



# **The complex maze of medical malpractice and the PCF**

**THE LAW, FACTS, AND  
SOLUTIONS THAT DON'T  
ENDANGER THE PUBLIC**

CCJ, 11/7/25  
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# What I'll cover

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1. Accuracy in law
  - a. The 7th Amendment of the Constitution
  - b. Timeline for creation of the Medical Malpractice act/ PCF - 1976 to present
2. Accuracy in facts & research:
  - a. National doctor shortage
  - b. Punitives - who is paying them and why?
  - c. Patient control over jury/settlement v. OSI PCF quasi insurance agency ("lump sum")
  - d. Attorneys fees
3. Solutions that don't endanger the public
  - a. Stop scaring doctors away
  - b. Compete for doctors with the country: Quality of life and pay (loan forgiveness)
  - c. Increase patient safety - decrease medical malpractice
  - d. Regulate insurance industry and private equity to decrease harm to patients/med mal

## Accuracy in Law: The 7th Amendment to the Constitution

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# The history of the NM Medical Malpractice Act

Superintendent of Insurance gives hospitals deal to come into PCF with a \$600k cap, threatening the solvency of the PCF and resulting in multiple taxpayer bailouts.

**2013: OSI gives hospitals \$600k cap**

Again, insurance companies threaten to stop insuring docs - this time in clinics. Trial lawyers and patients **compromise again** to reduce "cap" to \$1m. From 2021 to 2024, over \$100m in taxpayer funds put into the PCF to make up for the deficit caused by low premiums.

**2022-2024: Indep clinics cap reduced to \$1m, taxpayers put \$100m in PCF**

**1976- Caps for indep docs**

Insurance companies threaten to leave NM. Legislature passes MMA/PCF with a \$400k cap to indep doctors, then to \$500k, \$600k in 1995.

**2021: HB75 Med Mal PCF compromise**

- 2021: Medical malpractice updates:**
- 1. After 30 years of stagnant "cap," increased**
    - a) From \$600k to \$750k: independent doctor**
    - b) From \$600k to \$6m hospitals, over 6 years, adjusting for inflation.**
  - 2. Created transparency and oversight of the PCF: 3<sup>rd</sup> party actuary and PCF Advisory**
  - 3. Created a path for PCF to become solvent**

**2025:**

Insurance companies and corporations use national doctor shortage to demonize trial lawyers and propose policy changes that endanger the public.

Accuracy in facts and research:

## **Is there a doctor shortage? Of course, but what data is correct?**

LFC (nonpartisan data): 40% of need met in NM, need 200 primary care doctors

HRSA (federal agency): NM is in median for doctors per capita

NM Medical Board: Slight increases in past 3 years (LHHS presentation 11/5/25)

Physicians Advocacy Institute (made up of medical society CEOs/Board Members): 2019-2024, lost 248 doctors

