New Mexico and National Evidence on Medical Malpractice Reform

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My medical malpractice research

- 20 years of research
  - ~40 published articles in major peer-reviewed journals
  - 2021 book: Black, Hyman, Paik, Sage, and Silver, *Medical Malpractice: How It Works, What It Does, and Why Tort Reform Hasn't Helped*
    - national data on tort reform
    - detailed study of Texas (unique detailed data)
    - If you want a book copy: email me at bblack@northwestern.edu

- I'm an equal opportunity annoyer
  - Sometimes my research annoys Democrats
  - Sometimes my research annoys Republicans
  - My research goal is to present facts
    - Developed **as carefully and as neutrally as I can**
    - Using state of the art causal inference methods

A bit more about me

- Nicholas J. Chabraja Professor, Northwestern University
- 39,000 citations to my work on Google Scholar:
  - https://scholar.google.com/citations?user=IrFKM04AAAAJ&hl=en
- 270,000 downloads of my work on SSRN
  - http://ssrn.com/author=16042
- Personal webpage at Northwestern:
  - https://www.law.northwestern.edu/faculty/profiles/bernardblack/
- Expertise in causal inference methods
  - Annual workshop at Northwestern on Research Design for Causal Inference
  - https://www.law.northwestern.edu/research-faculty/events/conferences/causalinference/

I will focus on independent physician liability

- And on damage caps (the most important med mal reform)
- NM damages cap for hospitals is large enough to be rarely relevant
  - Hypothetical payouts above the cap would be rare
- I will argue that your cap for physicians is also almost irrelevant
- Middle category in your law: independent outpatient facility
  - Less and less important nationally
    - Major health systems are consolidating, integrating
  - I don't understand why treated differently than hospitals

Major takeaways from our research 1

1. Damage caps do **not** reduce healthcare costs
   - And might increase them!
2. Damage caps will **not** bring more physicians to your state
   - Except maybe plastic surgeons
   - Physicians move to where the (insured) patients are
3. Damage caps **do reduce** deterrence
   - **More** adverse patient safety events in hospitals
4. Paid claims are **not random lightning strikes**
   - There are reasons why paid claims get paid.
   - One paid claim (last 5 years) → 4x higher risk of a paid claim in next 5 years
5. Blockbuster verdicts are (almost) irrelevant to real risk
   - Even without caps! Policy limits = de facto caps
   - Cases settle in shadow **not** of jury award, but **of collectible amount** after award

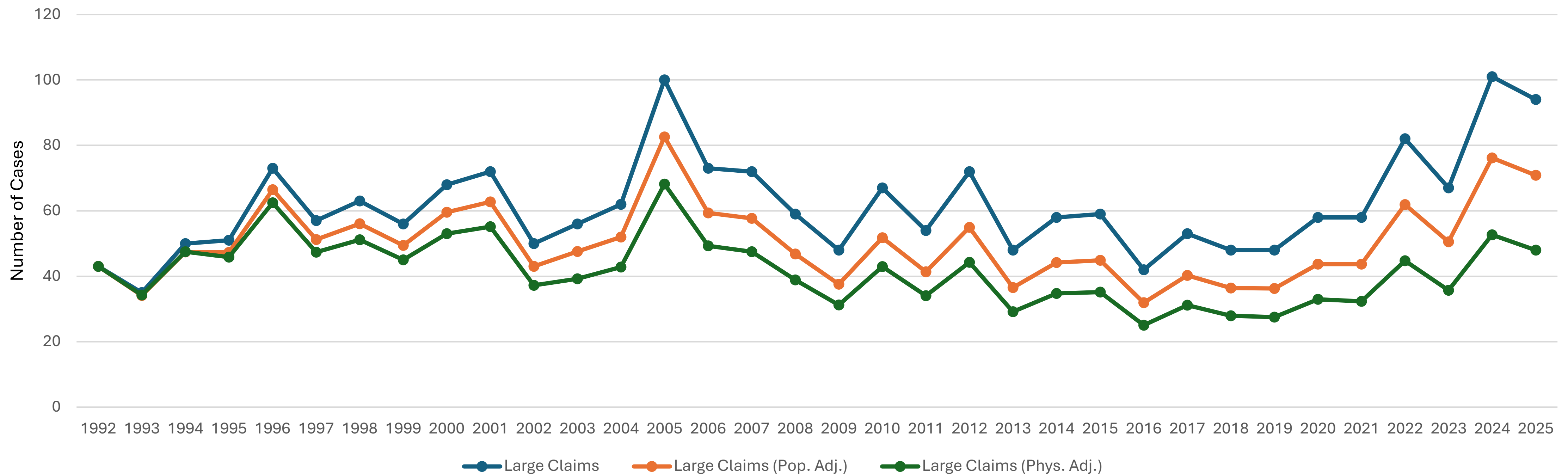
Major takeaways from our research 2

6. Physician personal out-of-pocket payments are **really rare**
    - Especially for physicians with reasonable limits ($1M+)
    - When made, usually not large
7. Smaller claims are being squeezed out of med mal system
    - Too costly to bring
    - Attorney fee cap proposal will make this problem worse
8. New Mexico cap for physicians is usually irrelevant
    - I would scrap the cap
    - And protect physicians who buy a policy with minimum limits
        - say $2M, indexed to inflation

New Mexico Med Mal Landscape

- Physician claims
- Physician mean/median payouts
- Total payouts
- Physician supply
- Medical malpractice premia
- Compare NM to Texas ($250k non-econon cap)
  - And to Arizona (no damages cap)

New Mexico Large Paid Claims (>$50k in 2024$)



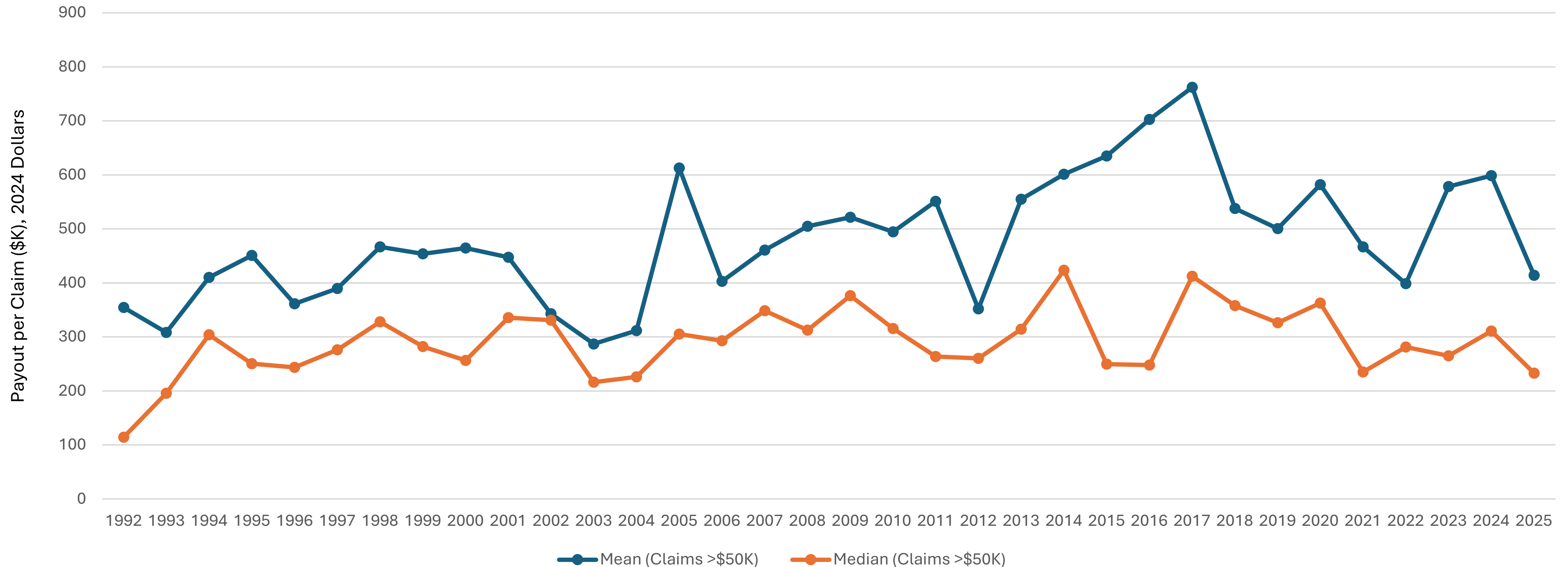
Focus on bottom line in the graph (physician adjusted). That's the line that matters for physicians.
And on "large" claims (almost all $). Smaller claims are going away.
I combined non-PCF and PCF claims for same plaintiff/defendant

2025 is annualized in all graphs (data for 1H 2025)

2005 is weird, driven by delayed PCF payments?

