New York State Bar Association
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# Memorandum in Opposition

## Committee on the Tort System

TORT #2 March 18, 2011

S. 2809-B, PART H By: BUDGET
A. 4009-B, PART H By: BUDGET
Senate Committee: Finance
Assembly Committee: Ways and Means

## THE COMMITTEE ON THE TORT SYSTEM OPPOSES PART H OF THE EXECUTIVE BUDGET, IN RELATION TO MEDICAL MALPRACTICE

### I. INTRODUCTION

Governor Cuomo has submitted a budget to the Legislature that includes several proposals that would have a profound impact on the civil justice system. These proposals include the creation of a Medical Indemnity Fund (Fund) and the institution of a $250,000 cap on non-economic damages in medical malpractice cases. Additionally, there are provisions that would amend the Civil Practice Law and Rules with respect to certificates of merit, expert disclosure in medical malpractice actions, and mandatory settlement conferences. These proposals can be found in Part H of S2809-B/A4009-B at §§52-52M.

### II. BACKGROUND ON THE PROCESS THAT GENERATED THE GOVERNOR'S PROPOSAL

The above-referenced proposals were recommended to the Governor by the Medicaid Redesign Team (MRT), which he created shortly after taking office. During his State of the State address on January 5, 2011 Governor Cuomo said that, "[w]e need to redesign the Medicaid program." Consequently, he created the MRT, to "find efficiencies in the program so we actually provide a better service for less money." The MRT was said to include "stakeholders," who would re-invent the program as part of the 2011-12 State budget due to be in place by April 1.

The MRT was to submit its first report with findings and recommendations to the Governor by March 1 for consideration in the budget process. However, it completed its work early, submitting its recommendations to the Governor on February 24, 2011, which unfortunately limited the opportunity for any meaningful input from groups that

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would be impacted by the MRT's proposals. It should be noted that while the MRT's proposals were submitted to the Governor and accepted by him on February 24, the bill language that would make these significant changes was not available for review until the late in the day on March 3, 2011.

On February 23, 2010 the Committee on the Tort System presented to the NYSBA Executive Committee its objections with respect to the MRT's proposals to create the Fund and institute a cap on non-economic damages. The Committee's objection to the cap was based on this Association's long standing opposition to such a proposal. The objection to the creation of the Fund was based on the process by which the proposal was devised, namely, the lack of notice that medical malpractice proposals were being considered as part of the process to slash the State Medicaid budget, lack of representation on the MRT of groups most familiar with the civil justice system, and the speed with which the MRT's proposals were advanced to the Governor, thus foreclosing the opportunity for meaningful input by interested parties. The Committee continues to raise these objections and now opposes the creation of a Fund on substantive grounds as well.

## III. DISCUSSION OF THE GOVERNOR'S PROPOSAL

### a. Cap on Noneconomic damages in medical malpractice cases

Part H, §52-I of the bill would add a new Article 50-C to the Civil Practice Law and Rules to provide that noneconomic damages suffered by an injured plaintiff in the case of medical malpractice shall not exceed $250,000. The bill also provides that the $250,000 cap shall be adjusted in accordance with the Consumer Price Index.

Noneconomic damages compensate for injuries like permanent disability, disfigurement, blindness, loss of a limb, paralysis, trauma, or pain and suffering. Importantly, pain and suffering includes the loss of one's ability to enjoy life. The proposed cap would apply no matter how meritorious a case is, no matter how egregious the negligence and no matter how severe the injury.

The New York State Bar Association has a long-standing position in opposition to caps on non-economic damages in medical malpractice or any other tort action. The Association's position is summarized as follows:

> The purpose of our tort system is to make whole or compensate the victims of harm caused by the negligence by others;
>
> In addition to out-of-pocket economic damages -- such as lost wages -- our system provides that a victim may be compensated for pain and suffering that results from serious injury. To cap this type of compensation would unjustly discriminate against accident victims who suffer the most devastating physical and psychological losses;

Considering only economic loss would be unfair to victims because it does not deal with the loss of enjoyment of life.

Awards for non-economic injuries serve to deter corporate and governmental misconduct and to protect innocent citizens. A cap would eliminate the deterrence. Victims and society would then have to subsidize the cost of high-risk activities.

The Committee recommends that the Association continue to **OPPOSE** caps on non-economic damages in all tort actions.

**b. New York Medical Indemnity Fund**

The Fund that the Governor is proposing would establish a funding source for certain costs associated with birth related neurological injuries. The stated purpose is to "reduce premium costs for medical malpractice insurance coverage."

