Amending The New Mexico Medical Malpractice Act

Seeking a Second Opinion 2010

NEW MEXICO MEDICAL SOCIETY

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2010 Legislature Fast Approaching

John Anderson JD

Legal Counsel

The 2010 30-day Legislature begins on January 19 and one of the issues likely to be considered are changes to the New Mexico Medical Malpractice Act. This packet is devoted to a discussion of liability insurance issues intended to assist NMMS members in communicating with legislators about the importance of preserving the Malpractice Act. At the end of the day, it is the Legislature which will have to make those tough decisions - not physicians, and not trial lawyers. So, visit with your senators and representatives as soon as possible.

During the past eight years, the Richardson Administration and the Legislature have provided physicians tax relief and increased Medicaid reimbursement. However, a major change to the Medical Malpractice Act would significantly cut into those gains by way of increased premium costs. What is at stake? The retention and recruitment of physicians could be weakened with significant amendments to the act. A loss of physicians in rural New Mexico Communities cripples the health care delivery system in the area, affects jobs in the community, lowers gross receipts tax to the local governments, and hinders the overall economic development hopes of those communities.

There was a time in 1975 when the physicians of New Mexico were without an insurance carrier. A health care crisis was the order of the day. In 1976, the Legislature enacted the New Mexico Malpractice Act which saved the day and has served the New Mexico medical community and its patients well. Please remind your legislators of the importance of the Malpractice Act.

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Malpractice Challenge 2010: Impact to Physicians & Patients of Opening the Act

Jerry D. McLaughlin II, MD

President, New Mexico Medical Society

The NM Division of Insurance and many state legislators have expressed concerns about the Medical Malpractice Act. They are concerned that the "cap" on claims settlement awards are too low and that that could result in the Act being unconstitutional.

Any changes to the Act will have repercussions on all physicians in the state. Those changes being considered by the Division of Insurance and those proposed by the NM Trial Lawyers Association would have a major impact on the cost of practicing medicine to physicians and the accessibility of care for patients.

If, despite the NM Medical Society's efforts, the proposed changes come to pass, physicians will have choices:

- stay in their practices and absorb the increased premium costs,
- become "employed,"
- retire early or leave the state, or,
- switch out the superior occurrence policy required by the Act for a claims-made policy that lacks the protection afforded by a "cap".

The Act, held up as model legislation for other states, has been a positive and stabilizing force for physicians and the practice of medicine in the state for 33 years. The short term effects of changing it are disputable; the long term effects are, unfortunately, indisputable.

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Update on Amending Medical Malpractice Act:
The NM Malpractice Act is a multi-faceted issue and any proposed amendments to it would compound the complexity exponentially. This paper attempts to give a brief history and perspective on the issues. There are three recent events to consider -

1. Adding hospitals under the protection of the Malpractice Act (July 2009)
2. A hearing with the Courts and Justice Interim Legislative Committee (July 2009)
3. Subsequent developments (August 2009)

Continued

Hospitals

In early July, the Division of Insurance (DOI) allowed hospitals to reenter under the protection of the Medical Malpractice Act. This development could significantly impact the Act due to:

1. Occurrence limits. Physician policies set forth a limit of three liability occurrences per year whereas hospitals have an unlimited number of occurrences per year due to differences in staff sizes and procedure and treatments offered and their frequency.
2. Limit of liability. Due to the considerable differences between types of interventions, severity of patient condition, and diversity of staff in a hospital compared to a physician practice, liability exposure is higher for a hospital and the limit should correspond accordingly and not be equated to the exposure of a single physician.
3. Employees who are not defined under the definition of covered healthcare providers in the Act are now included under hospitals, dramatically increasing the number and type of providers.
4. The Medical-Legal Panel, a vital component to the Act, is not suitable to review hospital liability cases.