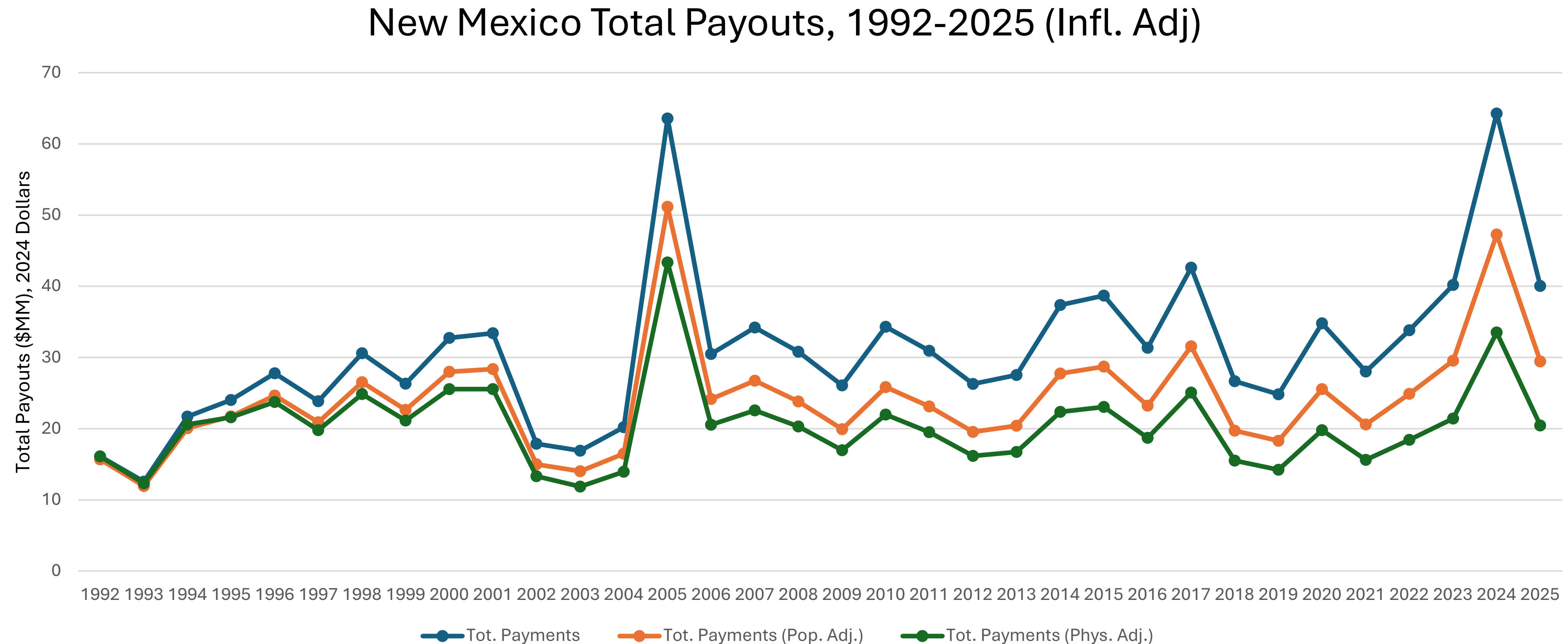
Limitation: I have data from NPDB only for **paid** claims

NM Mean/Median Payout per Large Paid Claim (2024$)



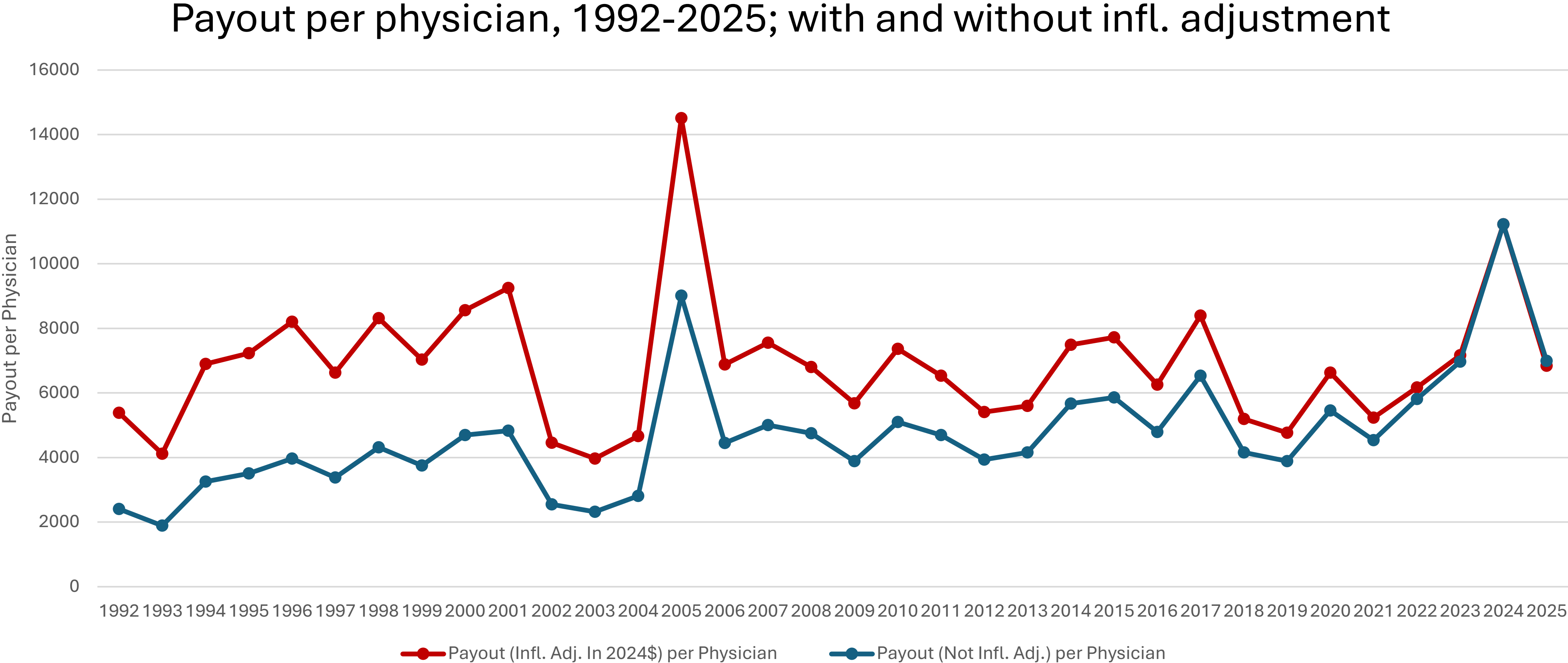
No time trend, for either mean or median

NM Total Payout on Large Paid Claims (2024$)



Here too, the bottom (green) line is the one that physicians care about.

NM Total Payout per Physician (1002-2025)

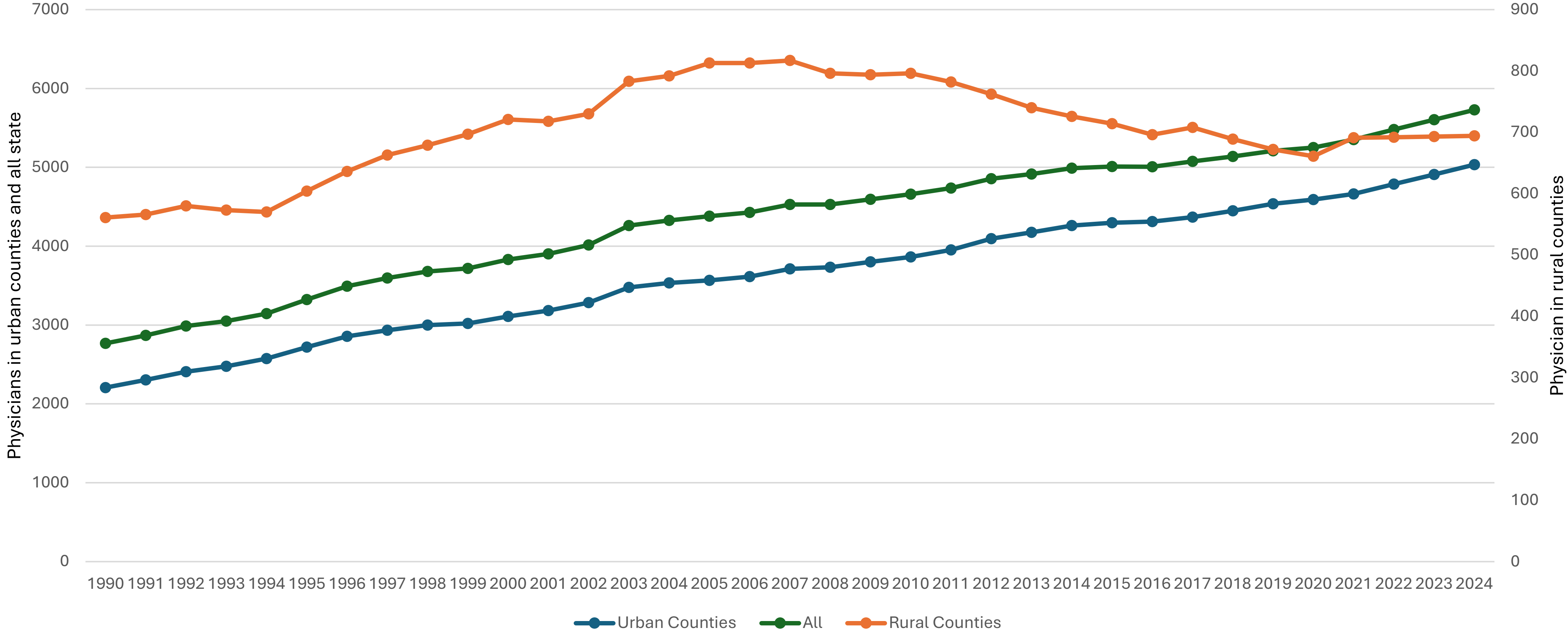


Over long period, essential to adjust for inflation.
Otherwise you will see spurious trends, driven by inflation.