The Fund, which targets some of the most, if not the most, vulnerable plaintiffs—neurologically injured new born babies—would come into play only after a case has been brought in a court proceeding and has concluded either with a jury verdict or an agreed upon settlement. It would pay the "medically necessary health care costs," which is defined to mean *future* medical costs actually incurred for services rendered, which are medically necessary as that term is to be defined in regulation by the Commissioner of Health. This fund is one which only reimburses victims after their expenses have been incurred. Given this reimbursement scheme, the injured infant could essentially become a perpetual litigant on what future health care costs qualify as medically necessary despite having had a verdict in his or her favor. Unlike all other medical malpractice cases, these plaintiffs would not automatically receive most of the money a jury awarded or the settlement agreement proposes they should have, with the exception of capped non-economic damages.

Alarmingly, the bill provides that if the total of all current estimates of the Fund's liabilities equal eighty percent (80%) of the Fund's assets, then the Fund SHALL NOT ACCEPT any new enrollments until a new deposit has been made. The bill continues that when, the Fund's liabilities no longer exceed the Fund's assets, the administrator shall enroll new applicants.

There is no provision made for what should happen to injured infants who are barred from being enrolled in the Fund during this prohibited enrollment period. Would they be eligible for Medicaid? If so, the question arises as to how this creates savings for the Medicaid system, which is the purported goal of this proposal.

To be clear, the Fund would apply only after the injured infant's claim that his or her injuries were the result of a provider's negligence has resulted in a favorable verdict or settlement. Once that hurdle is overcome, only then would the injured infant be eligible to receive the minimal level of care the fund may provide. This is because the fund

would only cover what it deems "medically necessary," the definition of which is vague at best, and as provided in the bill the Fund would pay only Medicaid rates to health care providers.

Given these restrictions, many doctors and other health care providers may decline to treat injured infants covered by the Fund, based on the lower reimbursement rates and the risk that providers would be denied payment because the treatment provided is not deemed "medically necessary" by the Fund.

Furthermore, proposed §2999-j(2) provides that in determining costs to be paid from the Fund, any cost that was or will be paid from any collateral source as provided in CPLR §4545 (excluding Medicaid and Medicare), shall not constitute "medically necessary health care costs." This means that collateral sources, to the extent that they are available to the injured infant, would be required to cover all expenses before the fund pays anything -- in other words the health insurer is the payer of first resort. This point is confirmed by the fact that proposed §2999-j(12) expressly states that health insurers are to be the primary payers of medically necessary health care costs of the injured infant. This provision shifts the burden from the negligent medical care provider to the health care insurer. This scenario presents the real possibility that health care insurance premiums would increase for **all** consumers, while insulating from liability the medical care provider whose negligence caused the injury.

Conclusion with respect to the Medical Indemnity Fund

The Fund proposal discussed above and included in the Executive budget misses the mark in addressing medical malpractice. The focus of any proposal to address medical malpractice should be increasing patient safety, not capping the amount an injured person can recover and removing the recovery rights of children who have been seriously and permanently injured by malpractice.

Some in the health care industry have long complained about the perceived explosion in malpractice actions to justify their prescription for "reform." However, case filing numbers for the last 20 years have remained relatively flat. In 2009 (the most recent year for which the Office of Court Administration has complete information to report) filings were at the lowest level since the early 1990's. In 1993 there were 3,976 filings. In 2009 there were 3,961 filings.

The impact the Fund proposal would have on the care received by neurologically impaired infants could be detrimental. This vulnerable population would be at the mercy of the Fund administrator to determine what costs would be reimbursed as medically necessary to treat the injuries inflicted on them by the negligence of a health care provider. Instead of being able to make health care choices that make the most sense for the injured infant and pay for such care with the money awarded by a jury, the infant and his or her family would be required to apply to the Fund, with the hope that the Fund will agree that the care sought is medically necessary. Only then would such costs be reimbursed and only at Medicaid rates. This sets the stage for potential ongoing disputes over what is medically necessary for the infant.

Currently, our civil justice system allows infants who are injured through malpractice to recover from the responsible party. This allows the infant and his or her family to pay for the care that best suits the infant's needs, typically, through a judicially approved structured settlement that accounts for the anticipated needs of the child defined by a life care plan. Moreover, to the extent that any verdict which is found, upon law and facts, to be excessive, CPLR§5501(c) provides that the appellate division shall determine that an award is excessive if it deviates materially from what would be reasonable compensation. This safeguards defendants from having to pay excessive awards.

This proposed legislation seeks to solve the problem of medical malpractice by insulating the doctors, hospitals and other health care providers who negligently caused neurological impairments in infants.