Courts and Justice Interim Legislative Committee Hearing

A special New Mexico Medical Society (NMMS) Liaison Committee with the New Mexico Trial Lawyers Association (NMTLA) was established in 2007 by HM-25 of the NM legislature. The Memorial requested the DOI to oversee a study on the merits and effects of revising the "cap" — the set limitation of recovery for malpractice claims under the Medical Malpractice Act — and to report their findings back to the legislature. The committee met once in 2007, became very active in 2008 and 2009, and made its first report back to the Legislature on July 16, 2009. At this hearing, the Superintendent of Insurance and representatives from both NMMS and NMTLA made presentations to the Courts and Justice Interim Legislative Committee.

At the hearing, the Superintendent of Insurance recommended increasing the limit of liability ("cap") from $600,000 to $1,000,000 while keeping the primary carrier limit at $200,000. The DOI proposal would increase the potential maximum non-medical damages payout from the PCF on an individual claim from $400,000 to $800,000. NMTLA recommended the "cap" be raised to $2,000,000 with the primary carrier limit remaining at $200,000 and the PCF being responsible for $1,800,000. NMMS previously had recommended increasing the "cap" to $700,000, increasing the primary carrier limit of liability from $200,000 to $400,000, and reducing the PCF exposure on an individual claim from $400,000 to $300,000. Unlimited past and future medical care would remain as a benefit under all three of these proposals.

	Current Status	DOI Proposal	NMTLA Proposal	NMMS Proposal
APA/AIG/MedPro	$ 200,000	$ 200,000	$ 200,000	**$ 400,000**
PCF	$ 400,000	$ 800,000	$ 1,800,000	**$ 300,000**
Total CAP	$ 600,000	$ 1,000,000	$ 2,000,000	**$ 700,000**

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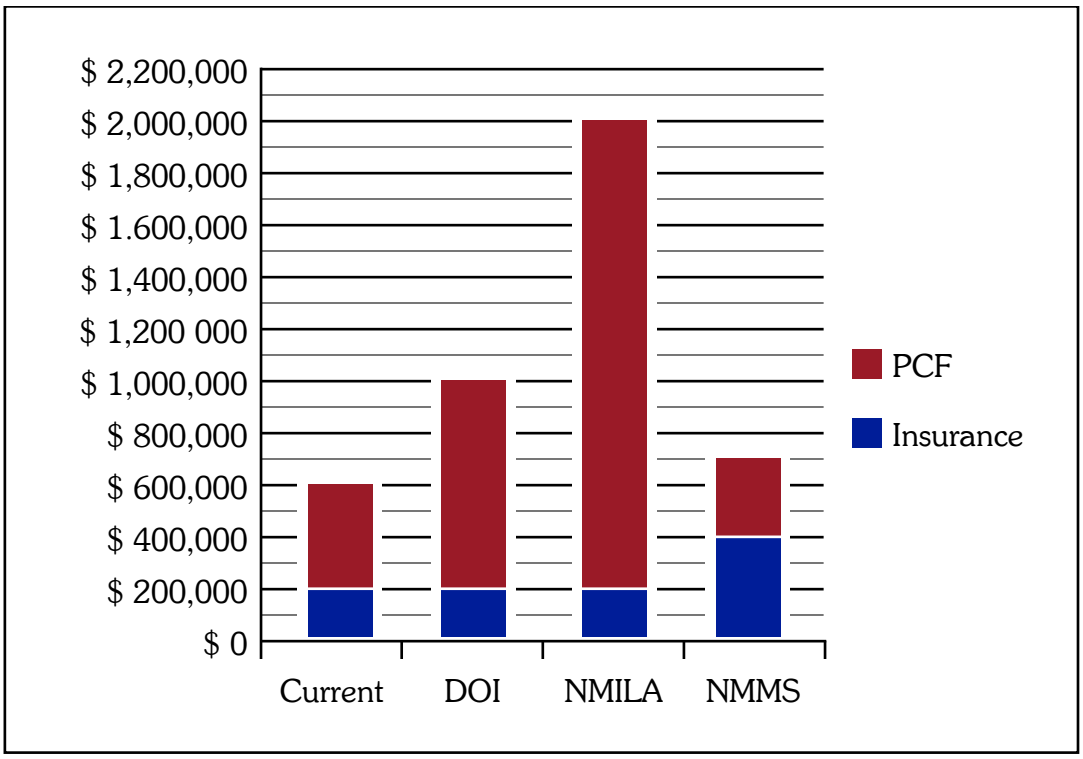
Malpractice Challenge 2010 *(continued)*



