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HEARING ON PROFESSIONAL AND FINANCIAL BARRIERS

FACING WOMEN'S HEALTH CARE PROVIDERS

Testimony to the New York City Council

Committee on Health, jointly with the Committee on Women's Issues

January 31, 2012

250 Broadway, 14th Floor, NYC

Good afternoon. My name is Carol Pittman. I am a Community Affairs Representative at the New York State Nurses Association. The Nurses Association serves as the collective bargaining agent for more than 37,000 RNs at 150 healthcare facilities in New York State, 26,000 of whom work in the five boroughs.

The City Council's proposed Resolution calls upon the New York State Department of Financial Services and the New York State Department of Health to devise a comprehensive solution to address the financial and professional barriers to women's access to obstetric care, among them the high cost of medical malpractice insurance for healthcare practitioners.

The Nurses Association believes that the best approach to addressing the high costs of medical malpractice insurance for healthcare practitioners is to address the quality of care and the environments in which it is provided.

Let us take a look at some concrete barriers women's access to healthcare in the Bronx, from a study done by Bronx Health Link Inc:

- According to the 2010 census, 28.4% of Bronx residents live below the poverty line (38% of children). In 2005, 29% of adults under 65 were uninsured (US Census Bureau, 2010).
- Research conducted by the Bronx Health Link Inc. shows that preventing low-birth weight frees up $90,000 in funding and allows women to get access to the care that lowers their chances of producing low-birth weight infants (Lederer, 2011).
- The Bronx Health Link Inc. produced a study in June 2008 focusing on Mexican women's access to healthcare in the Bronx. All participants reported a lack of Latino physicians, the lack of cultural awareness about their community and the lack of translation services, which is significant because according to the 2010 US Census, 56% of Bronx residents speak a language other than English at home (Casado et al., 2008).
- Many of the women requested physicians that looked like them (Casado et al., 2008).
- The situation within the black community is similar, in which patients lack physicians that look like them. Approximately, 2.2% of U.S. physicians are African-American, versus 13% of the population. This is due to the systematic discrimination by the medical profession

against Blacks and Latinos (Casado, 2009). NYSNA supports all initiatives to expand the candidate pool and access to medical education for all ~~candidates of color~~. African American, Latino and other candidates of color from underrepresented communities.

The New York State Nurses Association knows these disparities in care can cause women to seek out medical attention later rather than sooner and inhibit the delivery of culturally sensitive care. These are issues that must be addressed in any comprehensive plan to address professional barriers to women's reproductive care.

By supporting a workplace that encourages best practices, both in caring for patients and in retaining its workforce, and by collecting and disclosing quality and staffing data, we can create a healthcare environment that reduces the incidence of adverse events and subsequently reduces the liability risk of healthcare practitioners.

The NYS Department of Health has implemented the Medical Indemnity Fund in the Medicaid Program, to provide a funding source for future healthcare costs associated with birth-related neurological injuries, in order to reduce premium costs for medical malpractice insurance coverage. The Indemnity Fund is anticipated to realize a savings of approximately $320 million in premiums. The Nurses Association believes a much more comprehensive approach needs to be taken to deal with this multifaceted issue.

The NYS Department of Health must participate in the development and implementation of quality improvement programs to enhance the quality of the care provided in New York's healthcare facilities. Practice guidelines, best-practices, evidence-based care and an experienced workforce must be incorporated into the care provided, in order to moderate the environment where adverse events can occur. The NYS Department of Health must incentivize the adoption of quality programs through enhanced reimbursed rates for both providers and hospitals.

Healthcare practitioners perform in a demanding, stressful environment where proper decision making is a critical function. Under-staffing has resulted in nurses working longer hours and caring for more acute and more complex patients. It is imperative that the State Legislature passes the Safe Staffing for Quality Care Act (S4553/A921) and that the NYS Department of Health implements the mandate. Ensuring safe staffing levels in hospitals will decrease patient complications and adverse events, improve the quality of care provided, improve the healthcare work environment and ultimately save healthcare system costs through decreased lengths of patient stay, decreased costs of medical malpractice related to avoidable occurrences, and decreased rates of nursing staff turnover.

In order to cultivate the safest healthcare delivery environment, we must ensure that the ban on mandatory overtime (Chapter 493 of the Laws of 2008, LAB 167), that went into effect on July 1, 2009 is enforced. It will ensure that nursing staff are working reasonable hours, protecting the public health and quality of patient care. We must dedicate the resources necessary to investigate and discipline healthcare facilities that violate this ban.

The Nurses Association also urges the New York City Council to call upon the NYS Department of Health to implement the Nursing Care Quality Protection Act that was signed by Governor Patterson on September 17, 2009 (Chapter 422 of the Laws of 2009, PHL 2805t) and was supposed to have been implemented in March 2010. This law would require hospitals to disclose certain nursing quality indicators along with their staffing mix, nursing care hours per patient day and nurse to patient ratios. This type of data would provide insight into the environment of care when an adverse event occurs, and would generate meaningful plans for improvement.

Lastly, we urge the New York City Council to call upon the state Legislature to pass the Reproductive Health Act (S2844/A6112). Enactment of this legislation would codify protections that confirm the right of individuals to make reproductive decisions. It establishes a right to privacy in making personal reproductive decisions and its enactment may encourage more providers to offer a full range of women's health services.

The high cost of medical malpractice insurance exists within New York's complex and flawed healthcare delivery system. As I've outlined, there are a variety of interventions that would address the multifaceted issues that contribute to these high costs. The New York State Nurses Association supports the Council of the City of New York's resolution to call upon the New York State Department of Financial Services and Department of Health to devise a comprehensive solution to address the financial and professional barriers to women's access to obstetric care.

Thank you for your time and consideration.

Testimony of Leslie Kelmachter, President
New York State Trial Lawyers Association (NYSTLA)

Before

New York City Council Committee on Health
Maria Del Carmen Arroyo, Chair
New York City Council Committee on Women's Issues
Julissa Ferreras, Chair

Tuesday, January 31, 2011

Introduction

My name is Leslie Kelmachter, and I am President of the New York State Trial Lawyers Association. I am testifying today on behalf of our 4,000 lawyer members, and their hundreds of thousands of clients. I am here to give the patient's view on the issues that are being discussed today and I want to thank the Chair for inviting us to speak at this hearing.

NYSTLA has always supported efforts to improve access to quality, affordable healthcare services, and the issue of access to obstetrical and gynecological care is of special importance to me. We have also supported comprehensive solutions to help stop medical mistakes before they happen, which hospitals and doctors in New York City have proven can improve patient outcomes and lower the costs of medical malpractice.

NYSTLA also believes, however, that as we work to find ways to improve the healthcare delivery system, we must not sacrifice the civil justice rights of patients who become victims of preventable medical errors, especially those whose injuries mean a lifetime of pain and constant care.

The City Council must approach this complex issue with all the facts at hand. Unfortunately, many of the assumptions in Council Resolution 84-A are misleading and create the false impression of a malpractice insurance "crisis," – one which lobbyists for the healthcare industry say demands that we significantly curtail the rights of the tens of thousands of patients who are hurt or even killed by inexcusable medical errors.

There Is No Medical Malpractice "Crisis" In New York

First, New York as a whole is not experiencing a shortage of OB / GYN practitioners. In fact, New York has the third highest ratio of ob-gyns to population of any state. According to a SUNY Albany Center for Health Workforce Studies estimate, this ratio is projected to increase -- from 2006 to 2030, the demand for ob-gyns is projected to rise increase by 0.9%, while the supply of will rise by 5.1%.