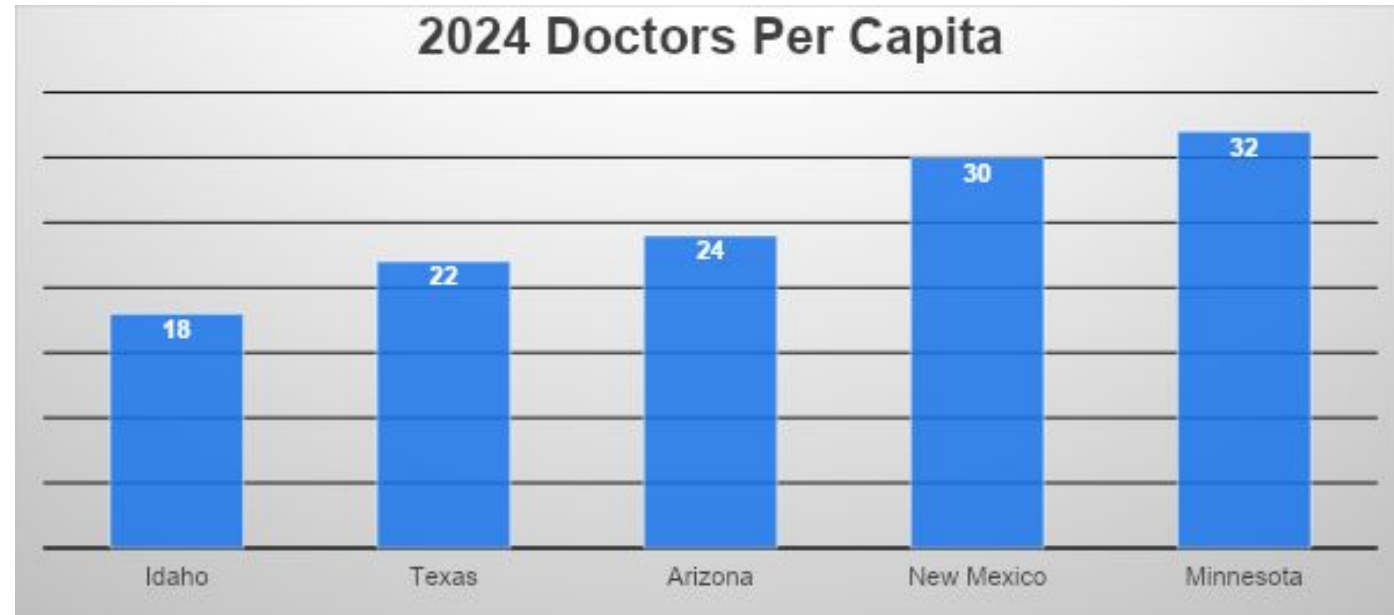
Unknowns: Licensed physicians have increased, but we don't know from day to day how many doctors are actually providing healthcare in NM - no data on this (locum tenens, telehealth from doctors out of state, VA & IHS doctors, etc.)

Question: What we do know is - like the rest of the country - we're waiting to see a doctor.



<https://www.kff.org/>

Doctor numbers compared to medical malpractice caps and laws.



	2024 population	2024 total physicians	# of physicians per 10k population	state med mal cap
Idaho	2,001,619	3,618	18	\$250k with COLA (~\$490k)
Texas	31,290,831	67,516	22	\$250K, aggregate of \$500k, no cap for economic damages
Arizona	7,582,384	18,052	24	Jury decides - no caps
Minnesota	5,793,151	18,419	32	Jury decides - no caps
New Mexico	2,130,256	6,340	30	\$750k for indep docs, \$5.5m for hospitals.



# What doctors say brings them to a state:

- 69% Comfortable, enjoyable living environment
- 45% Friends and family live nearby
- 39% Relative value of my specialty
- 34% Climate/Temperature
- 31% Job opportunities
- 24% Malpractice climate and premiums

Although we may need private equity hospitals, we can't ignore that they are contributing to higher rates of injuries to patients/ higher rates of medical malpractice. We can and we should regulate them to protect public safety

- 25% higher rate of patient injury than non-private equity hospitals (higher rates of medical malpractice).
  - increased falls, central-line-associated bloodstream infections, surgical site infections, myocardial infarction, pneumonia.
- Costs taxpayers more - more likely to charge more per inpatient day, higher cost-to-charge ratios for emergency departments, higher total cost-to-charge ratios

Health Care	100/100
Share of hospitals that are private equity-controlled	24.4%
Average Medicare patient survey rating of private equity-controlled acute care hospitals (1 = lowest, 5 = highest)	2.6
Rate of readmission after discharge from private equity-controlled acute care hospitals	14.4%
Share of nursing homes that are private equity-controlled	35.3%
Average Medicare quality rating of private equity-controlled nursing homes (1 = lowest, 5 = highest)	2.1
Substantiated complaints per private equity-controlled nursing home (2019-2022)	8.0
Share of population in a metro area where a single private equity firm controls over 30% market share of one or more physician specialties	61.4%