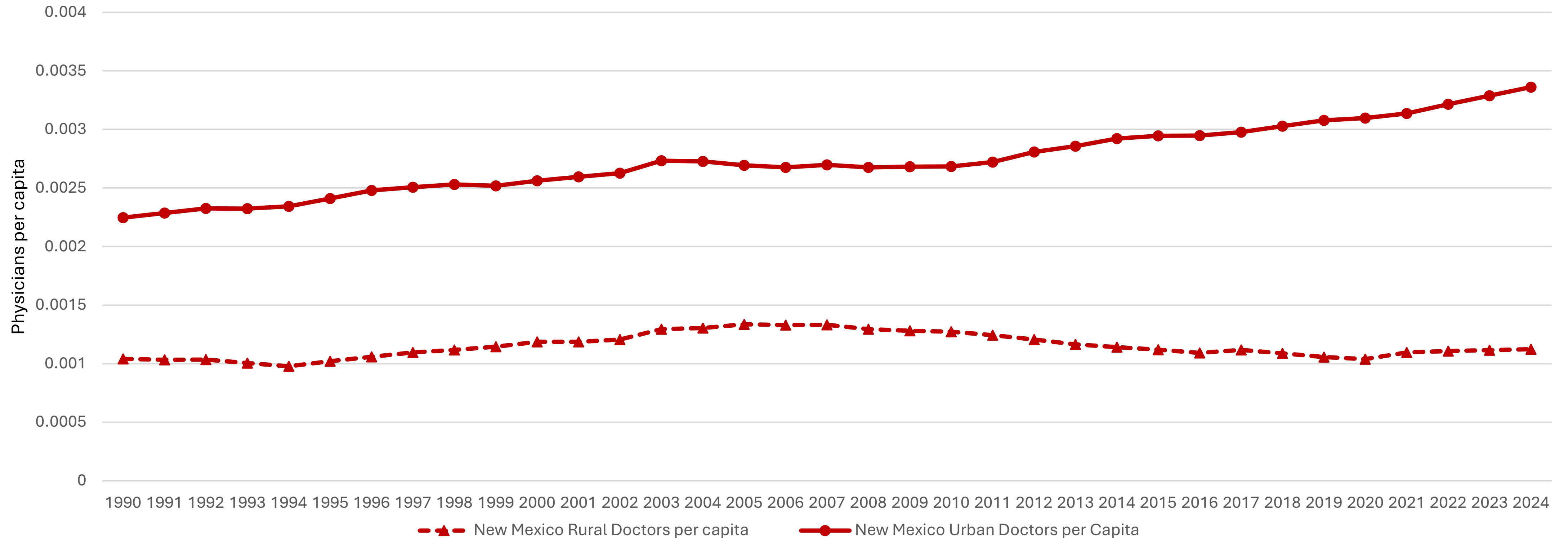
New Mexico summary

- Over the 33 years with data (1992-2025)
- Nothing extraordinary
  - Not in paid claims per physician
  - Not in mean or median payout per claim
  - Not in total payout per physician

New Mexico Physician Supply

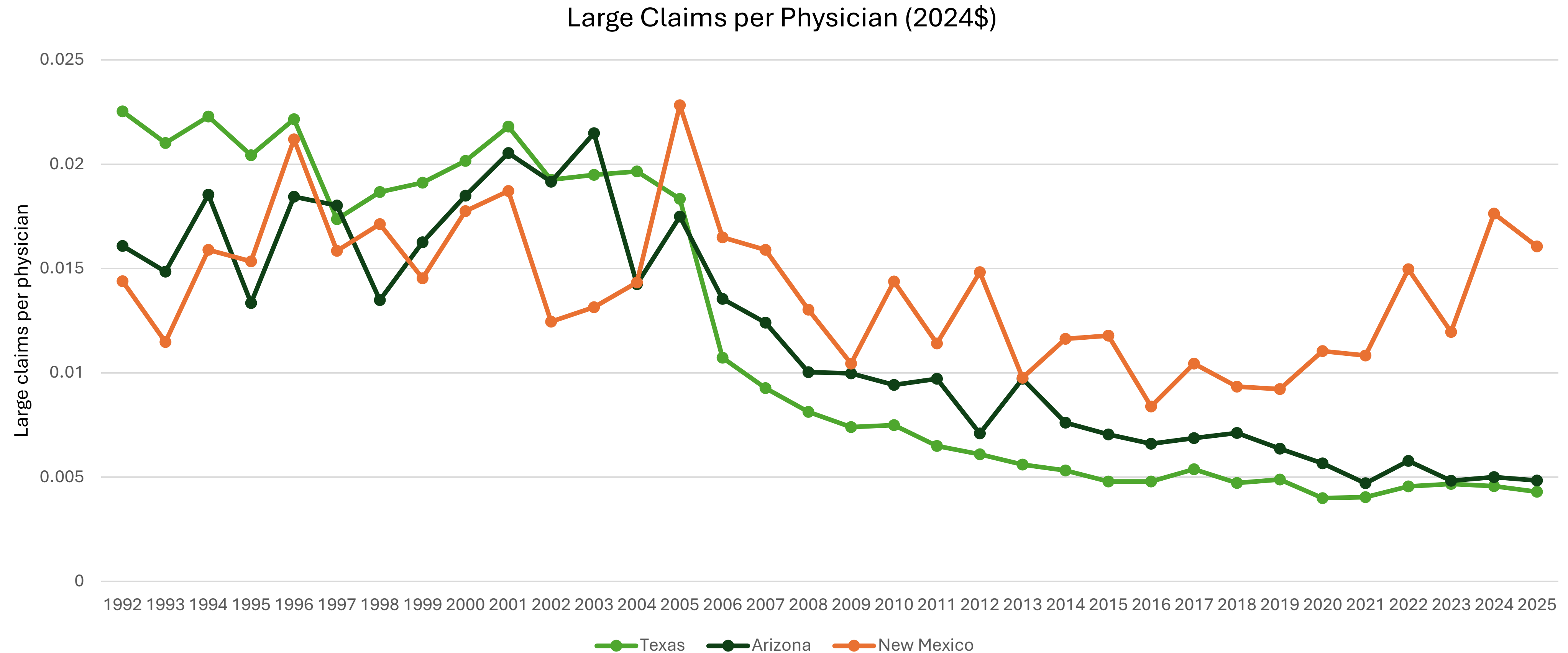


New Mexico Physicians per Capita



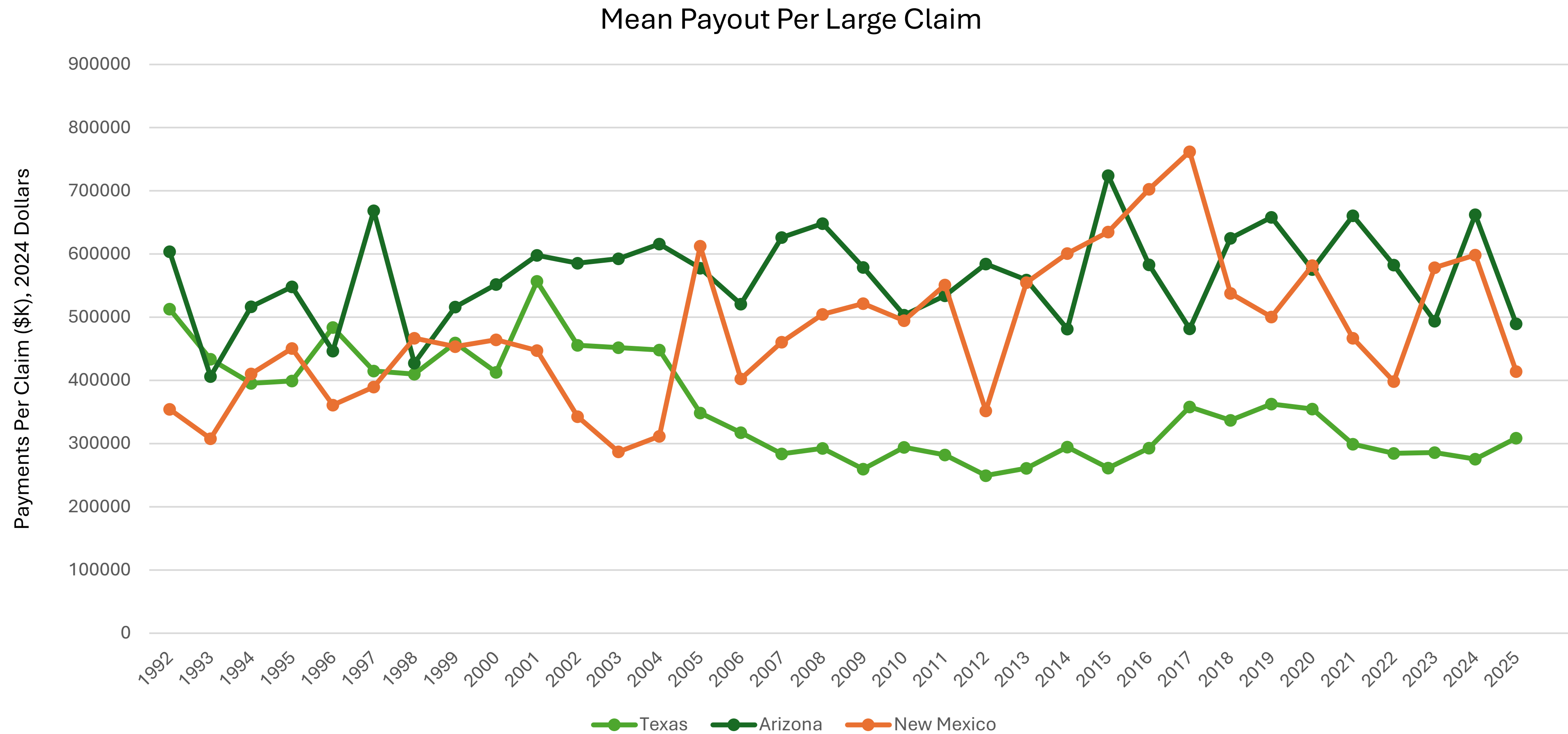
Shortage of rural physicians is a national problem.
In all states, with and without damage caps.
Needs a targeted approach.

