Blake	New Mexico Medical Society
Kent Cravens	New Mexico Dental Association
Jeff Dye	New Mexico Hospital & Health Systems Association
Linda Sechovec	New Mexico Health Care Association
Chris Tapia	Laurel Healthcare
Lydia Pendley	New Mexico Public Health Association
Jessica Sutin	New Mexico Department of Health
Stephen Durkovich	New Mexico Trial Lawyers Association
Michael Hart	New Mexico Trial Lawyers Foundation
Alice Lorenz	New Mexico Defense Bar
Christina Vigil	New Mexico State Bar
Manuel Tijerina	Risk Management Division of General Services Department
Paul Ritzma	Human Services Department
Larry Heyeck	Medicaid
Michelle Welby	Office of the Governor

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September 13, 2005

Via Fax and U.S. Mail

Secretary Pamela S. Hyde, J.D.
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Re: Medicaid Reimbursement for Providers of Obstetrical Services

Dear Secretary Hyde:

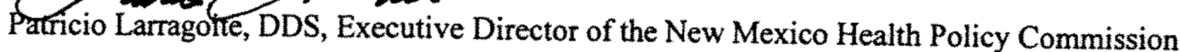
On behalf of the Senate Memorial 7 Task Force which we co-chair, we wish to respectfully urge the Human Services Department to increase Medicaid reimbursements to all providers of obstetrical services within the state, including licensed midwives, nurse midwives, obstetricians and family physicians, by an aggregate annual amount of $800,000. We also support the extension of Medicaid reimbursements to all providers of obstetrical services regardless of the status of their coverage for exposure to professional medical liability.

We wish to convey that all members present at the last meeting of the Task Force, including the New Mexico Medical Society, the New Mexico Health Care Association, the American College of Nurse Midwives, the New Mexico Midwives Association, the New Mexico Nurse Anesthetist Association, the New Mexico Nurse Practitioner Council, the New Mexico Hospital and Health Systems Association, Laurel Healthcare, the New Mexico Trial Lawyers Association, the New Mexico State Bar, the New Mexico Defense Bar and the Risk Management Division of GSD, were unanimous in their support of both of these recommendations.

We remain available for any questions you may have regarding this request.

Sincerely,

Eric P. Serna, Superintendent of Insurance



Patricio Larragoite, DDS, Executive Director of the New Mexico Health Policy Commission

Cc: Governor Bill Richardson

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August 1, 2005

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Re: ***Task Force on Healthcare Practitioner's Liability Insurance***

Dear Mr. Serna and Dr. Larragoite:

The New Mexico Trial Lawyers and the New Mexico Medical Society feel that the fundamental purpose of the task force is to better healthcare for the people of this State. As we see that objective, it means proposing legislation that will positively benefit the problems underlying the issue of insurance rates and availability as opposed to discounting the healthcare providers' bill when citizens have been treated negligently. The problems with healthcare, which are reflected in insurance rates and availability, are as follows:

1. ***Home Delivery of Babies***. The delivery of babies is one of the highest risk tasks in medicine. In order to reduce the risk, all of the tools that are available to a health care provider must be used. Those include both internal and external fetal heart monitors, the availability of c-section surgical facilities, personnel skilled in the intubation of neonates and the like. None of those facilities or people are there for pregnant mothers or newly delivered infants delivered in the parent's home. They exist only in a hospital. Consequently, deliveries of babies must be confined to a hospital setting absent emergent circumstances.

2. ***Delivery of Babies by Untrained Persons***. Midwifery training ranges from persons with a high school diploma and six months of training, to persons with a master's degree and three years of training. Even at that, midwifery training is far less than that required of an obstetrician. Training requires not only an acquaintance with the mechanics of delivery, but more importantly learning how to respond calmly and efficiently to a wide variety of emergent conditions. That, of course, is the subject of an OB residency. As a consequence, we suggest a change in the law to insure that children will not be delivered by anyone who has less than a master's degree, and three years of formal training in the delivery of children.

3. ***Supervisory Obstetricians***. To the same end, the law should be changed to insure that nurse midwives should be supervised by an obstetrician in hospitals located in population centers greater than 10,000 persons.

4. ***Unqualified Nurse Anesthetists***. Nurse anesthetists are in a position comparable to nurse midwives. They too have a wide variety of both education and experience. Some have gone to two year nursing schools, some have gone to four year nursing schools. All go to at least a year of nurse anesthetist formal training and then there is a great disparity in the range of supervised training required with some receiving one year of training and some two years. More training is required of some of New Mexico's existing anesthetists and that training must be uniform. To that end, all nurse anesthetists must have a four year college degree in nursing, one year of anesthesia school, one year of training in an ICU and two years of formal training in anesthesia before they are allowed to practice in this state.

For this provision as well as with the provisions relating to nurse midwives, there can be no grandfathering. It is not fair to New Mexico patients that substandard and unqualified persons be allowed to perform critical medical tasks.

5. ***Patient Rescue***. Nurse anesthetists are often unable to recognize emergencies, and when the reality of an emergency forces itself into the consciousness of the nurse anesthetist, the nurse anesthetist is often unequipped to handle the emergency. To that end, there must be a trained, board certified, emergency room physician or a board certified anesthesiologist on duty at the time the nurse anesthetist is providing anesthesia in all hospitals where there are more than 500 surgical cases performed in a year.

6. ***Nursing homes***. Numerous nursing homes have gone bankrupt in the past decade. These bankruptcies have been occasioned by illegal executive profit taking and

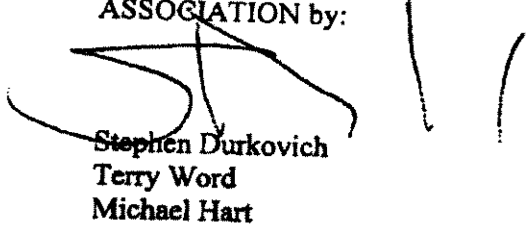
the fact that nursing homes are understaffed and underinsured as a matter of institutional policy. Insurance companies withdraw coverage as a consequence of the results of this understaffing and the nursing homes go bare. Nursing homes should therefore be required to be insured under policies with no aggregate limit. In addition to insurance, nursing homes should be required to post a cash bond of $5 million for each individual facility they operate in the State of New Mexico.

We feel that if the above measures are addressed, the problems of unavailability or excessive rates will disappear for the allied healthcare providers.

We trust these proposals will be thoroughly examined by the task force.