Subsequent Developments

As of mid-August, it is unclear if a bill amending the Malpractice Act will be introduced into the 2010, 30-day session. The Department of Insurance wants to conduct a new actuarial study before pursuing legislation. The Society disagrees with some of the conclusions of and data used by DOI in the past and a new study would address those issues. Until there is new data to base a proposal on, there is a tentative understanding that no legislation will be put forth in 2010. In the meantime, our goal is to have each physician meet with their legislator prior to January 2010 and discuss this matter. It is very important that our legislators are knowledgeable about the impact of amending the Act in the event legislation were to be introduced.

Review of the Issues:

2007 Actuarial Study

An independent actuarial study commissioned by the DOI concluded that, as of December 31, 2007, the Patient Compensation Fund (PCF) was unable to provide any useful, detailed data — either individual or aggregate claims - by accident/policy/report years. This situation significantly constrains the ability to accurately evaluate the PCF's financial condition. The enabling statute for the PCF (41-5-25) requires that the PCF surcharges be based on data obtained from New Mexico experience if available. The current data available is based on New Mexico losses limited to $100,000 from the two major primary insurers in the state that participate in the PCF. As a result, the actuary recommended that NM's PCF should develop a detailed claims database going back to the inception of the program in March 1976. Additionally, the actuary recommended that an increase in physician contributions between 15.6% and 17.1% would be needed to secure the PCF as actuarially sound.

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Department of Insurance
The DOI reported that, if the "cap" established by the Medical Malpractice Act was adjusted using the annual consumer price index of 2.65% from 1976 to 2009, it would result in an increase from $600,000 to $1,919,221 to account for 33 years of growth in cost of living.

Effective October 1, 2009 the PCF will increase the required contribution by 9.5% from all health care providers participating under the Medical Malpractice Act. Participating providers include medical and osteopathic physicians, podiatrists, physician assistants, chiropractors, certified registered nurse anesthetists, hospitals, corporations, and outpatient facilities.

The table below projects the DOI's estimated increase in an individual physician's premiums from changes in the primary layer and limit of liability.

Percentage Increase in Liability Premium by Liability Limit

Primary Carrier Limit	$ 800,000	$ 1,000,000	$ 1,200,000	$ 1,700,000
$ 200,000	2%	3%	4%	5%
$ 300,000	8%	9%	10%	12%
$ 400,000	13%	14%	15%	16%

NMMS Concerns
Among the Medical Society's concern with the estimated figures is that they disregard the 2007 actuarial report stating physician contributions needed to increase between 15.6% and 17.1% in order to secure the PCF at the current "cap." The figures also ignore trending factors (cost of living adjustments) that show a minimal annual increase of 4% per year. In addition, the projections do not reflect the downward turn of investment income, inclusion of hospital participation under the Act and the addition of a large group practice.

One consequence of raising the limit of liability is that the limit gradually loses its effectiveness as it increases. Once it exceeds a certain increased level, physicians will no longer participate and will choose instead to purchase claims-made policies outside of the Act. Losing physicians from the Act will have a detrimental effect on the balance of the PCF. If the PCF value decreases or if the PCF becomes insolvent, there will be inadequate funds to compensate injured patients, current and future. Not only is this a poor outcome for patients but it will be for the state as well. If the past and future medical expenses for injured patients are not covered by the PCF, those patients will turn to state programs for treatment reimbursements.