Nor is the rate of malpractice insurance premiums seeing exponential growth. According to a report from Public Citizen, between 1991 and 2007, the average annual malpractice premium increase in New York State was 3.5%, far less than the overall rate of healthcare cost inflation. In 2008 and 2009, New York's medical malpractice insurance premiums were unchanged and in 2010 the State's Department of Financial Services approved an increase of only 5%. In 2011, both the Medical Liability Mutual Insurance Company and Physicians Reciprocal Insurers -- which together insure the vast majority of New York physicians, approved a 7.5% "claims-free" discount, which will benefit over half of their insured physicians.

Contrary to Resolution 84-A, malpractice costs are not driving significant numbers of doctors away from our state. Every year, the SUNY Albany Center for Health Workforce Studies conducts an annual survey of graduating Residents. Of those who are planning to leave New York State, only 1% responded that the main reason for doing so is the cost of medical malpractice insurance in New York.

In addition, recent legislation enacted in Albany is already set to lower malpractice premium costs for New York ob-gyns. According to the Greater New York Hospital Association (GNYHA), the Medical Indemnity Fund for Neurologically Impaired Newborns, established in 2001, could reduce insurance costs for hospitals by as much as 20%.

As we have heard today, access to high-quality obstetrical and gynecological care in low-income and minority areas continues to be woefully inadequate. But what is driving the problem?

Liability Insurance Costs Are Not A Barrier To Healthcare Access in New York

There is little evidence that doctors' decisions on where to practice are determined by malpractice insurance costs. Medical malpractice insurance premiums are higher in New York City and the surrounding communities than upstate New York, but according to the SUNY Albany Center for Health Workforce Studies Annual New York Physician Workforce Profile, in 2009 there were 29% more physicians per population downstate than upstate. In Nassau County, which has the highest malpractice insurance premiums in the state, there were 85% more physicians per population than in upstate communities.

Healthcare disparities for low-income and minority patients are a nationwide problem, and New York City is far from unique in this regard. But state healthcare policy clearly

contributes to the problems we are hearing about today. In 2009, 75% of all deliveries in the Bronx, for example, were funded by Medicaid or Family Health Plus, compared to 45.7% statewide. Yet, in 2008, New York had the 47th lowest Medicaid obstetrical care fees, according to Kaiser Foundation State Health Facts. From 2003 to 2008, Medicaid reimbursement rates for obstetric care increased 8.8% nationwide, but were unchanged in New York, even as costs for doctors providing such care continued to rise.

Since 2008, Albany has raised Medicaid reimbursement rates for obstetrical care, but many years of having some of the lowest rates in the country have had an enormous impact on providers of ob-gyn services in low-income areas – and reimbursement rates are still too low.

Liability Premiums Could be Reduced Now

Although malpractice insurance costs are not the driver of health care disparities or doctor shortages, NYSTLA continues to support initiatives to lower these costs that do not sacrifice the rights of patients.

There is every indication, in fact, that rates for New York practitioners could be lowered right away without any changes to health care policy. In 2010, the Medical Liability Mutual Insurance Company, which insures most New York doctors, ran a surplus of $837 million, up from $491 million in 2009 and $162 million in 2006, all while the number of malpractice claims has continued to drop. MLMIC's new 7.5% discount for safe doctors is a good start, but there should be more reductions in premium prices immediately.

Curbing Medical Errors Is the Best Way to Save Money

But the biggest driver of malpractice insurance costs is tragic and preventable medical errors themselves. Numerous recent studies indicate that rates of hospital and doctor error can be significantly reduced simply by implementing rigorous patient safety programs and commonsense measures like checklists and mandatory hand-washing.

According to an article in the *American Journal of Obstetrics & Gynecology*, a comprehensive safety program implemented from 2003 to 2009 at New York Presbyterian-Weill Cornell Medical Center reduced yearly obstetric-related malpractice payment by 99%, saving $25 million a year while dramatically reducing maternal and fetal injuries. The program included steps as simple as enhanced communications among staff, improved medical record charting, standardized staffing requirements, proper training and supervision, and stricter controls on the use of dangerous medications.

The Hospital Corporation of America, a nationwide chain of hospitals, implemented a "comprehensive redesign of patient safety processes" in obstetrics that more than halved the number of obstetrical claims against HCA facilities and resulted in "nearly a 5-fold reduction in the cost of claims" according to an article in *American Journal of Obstetrics and Gynecology*. "In this large health system, with nearly 200 hospitals nationwide, obstetric malpractice claims currently rank behind 'accidents on hospital grounds' in terms of litigation loss and cost," the study's authors wrote.

If New York Presbyterian-Weill Cornell and HCA can do this, so can others. Unfortunately, many New York hospitals have a long way to go when it comes to leadership in patient safety. The annual HealthGrades Patient Safety in American Hospitals Study for both 2010 and 2011 ranked New York as one of the ten "worst" states for hospital patient safety. And in 2010, the U.S. Agency for Healthcare Review and Quality reported in its annual National Healthcare Quality Report that New York State's "hospital care quality" is "weak" based on how well hospitals performed on 31 measures of care quality.

Conclusion

We can do better than this. NYSTLA stands ready to work with elected leaders in the City Council and partners in the healthcare industry to find every way possible to improve patient safety, increase quality of care, and as a result lower medical malpractice costs and greatly improve patient outcomes.

Thank you again for giving me the chance to submit this testimony today.

Testimony of Mary Walling, Esq.
New York State Trial Lawyers Association (NYSTLA)

Before

New York City Council Committee on Health
Maria Del Carmen Arroyo, Chair
New York City Council Committee on Women's Issues
Julissa Ferreras, Chair

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PATIENT SAFETY AND TRAINING PROGRAMS
- THE MOST EFFECTIVE WAY TO REDUCE COST -

1. In December 1999, Institute of Medicine reported that *"medical errors cause up to 98,000 deaths and more than 1 million injuries each year in the United States."* The response - major initiatives to improve patient safety were announced nationwide.

2. In November 2010, a study published in the New England Journal of Medicine found that 10 years later *"harm resulting from medical care remains very common"*. The findings were "*disappointing*" but "*not entirely surprising*" as *"the penetration of evidence-based safety practices has been quite modest..."* The study called for new efforts to focus on those patient safety initiatives that did work.

Patient Safety Performance in New York Hospitals

3. Meanwhile, in 2010, U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, ranked New York 36th out of the 50 states in the overall quality of hospital care, finding it to be *"weak"* as compared to that of all other states.

4. The annual HealthGrades Patient Safety in American Hospitals Surveys for both 2010 and 2011 scored New York's "Overall Average" for hospital safety in a study of Medicare patients to be among the *"Bottom 10 States"*.