Very truly yours,

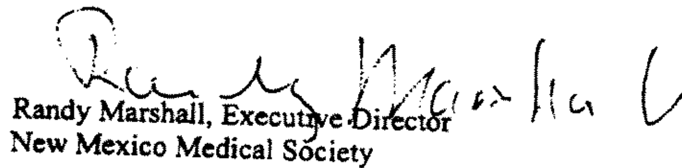
NEW MEXICO TRIAL LAWYERS ASSOCIATION by:



Stephen Durkovich
Terry Word
Michael Hart

NEW MEXICO MEDICAL SOCIETY by:

Kathleen Blake, MD, Immediate Past President



Randy Marshall, Executive Director
New Mexico Medical Society

SD:csg
cc: Peter Mallery
John Anderson

NEW MEXICO PUBLIC REGULATION COMMISSION

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August 12, 2005

Via Fax and U.S. Mail

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Randy Marshall and Kathleen Blake, MD
New Mexico Medical Society
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Dear Sirs and Madam:

Thank you for the ideas presented in your August 1 letter to us on how to remedy the problems in the availability and affordability of medical professional liability insurance for midwives, nurse anesthetists and nursing homes. We will share you ideas with the Senate Memorial 7 Task Force at our next meeting on August 18.

We do wish to note that the stated purpose of the Senate Memorial 7 Task Force is to "examine the malpractice dilemma and its impact on providers and patients." We share your interest in bettering the healthcare of New Mexicans but note that there are other task forces, such as Insure New Mexico, that are charged with examining these issues. We therefore suggest that you bring your healthcare-related proposals to these forums. We are, however, willing to temporarily step outside our roles as co-chairs and share in this letter our informal thoughts on your proposals in order to enhance their presentation to appropriate audiences.

Regarding the safety of home deliveries, we are aware that the literature on this subject is both voluminous and conflicting. Key studies finding for and against home births have been published in the June 2005 issue of the British Medical Journal and the August 2002 issue of Obstetrics and Gynecology. You may wish to review these studies if you have not done so already.

Regarding the training of midwives, we share your desire to strengthen the certification and recertification requirements for all practitioners providing obstetrical services, whether family physicians, midwives or obstetricians. Neither we nor the task force, however, are properly qualified to opine on how to craft those standards.

Regarding the supervision of nurse midwives by obstetricians in population centers greater than 10,000, we are concerned that this would create disparate standards of care between the several communities that exceed that size and the many communities, including Taos, Ruidoso, Espanola, Grants, Silver City, Raton, Tucumcari, Santa Rosa, Socorro, Clayton, Lovington and Truth or Consequences, that currently do not. Also, the issue of whether family physicians who perform deliveries should be under the supervision of an obstetrician needs to be addressed.

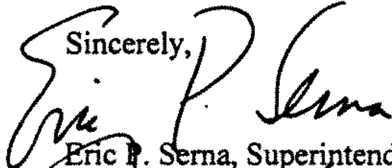
Regarding the training of nurse anesthetists, we are again not the proper party to study certification standards. Part of our written findings to the Senate can include a recommendation that the pertinent licensing boards and professional societies study certification and recertification requirements for all healthcare providers to ensure appropriate standards of care throughout the state.

Regarding the supervision of nurse anesthetists in hospitals where more than 500 surgeries are performed annually, we are again concerned about the establishment of dual standards of care in New Mexico. Furthermore, as in the issue of home deliveries, it is our understanding that the literature on the relative safety of anesthesia delivered by nurse anesthetists vs. anesthesiologists is inconclusive. We also note that the Centers for Medicare and Medicaid Services have eliminated the requirement that CRNAs be supervised by physicians.

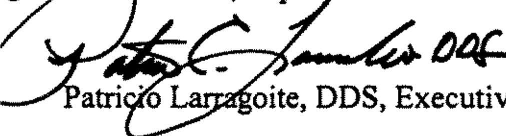
Regarding nursing homes, there are a variety of reasons for the financial difficulties faced by those facilites, including cuts in Medicare and Medicaid reimbursements as well as dramatic increases in the frequency and severity of lawsuits. Requiring a $5 million cash bond per facility as well as the purchase of liability insurance polices with no aggregate limits would further exacerbate the financial difficulties of these institutions and price their services out of reach of most low and middle-income New Mexicans.

We look forward to your continued support in finding cooperative and constructive solutions to the medical malpractice availability and affordability problems outlined in Senate Memorial 7. We thank you in advance for your active support for whichever legislative proposals our Task Force recommends.

Sincerely,



Eric P. Serna, Superintendent of Insurance



Patricio Larragoite, DDS, Executive Director of the New Mexico Health Policy Commission

Market Data from Insurance Division

NEW MEXICO MEDICAL MALPRACTICE INSURANCE MARKET

Physicians & Surgeons

NAME OF INSURER	TYPE OF INSURER	DIRECT WRITTEN PREMIUMS 2000	%	2001	%	2002	%	2003	%	2004	%
American Physicians Assurance Corp	Admitted	8,304,974	65.9%	9,105,904	63.9%	11,334,916	59.8%	16,137,096	66.3%	20,388,568	75.8%
Medical Protective Company	Admitted	2,609,080	20.7%	3,285,195	23.0%	3,900,049	20.6%	5,432,010	22.3%	4,167,367	15.5%
Evanston Insurance Company	Surplus Lines	4,507	0.0%	4,594	0.0%	130,587	0.7%	216,453	0.9%	405,115	1.5%
Lexington Insurance Company	Surplus Lines	0	0.0%	0	0.0%	0	0.0%	91,943	0.4%	385,992	1.4%
Doctors Company An Interins Exchange	Admitted	162,591	1.3%	233,254	1.6%	272,972	1.4%	186,007	0.8%	268,232	1.0%
Professional Underwriters Liability Ins Co	Surplus Lines	22,847	0.2%	51,559	0.4%	516,863	2.7%	971,421	4.0%	165,841	0.6%
Mutual Insurance Co of Arizona (MICA)	Admitted	5,929	0.0%	223,865	1.6%	286,840	1.5%	345,289	1.4%	100,262	0.4%
VHA Mountain States Reciprocal	Risk Retention Group	0	0.0%	0	0.0%	0	0.0%	79,015	0.3%	355,884	1.3%
OMS National Insurance Company	Risk Retention Group	188,523	1.5%	185,358	1.3%	188,250	1.0%	204,213	0.8%	231,538	0.9%
Podiatry Insurance Company of America	Risk Retention Group	63,955	0.5%	77,796	0.5%	122,555	0.6%	201,874	0.8%	19,710	0.1%
Ophthalmic Mutual Insurance Company	Risk Retention Group	0	0.0%	31,384	0.2%	24,139	0.1%	19,548	0.1%	40,179	0.1%
Doctors Insurance Reciprocal	Risk Retention Group	32,544	0.3%	65,118	0.5%	0	0.0%	0	0.0%	0	0.0%
Admiral Insurance Company	Surplus Lines	0	0.0%	0	0.0%	40,000	0.2%	65,000	0.3%	77,000	0.3%
American Casualty Co of Reading PA	Admitted	3,558	0.0%	6,256	0.0%	9,153	0.0%	12,156	0.0%	17,303	0.1%
Steadfast Insurance Company	Surplus Lines	11,640	0.1%	9,402	0.1%	16,683	0.1%	18,242	0.1%	5,448	0.0%
Preferred Professional Insurance Co	Admitted	518,714	4.1%	492,881	3.5%	1,814,340	9.6%	23,499	0.1%	2,313	0.0%
TIG Specialty Ins Corp	Surplus Lines	0	0.0%	0	0.0%	0	0.0%	76,371	0.3%	0	0.0%
American Continental Insurance Co	Admitted	116,954	0.9%	93,186	0.7%	0	0.0%	0	0.0%	0	0.0%
St. Paul Fire & Marine Insurance Co	Admitted	0	0.0%	371	0.0%	3,124	0.0%	0	0.0%	0	0.0%
All Other Companies		558,749	4.4%	395,122	2.8%	291,141	1.5%	265,301	1.1%	278,707	1.0%
TOTAL ALL INSURERS		12,604,565	100.0%	14,261,245	100.0%	18,951,612	100.0%	24,345,438	100.0%	26,909,459	100.0%