Additional concerns with increasing liability rates excessively are that it encourages physicians to reduce hours, take early retirement, or move to a state with a more favorable malpractice/liability environment. This reduction of medical care would disproportionately affect rural communities and physicians practicing in high-risk specialties.

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Malpractice Challenge 2010 *(continued)*

NM Medical Society Recommendations:

The NMMS proposal on malpractice reform, made at the 2009 legislature and reported in the NMMS annual House of Delegates Handbook (see pages 105-109, Report of the Liaison Committee NMMS & NMSB), is as follows:

1. Request Department of Insurance to undertake a 2009 actuarial study of the PCF before considering any changes to the "cap"; the 2007 study is out of date.
2. Require the Department of Insurance to develop a detailed claims database going back to the inception of the Medical Malpractice Act in March, 1976.
3. Conduct an independent actuarial study of the PCF using this comprehensive database, to determine the true impact on premiums by classification and projected increases in the liability limit.
4. Increase the underlying limit from $200,000 to $400,000 and overall limit of liability from $600,000 to $700,000 (reflects a 3%-5% total rate increase).
5. Retain an occurrence policy.
6. Create a separate limit of liability under the Act of $1,000,000 for hospitals and for corporations that employ more than 50 physicians.
7. Establish a separate PCF for hospitals and large corporations.
8. Oppose any further amendments to the Act.
9. Work with NMTLA to pursue legislation for children diagnosed with neurological-impairment at the time of delivery.
10. Support NM Hospital Association legislative proposals for separate liability acts for physicians and hospitals, similar to the Texas model.

NM Medical Society Members are asked to:

1. Get to know your legislators. Take them out to lunch or dinner before the legislative session, and educate them on the many issues facing physicians, especially the importance of a strong Medical Malpractice Act.
2. Contribute yearly to the Medical Society's political action committee (NEMPAC). Imagine the huge impact if every physician contributed $500.
3. Respond to the Medical Society's communications asking you to contact your Representatives and Senators.

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Preserving New Mexico's Medical Malpractice Act — Speaking Points

Peter Beaudette MD, Kathy Blake MD, William Boehm MD, and Dan Derksen MD

Ad Hoc Committee on Malpractice

Background:
In 1975 the last medical liability carrier left New Mexico, creating a crisis in access to health care. In 1976, the legislature passed the Medical Malpractice Act, which facilitated the creation of NM Physicians Mutual, which became American Physicians Assurance Corporation. Many features of New Mexico's Act are emulated by other states.

New Mexico's Act:
- Institutes a mandatory screening panel for medical liability claims (3 physicians and 3 lawyers)
- Caps non-medical damages (currently at $600,000)
- Requires occurrence for policies (no tail)
- Assures payment for all past and future medical expenses (Patient Compensation Fund)

New Mexico's Experience Shows That the Cap on Non-medical Damages:
- Discourages frivolous litigation
- Sets reasonable settlement boundaries
- Makes losses and underwriting more predictable
- Controls spiraling liability premiums seen in other states without caps
- Increases recruitment and retention of physicians, especially in high-risk specialties (general surgery, obstetrics, neuro-surgery) and in rural areas

Raising the Cap:
- Creates higher awards and settlements for a small number of patients
- Generates higher revenues for lawyers

Unintended Negative Consequences of Raising the Cap as Experienced in Other States:
- Increases medical liability premiums an estimated 5% for each $100,000 increase in cap
- Increases costs to Medicare, Medicaid, and other public and private insurance through defensive medicine practices, at a time when the costs are straining or bankrupting individual patient, state and federal budgets

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Preserving New Mexico's Medical Malpractice Act *(continued)*

- Reduces access to medical care, disproportionately affecting rural communities and physicians practicing in high-risk specialties
- Encourages physicians to reduce hours, take early retirement, or move to a state with a more favorable malpractice/liability environment
- Restricts patient choice of physicians and of which procedures are available in the state
- Affects ALL physicians and ALL patients. Reducing the number of physicians in a state where 30 of its 33 counties are currently federally designated health professions shortage areas (HPSA's) will exacerbate patient access to health care
- Increases overhead costs to physician practices that employ New Mexicans
- Benefits a small number of individual patients, but harms many others by reduced access when physicians close their practice and move to other states with equitable caps