Successful Patient Safety Initiatives

5. In June 2005, the Wall Street Journal reported that 20 years earlier *"some anesthesiologists chose a path many doctors in other specialties did not. Rather than pushing for laws that would protect them against patient lawsuits, these anesthesiologists focused on improving patient safety. Their theory: Less harm to patients would mean fewer lawsuits."* The results: "*Over the past two decades, patient deaths due to anesthesia have declined to one death per 200,000 to 300,000 cases from one for every 5,000 cases*" – a 40-fold drop. "*Anesthesiologists typically pay some of the smallest malpractice premiums around. That's a huge change from when they were considered among the riskiest doctors to insure."*

6. In December 2006, a study published in the New England Journal of Medicine reported that "*Each year central venous catheters cause an estimated 80,000 blood-stream infections and result in up to 28,000 patient deaths in ICUs."* To address this problem in Michigan, the Michigan Keystone ICU Patient Safety Program was implemented at 108 ICUs, which included measures like hand washing, removal of unnecessary catheters and using full-barrier precautions during the insertion of central venous catheters. "*The program resulted in up to a 66% reduction in catheter-related bloodstream infection rates."*

7. In August 2008, the American Journal of Obstetrics and Gynecology reported that the Hospital Corporation of America, through a comprehensive patient safety program in obstetrics, *"had more than halved the number of obstetrical claims against HCA facilities and resulted in nearly a 5-fold reduction in the cost of claims... [W]ith nearly 200 hospitals nationwide, obstetric malpractice claims currently rank behind `accidents on hospital grounds' in terms of litigation loss and cost."*

8. In November 2009, The Joint Commission Journal on Quality and Patient Safety reported that a comprehensive perinatal patient safety program implemented by Catholic Healthcare Partners (Cincinnati) at 16 perinatal centers had "*resulted in a 65% decline in obstetrical occurrences (a 'birth-related event or injury that may lead to a*

claim')" and *"the average cost per obstetrical claim fell from $1 million to less than $500,000 and the number of new claims reported decreased by 48%."*

9. In April 2010, the RAND Corporation issued a study showing that "*Reducing the number of preventable patient injuries in California hospitals from 2001 to 2005 was associated with a corresponding drop in malpractice claims against physicians*"; demonstrating "*a link between improving performance on 20 well-established indicators of medical safety outcomes and lower medical malpractice claims.*"

Successful Patient Safety Initiatives in New York

10. In February 2011, *American Journal of Obstetrics & Gynecology* published a study of a comprehensive obstetrics safety program that had been implemented in 2002 at New York Presbyterian Hospital. The results were dramatic: "*The average yearly compensation payment in the 3 years from 2007 to 2009 was $2,550,136 as compared with an average of $27,591,610 in the previous 4 years (2003-2006), a yearly savings of $25,041,475 (total: $75,124,424) during the last 3 years... For the last 6 years, there has been no maternal death on labor and delivery... [N]o permanent Erb's palsy since we began shoulder dystocia drills in 2008... Since 2007 there was only one infant born of a total of 15,932 deliveries with the diagnosis of hypoxic ischemic encephalopathy (HIE) ... [and] that infant had no moderate or severe neurodevelopment impairments.*"

Insurance and Risk Management Companies invested in Patient Safety to Reduce Costs

11. Controlled Risk Management Company (CRICO), serving 21 hospitals, more than 12,000 physicians (including residents and fellows), and 207 other health care organizations in Harvard medical community, writes that it "*uses medical malpractice data to help hospitals across the nation dramatically reduce medical errors and minimize financial loss... offer[ing] proven methodologies and data-driven insights that reveal hidden areas of risk and deliver actionable intelligence to drive fundamental change that transforms the safety of patient care...*"

12. "[P]reventable medical errors...[are] a serious public health problem... errors designed into our systems are waiting to be made...What would it look like if

leaders were to direct attention to the issue of medical error?...When errors occur, we would learn and prevent, rather than blame and hide... Our patients would be injured less often, and health care costs would go down considerably...frivolous' malpractice suits are less common than the politicians espousing them... Rather than dwell on the frivolous bogeyman, politicians, and health care providers will likely be more successful at reducing patient injuries, costs, and lawsuits by studying the underlying causes of the malpractice cases that reflect suboptimal care and present opportunities to repair flaws in the health care delivery system. Seriously...

13. "For more than 20 years we have used closed claims and suits as powerful teaching tools."

14. In 2008, the rate of paid claims per 1,000 physicians was 15.7 in New York and 11.12 nationally. For CRICO it was 4.0 – almost 3 times lower than the national average and almost 4 times lower than that in New York. For CRICO itself, the rate of claims dropped from 2.81 per 100 physician coverage years in 2000 to 2.04 in 2009, a drop of more than 25%.

15. "In 2001, CRICO...introduced an incentive for anesthesiologists who received training in Crisis Resource Management ... CRICO believes that this has made a difference and has since tripled the incentive, which is now 19%."

16. In 2004, *"a 10% incentive was implemented for OB/GYN physicians who participated in either a simulation-based training program ..."* In 2007 it was reported that *"CRICO claims have been trending lower at those institutions with active team training or simulation training. CRICO... is now planning additional incentive programs in other specialties ..."* That same year CRICO also reported that *"preliminary results [for its OB discount program] at BIDMC [Beth Israel Deaconess Medical Center], the location for the first team training, are very encouraging. In the three years prior to team training, BI had 7 OB claims and suits with 5 (71%) being high severity. In the three years post training, claims and suits dropped to 2 and high severity to 1. Another measure, the Adverse Outcomes Index ...shows a 55% drop over the same period of study. This would tend to validate the claims experience."*

17. In 2008, Robert Hanscom, CRICO vice president of loss prevention and patient safety, stated that *"[Many insurers] focus on tort reform to reduce malpractice costs, but I don't think that's the answer...The answer is prevention, which means making*

sure institutions provide as highly reliable an environment as possible." When asked at a MRT hearing, in October 2011, if that was still his position, he said, "*oh yes...I feel as if I'm telling that to someone every other day.*"

18. City of New York Office of the Comptroller Claims Report for Fiscal Years 2009 & 2010 stated that "*Since FY 2001, HHC has been pro-active in the areas of risk and litigation management with impressive results. The number of tort claims against HHC has dropped 26 percent since FY 2001... [T]heir efforts have resulted in a decrease in overall medical malpractice claim filings from a high of 889 in FY 2000 to 650 in FY 2010, the lowest number of new filings in the last 11 years. Settlement costs have also decreased significantly. In FY 2003, the City paid a 10-year high of $195.4 million for medical malpractice claims. In contrast, the City paid $130.1 million in FY 2010, the second lowest payout in the last 11 years.*"

19. In the fall of 2011, The American Journal of Maternal/Child Nursing published a study by two perinatal safety nurses at NY Presbyterian Hospital and Yale-New Haven Hospital which showed that since implementing a comprehensive perinatal patient safety program, with the help of their carrier, MCIC Vermont Inc., the rate of ob claims had dropped dramatically (67%).

20. Medical Risk Management, based in Connecticut, writes that it has a "*proven track record of reducing malpractice claims, premiums, and improving patient safety through a comprehensive risk management education program and consulting services...Beginning in 2006 MRM and Connecticut Surgical Group have worked together in reducing malpractice claims by 89%...Since 2003 MRM and ProHealth Physicians have worked together to reduce their malpractice premiums by over 50%.*"

21. The Sullivan Group, a risk management company based in Illinois, writes that *"[o]ver 600 clients have instituted The Sullivan Group's Emergency Medicine Risk Initiative (EMRI®), which includes web-based patient safety education, real-time risk management tools at the bedside, and web-based performance appraisal with feedback to the emergency department team. The results have been dramatic. One client with over 180 hospitals has reduced its emergency medicine malpractice claims by 38% over a 3-year period and removed tens of millions of dollars from company malpractice reserves."*

Supporting Women's Health

Everyone wants to ensure that New Yorkers have access to the healthcare services they need. Proposed Resolution 84-A would not advance this goal. The real issues facing women's health services include wholly inadequate health provider reimbursement by Medicaid and commercial insurers and too little financial assistance in caring for the uninsured. We should also be focusing on the critical role of improving patient safety and reducing the number of medical errors in preventing injuries and deaths and saving scarce healthcare dollars, which can be reinvested in preserving and expanding services.