TYPE OF INSURER	DIRECT WRITTEN PREMIUMS 2000	%	2001	%	2002	%	2003	%	2004	%
Admitted Carriers	12,225,464	97.0%	13,767,491	96.5%	17,900,354	94.5%	22,391,358	92.0%	25,212,752	93.7%
Risk Retention Groups	285,022	2.3%	359,656	2.5%	334,944	1.8%	504,650	2.1%	647,311	2.4%
Surplus Lines Carriers	94,079	0.7%	134,098	0.9%	716,314	3.8%	1,449,430	6.0%	1,049,396	3.9%
TOTAL ALL INSURERS	12,604,565	100.0%	14,261,245	100.0%	18,951,612	100.0%	24,345,438	100.0%	26,909,459	100.0%

Notes:

AP Capital dominates the physicians' market throughout the 5-year period.

Medical Protective's market share drops in 2004 following decision not to write new business in New Mexico.

Preferred Professional, a writer of occurrence policies, essentially exits the market in 2003 - 2004.

VHA Risk Retention Group enters New Mexico physicians' market in 2003.

NEW MEXICO MEDICAL MALPRACTICE INSURANCE MARKET

Other Health Care Professionals

NAME OF INSURER	TYPE OF INSURER	DIRECT WRITTEN PREMIUMS 2000	%	2001	%	2002	%	2003	%	2004	%
National Union Fire Insurance Co of PA	Admitted	0	0.0%	79	0.0%	131,118	3.3%	570,114	12.2%	808,678	14.5%
American Casualty Co of Reading PA	Admitted	374,901	13.4%	354,127	11.3%	413,123	10.4%	502,806	10.7%	708,469	12.7%
Medical Protective Company	Admitted	401,950	14.4%	469,832	15.0%	505,902	12.7%	601,206	12.8%	659,853	11.8%
Gulf Insurance Company	Admitted	255,173	9.1%	210,621	6.7%	360,069	9.1%	352,879	7.5%	521,622	9.4%
Chicago Insurance Company	Admitted	311,099	11.1%	340,334	10.8%	387,226	9.7%	516,156	11.0%	485,835	8.7%
Illinois Union Insurance Company	Surplus Lines	0	0.0%	0	0.0%	74,919	1.9%	51,258	1.1%	444,441	8.0%
American Insurance Company	Admitted	0	0.0%	0	0.0%	63,006	1.6%	222,238	4.7%	322,178	5.8%
Admiral Insurance Company	Surplus Lines	300	0.0%	0	0.0%	0	0.0%	0	0.0%	312,791	5.6%
Evanston Insurance Company	Surplus Lines	38,599	1.4%	59,707	1.9%	166,535	4.2%	219,754	4.7%	277,622	5.0%
NCMIC Insurance Company	Admitted	218,816	7.8%	234,616	7.5%	270,036	6.8%	270,037	5.8%	268,059	4.8%
Western World Ins Co	Surplus Lines	26,370	0.9%	49,627	1.6%	35,643	0.9%	158,975	3.4%	163,444	2.9%
TIG Insurance Company	Admitted	183,245	6.5%	254,094	8.1%	409,625	10.3%	171,921	3.7%	69,209	1.2%
Doctors Company An Interins Exchange	Admitted	0	0.0%	0	0.0%	0	0.0%	111,019	2.4%	40,327	0.7%
Lexington Insurance Company	Surplus Lines	0	0.0%	0	0.0%	0	0.0%	92,176	2.0%	39,299	0.7%
St. Paul Fire & Marine Insurance Co	Admitted	324,448	11.6%	361,181	11.5%	142,542	3.6%	34,326	0.7%	6,877	0.1%
Lumbermens Mutual Casualty Company	Admitted	0	0.0%	109,672	3.5%	150,648	3.8%	69,873	1.5%	0	0.0%
American Assoc of Orthodontists Ins Co	Risk Retention Group	0	1.5%	31,166	1.8%	33,406	2.2%	35,398	0.7%	0	0.3%
TIG Specialty Ins Corp	Surplus Lines	55,661	2.0%	68,590	2.2%	264,634	6.7%	0	0.0%	0	0.0%
American Continental Insurance Co	Admitted	85,166	3.0%	20,762	0.7%	0	0.0%	0	0.0%	0	0.0%
All Other Companies		524,059	18.7%	572,957	18.3%	564,777	14.2%	705,716	15.1%	447,859	8.0%
TOTAL ALL INSURERS		2,799,787	101.5%	3,137,365	100.8%	3,973,209	101.3%	4,685,852	100.0%	5,576,563	100.3%

TYPE OF INSURER	DIRECT WRITTEN PREMIUMS 2000	%	2001	%	2002	%	2003	%	2004	%
Admitted Carriers	2,616,992	93.5%	2,883,841	91.9%	3,350,726	84.3%	4,084,041	87.2%	3,998,466	71.7%
Risk Retention Groups	9,167	0.3%	55,832	1.8%	33,406	0.8%	35,398	0.8%	45,012	0.8%
Surplus Lines Carriers	173,628	6.2%	197,692	6.3%	589,077	14.8%	566,413	12.1%	1,533,085	27.5%
TOTAL ALL INSURERS	2,799,787	100.0%	3,137,365	100.0%	3,973,209	100.0%	4,685,852	100.0%	5,576,563	100.0%

Notes:

Surplus lines market share grows from 6% in 2001 to 15% in 2002 to 27% in 2004.

According to AP Capital, it does not write Other Health Care Professionals in New Mexico.