Based on the forgoing discussion the Committee **OPPOSES** the creation of a Medical Indemnity Fund.

**c. Proposals to amend the CPLR in Medical Malpractice Actions.**

§52-d of the bill would amend CPLR §3012-a, in relation to certificates of merit in medical malpractice actions, to provide that the plaintiff's attorney must certify as to each named defendant that there was an expert review of the case by an expert in the same specialty as the defendant. Additionally, §52d would remove from CPLR §3012 the exception that allows the plaintiff's attorney to execute a certificate of merit stating that he or she was unable to obtain the expert consultation after making three good faith attempts.

The Committee **OPPOSES** this provision in that it would require an expenditure that no practitioner could afford to undertake except in the most catastrophic cases.

§52-e of the bill would amend CPLR 3101 to require that the names of medical experts in medical malpractice cases be disclosed. This is accomplished by deleting from the statute language that allows parties to omit the names of medical experts. The Association has supported similar amendments in the past. The Committee recommends that the Association continue to **SUPPORT** such an amendment.

§52-e would also require depositions of experts in malpractice cases. Doing so would dramatically increase costs of malpractice cases for both plaintiffs and defendants. It would seem that this proposal on its face would increase medical malpractice costs for all parties involved. Increasing costs runs counter to the goal of reducing costs in malpractice cases. The Committee **OPPOSES** this amendment.

§52-f of the bill would add a new rule to the CPLR that would require settlement conferences in malpractice case 45 days after filing the note of issue. The Committee **SUPPORTS** this amendment.

§52-h of the bill would amend Public Health Law §2805-m to remove the provision that statements made at peer review conferences are discoverable by parties in an action that is the subject matter of such conference where the statement is made by someone who is a party in the action. Other than to further insulate medical professionals from liability in medical malpractice actions the purpose of this amendment is unclear. The Committee **OPPOSES** this amendment.

**d. Effective Date**

Part H, §96, paragraph z provides in pertinent part that the sections of Part H dealing with medical malpractice "…shall take effect on the ninetieth day after it shall have become law, provided that it shall apply to birth-related neurological injury lawsuits in existence as of the date of enactment and to all birth-related neurological injury lawsuits commenced subsequently to the date of enactment…" By its terms, this new law applies to pending lawsuits. The Committee **OPPOSES** the effective date of this proposal.

**e. Appropriations Language**

In addition to proposing these medical malpractice amendments in Article VII language bills, the Governor also included certain substantive provisions related to medical malpractice in appropriations language. Such a practice is not typically seen in the budget process. Particularly notable is the following language from pages 396-397 of S.2803-B/A.4003-B (emphasis supplied):

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Provided, notwithstanding any other law or rule to the contrary, that in order to make expenditures from these appropriations and achieve savings necessary to meet the department of health state funds medicaid expenditure cap as referenced above, **a court shall issue an order in every medical, dental or podiatric malpractice action commenced during state fiscal year 2011-12 and state fiscal year 2012-13 pending before it, on its own**

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**motion or on the motion of any defendant in such action liable for damages arising from pain and suffering, loss of services, loss of consortium, or other nonpecuniary damages suffered by an injured plaintiff, limiting the recovery of such damages from every defendant liable for malpractice in such action, to no more than $250,000,** provided that such sum may be adjusted in

accordance with Consumer Price Index for all Consumers, as published annually by the United States Department of Labor, Bureau of Labor Statistics, and further provided there shall be established the New York State Medical Indemnity Fund, to provide a funding source for certain costs associated with birth related neurological injuries pursuant to a chapter of the laws of 2011 enacted as legislation submitted by the governor, which fund shall be contingent upon the enactment of a $250,000 cap on non economic damages pursuant to this appropriation or pursuant to such chapter.

## IV. PATIENT SAFETY

### a. The Governor's Proposal

The Governor's proposal includes §52-a of Part H the New York State Hospital Quality Initiative. §52-a provides for overseeing the general dissemination of initiatives, guidance, and best practices to general hospitals. While the Committee applauds the inclusion of patient safety initiatives in the Governor's bill, this proposal does not go far enough. Our fundamental point is that patient safety should be the focus of any effort to address medical malpractice. The prevention of malpractice events through patient safety initiatives makes the most sense economically and for the welfare of the patient.

### b. Alternatives to the Governor's Proposal

1. American Journal of Obstetrics and Gynecology

As the MRT's process wound down with the Governor accepting the MRT's proposals well in advance of the established and expected March 1 deadline, a revealing article came to light. The article, which was published in the February 2011 issue of the *American Journal of Obstetrics and Gynecology*, entitled *Effect of a comprehensive obstetric patient safety program on compensation payments and sentinel events*, concluded that:

> Making significant changes on a labor and delivery unit including such features as the implementation of a standardized oxytocin protocol, electronic charting, team training, and improving situational awareness through a central communication system, should be considered by all obstetric services. As we have shown,

> these changes can increase patient safety, decrease sentinel events, and as a consequence, reduce compensation payments.