[https://pestakeholder.org/pehp-private-equity-hospital-tracker/#hospital\\_tracker](https://pestakeholder.org/pehp-private-equity-hospital-tracker/#hospital_tracker)

file:///Users/juliannakoob/Downloads/PESP\_RiskIndex\_OnePager\_May2024-NewMexico-1.pdf



**PROBLEM: SHORTAGE OF DOCTORS AND INSURANCE PREMIUMS**  
**Proposed solutions that don't result in more doctors and that endanger the public**

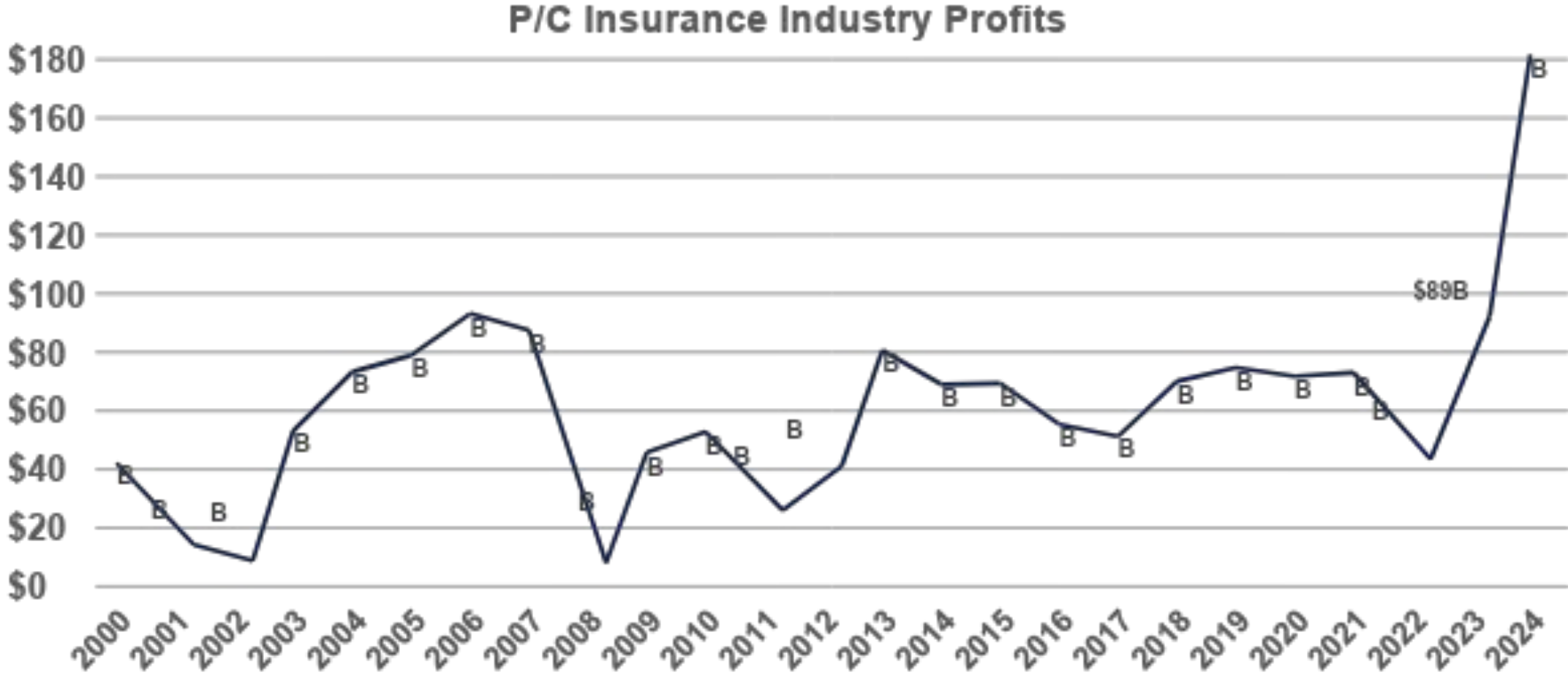
PROPOSED SOLUTION	WHO IT HELPS	WHO IT HURTS
<p><b>Caps on attorneys fees:</b>            This has been an insurance industry agenda for the past 40 years.</p> <p>Attorney fees are already regulated by the Judiciary.</p>	<p>Attorney fee caps do not prevent harm to patients, they prevent access to justice. They increase profits to insurance companies and multi-billion dollar corporations because it decreases the number of attorneys who can take these expensive and 5+ year long cases.</p>	<p>Patients and public safety. Attorneys are only paid if there is a settlement or a jury verdict, which can take 5+ years. The attorney pays out of their own pocket tens of thousands of dollars for medical experts and costs.</p> <p><b>Fewer lawsuits doesn't mean fewer medical malpractice injuries to New Mexicans. It means less accountability to the wrongdoer.</b></p>
<p><b>Punitive damages caps:</b>            Although doctors are afraid of punitive damages taking their personal property, there is only one known incident of any doctor paying punitive damages in NM (watering down chemo drugs).</p>	<p>Punitive damages caps increase the profits of Multi-billion dollar corporations and insurance companies by decreasing the amounts they have to pay when they've done something egregious (Opioid, Uber, tobacco).</p>	<p>Capping punitive damages endangers the public by disincentivizing the wrongdoer to change their systems and make the public safer (tobacco required to disclose risk on its products, auto industry required to put seatbelts in vehicles, opioid industry regulated, firing a doctor who has had multiple act of medical malpractice).</p>
<p><b>Restrict venue</b></p>	<p>Insurance companies and the wrongdoer corporation by making it harder to achieve justice</p>	<p>The patient's family. Venue can only be moved from the place of injury if the patient died or is a minor. The purpose is to have access to an unbiased jury.</p>
<p><b>End PCF payment directly to harmed patient:</b> so called "lump sum"</p>	<p>The PCF alleges this is necessary because it allows the PCF to control the amount of payments for future medical services instead of the patient getting a total payment that they manage themselves.</p>	<p>Paying victims their future medical costs at one time allows families to invest their money to set them up for the future. Prohibiting this forces families to submit their medical bills to the PCF and hope the PCF pays the bills. Like any insurance company, if the PCF denies the claim, the patient is stuck with that bill.</p>