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Uncertainty Breeds Lack of Confidence

Deborah A. Solove JD

Legal Counsel

We are in the midst of a major recession. You may ask what the nation's recession has to do with keeping the cap intact under the New Mexico Medical Malpractice Act. All around me, news pundits suggest that consumers will not spend money, banks will not lend and the economy will grind to a halt all because of the uncertainty in the marketplace. Doesn't the same question exist with regard to medical liability insurance? If physicians are uncertain about whether premiums will increase, whether they will continue to be insurable in the State of New Mexico or elsewhere, and whether they can make ends meet in general, both in a rural practice and in an urban practice in our state, they may choose to not come and/or not engage in the private practice of medicine in New Mexico. Without adequate physician recruitment and/or a viable practice option in New Mexico, dire consequences will follow. This is not unlike what will happen in the economy if the underlying uncertainties are not addressed and confidence is not restored.

New Mexico is a poor state with many rural communities; therefore, we have a high level of Medicare and Medicaid patients. Medicare and Medicaid pay very little to treating physicians and, when you couple this poor reimbursement with increasing premiums, physicians are forced to consider moving to other states where medical malpractice caps are in place to offset the low pay for Medicare and Medicaid if the cap is removed. Private practitioners, responsible for their own premium payment, are especially at risk. If the caps are not maintained, these physicians will leave in droves leaving only two major providers for the entire state (Lovelace and Presbyterian). Without some mix of independent, private physicians and major healthcare providers, consumers have less choice and it discourages other health insurance companies from servicing this area. Lack of competition amongst insurance providers drives up costs to consumers. Most assuredly, with less outside influence, those few independent physicians that remain will not be able to negotiate effectively with managed care organizations.

Access to specialized care is always threatened when caps are not in place and premiums rise. One need only look at the experience in other states where caps were removed to see that access to care is denied due to inadequate numbers of both specialists and primary care physicians. Physicians in Fayette County, Pennsylvania stopped delivering babies in an effort to reduce their malpractice premium expense. Obstetricians pay incredibly high rates simply

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Uncertainty Breeds Lack of Confidence *(continued)*

as a result of "bad baby litigation." In Nevada, where a substantial fee increase occurred, the Nevada School of Medicine indicated that in Clark County, there should be approximately 150 to 160 obstetricians delivering babies in order to meet the needs of the Las Vegas community. However, there were only eighty-five in practice due to Nevada's ongoing litigation crisis. Without a cap, this high risk practice could be forced into a situation much like Florida, where many physicians practice "bare." That does no good to either the New Mexico consumer or the New Mexico physician community.

Oftentimes, physicians simply stop practicing in the event of a premium increase. Combined with our low reimbursement and high overhead expenses, if a premium increase occurs as a result of lack of a cap (which most assuredly will happen), many physicians will simply choose to retire in addition to the issue of them simply leaving the state. A doctor in a small town in North Carolina decided to take early retirement when his premium skyrocketed from $7,500.00 to $37,000.00 per year. His partner, unable to afford the practice expenses by himself, closed the practice and went to work at a teaching hospital. This is yet another example of what happens when premium increases cause a domino effect.

When physicians in Ohio saw their malpractice premiums increase earlier in this decade, retirement loomed for many of them. One physician had to spend approximately seven months of his yearly income in order to cover his $84,000.00 insurance premium. He concluded that he would have had to work ninety hours a week in order to make up for the premium increase dealt in that state. In Washington, when physicians were faced with a tripling of their premiums, they voted with their feet and left the area. The Washington State Medical Association reported a 31% increase in the number of physician members moving out of the state once premiums rose.