NEW MEXICO MEDICAL MALPRACTICE INSURANCE MARKET

Hospitals

NAME OF INSURER	TYPE OF INSURER	DIRECT WRITTEN PREMIUMS									
		2000	%	2001	%	2002	%	2003	%	2004	%
Truck Insurance Exchange	Admitted	6,635,173	58.8%	8,353,819	64.7%	8,153,001	53.3%	0	0.0%	0	0.0%
Mutual Insurance Co of Arizona (MICA)	Admitted	1,054,400	9.3%	1,353,097	10.5%	2,995,912	19.6%	1,975,359	28.2%	-2,906	0.0%
American Excess Insurance Exchange	Risk Retention Group	0	0.0%	0	0.0%	1,468,732	9.6%	2,315,400	33.1%	2,835,600	33.7%
Lexington Insurance Company	Surplus Lines	0	0.0%	1,563,127	12.1%	1,099,006	7.2%	302,975	4.3%	2,890,057	34.4%
Medical Protective Company	Admitted	0	0.0%	457,000	3.5%	540,000	3.5%	0	0.0%	0	0.0%
Health Care Indemnity, Inc.	Surplus Lines	653,120	5.8%	531,520	4.1%	522,116	3.4%	1,338,314	19.1%	884,352	10.5%
Evanston Insurance Company	Surplus Lines	1,517	0.0%	65,347	0.5%	102,853	0.7%	129,529	1.9%	143,860	1.7%
VHA Mountain States Reciprocal	Risk Retention Group	0	0.0%	0	0.0%	0	0.0%	151,608	2.2%	711,104	8.5%
Steadfast Insurance Company	Surplus Lines	6,978	0.1%	0	0.0%	1,507	0.0%	19,303	0.3%	866,740	10.3%
First Specialty Insurance Corp	Surplus Lines	0	0.0%	0	0.0%	0	0.0%	523,000	7.5%	0	0.0%
Executive Risk Indemnity Inc	Admitted	0	0.0%	0	0.0%	396,970	2.6%	0	0.0%	0	0.0%
St. Paul Fire & Marine Insurance Co	Admitted	0	0.0%	8,676	0.1%	0	0.0%	218,153	3.1%	0	0.0%
American Continental Insurance Co	Admitted	2,264,755	20.1%	454,611	3.5%	0	0.0%	0	0.0%	0	0.0%
All Other Companies		664,784	5.9%	115,697	0.9%	6,639	0.0%	24,433	0.3%	83,599	1.0%
TOTAL ALL INSURERS		11,280,727	100.0%	12,902,894	100.0%	15,286,736	100.0%	6,998,074	100.0%	8,412,406	100.0%

TYPE OF INSURER	DIRECT WRITTEN PREMIUMS									
	2000	%	2001	%	2002	%	2003	%	2004	%
Admitted Carriers	10,338,444	91.6%	10,634,321	82.4%	12,092,522	79.1%	2,217,945	31.7%	48,930	0.6%
Risk Retention Groups	68,314	0.6%	76,549	0.6%	1,468,732	9.6%	2,467,008	35.3%	3,546,704	42.2%
Surplus Lines Carriers	873,969	7.7%	2,192,024	17.0%	1,725,482	11.3%	2,313,121	33.1%	4,816,772	57.3%
TOTAL ALL INSURERS	11,280,727	100.0%	12,902,894	100.0%	15,286,736	100.0%	6,998,074	100.0%	8,412,406	100.0%

Notes:

Abrupt exit in 2003 of market leader, Truck Insurance Exchange, leads to self-insurance of roughly half the market.

MICA, largest admitted writer in 2003, exited the market in 2004.

Admitted carriers' share of the market shrinks from 92% in 2000 to 1% in 2004.

American Excess Insurance Exchange (a risk retention group) and Lexington (surplus lines) now dominate the New Mexico market.

Other Health Care Facilities

NAME OF INSURER	TYPE OF INSURER	DIRECT WRITTEN PREMIUMS									
		2000	%	2001	%	2002	%	2003	%	2004	%
Lexington Insurance Company	Surplus Lines	0	0.0%	164,660	18.3%	898,163	62.7%	2,387,720	68.0%	2,873,223	80.3%
Admiral Insurance Company	Surplus Lines	49,532	7.4%	70,029	7.8%	201,835	14.1%	699,405	19.9%	322,498	9.0%
St. Paul Fire & Marine Insurance Co	Admitted	203,329	30.3%	315,641	35.2%	134,485	9.4%	85,223	2.4%	53,569	1.5%
American Alternative Insurance Corp	Admitted	0	0.0%	22,735	2.5%	41,178	2.9%	66,350	1.9%	88,554	2.5%
Royal Surplus Lines Ins Co	Surplus Lines	125,250	18.6%	179,614	20.0%	18,052	1.3%	62,315	1.8%	0	0.0%
Western World Ins Co	Surplus Lines	50,502	7.5%	36,150	4.0%	104,803	7.3%	37,284	1.1%	13,371	0.4%
Steadfast Insurance Company	Surplus Lines	11,051	1.6%	19,619	2.2%	18,938	1.3%	13,234	0.4%	5,055	0.1%
Travelers Property Cas Co Of America	Admitted	132,557	19.7%	0	0.0%	4,106	0.3%	5,371	0.2%	389	0.0%
Illinois Union Insurance Company	Surplus Lines	0	0.0%	0	0.0%	0	0.0%	0	0.0%	178,137	5.0%
All Other Companies		99,763	14.8%	88,929	9.9%	11,204	0.8%	154,421	4.4%	41,772	1.2%
TOTAL ALL INSURERS		671,984	100.0%	897,377	100.0%	1,432,764	100.0%	3,511,323	100.0%	3,576,568	100.0%

TYPE OF INSURER	DIRECT WRITTEN PREMIUMS									
	2000	%	2001	%	2002	%	2003	%	2004	%
Admitted Carriers	435,649	64.8%	427,305	47.6%	190,973	13.3%	199,407	5.7%	182,512	5.1%
Risk Retention Groups	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Surplus Lines Carriers	236,335	35.2%	470,072	52.4%	1,241,791	86.7%	3,311,916	94.3%	3,394,056	94.9%
TOTAL ALL INSURERS	671,984	100.0%	897,377	100.0%	1,432,764	100.0%	3,511,323	100.0%	3,576,568	100.0%

Notes:

Admitted carriers' share of the market has shrunk from 65% in 2000 to 5% in 2004.

Lexington, an AIG surplus lines carrier, has dominated the market from 2002 through 2004.

Travelers and Royal, which dominated the market in 2000 along with St Paul, are now essentially gone.