New York's med mal premiums have not contributed to physician shortages.

- **In fact, New York ranks 4th in the US in physicians to population and from 2003 to 2009, New York's physician-to-population ratio increased 5%** (compared to 3% in Texas, which enacted "tort reform" in 2003). New York has been steadily gaining physicians -- 51,193 in 1995, 64,818 in 2009.

- **New York has the 3rd highest ratio of ob-gyns-to-population of any state**, according to American Medical Association data. It is clear, therefore, that **the malpractice insurance premiums have not impacted the supply of ob-gyns.** And a 2010 study by the SUNY Albany Center for Health Workforce Studies projected that from 2006 to 2030 the supply of ob-gyns in New York will grow faster than demand.

- **Malpractice costs are not driving doctors away from the city.** Medical malpractice insurance premiums are significantly higher downstate than upstate, but according to the SUNY Albany Center for Health Workforce Studies *Annual New York Physician Workforce Profile*, in 2009 there were 345 full-time-equivalent physicians per 100,000 population downstate compared to 244 per 100,000 upstate – a 29% difference. In Nassau County, where physicians pay the highest premiums in the state, there were **452** full-time physicians per 100,000 population.

  Moreover, according to the SUNY Albany report, in 2009 Nassau County had 22 full-time equivalent ob-gyns per 100,000 population versus 16 statewide. Yet Nassau County ob-gyns pay the highest medical malpractice insurance premiums in the state and in 2009 Nassau County's birth rate was lower than the state rate.

Ob-gyns are not relocating to other states.

- **Physicians are not relocating to other states.** There is no evidence of this at all. One good indication that medical malpractice premiums are not an important factor in deciding where to practice are the results of the SUNY Albany Center for Health Workforce Studies annual New York Residency Training Outcomes Survey. Residents leaving their programs are asked where they plan to practice. Residents who stated they are planning to leave New

York were asked why. In the most recent survey, an inconsequential **1% responded that the main reason for doing so is the cost of medical malpractice insurance in New York.** The cost of medical malpractice insurance was ranked below other reasons such as, "New York's taxes" (2%), New York's "cost of living" (4%), "better job for spouse/partner outside New York" (5%), "better jobs in a desired practice setting outside of New York" (8%), "better salary outside of New York" (10%), "better jobs in desired location outside of New York" (12%) and "proximity to family"(32%).

- **Premiums are competitive with neighboring states.** Medical malpractice insurance premiums charged in Manhattan by the Medical Liability Mutual Insurance Company, which insures the majority of New York physicians, are significantly less than premiums insurers charge in New Jersey and Connecticut. MLMIC premiums in Brooklyn, Queens, the Bronx and Staten Island are virtually the same or very close to New Jersey and Connecticut, according to *Medical Liability Monitor*. They are less than premiums on Long Island.

New York medical malpractice insurance premium increases over the last two decades have been moderate.

There is no medical liability "crisis" as alleged in the proposed Resolution. According to the consumer advocacy organization Public Citizen, "The average rate hike [in New York] between 1991 and 2007 was only 3.5 percent, or slightly more than half the overall U.S. medical inflation rate (6.5 percent)." In 2008 and 2009 New York's medical malpractice insurance premiums were frozen and in 2010 the State approved an increase of 5%. And in 2011, the Medical Liability Insurance Company (MLMIC) and Physicians Reciprocal Insurers, which covers the vast majority of New York's physicians, approved a 7.5% reduction for more than half their physician policyholders.

The reasons women in low-income communities are less likely to receive obstetrical services have nothing to do with medical malpractice insurance premiums.

Among the real contributors are:

- *Medicaid pays far too little.* The Kaiser Foundation reports that as recently as 2008 New York had the 47th lowest Medicaid obstetrical care fees relative to the national average. Rates have been raised some since then but still remain far below real costs. Clinics and other providers of ob-gyn services are therefore under enormous financial pressure.

  For years, a disproportionately large share of government healthcare funding has gone to advanced acute care, specialists and hospital inpatient services and too small a share to primary care, including obstetrical and women's health providers. This imbalance is only now beginning to be addressed by the State and federal governments.

- *The large numbers of uninsured New Yorkers adds to the financial burden of healthcare providers, especially in low and moderate-income communities.* According to the New York City Department of Health and Mental Hygiene's 2009 Community Health Survey, between 20% and 30% of the residents of Northern Manhattan, Western Queens including communities such as Flushing and Elmhurst, and Brooklyn communities such as Sunset Park

and Canarsie, are uninsured. In 2007, 52% of births in NYC in 2007 were to foreign-born women, up from 48% in 1998; many of these women were uninsured.

Another threat to obstetrical services for lower-income women: hospital closures.

St. Vincent's and St. Mary's were among the hospitals that had obstetrics departments that closed in recent years. Now five Brooklyn hospitals that serve mostly lower-income patients are threatened with merger and/or closure and several of them have obstetrics departments.

Medical malpractice payments are not the reason these hospital are on the edge. Hospitals in low-income communities simply do not have enough revenue. Medicaid reimbursements remain far below costs. A *New York Magazine* article in 2010 on the closure of St. Vincent's Medical Center and the financial crisis facing hospitals that mostly serve lower-income patients reported, "The hospital industry complains that since 2007 the New York State Legislature has cut Medicaid funding nine times, at a cost of $900 million to local hospitals."

Hospitals also lose money treating uninsured New Yorkers, inasmuch as the State's Hospital Indigent Care Pool underpays hospitals that account for the lion's share of uncompensated care, placing an additional burden on many hospitals in lower-income communities. The 2010 *New York Magazine* article quoted Joel Perlman, the chief financial officer of Montefiore Medical Center, saying that 80 percent of the cost of treating the uninsured is absorbed by the hospital.

Ensuring that hospital services, including obstetrics, remain readily available to all communities, including low-income communities, must be a top priority for the New York State Department of Health.

Hospital medical malpractice insurance costs are heading down.

According to the Greater New York Hospital Association, obstetrics accounts for 35% to 50% of hospital medical malpractice payments. **These payments will be lowered substantially by the Medical Indemnity Fund for Neurologically Impaired Newborns which was enacted last year.** According to GNYHA in March 2011, "actuaries estimate [the Fund] could reduce hospital costs by as much as 20%."

Costs could come down further if hospitals and doctors get serious about patient safety.

Hospital obstetric medical malpractice can be additionally slashed by reducing medical errors.

- New York Presbyterian –Weill Cornell Medical Center implemented a comprehensive safety program, including enhanced communications among staff, improved medical record charting, standardized staffing requirements, proper training and supervision, and controlled medication usage. According an article in the *American Journal of Obstetrics & Gynecology*, **from 2003 to 2009 yearly obstetric-related malpractice payment totals were reduced by 99% and obstetric liability payments by $25 million per year.** Maternal deaths and other injuries during labor and delivery were eliminated. If New York Presbyterian-Weill Cornell can do this, so can others.