When physicians retire and/or leave a state, access, especially in rural areas, is greatly decreased. Particularly in family medicine and obstetrics and gynecology, physicians find that a rural practice cannot be supported. A 2003 report by the U.S. Department of Health and Human Services reported that patients are having a harder time finding a physician since some physicians have limited their practice to patients without complicated health conditions which are more likely to lead to lawsuits. Without caps, physicians will continue to avoid treating complex health issues or patients who are seen as litigious. A further extrapolation would be a decrease in specialists when caps are not in place. One need only look to Mississippi, another poor state, to see what happens when caps are not in place. Mississippi had experienced a serious shortage of neurosurgeon and ob/gyn specialists. Once caps were enacted (and kept in place), not only has there been an increase in such specialists, but physician premiums decreased between 5% and 20%. In a state much like our own, some physicians have now received 25% rebates on premiums paid for their first million of coverage. With this decrease in rates, more specialists are able to operate in these states. Physician recruitment is enhanced. Unlike Pennsylvania, where a third of residents in ob/gyn plan to leave the state after completing residency because of the lack of affordable malpractice coverage, our state would encourage the recruitment of newly graduated physicians by having a favorable premium climate.

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Uncertainty Breeds Lack of Confidence *(continued)*

Peripheral problems also develop. Many physicians, who may work full or part-time in their own private practices but donate care to free clinics and other volunteer organizations, may be reluctant to serve in such capacities when they do not have malpractice insurance that would cover and/or cap their exposure. This makes it more difficult for physicians to serve low income families. The clinics would have to spend their precious resources to obtain their own coverage and have less money available to provide care to the people who need it most. When physician premiums increased, a proven decrease in charity care occurred in Pennsylvania.

In addition to insuring stability and lowering premiums, caps have other benefits. Caps encourage early settlement on cases that have merit because it puts a ceiling on physician liability. Physicians are less threatened and more willing to attend mediations with an open mind when the damages are controlled.

The Medical Malpractice Act was enacted in the 1970's to address a looming crisis of uninsurability in our state. It has served the physicians well since that time. Much like correcting the stock market, we need to have active rather than passive measures to insure our stability. I recommend that each physician contact their state representative and express their concern about having the cap removed. Without your help, the trial lawyers, which heavily lobby our state and national leaders, will prevail.

In closing, research has shown that states with caps in place increase the supply of physicians per capita by 12% relative to states without caps. With more physicians, more insurance companies will compete in the state, reducing premiums for physicians. We need this kind of stability and certainty in 2008 as much as we needed it thirty years ago when the initial malpractice act was enacted.

Thanks for your support.

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Why Not Repeal the New Mexico Medical Malpractice Act?

Jeff Haisley

New Mexico Regional Manager, American Physicians Assurance Corporation

Some individuals and groups think and argue that the New Mexico Medical Malpractice Act has outlived its usefulness and should be repealed. Two major reasons put forward by those in New Mexico who maintain that the Act is unnecessary and unfair and should be repealed include 1) that the Act is unfair to injured patients and their families, that without the limitation on recoverable damages, injured patients could receive fair and just compensation for their injuries, and 2) Physicians should no longer receive special and unjustified treatment as a class of individuals in society because any awards of money (damages) against them for professional negligence in civil actions are artificially limited by the legislation while those awarded against others in the state are not.

In order to better appreciate the arguments to the contrary and the reasons why it is of critical importance to maintain the New Mexico Medical Malpractice Act for physicians in the state, it is important to understand that the Act was created in 1975 and put into effect in 1976 in order to help to assure access to health care for those citizens in need of care and treatment. The Act was drafted out of necessity in response to a decision made by the major provider of professional liability insurance for physicians in New Mexico at the time to exit the local market. No other insurance company was willing to issue policies covering professional liability claims against New Mexico's doctors. That unavailability led to the successful effort by the physicians of the New Mexico Medical Society to form their own insurance company to exclusively write this line of business. The company, New Mexico Physicians Mutual, issued its first insurance policies in March of 1976.