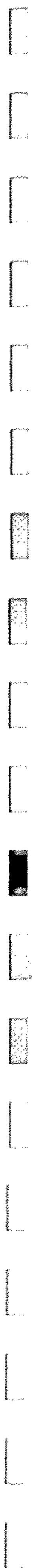
American Physicians Assurance Corporation
Occurrence - $1M/$3M Limits
New Mexico

Specialty	All Years Change %	Rates Effective 6/1/2005	Change %	Rates Effective 6/1/2004	Change %	Rates Effective 6/1/2003	Change %	Rates Effective 6/1/2002	Change %	Rates Effective 8/1/2001
Nurse Midwife	37.3%	14,085	5.1%	13,405	11.0%	12,076	7.0%	11,287	10.0%	10,261
Nurse	37.5%	175	5.0%	167	11.2%	150	7.0%	140	10.0%	127
Nurse Anesthetist (Supervised)	37.3%	8,631	5.1%	8,214	11.0%	7,400	7.0%	6,916	10.0%	6,287
Nurse Anesthetist (Unsupervised)	37.3%	28,752	5.1%	27,362	11.0%	24,650	7.0%	23,037	10.0%	20,943
Nurse Practitioner	37.3%	725	5.1%	690	11.0%	622	7.0%	581	10.0%	528
Optometrist	37.3%	1,217	5.1%	1,158	11.0%	1,043	7.0%	974	10.0%	886
Pharmacist	37.0%	270	4.9%	258	10.8%	232	7.1%	217	10.0%	197
Physical Therapist (Owner)	38.5%	190	5.4%	181	11.2%	162	7.4%	151	10.0%	137
Psychologist	37.2%	983	5.1%	935	11.0%	843	6.9%	788	10.0%	717
Surgeon's Assistant	37.4%	948	5.1%	902	11.0%	812	7.0%	759	10.0%	690
Physician's Assistant (Class 1)	37.3%	2,815	5.1%	2,680	11.0%	2,414	7.0%	2,255	10.0%	2,050
Physician's Assistant (Class 2)	37.3%	3,758	5.1%	3,576	11.0%	3,221	7.0%	3,010	10.0%	2,736
Physician's Assistant (Class 3)	37.3%	4,523	5.1%	4,305	11.0%	3,878	7.0%	3,625	10.0%	3,295
Neurosurgery	87.3%	97,168	5.4%	92,181	9.8%	83,941	18.2%	71,029	36.9%	51,869
Anesthesiologists	68.9%	31,370	-1.3%	31,786	4.6%	30,393	17.3%	25,913	39.5%	18,569
Obstetrics and Gynecology	119.9%	89,710	3.6%	86,617	19.7%	72,363	24.8%	58,003	42.2%	40,801
Emergency Medicine (Part Time)	80.1%	33,440	5.2%	31,786	4.6%	30,393	17.3%	25,913	39.5%	18,569
Emergency Medicine (Full Time)	69.7%	34,905	4.6%	33,376	4.8%	31,840	5.2%	30,257	47.1%	20,567
Radiologists	80.1%	33,440	5.2%	31,786	4.6%	30,393	17.3%	25,913	39.5%	18,569
General Surgery	32.2%	68,562	3.9%	65,957	3.6%	63,679	9.8%	58,003	11.8%	51,869
Family/General Practice	69.3%	16,704	5.1%	15,893	9.8%	14,472	14.9%	12,600	27.7%	9,869
Pediatrics	73.0%	17,075	3.8%	16,449	9.3%	15,052	15.8%	13,001	31.7%	9,869
Internal Medicine	88.5%	16,704	5.1%	15,893	9.8%	14,472	14.9%	12,600	42.2%	8,863
Orthopedic Surgery	21.3%	49,492	2.1%	48,474	4.7%	46,312	4.9%	44,162	8.2%	40,801
Plastic Surgery	23.9%	45,453	0.3%	45,296	4.3%	43,418	6.7%	40,683	10.9%	36,699
Psychiatry	85.9%	13,886	5.3%	13,191	4.8%	12,591	19.6%	10,523	40.9%	7,471
Urgent Care	28.2%	18,233	2.0%	17,880	2.9%	17,368	4.0%	16,697	17.4%	14,225
Cardiovascular Surgery	23.9%	45,453	0.3%	45,296	4.3%	43,418	6.7%	40,683	10.9%	36,699

Medical Protective - Rate History
Occurrence - $1M/$3M Limits
New Mexico

Specialty	All Years Change %	Rates Effective 1/1/2005	Change %	Rates Effective 1/1/2004	Change %	Rates Effective 4/1/2003	Change %	Rates Effective 4/1/2002	Change %
Nurse Midwife	135.0%	36,366	18.0%	30,818	16.4%	26,486	36.9%	19,347	25.0%
Nurse	218.4%	623	18.0%	528	40.8%	375	36.9%	274	40.0%
Nurse Anesthetist (Supervised)	99.7%	13,400	18.0%	11,356	25.3%	9,060	21.3%	7,472	11.4%
Nurse Anesthetist (Unsupervised)	99.7%	13,400	18.0%	11,356	25.3%	9,060	21.3%	7,472	11.4%
Nurse Practitioner (Non-prescribing)	218.4%	3,529	18.0%	2,991	40.8%	2,124	36.9%	1,552	40.0%
Nurse Practitioner (Prescribing)	218.4%	5,190	18.0%	4,398	40.8%	3,124	36.9%	2,282	40.0%
Optometrist	218.4%	1,246	18.0%	1,056	40.8%	750	36.9%	548	40.0%
Pharmacist	218.4%	1,246	18.0%	1,056	40.8%	750	36.9%	548	40.0%
Physical Therapist (Non-Owner)	218.4%	1,246	18.0%	1,056	40.8%	750	36.9%	548	40.0%
Physical Therapist (Owner)	218.4%	2,491	18.0%	2,111	40.8%	1,500	36.9%	1,096	40.0%
Psychologist	218.4%	2,491	18.0%	2,111	40.8%	1,500	36.9%	1,096	40.0%
Surgeon's Assistant	218.4%	5,583	18.0%	4,732	40.8%	3,361	36.9%	2,456	40.0%
Physician's Assistant (Non-Prescribing)	218.4%	3,529	18.0%	2,991	40.8%	2,124	36.9%	1,552	40.0%
Physician's Assistant (Prescribing)	218.4%	5,583	18.0%	4,732	40.8%	3,361	36.9%	2,456	40.0%
Neurosurgery	208.5%	176,395	18.0%	149,490	45.5%	102,759	43.7%	71,489	25.0%
Anesthesiologists	99.7%	28,573	18.0%	24,215	25.3%	19,319	21.3%	15,933	11.4%
Obstetrics and Gynecology	135.0%	121,771	18.0%	103,196	16.4%	88,688	36.9%	64,785	25.0%
Emergency Medicine (Part Time)	218.4%	66,005	18.0%	55,939	40.8%	39,734	36.9%	29,026	40.0%
Emergency Medicine (Full Time)	218.4%	66,005	18.0%	55,939	40.8%	39,734	36.9%	29,026	40.0%
Radiologists	426.0%	39,339	18.0%	33,340	33.7%	24,928	138.0%	10,472	40.0%
General Surgery	182.9%	106,178	18.0%	89,982	40.1%	64,232	36.9%	46,918	25.0%
Family/General Practice**	218.4%	23,811	18.0%	20,179	40.8%	14,334	36.9%	10,472	40.0%
Pediatrics	282.1%	28,573	18.0%	24,215	43.9%	16,827	60.7%	10,472	40.0%
Internal Medicine	146.8%	32,093	18.0%	27,197	40.8%	19,319	6.1%	18,209	40.0%
Orthopedic Surgery (No Spines)	138.8%	81,939	18.0%	69,441	35.2%	51,379	19.8%	42,897	25.0%
Orthopedic Surgery (Spines)	158.3%	106,178	18.0%	89,982	53.2%	58,722	14.3%	51,383	25.0%
Plastic Surgery	138.8%	71,696	18.0%	60,759	40.8%	43,159	15.0%	37,531	25.0%
Psychiatry	165.3%	15,529	18.0%	13,159	32.0%	9,973	21.7%	8,196	40.0%
Urgent Care	218.4%	23,811	18.0%	20,179	40.8%	14,334	36.9%	10,472	40.0%
Cardiovascular Surgery	170.4%	121,771	18.0%	103,196	33.9%	77,070	36.9%	56,298	25.0%