Large Paid Claims per Physician (NM, TX, AZ)

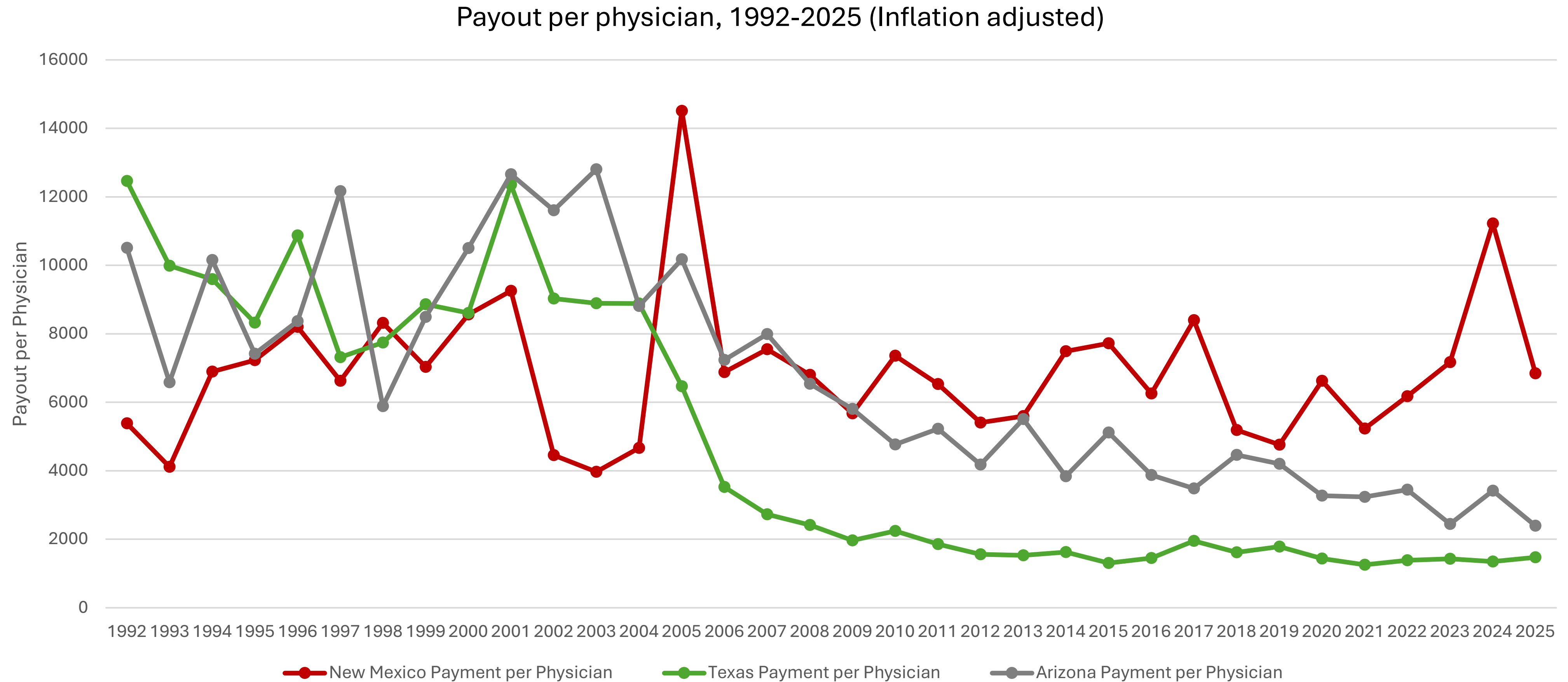


NM looks okay by itself.
Less so in comparison to your neighbors

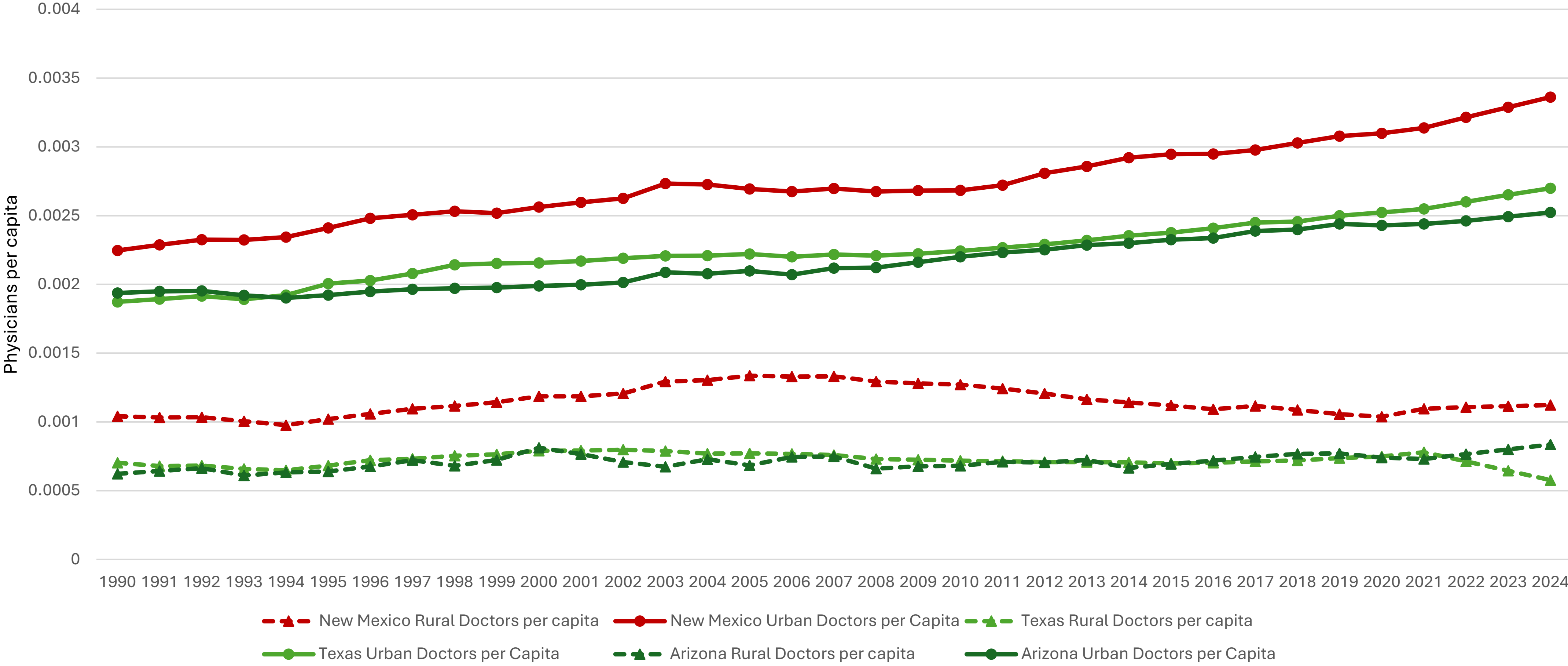
Mean Payout per Large Paid Claim (2024$)



Total Payout on Large Paid Claims (2024$)



NM, TX, AZ Urban and Rural Physicians per Capita



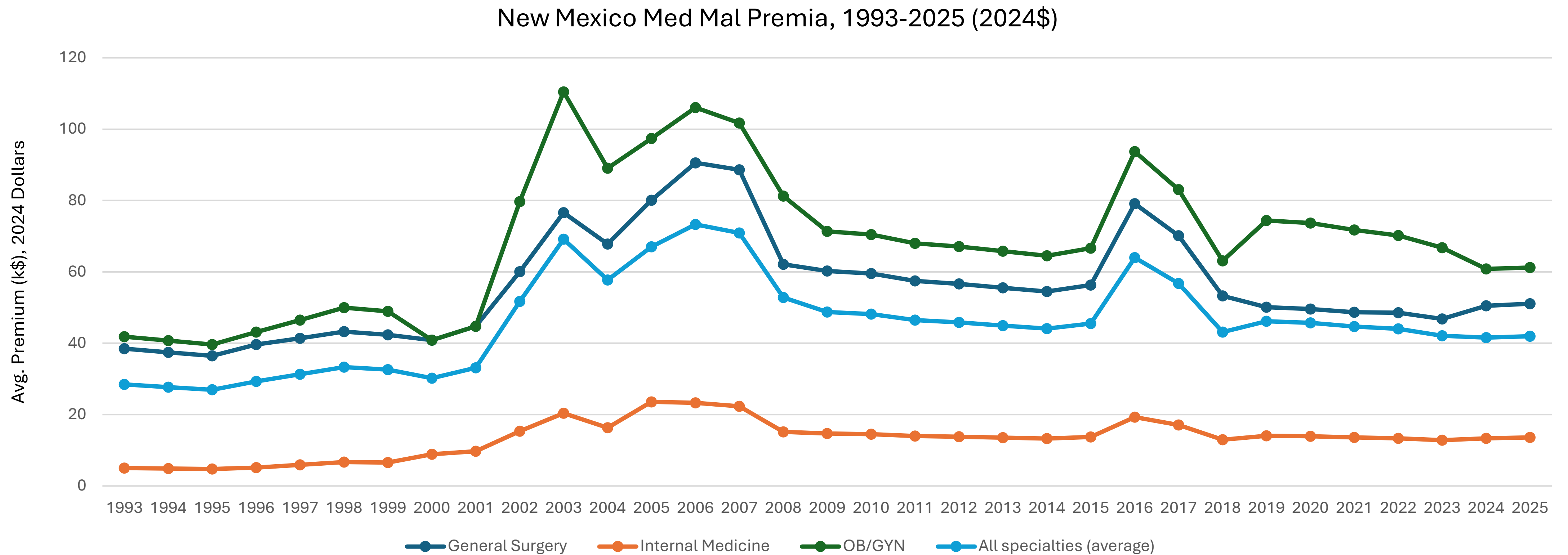
Medical Malpractice Premia

Source: Medical Liability Monitor (MLM)