Even though it opened its doors insuring barely a thousand physicians, New Mexico Physicians Mutual was able to issue policies because of the three major prongs of tort reform contained in the New Mexico Medical Malpractice Act. Those prongs include:

1. a shortened statute of limitations, reducing the allowable time a plaintiff had to decide before for the filing of a lawsuit

2. a mandatory screening panel to hear and preliminarily evaluate allegations of professional negligence brought against physicians, thus discouraging frivolous litigation

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Why Not Repeal the New Mexico Medical Malpractice Act? *(continued)*

3. a cap on recoverable damages in any lawsuit pursued against a health care provider protected under the legislation which assured adequate insurance coverage would be available for damages arising from negligently caused patient injuries.

In addition, original language in the New Mexico Medical Malpractice Act requires that insurance companies that protect health care providers must issue occurrence form policies, which are in some important ways a much less complicated form of insurance that better benefits the health care provider than a claims-made form. Occurrence form policies were preferred (then and now) because of less burdensome reporting requirements in order to trigger coverage and because the usual need to purchase an expensive extended reporting endorsement (tail coverage) is eliminated.

With regard to fairness to injured patients and families it is important to remember that while the New Mexico Medical Malpractice Act currently limits collectible damages per patient to $600,000 for proven expenses other than medical expenses, there is no statutory limit for past and future medical and other medically related expenses associated with the injury.
The argument that the New Mexico Medical Malpractice Act is unconstitutional because its language unfairly limits recovery against a protected physician is made with regard to tort reform in states across the nation. However, a damages recovery limit is the key feature and most important provision contained in any effective state tort reform. It discourages litigation, sets boundaries within which reasonable settlements can be reached, and increases predictability of losses and amounts of those losses from professional liability claims against physicians. It can and usually does hold down the costs of insurance premiums.

It is somewhat difficult to gauge the exact positive impact of effective tort reform legislation on recruitment and retention of doctors to a state. However, there is certainly compelling evidence of the positive impact of relatively new reform such as that put into place in Texas (see article in this edition by Josie Williams MD). Studies consistently indicate that states with medical liability reform experience increased numbers of physicians coming to that state.

By every measure of which I am aware, it is clear that the Malpractice Act is a positive factor in physician recruitment and retention efforts in New Mexico.

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Texas Liability Reforms Work

Josie Williams MD

President, Texas Medical Association

When the Texas Legislature convened in January 2003, Texas was in a crisis. Trial lawyers had abused the legal system by filing frivolous medical liability lawsuits. As a result, patients' access to care was limited because physicians in many high-risk specialties were scarce. Doctors couldn't afford their premiums. New physicians were reluctant to come to Texas. Insurance carriers were leaving the state because of an unhealthy business climate.

However, that changed because the Texas Medical Association, its allies, and our patients convinced lawmakers to pass a landmark liability reform, the Medical Malpractice and Tort Reform Act of 2003. The centerpiece was a $750,000 cap ($250,000 for physicians, $250,000 for the first hospital or health care facility, and $250,000 for any additional facilities) on judgments for noneconomic damages, such as pain and suffering, in liability cases. Texas voters then did their part by approving Proposition 12, a state constitutional amendment that ratified the legislature's authority to adopt the caps.

Five years later, the change has been remarkable.

An online survey of physicians completed in September shows that Texans now have more physicians offering more care. The TMA survey of 1,391 TMA members found that since 2003, Texas physicians provide more services and care for more patients with complex or high-risk problems, and find it much easier to recruit new physicians to their communities, even among high-risk specialties.

Almost 90 percent of the survey respondents "strongly agree" or "agree" they are more comfortable practicing medicine in Texas now compared with 2003.