- Outside of New York, at Hospital Corporation of America hospitals, a "comprehensive redesign of patient safety processes" in obstetrics more than halved the number of obstetrical claims against HCA facilities and resulted in "nearly a 5-fold reduction in the cost of claims" according to an article in *American Journal of Obstetrics and Gynecology.* "**In this large health system, with nearly 200 hospitals nationwide, obstetric malpractice claims currently rank behind `accidents on hospital grounds' in terms of litigation loss and cost**," the authors wrote.[1]

Obstetricians are not cutting back because of medical malpractice insurance.

The proposed Resolution claims that the "medical liability crisis" has "forced some ob-gyn physicians to cut back on the scope of their business." But according to a study reported in the *Journal of Family Practice* of whether New York physicians facing higher medical malpractice insurance charges are more likely to discontinue obstetric practice than physicians experiencing smaller increases, "There is no relationship between the level of increase in liability insurance premiums and the likelihood of discontinuing obstetric practice in New York."[2]

Some ob-gyns are cutting back because **reimbursement rates are too low**. About half of deliveries in New York City are covered by Medicaid, which, as explained above, reimburses far too little. Commercial insurance reimbursement rates are also much too low. As ACOG noted in a 2008 issue paper:

> "It has become cheaper to have children delivered by qualified professionals than to pay for many other everyday services and expenses. For example, most laptop computers now cost much more than it does for an ob-gyn to deliver a baby. Plumbing repair services can reach $5,000 or more, and replacing a household furnace could reach $3,000...
>
> Frustration has also been documented in ACOG District II/NY member surveys regarding inadequate reimbursement rates by commercial insurers, with 41% of respondents reporting a delivery reimbursement rate between $1,500 and $2,500, and 11% receiving below $1,500. Obstetrical care continues to be a dangerously undervalued service and unsustainable profession in New York State."

Another important reason: **Obstetrics is one of the most personally demanding and exhausting fields of medical practice**. Ob-gyn physicians must be on call at night and on weekends. An increasing proportion of ob-gyn physicians are women, who often still bear the primary burdens of maintaining a household and raising a family.

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[1] Clark et al, "Improved outcomes, fewer cesarean deliveries, and reduced litigation: results of a new paradigm in patient safety," *American Journal of Obstetrics and Gynecology*, August 2008.

[2] Grumbach K, Vranizan K, Rennie D, Luft HS, "Charges for obstetric liability insurance and discontinuation of obstetric practice in New York," *Journal of Family Practice*, May 1997.

Ob-gyns are not giving up obstetrics in New York any more than they are nationally.

The proposed Resolution cites a report by the American Congress of Obstetricians and Gynecologists that since 2003, 66.3% of New York ob-gyns "have made one or more changes to their practice due to the affordability and/or availability of professional liability coverage." In fact, that survey found that ***69.8% of ob-gyns nationally*** reported making changes due to the affordability or availability of professional malpractice insurance; these include states that have adopted so-called "tort reform" measures long promoted by ACOG such as caps on payments to malpractice victims.

In fact, for decades ACOG has been saying that across the U.S. obstetricians have quit delivering babies or cut back their practice because of high premiums. In September 1988, *Health and Fitness News Service* reported, "Obstetricians are packing up their fetal monitors and calling it quits, according to a survey by the American College of Obstetricians and Gynecologists (ACOG). Last year 12 percent left the field because of increasing malpractice suits and the rising cost of malpractice insurance."[3] A subsequent ACOG member survey found that from 1999 to 2003 one-in-seven ob-gyn physicians had stopped practicing obstetrics because of the risk of medical liability claims.[4] If all of the ob-gyns that ACOG surveys say were cutting back or quitting really did so, there would hardly be any left today. And it's no wonder their surveys are unreliable. In ACOG's most recent national member survey in 2009 **only 5,644 of 31,655 of ob-gyn physicians surveyed responded.** Credible conclusions about all ob-gyns cannot be drawn from this small, unscientific sample, in which ob-gyns for whom these costs are a concern would be more likely to respond.

New York's medical malpractice insurance companies can and should reduce physician premiums.

In 2010, the Medical Liability Mutual Insurance Company, which insures most New York doctors, had a surplus of $837 million, up from $491 million in 2009 and $162 million in 2006. Net income was $301 million in 2010, up from $107 million in 2009 and $55 million in 2008. The number of medical malpractice case filings in New York has declined steadily over the last several years and in 2010 there were fewer filings than in any year since at least 1995. MLMIC's recent 7.5% discount is welcome, but there should be more reductions.

Indeed, trends point to fewer medical malpractice claims and lower premiums in the future. The number of medical malpractice case filings in New York has declined steadily over the last several years and in 2010 there were fewer filings than in any year since at least 1995.

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[3] Accessed at http://articles.sun-sentinel.com/1988-09-06/features/8802210200_1_obstetricians-malpractice-insurance-six-days

[4] Jennifer Silverman, "ACOG survey: one in seven quit obstetrics from 1999 to 2003." Accessed at http://findarticles.com/p/articles/mi_m0CYD/is_16_39/ai_n6179301/

A program in which a provider whose negligence injured a patient apologizes and offers a settlement disadvantages patients.

The proposed Resolution praises a program at the University of Michigan Health System in which a provider whose negligence injures a patient apologizes and offers a settlement. Offering so-called "fair" compensation in this manner sidesteps the civil justice system and severely disadvantages patients who are harmed by medical negligence. Apology-settlement offer programs have no judge, no jury, no right to counsel to safeguard fairness to injured patients. Patients without counsel after suffering a major injury fee are pressured to resolve their cases too soon, and for less compensation than they need for their injuries. There may be fewer claims and they may be resolved faster under such a program, but the cost is denying many patients and families fair and necessary compensation. Furthermore, programs like Michigan's eliminate some of the incentive to improve safety that is afforded through the civil justice system, which holds wrongdoers accountable for their mistakes.

These programs are especially disadvantageous to people of color because, unfortunately, they are disproportionately hurt by medical malpractice. Dozens of studies published in major academic journals in recent years have established how people of color experience more missed diagnoses, delayed treatment and interventions, and poorer quality of care generally. A study by the Institute of Medicine of the National Academies found, "U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services." The U.S. Agency for Healthcare Research and Quality reported that healthcare quality for Hispanics and African Americans in New York is lower than in nation as a whole.

There are important measures that New York State can and should take to improve healthcare services to women in New York City.

In addition to ensuring that *all* communities be well-served by hospital obstetrics departments, to ensure that there is quality and safe women's health services:

- **The Department of Health's Office of Professional Medical Conduct can and should do much more to prevent incompetent, unsafe ob-gyns from continuing to practice medicine.** A study issued in 2007 by the public interest group Public Citizen found that in New York only four percent of physicians accounted for 49.6% of dollars paid for malpractice incidents since 1991 and only 10.8% of these doctors had received licensure actions.[5] Considering that obstetrics accounts for up to half of hospital medical malpractice payments, keeping incompetent ob-gyn physicians from practicing would not only save lives and prevent injuries among women and their newborns, it would dramatically reduce the incidence and cost of malpractice.

- **To help reduce hospital medical errors in obstetrics and gynecology, the Department of Health's hospital medical adverse event reporting system, the New York Patient Occurrence Reporting and Tracking System (NYPORTS), should be restored and reinvigorated.** When implemented in the 1990s, NYPORTS was to be the Health Department's primary means to find out about adverse events in hospitals so that they can

[5] Public Citizen, *op cit.* p 24.

intervene and ensure that unsafe conditions are corrected. However, various reports over the years, include a report on NYPORTS in 2009 by the NYC Comptroller, documented that many hospitals largely ignore adverse event reporting requirements, An article about NYPORTS in the Hearst Newspapers in 2009 was headlined, "Once groundbreaking, N.Y. system now dysfunctional."[6] Indicative of the low priority NYPORTS is assigned at the Department of Health: the program has no dedicated no full-time staff and it issues its annual reports years late.