Note: MLM average >> average for all physicians

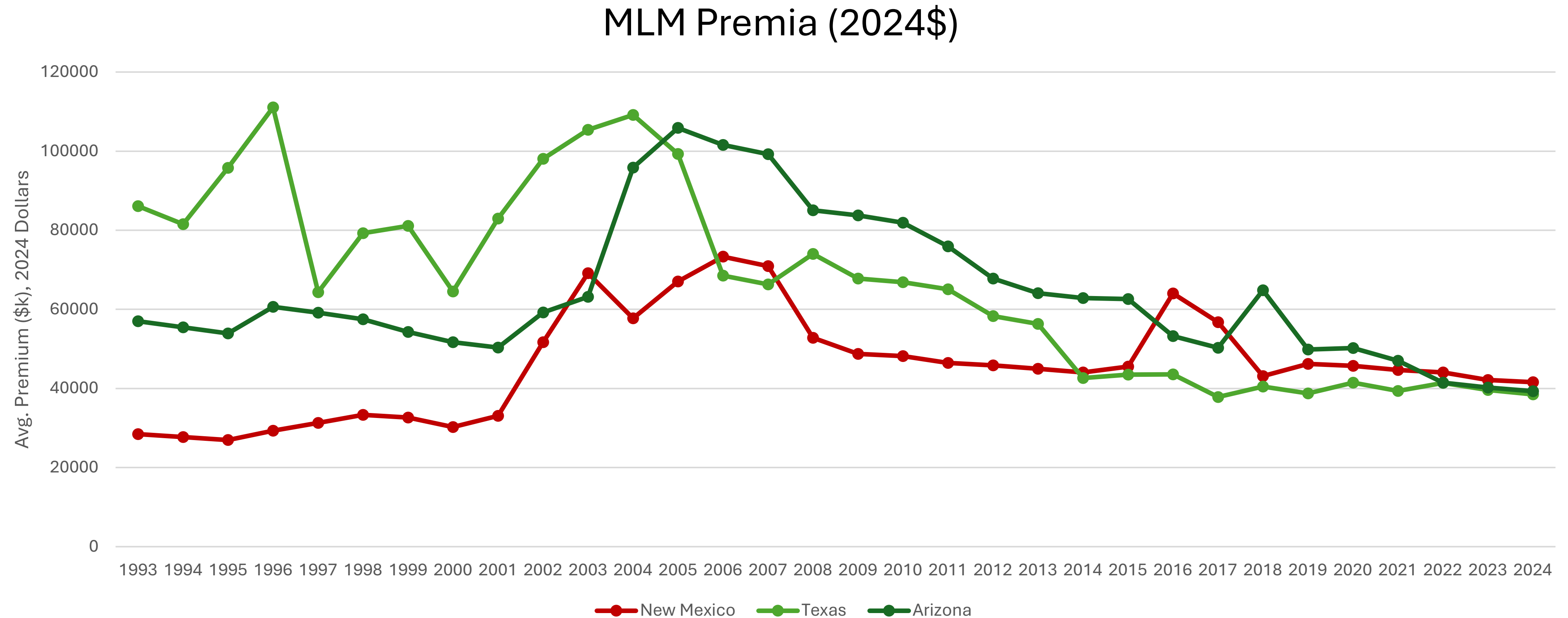
Two of the three MLM specialties are high risk; internal medicine is medium risk

So more representative of typical physician premia



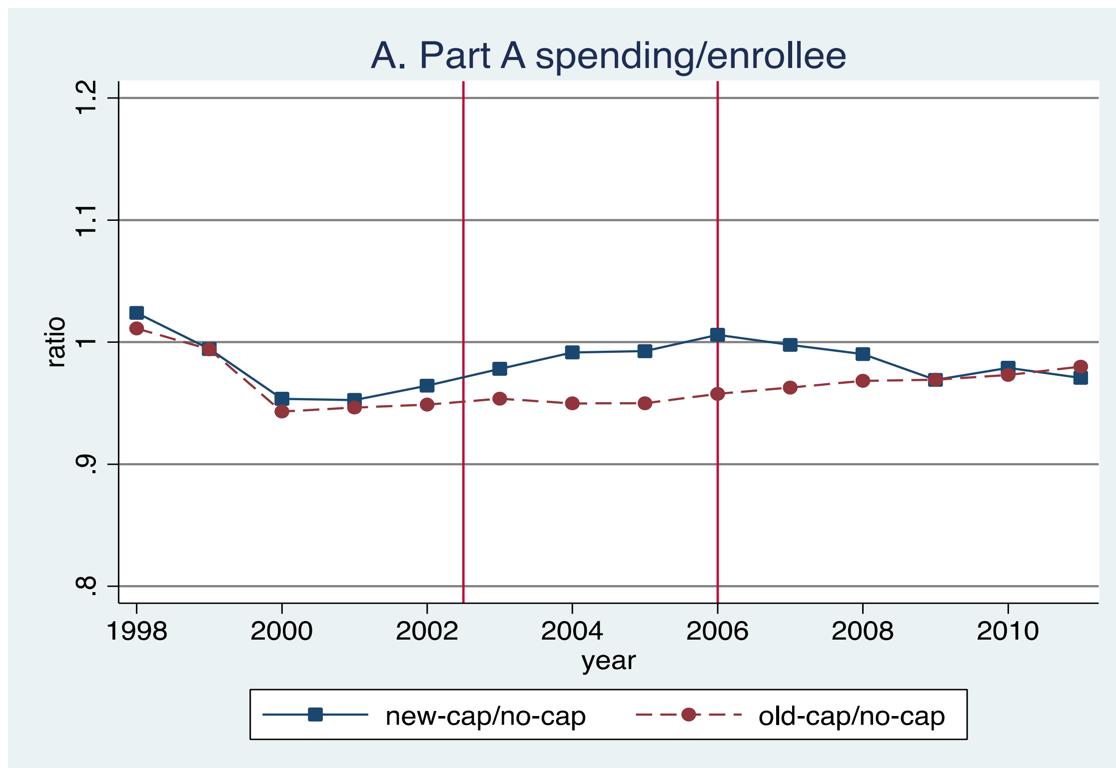
Medical Malpractice Premia

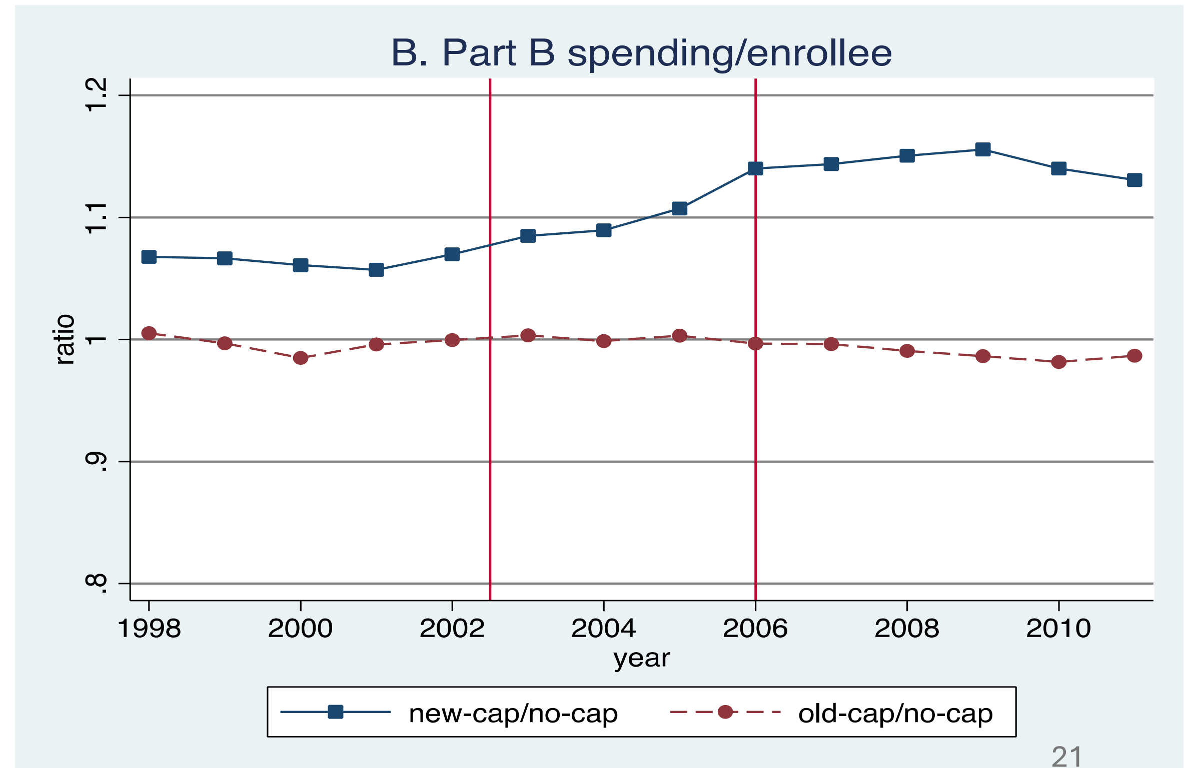
Source: Medical Liability Monitor (MLM)
Note: Weighted average premia across three specialties, weighting by county population