**PROBLEM: shortage of doctors - NM needs 200 primary care docs**  
**Data driven solutions with support**

<b>PROPOSED SOLUTION:</b>	<b>WHO IT HELPS</b>	<b>WHO IT HURTS</b>
<b>Major loan forgiveness:</b> The avg debt for med students is \$250k. Paying off \$200k to 200 primary care = \$40m	Everybody, particularly in rural communities.	\$40m would be taken from reserves, so some might argue that's not good for taxpayers.
<b>Tax credits for doctors.</b>	Doctors, who will have more income.	Taxpayers, but much less than GRT.
<b>Housing downpayment</b> assistance through MFA program	Directly helps provider and literally creates roots in community	Taxpayers, or reserves in MFA
<b>Pass safe staffing ratio legislation</b>	Providers and patients. Increases accountability to corporations to provide safe care and decreases moral injury to providers (the injury providers experience when they harm someone)	Medical corporations say this is impossible because we don't have enough nurses. However, other states have shown this increases providers by decreasing moral injury.
<b>create fair reimbursement for independent clinics</b>	Small clinics and independent doctors, who can't reimburse at the same rates as hospitals.	Higher cost to Medicaid budget, but it could result in more clinics in rural communities.
<b>Prohibit insurance preauthorizations</b> and prohibit salaries or bonuses based on RVUs ("production, number of procedures, etc.). Regulate the insurance industry.	Everybody. Frees up providers to practice the way they want to and how they were trained to practice. Increases safety and quality of care. Decreases cost of care.	Insurance industry can no longer use preauthorizations as a tool to increase profit.



# Insurance Industry profits



Source: U.S. Property & Casualty and Title Insurance Industries – 2023 Full Year Results, 2024; P/C Insurers Record \$9.3 Billion Q1 Underwriting Gain: AM Best, Insurance Journal, June 12, 2024.