[6] Kyla Calvert, "Once groundbreaking, N.Y. system now dysfunctional," *Hearst Newspapers*, July 30, 2009.

Testimony by Iffath Abbasi Hoskins, MD, FACOG
Chair of OBGYN and SVP at Lutheran HealthCare in Brooklyn Representing
Lutheran Medical Center, Lutheran Family Health Centers and
The American College of Obstetricians and Gynecologists,
District II

Before
The Committees on Health and Women's Issues of the New York City Council
Joint Oversight Hearing on Professional and Financial Barriers Facing Women's Health Care Providers

Proposed Resolution NO. 84-A
Calling Upon the New York State Department of Financial Services and the New York State Department of Health

January 31, 2012 at 1:30PM
14th Floor Committee Room
250 Broadway
New York, NY

Thank you, Council Members for recognizing that meaningful medical liability reform in New York City must become a reality for the sake of women's health and their newborns. As south Brooklyn's community health care safety net, we know that this reform is necessary to preserve critical access to prenatal and postnatal care – it creates better outcomes, healthier babies and healthier moms.

My name is Dr. Iffath Abbasi Hoskins, I am a practicing obstetrician-gynecologist and a sub specialist in Maternal Fetal Medicine (high risk/complicated obstetrics) at Lutheran HealthCare in Brooklyn. That includes the

medical center along with our community network of federally qualified health centers from Flatbush to Park Slope to Sunset Park, Bay Ridge and beyond. This special and unique network enables us to truly develop the special bond between mom and provider that fosters the best type of care navigation – we have a relationship with our patients.

I am here both as a representative of the New York State District of the American Congress of Obstetricians and Gynecologists - (ACOG) and as the Senior Vice President, Chair and Residency Director in the Department of Obstetrics and Gynecology at Lutheran. More importantly, I'm here representing more than 4,300 Brooklyn moms and families whose pregnancies we nurture to provide save births and the newborns we care for from cradle to career.

ACOG is the national leading group of board certified physicians providing health care to women. It is are a public and private organization of about 55,000 members nationally and 4,500 in New York State. Our mission is to advocate for quality health care for women while maintaining high standards of clinical practice and education for our members. I am a former national Vice President of ACOG – and currently serve as the Director of Communications in New York, where I also serve on the Legislative Committee.

ACOG opened an office in the 1980's in Albany to begin to lobby the legislature on the problems of medical liability insurance. Since this time, we have

been trying to achieve meaningful medical liability reform. This issue has been a top priority for our ACOG members for over 20 years.

The facts about our specialty are startling:

Nearly 95% of New York ob-gyns have had at least 1 medical liability claim filed against them during their careers. 95% of New York ob-gyns ARE NOT bad doctors – yet we continued to be burdened with astronomical and uinte4ndable malpractice rates.

An ob-gyn in New York State can expect to be sued over 3 times in their career – that is higher then the national average. The rising amount of an obstetric claim contributes to the rising costs of our liability premiums. Because of the cost of liability insurance, many ob-gyns quit obstetrics. In 2007, sixty-three (63) ob-gyns dropped obstetrics and practice only gynecology; 122 ob-gyns changed their coverage to "uncomplicated obstetrics" – (no surgery – no c-sections) and 30 obstetricians were non-renewed by their insurance carrier. These numbers are representative of only one insurance company in New York.

If an ob-gyn decides to stop practicing obstetrics their liability rate can drop by more then three-fourths. For example, an ob-gyn practicing in the Bronx will pay about $176,000 in annual premiums. However, if that same ob-gyn decides to stop delivering babies their rate is reduced and he/she would pay about $40,000 in annual premiums. $176,000 to $40,000 – why wouldn't you give yourself a

$130,000 raise, stop getting up in the middle of the night and end the constant threat of a lawsuit.

As a Chair and Residency Director at Lutheran, I am well aware that medical students think twice about choosing obstetrics and gynecology as their preferred specialty. I've spoken to these young people (including our own graduating resident physicians) and they fear the litigation rates and high medical liability premiums in New York State. More and more of these resident physicians graduate from the finest obstetric and gynecologic training programs in New York City – and then simply leave New York State. This is a drain of our most valuable treasures—our bright, well-trained doctors. Why should our own communities be deprived of this talent?

For years you have heard my colleagues speak about the medical liability crisis and how it affects physicians in New York State. Medical liability premiums are driving individuals away from our maternity care system. Unfortunately, many doctors are now being forced to make the decision to stop performing high-risk procedures and/or give up delivering babies completely. Almost 70 percent of my ob-gyn colleagues who were recently surveyed by ACOG, reported making drastic changes to their practices, including decreasing the number of high-risk obstetrics patients they see, increasing the number of c-sections they perform, or giving up obstetrics all together. Is this the right recipe for high quality care? No! Does this

support the right to access for every woman regardless of her ability to pay? Certainly not!

There are currently no ob-gyn private practices in the Bronx – they simply cannot afford to practice independently. Let me repeat: No private ob-gyn practices in the entire borough of the Bronx. Doesn't that astound you? Hospital labor and delivery units are closing throughout the city – for example in 2008, Brookhaven Memorial Hospital Medical Center's closed its maternity ward and delivery room services, Victory Memorial Hospital's labor and delivery unit closed in 2007, Sidney Hospital's obstetrical services closed in 2004, Elizabeth Seton Birthing Center's Manhattan location closed when its carrier raised premiums by 400%, and Brooklyn Birth Center closed in 2003 when its insurer ceased to provide malpractice insurance for midwives. In 2008 Long Island College Hospital threatened to close their maternity department. You have to ask yourself – which facility will be next to shut their doors on women and babies? Then ask yourself – how can this happen – in AMERICA –in 2012? When an obstetrical unit is shut down, the entire community suffers. Patients in need will likely lose access to quality and affordable health care. Female patients who are at high-risk can't find a doctor who's close by making her chances of prenatal care tougher to find. Providers and new mothers develop a significant relationship over 9 months of pregnancy that supports medical care compliance, and it breaks down barriers.

What is happening in New York State today, is the Berlin Wall of maternity care and it must come down -- we need to break down these barriers to access and health compliance for the sake of moms and babies everywhere and particularly in our most vulnerable populations that safety net systems like Lutheran serve.

Of course, any type of medical negligence must be dealt with appropriately. Over the years, New York ACOG has developed obstetric risk reduction strategies such as: hands-on simulation, protocol adherence, post graduate education, multi-year hospital obstetric initiatives, and in-office quality improvement audits that have improved maternal outcomes. ACOG strives for public policy incentives that translate these risk reduction strategies into ob-gyn medical liability premiums reductions.

ACOG has worked tirelessly for measures that would lower liability premiums and keep ob-gyns in practice in this state. At the same time, safety net providers are advocating and increasing access to maternity, prenatal and postnatal care. This recipe works. We have advocated for a no-fault compensation fund for neurologically impaired infants and a CAP non-economic damages for pain and suffering. Access to maternity care for New York City women is getting harder and harder to achieve.

Governor Cuomo and the legislature worked hard to make changes to the medical liability system, but the ultimate result has not proven to be very helpful

for the individual, private practicing ob-gyn or the community safety net that struggles each day – even one like Lutheran that has survived for more than 129 years. There is little evidence yet, that the program created in 2011 will continue to reduce liability premiums for private ob-gyns. I will let others in the room discuss this new system.