Market Data from Task Force Members



DEAN INSURANCE AGENCY, INC.

230 N. Westmonte Drive
Suite 2100
Altamonte Springs, FL 32714

Local: (407) 865--7477
Toll Free: (800) 721-3326
Fax: (407) 865-7557

November 1, 2005

National College of Midwifery, Inc.
Beth Enson, Admin.
209 State Road 240
Taos, NM 87571

Dear Beth,

I've been privileged to represent and work with midwives, midwifery schools and birth centers since the early '90's. As you know, my insurance career spans over thirty years, specializing in handling the insurance needs of health care professionals and facilities countywide.

It has been an ongoing struggle locating carriers for Licensed Midwives, and we do not anticipate finding any affordable solutions in the near future. As you're aware, our sole carrier is only offering policies starting at $50,000 per year.

Licensed midwives have made outstanding strides over the years by attaining state licensure and further credentials including the CPM (certified professional midwife). However, these efforts cannot be recognized by way of an insurance program for this specialty due to the limited number of midwives countrywide. This pool of prospects just isn't large enough to attract any carrier that could file adequate rates and expect to make a profit in the current environment.

We believe our best chance of success for insuring midwives lies in states that have implemented caps on non-economic damages in addition to other tort measures (e.g. establishing medical boards, alternative dispute resolution, adopting MICRA components, etc.) States that have implemented caps show an increase in healthcare providers and a more stable insurance market, while savings result in both reduced damage awards and lower defense-related costs.

We will continue as your advocate and work to find solutions to this crisis.

Sincerely,

Ann A. Geisler, CPCU
C.E.O.

Senate Memorial Task Force 7
Analysis of Liability Insurance Trend for Licensed Midwives

The National College of Midwifery held a group liability insurance policy on behalf of interested faculty members from 2001 through 2004. Our policy was the only source of liability insurance coverage for interested NM licensed midwives during most of that time. Our insurance agent, Ann Geisler of Dean Insurance Agency in Florida, has been the primary agent working with licensed midwives in the US for many years.

The cost of these annual policies is as follows:

Year	Carrier	policy amount	cost per participant
2001-2002	ACE American Insurance Corporation	$8,140	$280

That year ACE exited the market for liability coverage for all healthcare providers. Ann Geisler was unable to find any carriers in the US writing liability insurance for licensed midwives at that time. She found us coverage in the UK through Lloyd's of London.

Year	Carrier	policy amount	cost per participant
2002-2003	Lloyd's of London	$69,600	$2,900
2003-2004	Lloyd's of London	$107,000	$3,834

At that point Lloyd's exited the market for liability coverage for Licensed Midwives. Ann was able to get us a preliminary quote from another UK carrier, Lexington, which owns AIG insurance. That quote was in the $750,000 to $1 million range, with a deductible in the $150,000 to $200,000 range. Ann did not get us a hard quote, as she knew this range was unaffordable to us.

While the College was unable to get a renewal policy from Lloyd's, the Northern NM Midwifery Center did purchase a policy for its five staff midwives (three full time, two back-up,) from Evanston Insurance Co. Currently, they are the only licensed midwives in NM to hold liability insurance.

Year	Carrier	policy amount	cost per participant
2004-2005	Evanston Insurance Co.	$57,000	$11,400

This cost was out of the range of affordability for the majority of National College of Midwifery faculty members who had been interested in possibly purchasing another group policy. Most of these faculty members work part time and do not have the income to cover this expense. Evanston Insurance Company out of Illinois is the sole current source of liability insurance for Licensed Midwives in the US and probably the world. Their policies start at $50,000, and are thus out of reach for the solo or partnership midwifery practice. Licensed midwives in the US generally make less than $30,000 annually. Those with the very busiest practices rarely make more than $50,000. Only births centers employing three or more midwives are able to afford policies through Evanston. I have heard that a risk purchasing group of six Alaskan midwives was trying to get coverage through Evanston, and have asked Ann Geisler to let me know if that group is able to get a quote. If so, it might be possible for another risk purchasing group to get coverage through Evanston in this way, though it would most likely be out of range of most NM LMs.

Both Ann Geisler and Don Letherer have told us that the carriers' decisions not to cover licensed midwives are due to the small numbers of licensed midwives practicing in the US, and the limited amount of revenue they are thus able to generate. Don Letherer has stated that there exists no central source of actuarial data on licensed midwives, also because our numbers are so small as to be statistically insignificant. I quote from another letter from Ann Geisler: "…since our midwifery program generates less than $10,000,000, it is almost impossible to generate interest from carriers… Unfortunately, as this insurance crisis deepens we are seeing fewer voluntary carriers and their terms are

becoming more restrictive. " 'Our midwifery program' refers to her entire national clientele of licensed midwives, not just our College.

To summarize, the cost for liability insurance for Licensed Midwives in NM has risen approximately forty-fold over the past five years. There exists only one source of insurance, Evanston Insurance Co., for licensed midwives. Even Evanston is restricting their liability for homebirth coverage. Home birth is a service included in the NM Licensed Midwives scope of practice, and a birthing option recommended by the World Health Organization and the American Public Health Association. The recent CPM Statistics Study published in the BMJ (formerly the British Medical Journal) concludes that births attended by Certified Professional Midwives have health outcomes equal to low-risk hospital births, with lower intervention rates and higher client satisfaction.