Damage Caps and Healthcare Costs

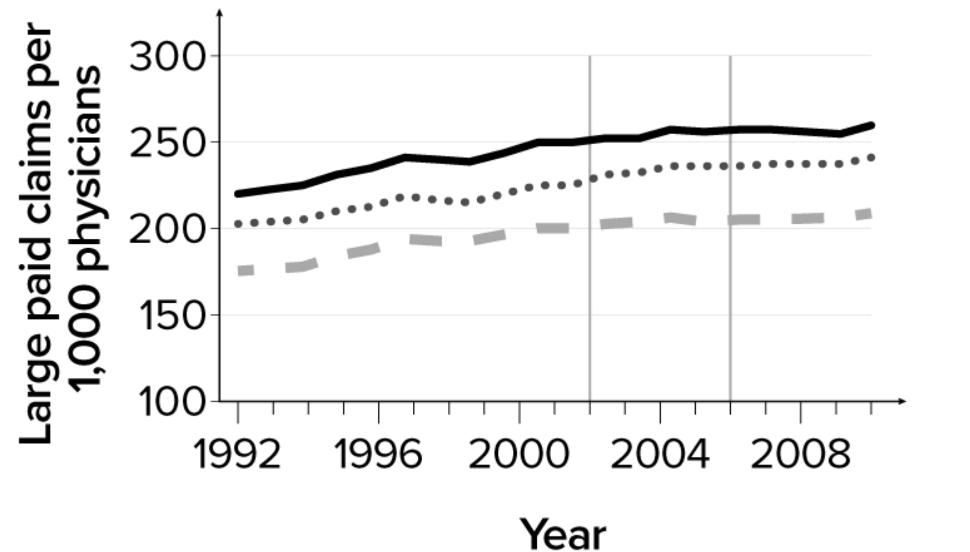
- Source: Medicare fee-for-service claims
- Prices are fixed
- So really measuring **quantity**
- Compare 9 new-cap states (2003-2005 caps) to no-cap and old-cap states

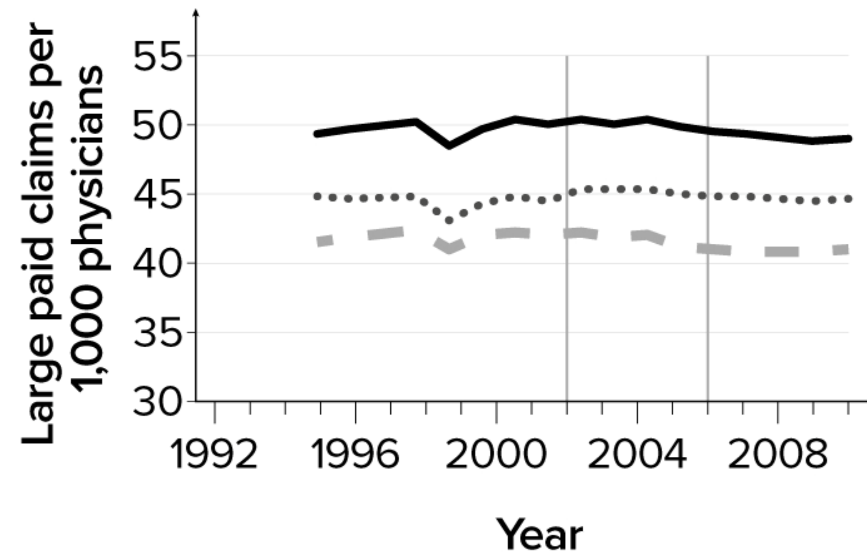




Damage Caps and Physician Supply

- Source: AMA data; active practicing non-federal physicians
- Compare new-cap states to no-cap and old-cap states



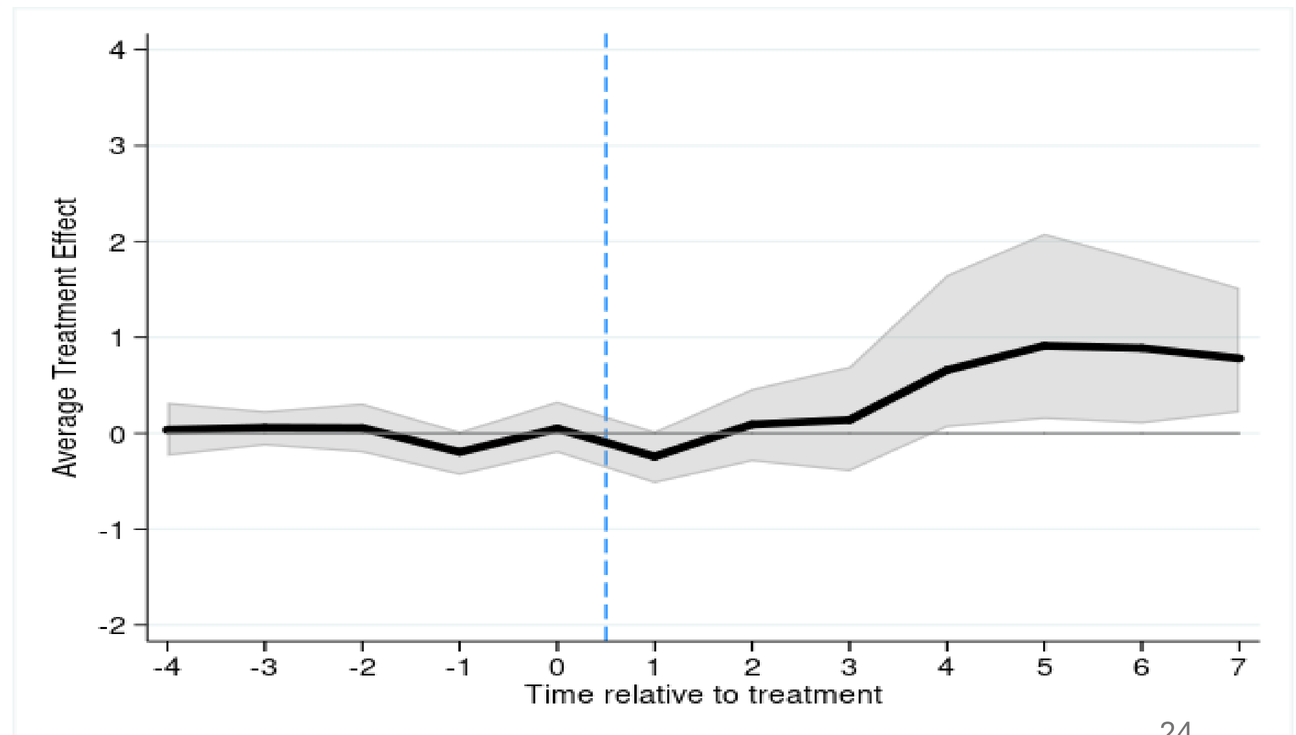


Finer look at physicians in specific specialties

- No effect of damage caps for individual specialties
  - Surgery (and surgery sub-specialties)
  - Ob-gyn
  - Gastroenterology
  - Urology
  - Emergency medicine
- No effect for rural physicians
- **Possible** increase in **plastic surgeons**

Damage Caps and Patient Safety

- Data for 5 new-cap states
- 21 “Patient Safety Indicators” (PSIs)
  - Often avoidable adverse events (e.g., post-surgery infection; wound splits open)
  - Most PSIs increase post-reform (77/105)
  - But not bad enough to kill you
    - No significant effect for mortality PSIs



Are paid claims random lightning strikes?