Let me finalize my remarks here by saying that the current medical liability system hurts the patient/physician relationship; it encourages the practice of purely defensive medicine; it leaves most malpractice victims uncompensated; is slow and cumbersome; it expends more than half of its income in overhead and transaction costs; it generates a high level of uncertainty regarding results for both physicians and truly injured patients; it impedes the predictability of costs for insurers; and it produces widely differing monetary awards for comparable victims.

For the sake of pregnant women throughout New York City, I hope this council can influence policy makers to make statewide reforms and long term cost-saving measures in the area of women's health. We must ensure that all women in New York have access to high quality maternity care. We live in one of the greatest cities in the world. The women of New York City – and their babies – deserve better.

David A. Friedman, MD FACOG
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January 31, 2012

New York City Council Hearing on Proposed Res. No. 84-A: Malpractice Crisis

First I would like to thank the Members and Staff of the Council for holding this hearing. The malpractice crisis in New York City has reached a level where the benefits of unfettered access to the courts for medical malpractice cases is being abused, and actually harming access to quality health care for all New Yorkers.

I would like to use my own recent experience as an example of the unfortunate path we are all headed if reforms are not instituted.

I was paying $168,000.00 per year for an OB/GYN policy in Brooklyn. I found that, combined with decreased reimbursements for Deliveries, I could not afford to continue Obstetrics in New York. My choice was to move out of New York, or stop OB.

I chose to stop OB, and moved my office from Brooklyn to the Upper East side. This cut my rates by $100,000.00 per year.

I am not alone. Many of my colleagues are doing the same thing. Every week I see more Docs at Lenox hill who used to practice in Brooklyn, but now are in Manhattan intead. This is because Malpractice rates are 20% lower in Manhattan, due to lower Jury awards.

The old Canard that a few bad Doctors spoil it for the rest of us simply is not true. Malpractice rates have very little to do with the quality of the care you deliver. It mostly has to do with which county you practice in. I was the same Doctor in Brooklyn that I was in Manhattan, but the rates dropped once I crossed the River.

I would like to draw your attention to the list of Annual Malpractice rates by county in New York State for OB/GYN's for the MLMC.

You can see that the rate for Syracuse, in Onondaga, is only 51k as compared to 166k in Brooklyn. It is not that the Doctors in Syracuse are over 3 times better than those in Brooklyn. It is that the Juries in Brooklyn are much more likely to give out high awards than those upstate.

Onondaga $51,068.00

Saratoga $51,068.00

Suffolk $181,132.00

Nassau $181,132.00

Bronx $171,233.00

New York $135,964.00

Queens $166,243.00

Kings $166,243.00

Richmond $171,233.00

Additionally, I would like to point out that the dramatic gains we, as OB/GYN's, have made in cutting the Maternal Mortality rates are being undermined by these impossibly high malpractice rates. In the last 100 years, we have been able to expect that Maternal Mortality rates would go down each year. Now, as fewer Doctors are available to deliver these babies in high risk population groups, we have seen an unprecedented and unacceptable rise in maternal deaths.

This is especially associated with a high Cesarean Section rate. And we now know that OB's often perform Cesareans to avoid being sued. This often leads to higher complications, including death. We can now draw a line between legal abuse and adverse medical outcomes.

The fields of Obstetrics and Gynecology were once two separate specialties. Ever since they merged, women and children's health care has improved exponentially. Now that more and more Doctors cannot afford to practice OB, the fields are splitting up again, with more Docs like myself focusing on Gynecology only. This reverses the strides we have made in women's health over the last century.

Access to care is not only limited by Doctors Giving up Obstetrics. More Doc's have stopped participating in HMO's in order to afford the high malpractice rates. This means that the Doctor my still be in the community, but financially out of reach for most patients.

Other Doctors limit the high-risk patients they care for, or high-risk procedures they perform, to avoid lawsuits.

It all boils down to more money being spent on defensive medicine and legal fees (estimated at hundreds of Billions of Dollars) and less access to basic quality healthcare.

What can we do about it? There are a Few solutions.

1. Limits on Pain and suffering awards. This was done successfully in Texas, and was proposed by Governor Andrew Cuomo here in New York.
2. Loser Pays, No-fault, or Pre-trial certification Boards have all been suggested or tried as well
3. Medical courts with specialized judges, and no juries, like family and Tax courts would take the unpredictable nature of Jury awards out of the system.
4. Allowing Doctors to Buy into the New York City pool that already covers employed Doctors, would help alleviate the situation until we can get state action.

One thing we know for sure, is that we must choose one or more of these options or we risk further damaging one of the best healthcare systems in the world.

Respectfully,

David A. Friedman, MD FACOG

NYPIRG

NEW YORK
PUBLIC INTEREST
RESEARCH GROUP

STATEMENT OF THE NEW YORK PUBLIC INTEREST RESEARCH GROUP BEFORE THE NEW YORK CITY COUNCIL COMMITTEE ON WOMEN'S ISSUES AND COMMITTEE ON HEALTH REGARDING PROPOSED RESOLUTION 84-A WITH RESPECT TO MEDICAL MALPRACTICE INSURANCE PREMIUMS FOR CERTAIN MEDICAL PROVIDERS JANUARY 31, 2012

Greetings. My name is Rebecca J. Weber and I am the executive director of the New York Public Interest Research Group (NYPIRG). NYPIRG is New York's largest non-partisan, non-profit student directed consumer protection, public health and environmental preservation organization. For some thirty years NYPIRG has sought to improve the quality and cost of the delivery of medical care in New York State. We have authored or co-authored dozens of reports on physician oversight, malpractice insurance and prescription drug costs.

The issue that is the subject of Proposed Resolution 84-A, which would call on the state Department of Financial Services and Department of Health to investigate the high cost of medical liability insurance in New York, is one that NYPIRG has analyzed repeatedly over the years.

NYPIRG agrees that the costs of medical liability insurance are suspiciously high. In fact, along with other healthcare consumer advocacy groups, such as the Center for Medical Consumers, we've called for a forensic audit to be conducted by an independent actuary to put medical insurers' books under the microscope.[1]

However, Resolution 84-A creates a one-sided and inaccurate impression that the so-called crisis in medical liability insurance is caused by some supposedly unreasonable proliferation of malpractice lawsuits. The numbers, in fact, tell a far different story.

Based on our years of research and advocacy on this issue, we urge you to withdraw this resolution and focus on the core problems of the current system: an epidemic of medical errors and medical insurers that are poorly managed and fail to disclose information about their premium-setting policies.

[1] At least a part of the state's medical liability insurance problems were inflicted by the state's1990's raid of some $700 million from the rainy-day fund set up by the state to cover payouts by risky doctors. The state's appropriation of the monies in this fund contributed to the instability in the marketplace. The raiding of the fund in combination with a downturn in the investment cycle, which insurers rely on to grow their premiums created severe problems for the carrier. *See A Self-Inflicted "Crisis": New York's Medical Malpractice Insurance Troubles Cause By Flawed State Rate Setting and Raid on Rainy Day Fund*, Public Citizen's Congress Watch, November 2007.