Interestingly, this article is based on a comprehensive patient safety program, which was instituted at the New York Presbyterian Hospital-Weill Cornell Medical Center. In 2002 the hospital began to implement in a step-wise fashion a comprehensive and ongoing patient safety program. With respect to medical malpractice obstetric compensation payments, the article reports the following results:

> The 2009 compensation payment total constituted a 99.1% drop from the average 2003-2006 payments (**from $27,591,610 to $250,000**). The average yearly compensation payment in the 3 years from 2007-2009 was $2,550,136 as compared with an average of $27,591,610 in the previous 4 years (2003-2006), a yearly saving (sic) of $25,041,475 (total: $75,124,424) during the last 3 years.

As this article dramatically illustrates, the focus of the effort to reduce incidents of malpractice and to achieve the stated goal of reducing medical malpractice premiums and the costs of Medicaid, should be the implementation of patient safety programs. Capping the amount an injured person can recover and removing the recovery rights of children who have been seriously and permanently injured by malpractice, does not prevent malpractice from occurring. The Committee urges that the proper solution to prevent malpractice in the first instance is legislation requiring the implementation of comprehensive patient safety programs. The New York Presbyterian Study provides the comprehensive systematic approach that can and ought to be taken by the health care industry to reduce its own malpractice costs. The Committee urges that such an approach is superior to the one taken in the Governor's proposal, because it would have the effect of reducing and very nearly eliminating malpractice in obstetrics cases.

2. Assembly Patient Safety Focused Legislative Proposals

In recent days the Assembly has advanced two proposals properly focused on the root cause of medical malpractice—medical errors. The first bill, A.6253, sponsored by Assemblyman Lancman is entitled the Medical Malpractice Savings Act. This bill would require the Commissioner of Health, drawing on the experience of New York Presbyterian Hospital-Weill Cornell Medical Center, to promulgate regulations to require all facilities with State licensed obstetrical programs to establish and implement a comprehensive obstetrics safety program to reduce medical errors and improve patient outcomes.

The Committee fully **SUPPORTS** this legislation and believes it is an appropriate approach to prevent medical malpractice in the first instance, thereby reducing costs to the health care industry.

A second proposal recently introduced as part of the Assembly's budget proposal is embodied in A.4009-C, Part H, §52 (Neurological Impairment Fund) and §52-a (New York State Obstetrical Patient Safety Assessment Workgroup).
The Assembly's Fund proposal would establish a New York State Neurological Impairment Fund to be managed by a nine member Board made up of appointees by the governor and the Legislature. The purpose of this Fund is to mitigate or subsidize costs related to medical malpractice or medical malpractice insurance premiums related to obstetric services of qualified hospitals. The Board would certify qualified hospitals as those hospitals that implement an obstetrical patient safety assessment program approved by the New York Obstetrical Patient Safety Assessment Workgroup. Such workgroup shall be created within the Department of Health and shall be comprised of medical, hospital and academic experts, patient representatives and other stakeholders as the commissioner deems necessary and appropriate. Such workgroup would be charged with establishing initiatives and guidance to general hospitals to encourage the reduction of birth-related neurological impaired injuries and approving obstetrical patient safety programs of such general hospitals.

The Committee fully **SUPPORTS** this proposal and believes that it is an appropriate approach to prevent medical malpractice in the first instance, thereby reducing malpractice costs to the health care industry.

There is significant support for the approach taken by the Assembly in these two proposals. As was written in the New York Times Editorial page on Sunday, March 13, 2011:

"The best solution is to greatly reduce the errors and bad outcomes that can lead to malpractice suits."

The editorial concluded by saying:

> The public deserves to hear a much fuller debate about malpractice reform. One that includes legal experts and patients' advocates — not just the hospital leaders who used their insider status to push through this long-sought and self-serving goal.

The Committee is in agreement with the above statements.

## V.CONCLUSION

Based on the foregoing discussion, and because no evidence has been advanced to support the proposition that the amendments made by the Governor's proposal will reduce medical malpractice cases or significantly increase patient safety, the Committee **OPPOSES** the Governor's budget proposal. Such changes are significant policy changes that should not be considered as part of the State's budget process. Indeed, policy changes of this magnitude should be considered in a process in which ALL interested parties are well represented, not just a select few.