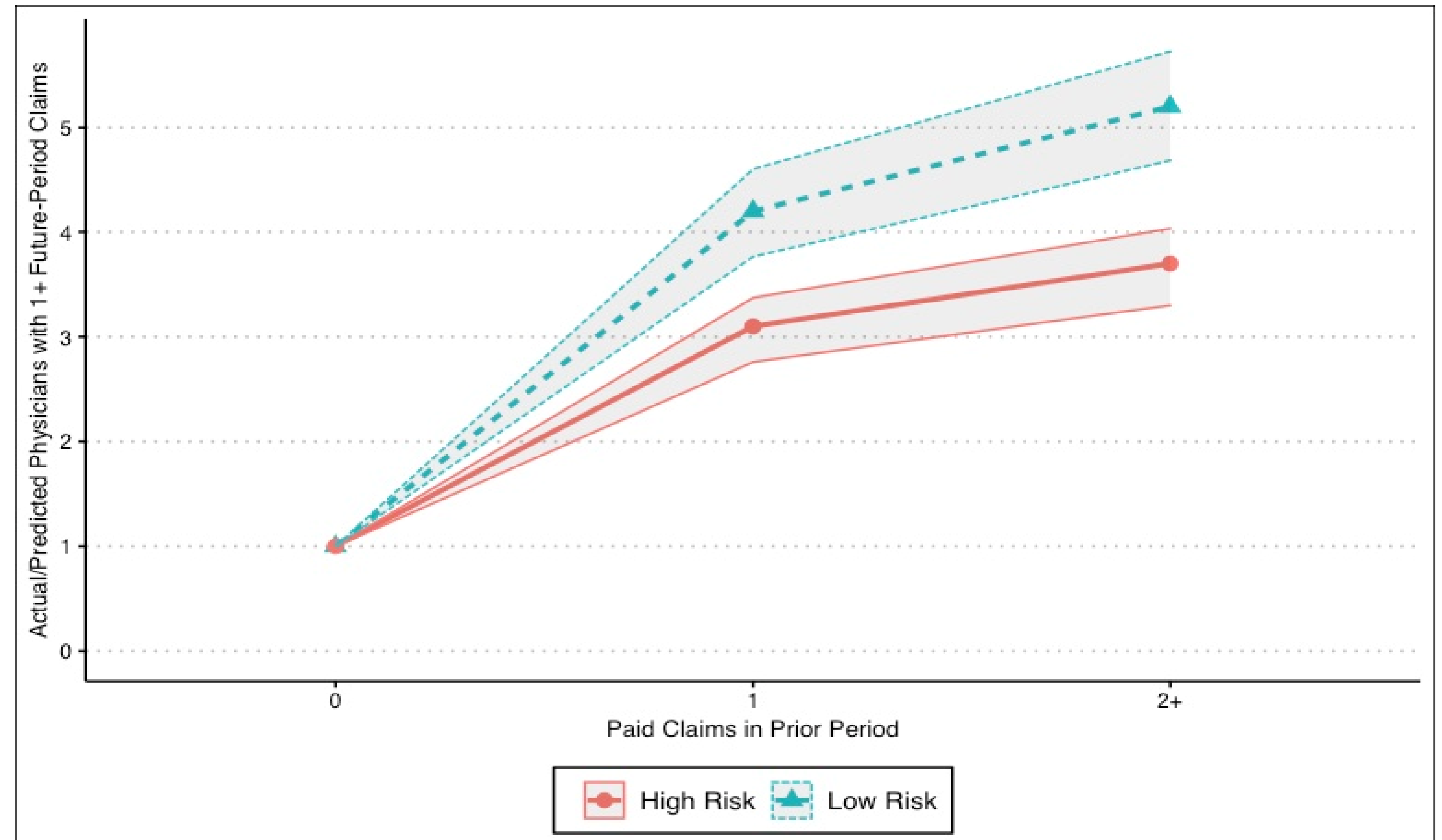
- Many physicians think so.
- They are wrong (on average)
- One paid claim (versus 0) in last 5 years:
  - **quadruples** risk of another paid claim in next 5 years
  - From 3.3% to 12.4%
- Larger multiples for 2+ prior or future claims

Some Physicians are Named, then Dismissed

- Plaintiffs' lawyers often are not sure, at the beginning of the case, "who done it" and who didn't.
- They have to name defendants broadly
  - Especially if **statute of repose** will bite, limited time to investigate
  - [Explain statute of repose, versus statute of limitations]
- Then they will (usually) dismiss the peripheral physicians
  - Why: Because costly to keep them in the case
  - And want to focus case on the bad actors

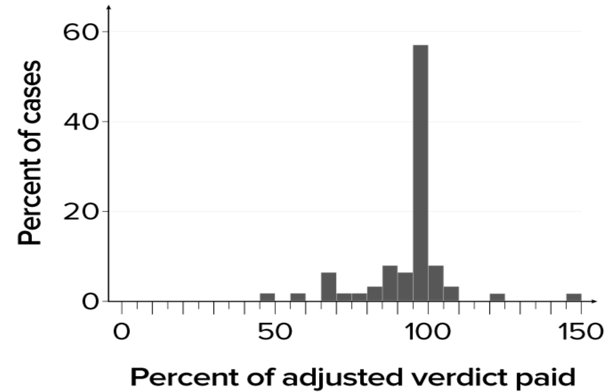
Are paid claims random events?

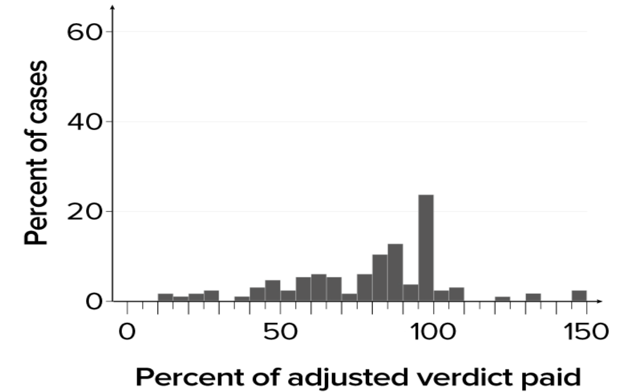
- Similar effects for high-malpractice-risk vs. low-risk specialties

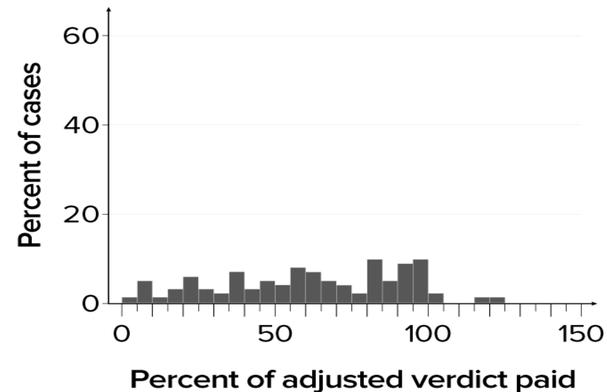


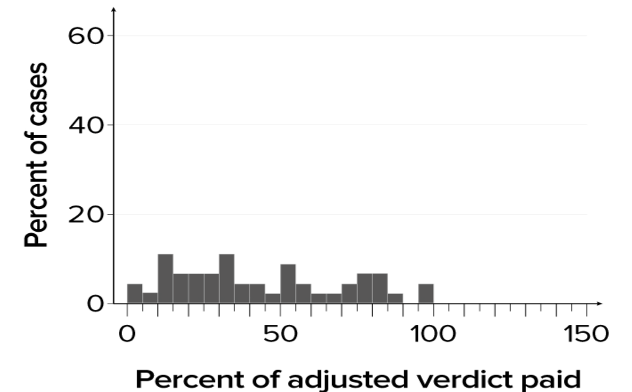
Physician Policy Limits as De Facto Caps

Texas data
Adjusted verdict = verdict + interest
Bigger verdict → larger "haircut"