TMA and our ally, the Texas Alliance for Patient Access, offer these examples of tort reform's impact in Texas:

- Texas has more physicians. The state licensed a record 3,621 new physicians in the 2007-08 fiscal year, a 9-percent increase over the previous record of 3,324 in 2006-07. The five-year tally of new licensees since 2003 is 14,496, or about 2,900 per year. The previous average for 1999-2003 was 2,226. Texas netted a 31-percent greater growth rate in

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Texas Liability Reforms Work *(continued)*

newly licensed physicians in the past two years than in the two years preceding reform. The physician growth rate in El Paso, for example, is 76 percent greater than pre-reform.

- The state's largest liability insurer, the Texas Medical Liability Trust (TMLT), will cut premiums an average of 4.7 percent Jan. 1, 2009, and pay physicians who renew their policies a 22.5-percent dividend. It's the sixth TMLT premium reduction in five years, saving physicians $380 million in decreased premiums since 2003. Other companies also reduced rates after tort reform.

- After years of decline, the ranks of medical specialists are growing. Fifty-two counties have a net gain in obstetricians, including 23 medically underserved counties. Texas added 195 orthopedic surgeons. Forty-three Texas counties have a net gain in orthopedists since 2003, including seven that previously had none. Texas added 49 neurosurgeons, a 12-percent growth compared with no growth in the two years before tort reform. If pending applicants are approved, the statewide total of pediatric intensive care, pediatric emergency medicine, and pediatric infectious disease specialists will double.

- Many physicians say they now provide more charity care, participate in volunteer programs, and accept more Medicaid and Medicare patients because of the liability reforms. They also are adding new in-office procedures and testing, nursing home coverage, and after-hours services.

- Since 2003, Texas physicians are more likely to accept high-risk patients and offer new services or procedures. Before 2003, many refused to accept patients with complex or high-risk problems, referring them to an increasingly shrinking pool of specialists in tertiary care centers. More than 18 percent of respondents now say they accept complex or high-risk cases they previously referred or denied. That's more than four and a half times greater than the 4-percent figure reported in the 2004 survey.

- Respondents to the survey told TMA they stopped referring patients with chronic pain and are more willing to treat patients with multiple complications - including cardiac, neurological, and immune deficiency problems - whom they previously would have referred to others. Eighty-five percent said the improved liability climate played a "very important" role in their decision to accept complex or high-risk cases. Twenty-two percent have started providing new services to patients since 2003. That compares with only 9 percent in 2004.

This is all great news for Texas patients and physicians. It proves the reforms worked. We now have a much healthier and robust system that is much better able to give Texans the medical care they need. Our challenge is to defend the reforms from attacks that surely will come in the 2009 legislative session. And we will.

New Mexico Medical Legal Panel Results
March 1, 1976 - February 28, 2009

4,456 Total Cases of Medical Legal Panel Results Heard

Percent	Number			
	4,267	cases resolved following hearing		
30.27%	1,292	cases settled		
37.40%	1,596	cases dropped		
31.80%	1,357	cases in suit-tried in court		
		Dismissed	974	
		Summary Judgment	143	
		Defense Verdicts	199	
		Total		1,316
		Plaintiff Verdicts	41	
		Total		1,357
Pending in suit			156	
Pending No Activity			33	
Total			189	

Distribution of Cases Found Not Negligent

Percent	Number			
	3,362	cases resolved following hearing		
20.00%	672	cases settled		
44.94%	1,511	cases dropped		
34.50%	1,160	cases in suit-tried in court		
		Dismissed	845	
		Summary Judgment	126	
		Defense Verdicts	163	
		Total		1,134
		Plaintiff Verdicts	26	
		Total		1,160
Pending in Suit			110	
Pending No Activity			21	
Total			131	

Distribution of Cases Found Negligent

Percent	Number			
	905	cases resolved following hearing		
65.26%	620	cases settled		
9.39%	85	cases dropped		
21.77%	197	cases in suit-tried in court		
		Dismissed	129	
		Summary Judgment	17	
		Defense Verdicts	36	
		Total		182
		Plaintiff Verdicts	15	
		Total		197
Pending in suit			46	
Pending No Activity			12	
Total			58	

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