To: Allan Seeley
From: Suzanne Stalls, CNM
Re: summary of malpractice costs from 2000-2005 for three representative midwifery practices in New Mexico

Suzanne Stalls, CNM
Women's Specialists of New Mexico
Albuquerque

Cost		Carrier
9/99-9/00:	$4,832.00	ACNM Insurance Services
9/00-9/01:	$5,913.00	ACNM Insurance Services
9/01-9/02	$6,475.00	ACNM Insurance Services
9/02-9/03	$8,334.00	ACNM Insurance Services
6/03-6/04	$8,771.99	Contemporary Insurance Services

Please note discrepancy in dates. ACNM Insurance Services stopped providing insurance services mid-year and Contemporary Insurance Services from Maryland began to provide insurance services, the only company in the country as far as we were aware.

6/04-6/05	$14,304.00	Contemporary Insurance Services
6/05-6/06	$17, 543.00	Contemporary Insurance Services

Kathy Autrey, CNM
Las Cruces

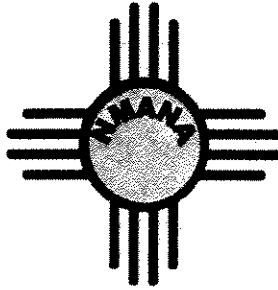
2000-2001	$4,263	ACNM Insurance Services
2001-2002	$5,913	ACNM Insurance Services
2002-2003	$8,334	ACNM Insurance Services
2003-2004	$9,260	ACNM Insurance Services/CIS
2004-2005	$15,333	Contemporary Insurance Services
2005-2006	$17,543	Contemporary Insurance Services

Theresa Okoro, CNM
Las Vegas

2001-2002	$1,702	ACNM Insurance Services
2002-2003	$4,190	ACNM Insurance Services
2003-2004	$11,087	Contemporary Insurance Services
2004-2005	$15,789	Contemporary Insurance Services

waiting on quote for 10-05 to 10-06

None of these midwives have had any claims.



New Mexico Association of Nurse Anesthetists
PO Box 92885
Anbuquerque, NM 87199

October 1, 2005 Report to SM7 Task Force

Since its inception in 1978, the New Mexico Medical Malpractice Act has listed Certified Registered Nurse Anesthetists (CRNAs) as health care providers eligible to participate in the Patient Compensation Fund (PCF). (NMSA 41-5-3) Unfortunately, approximately 85% of CRNAs in this state have been and continue to be denied access to the PCF.

There are primarily two reasons CRNAs are unable to participate in the PCF. First, the Act requires the provider to carry an occurrence policy, which CRNAs are unable to obtain on a national basis. Secondly, when attempting to purchase an occurrence policy through AP Capitol, CRNAs have consistently been discriminated against based on their employment arrangements. Currently, CRNAs who are not employed by anesthesiologists who participate in the PCF are denied insurance. Ironically, CRNAs who are "employed" are receiving liability insurance as a benefit and do not bare the cost on an individual basis. Only CRNAs who are self employed would be seeking independent liability insurance, and therefore could never meet the underwriting criteria set by AP Capitol.

While CRNAs can currently purchase affordable liability insurance, the market has been changing over the last several years, and the New Mexico Association of Nurse Anesthetists (NMANA) remains committed to being proactive in securing the best possible options for its members. Since 2001, three major insurers of CRNAs have exited the marketplace; PHICO,
St. Paul and TIG. Since January of 2003, CNA remains the lone admitted company writing standard policies for CRNAs, and they only offer a claims made product.

Over the last five years in New Mexico, liability premiums for a mature claims-made policy through an admitted company have increased approximately 13%, from $5,864 to $6,623. I was unable to obtain information on any non-admitted products. Rates for an occurrence policy issued by AP Capital have risen nearly 50% over the last five years, from $4,135 to $6,165. Of note, the surcharge fee for CRNAs decreased last year from $3,301 to $546. While some may view these rates as extremely low in comparison to our physician counterparts, keep in mind an anesthesiologist's salary is typically two to four times that of CRNA, depending on the location and practice setting. According to the 2004 AANA Practice Profile Survey, the mean salary in 2003 for a self employed CRNA (one who would be purchasing their own

liability policy) in New Mexico was approximately $134,000, including call and overtime pay. An average premium cost of $6,247 (in 2003) represents approximately 5% of the mean annual income.

Some members of the SM7 task force have opined that CRNAs practicing as solo providers represent a higher liability risk compared to those CRNAs who work under the supervision of an anesthesiologist. In fact, as of December 31, 1997, there were a total of 3,548 physician reports in the National Practitioner Data Bank with an anesthesia malpractice code, and only 481 nurse anesthetists' reports. On average, there is almost seven-times as many physician anesthesia-related malpractice payments made in a year compared to reported payments for CRNAs.[1]

These statistics are even more remarkable given that CRNAs are the hands on anesthesia providers for 65% of the 26 million anesthetics delivered each year. No studies to date that have addressed anesthesia care outcomes have found that there is a significant difference in patient outcomes based on whether the anesthesia provider is a CRNA or an anesthesiologist. Further evidence of the 100 year safety record of CRNAs is evidenced by data from St. Paul Fire and Marine Insurance Company, whose malpractice insurance premium rate for claims-made coverage for self-employed CRNAs decreased nationally a total of 52 percent from 1988 through 1998. At the time St. Paul was the country's largest provider of liability insurance for health care professionals, and insured both CRNAs and anesthesiologists. The recent modest increase in premiums over the last five years reflects not only a change in providers (2002) from TIG to CNA, but also administrative costs with CNA, who had previously not insured anesthesia providers.

The 85% of CRNAs in New Mexico who are eligible by statute but are denied access to the PCF practice at a disadvantage every day. In many cases, CRNAs are working side by side with surgeons who do participate in the PCF, and therefore become the "deep pockets" in the room. Without access to the PCF, CRNAs must carry higher liability limits, and lack the benefits of the three year statute of limitations, and the medical review commission. Because CRNAs employed by anesthesiologists do participate in the PCF, there is obvious discrimination among a group of providers based on nothing more than their employment arrangement. Given that CRNAs work in every hospital in the state, and are the sole anesthesia providers in more than half of all New Mexico hospitals, it is reprehensible that the vast majority are denied access to the PCF of which they are eligible to participate by statute.

The NMANA continues to seek the opportunity to work with the affected parties to resolve this injustice. It has been my honor to represent the CRNAs of New Mexico as a member of SM7.

Respectfully submitted,

Sharon K. Hensley, CRNA
Immediate Past President, NMANA

1. Nurse anesthetist malpractice and the National Practitioner Data Bank, L.M. Jordan, CRNA, PhD; R.E. Oshel, PhD; AANA Journal, December 1998

NMHHSA

New Mexico Hospitals &
Health Systems Association

October 4, 2005

The following information is intended to be responsive to the SM7 Taskforce on Medical Malpractice request for data on the market impact of liability insurance changes on hospitals.