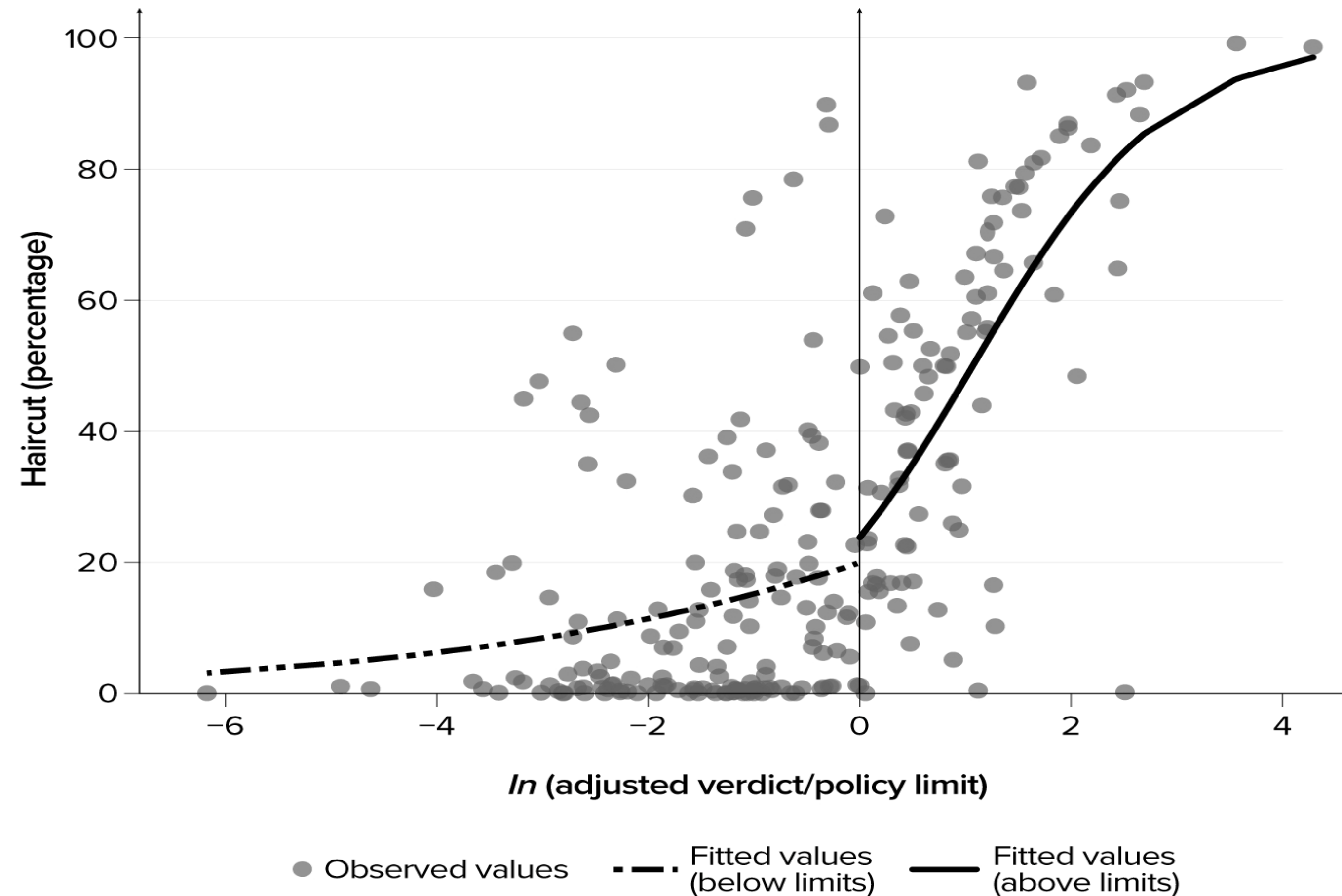








Haircuts much larger above limits

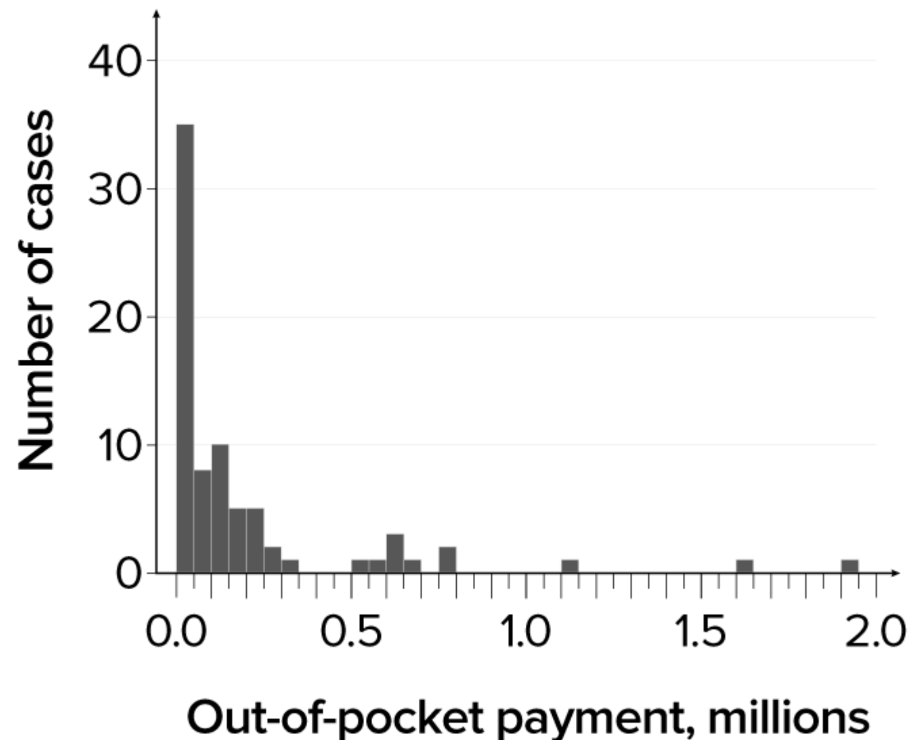


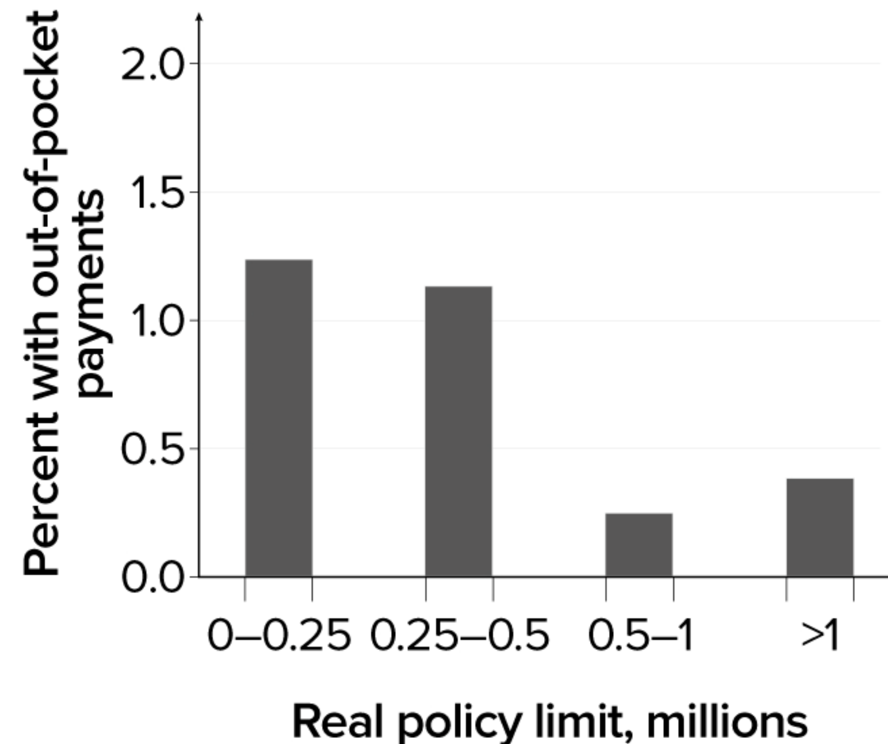
Haircut = % discount, relative to jury verdict

0% haircut = full recovery

Out-of-pocket payments are rare, usually small

77 payments in Texas in 18 years (pre-cap). Total $16M
Principal risk to physician net worth is divorce, not med mal.





The nearly meaningless NM damages cap

- Nominal cap: $750k adjusted for inflation
  - Medical costs are outside the cap
  - So are punitive damages
- Common physician policy limits: $1M/3M
  - $1M per event; capped at $3M per year
- For damages over $1M, policy limits are de facto cap
- The only gap is between $750k and $1M
  - Assuming no medical expenses
  - In most cases, no gap at all

Perverse consequences of NM cap

- Med Mal cases with justified punitive damages are rare
  - Actual payments are even rarer
  - In 25 years of Texas data on trials:
    - **Paid** punitive damages are ~2% of all payments
      - This allocates payments first to economic damages, then non-economic, then punitive

- New Mexico rule gives plaintiffs' lawyers incentives to claim punitive damages
  - Not to collect them . . .
    - But to create pressure for settlement
    - And maybe obtain a higher settlement amount

Advice 1: Scrap your complicated damages cap

- For independent physicians: It's not working
  - Rarely matters in actual cases
  - Encourages punitive damages claims
- And it wouldn't be a good idea if it were working
  - For the reasons I've tried to explain

Advice 2: Scrap your patient compensation fund

- It’s not working.
- By comparison to Texas (which has a damages cap) and Arizona (which doesn’t)
  - You have more paid claims
  - Payouts similar to Arizona (state with no damages cap)
  - Slower recoveries
  - Higher litigation costs

Perverse effects of Patient Compensation Fund

- Higher litigation costs
  - Must bring claim against physician (really, the physician's insurer)
  - Then against the PCF
- Slower recoveries
  - PCF payouts much slower than non-PCF payouts
  - PCF fights cases that a private insurer would settle
- Fund is expensive to run
- Higher cost and slower payout is not a good system
- There is a better way

Advice 3: Replace cap and PCF with

- Independent physician who buys qualifying insurance policy is **not personally liable**
  - **Period.** No exceptions. Including punitive damages.
  - Insurer still liable for unreasonable refusal to settle
    - No change from current insurance bad-faith law
- What is a qualifying policy? Standard policy; limits at least $X
  - I propose: minimum limits of **$2 million**
  - Indexed for inflation
- What about punitive damages, for rare bad actors?
  - Not important enough to worry about
  - Mostly, punitive damage claims complicate the system
  - Plaintiffs' lawyers know: If you win, you can't collect!
    - Because insurance won't cover them

Advice 4: Leave punitive damages alone

- Reform proposal would give 75% to state.
- I would not go down this road. Punitives are not important
  - In Texas: 2% of payouts in tried cases.
  - Tried cases are 3% of all cases
  - .02 * .03 = **.0006 (0.06%) of paid med mal damages**
  - The windfalls to some plaintiffs that you may be imagining don't exist
- Even if a patient safety fund was a good idea
  - Not sure about the value of a new state bureaucracy
  - It won't have enough funding to matter
- And if punitive damages are taxable . . .
  - No one will bother to collect them
- See advice #3: Give protection to independent physicians with qualifying policies

Summary

- Over the 33 years with data (1992-2025)
- Nothing extraordinary in New Mexico
  - Not in paid claims per physician
  - Not in mean or median payout per claim
  - Not in total payout per physician
- Damage caps
  - Won’t reduce healthcare cost
  - Won’t attract more physicians
  - Will reduce deterrence
- Reform proposals for independent physicians
  - Scrap the independent physician cap; scrap the PCF
  - Qualifying policy = full protection

Thank you!

- For the opportunity to present my research
  - And maybe have it influence legislative outcomes

My Medical Malpractice Research 1

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