Background

The New Mexico Hospitals and Health Systems Association (NMHHSA) represents all of the 41 general acute non-governmental hospitals in the state. NMHHSA conducted a Medical Malpractice survey of members to determine: premium increases over the past 5 years, access to coverage, and anecdotal comments. Overall, 24 members responded and the data took various forms but the summary follows.

Premium Increases

Roughly, premium **increases have *averaged* 49% per year** over the 5 year period ending 2005. For the 13 members that responded to this question, annual increases ranged from 13 to 292%. We used an "Olympic scoring method" and discarded these high and low rates, calculating the average on the remaining 11 respondents.

total % increase	years	ann. % increase
292%	1	292.0%
193%	1	193.0%
318%	5	63.6%
250%	4	62.5%
40%	1	40.0%
188%	5	37.6%
30%	1	30.0%
148%	5	29.6%
135%	5	27.0%
66%	3	22.0%
109%	5	21.8%
18%	1	18.0%
13%	1	12.7%
		~30%

The true average is likely higher than 30% because several of the hospitals that reported one year increases had higher but unreported increases in other years. It is not a sustainable business practice to have any expense line continue to increase at such a rate

Access Issues, Increased Retention and Miscellaneous Comments (from 8 separate hospitals or hospital systems)

Hospital was covered by MMI/St Paul from 1992 to 2002, when they quoted a renewal increase of about 100%. (We did not have significant increase in loss) Our secured coverage through Chubb, which we had for a year. Chubb then quoted renewal at a 40% increase, at which time we partnered with 12 other hospitals in the VHA Mountain States Region and developed a risk retention group. We have been covered through that program since 2003.

It is nearly impossible (if not completely impossible) for a facility as small as ours to get more than one response to our insurance RFPs. So, we take what we are offered regardless of our zero loss history, no L & D, and no surgery.

Last year, to maintain a reasonable premium increase, our deductible increased from $25,000 to $100,000 per incident and includes the cost of attorney's fees that were previously paid outside the deductible.

Retention went from $5,000/Indemnity to $25,000/Indemnity. We had to change carriers when MICA was driven out of our state.

Unfortunately we are insured through a self insurance program that commingles costs company wide. While we have seen increases it would be misleading to include our data as it is based on facility specific experience ratings and aggregate, company wide experience.

We changed our policy in 2002 from $25,000 deductible to $50,000 deductible. In 2005 we changed to increase retainage (not a true deductible) to $250,000.

We increased our limits by 25%. We did not see a significant increase in the number of lawsuits (frequency) during the 2001 - 2004 time period. On the whole, our medical malpractice history tracks the national trend. The number of cases per beds has not increased dramatically but the severity of the cases and the cost of settlement has increased by a significant factor. Obstetrics & surgery are our highest exposure specialties but we also pay a great deal for nursing care negligence as well. Looking down the road, we are likely to see an increase in emergency medicine and hospitalists cases. We think it likely that emergency medicine physicians, followed quickly by obstetricians, will be the first physician groups in true crisis in New Mexico (i.e. unable to get any kind of reasonable insurance or get insurance at all).

We were seeing growing increases which had become unaffordable. Our parent company set up a captive in the Caymans which we were unable to buy into but our exposure is really out there.

Jeff Dye
President & CEO
New Mexico Hospitals & Health Systems Association
2121 Osuna Rd. N.E.
Albuquerque, NM 87113

TO: Alan Seeley

FROM: Linda Sechovec

DATE: Tuesday, November 01, 2005

Alan,

Here's a summary of the local freestanding nursing facility data I gathered in response to suggestions at the last SM7 meeting. Also, enclosed is a national study by Aon with much more comprehensive information on a national level regarding nursing facility liability issues.

Thanks for all your help on this important effort.

Linda

Linda Sechovec, Executive Director
4411 McLeod NE, Suite G
Albuquerque, NM 87109
Phone 505-880-1088
Fax 505-880-1157
E-mail lsechovec@nmhca.org

September, 2005

Earlier this month, NMHCA mailed 62 surveys to facilities/companies asking for information on general and professional liability insurance for freestanding nursing facilities. These companies represented total bed capacity of 7,381 beds. Two facilities provided unusable information (one included information on premium costs that included other types of insurance coverage and one included no premium information) so their responses were discarded as spoiled. Valid responses were received from facilities/companies representing 2,776 beds or a 38% response rate. However, due to the volume of facilities with changes of ownership/management during the five year period surveyed and the inability of facilities to access the information, many responses did not include data for all years requested. To make the premium expense information relevant, our analysis was primarily viewed on a per bed cost basis.

Responders did report:

	Average Annual General & Professional Liability Premium Cost Per Bed	Range of Deductibles Per Claim	Other Facility Retention	# of Filed Lawsuits
2001	$306.35	$5,000-25,000	$0	0
2002	$652.18	$5,000-50,000	$0	2
2003	$730.26	$5,000-100,000	$100,000	4
2004	$736.73	$5,000-100,000	$100,000	9
2005	$663.50	$5,000-100,000	$100,000-500,000	5 thru Aug.

For all reporting years, policy limits of $1 million per claim and $3 million aggregate were reported by all facilities except one. Only two facilities reported umbrella coverage beyond the $3 million policy limits. Three companies -- CNA, AIG, Lloyds -- were commercial carriers for all but one respondent (49 bed capacity) during the five year reporting period.

During the period of 2001-2005,

- facilities faced climbing premium costs at a time when Medicaid revenues continued to fall below expenses incurred to provide Medicaid care (For 2002 BDO Seidman in their annual study reported $13.45 per patient day loss in NM for Medicaid care).
- General and professional liability insurance costs more than doubled while facilities took on increasing expense and exposure for out of pocket expenses beyond premium to fund deductibles and additional loss expenses retained by the facility/company. The highest deductibles reported quadrupled from $25,000 to $100,000 in 3 years from 2001-2003 as facilities assumed more exposure and risk in an attempt to control escalating premium costs.
- In 2001 and 2002 no facilities reported retentions beyond deductibles with their liability coverage. Presently, companies are reporting up to $500,000 retentions beyond per claim deductible amounts. It appears this is how facilities achieved a per bed cost decrease from 2004 to 2005. Depending on loss experience, this could threaten facility/company solvency in the future.

Public Regulation Commission
Insurance Division
P.E.R.A. Bldg., 4th Floor
1120 Paseo de Peralta
Santa Fe, New Mexico 87501
Phone: 827-4601
Fax: 827-4734
Website: http://www.nmprc.state.nm.us/insurance/inshm.htm

New Mexico Health Policy Commission
2055 South Pacheco, Suite 200
Santa Fe, New Mexico 87505
Phone: 505 424-3200
Fax: 505 424-3222
Website: www.hpc.state.nm.us