The theme of this resolution appears to be concern for women's access to obstetricians and gynecologists. We urge you to look more closely at the matter of physician access. The "disappearing doctor" and "disappearing specialist" myths were squarely debunked by *The Doctor is In*, an October 2004 report authored by Public Citizen, the Center for Medical Consumers and NYPIRG.[2]

- Despite claims that doctors are fleeing the state, as of 2009, New York State had the fourth highest ratio, nationally, of OB-GYNs (highlighted in Proposed Resolution 84-A) per number of women of childbearing age.
- And the total number of physicians was increasing faster in New York than nationally.
- Indeed, the number of doctors working in New York has grown at a significantly higher rate than the state's overall population. From 1995 through 2008 the number of active physicians practicing in New York increased over 20%. During the period 1995 through 2008, the state's population grew a mere 6%.[3]
- NYPIRG's June 2010 report, *System Failure: A Review of New York State's Doctor Discipline System*, found that New York had the third highest *per capita* number of doctors, based upon American Medical Association data for 2007,[4] and similarly found, based on the AMA data, that New York ranked fourth nationally for most OB-GYNs per 10,000 women of child-bearing age.

The greater concern should be the impact of poor medical care on women, children, and families. It is often women who bear the brunt of medical errors—either as victims themselves, or as primary caretakers of impaired children, or when they must take on the responsibilities of sole head of household due to the injury or death of their spouse or partner. Indeed, the Proposed Resolution cites national data that "missed diagnosis of breast cancer is the number one reason for malpractice claims."[5] And for women who have only a low or moderate income, the impacts of medical malpractice are even more difficult to bear.

The sad truth is that more than a dozen years after the landmark *To Err is Human* report by the Institute of Medicine, which found that as many as 98,000 Americans die annually from preventable medical errors in U.S. hospitals, we're not doing a much better job today at reducing medical errors and negligence that result in injury or death.[6]

Let's be clear: NYPIRG believes that individuals and their families who have suffered serious injuries or have been killed due to substandard, negligent care have a right to go to court to seek redress for their injuries and ensure that they have resources to address their future healthcare, quality of life and

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[2] This report may be accessed at www.citizen.org/documents/NYPIRG%20Doctor%20Report%2010-19-04.pdf.

[3] The report cited several studies finding that a host of factors unrelated to the costs of liability insurance, such as years of practice and physician age, were associated with a decision to discontinue obstetric care. *Id.* at 19, *et seq.*

[4] Horner, *et al., System Failure: A Review of New York State's Doctor Discipline System*, New York Public Interest Research Group, June 2010.

[5] For a discussion of the magnitude of the misdiagnoses of breast cancer and the horrendous impacts these errors wreak on patients see *Prone to Error: Earliest Steps to Find Cancer*, Stephanie Saul, *The New York Times*, July 19, 2010. This article may be accessed at www.nytimes.com/2010/07/20/health/20cancer.html?scp=2&sq=breast+cancer+misdiagnosis&st=nyt.

[6] *To Err is Human*, Institute of Medicine, November 1999. The IOM is a private nonprofit organization established to provide policy advice under a congressional charter to the National Academy of Sciences. *See* http://iom.edu/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf.

financial needs. This is a fundamental right based on fairness as embedded in our system of liberty and democracy.

The best policy for the healthcare delivery system for patients and families and for our economy, however, is to *prevent medical errors*. NYPIRG believes we need to devote more resources to injury prevention and improving the quality of medical care. A reduction in medical errors would result in fewer claims and reduced payouts, which, if insurance companies are operating in a fair, efficient and proper manner, should result in lower insurance costs.

Contraindication, NYPIRG's 2009 study of medical malpractice payouts using federal data compiled in the National Practitioners Data Bank ("NPDB"), presents an irrefutable case that medical malpractice payouts in New York have been consistent, stable and fair for years.[7] The NPDB data clearly shows that over a decade and a half (1993 – 2008), New York's medical malpractice payout experience, after adjustment for inflation, has remained stable. Malpractice payments in New York have risen at roughly the same rate as inflation from 1993 through 2008. In fact, the NPDB showed a drop in payments from $822 million in 2006 to $743 million in 2008, or roughly 10 percent.

Despite the hyper-inflated rhetoric depicting a litigation "crisis" in New York, the actual number of medical malpractice cases filed was roughly the same, hovering around 2,000 annually from 1995 to 2008, and the number of doctors practicing in New York State increased by over 20 percent, from 51,193 doctors in 1995 to 62,770 in 2008.

The medical profession itself should be taking stronger action to address the problem of malpractice, because the reality is that a small minority of doctors are responsible for the lion's share of malpractice payments. According to the NPDB, during the period 1992 through 2008 the number of New York doctors who made three or more malpractice payments was equivalent to only 6.6% of the total number of doctors who practiced in New York in 2008. Yet they were responsible for nearly half (49.9%) of all payments made during that period. Serious consideration should also be given to a requirement that all physicians periodically demonstrate maintenance of competency in the scope of their current practice as a condition of recertification

The medical malpractice "diagnosis" made by the insurance and medical lobby is clearly at odds with the reality as represented in the, National Practitioner's Data Bank, the nation's only comprehensive database of malpractice payments. While we are sympathetic to the rising cost of malpractice insurance experienced by New York doctors, as well as the overall high cost of coverage in our state, the increases appear to be the result of factors other than payments from the tort system. Moreover, rising malpractice insurance premiums have not had a demonstrable effect on the number of doctors practicing in the state.

We would be remiss if we failed to emphasize that a sterile discussion of medical errors and liability premiums leaves out the heartbreaking impacts that medical mistakes have on patients and families. The human toll is enormous and incalculable. And the truth is that very few malpractice incidents are reported, fewer complaints are filed and only an exceedingly small percentage of these incidents result in the filing of a lawsuit.

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[7] Horner, *et al., Contraindication: Federal Government Data Demonstrates that New York's Medical Malpractice Insurance Hikes are Contrary to Payment Trends*, June 2009. This report may be accessed at www.nypirg.org/pubs/health/2009.06_Contraindication.pdf.

The facts show what is really at the heart of the so-called medical liability crisis: Unrelenting, epidemic numbers of medical errors, and the failure of liability insurers to manage their risk, navigate market cycles and provide a transparent process for their underwriting, investment, claims handling and rate-setting practices. We urge your committees to focus on ways to reduce medical errors at New York City's hospitals and healthcare providers, including the need to beef up the state's Office of Patient Safety and ensure state funding for independent hospital report cards on patient procedure outcomes.[8]

NYPIRG is eager to help your committees and the City Council in the important fight to reduce medical errors and improve the quality of health care in New York.

[8] The 2011 New York State hospital report card can be accessed at www.myhealthfinder.com/.

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Statement by Joanne Doroshow
Executive Director, Center for Justice & Democracy at New York Law School
Co-Founder, Americans for Insurance Reform

Before the New York City Council Committee on Health
and Committee on Women's Issues

Oversight: Professional and Financial Barriers Facing Women's Health Care Providers.

January 31, 2012

I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy at New York Law School, a national non-profit organization that is dedicated to educating the public about the importance of the civil justice system. I am also Co-Founder of Americans for Insurance Reform, a coalition of nearly 100 public interest groups from around the country that seeks better regulation of the property/casualty insurance industry. In addition, I served on the New York State Governor's Medical Malpractice Task Force in 2007 and 2008 and worked closely with insurance experts on the current insurance situation in New York. Since 2002, I have testified in Congress six times on medical malpractice insurance issues.

I can hardly express how shocked I was to read Proposed Res. No. 84-A. This resolution repeats, without substantiation, the same talking points we have seen for years regurgitated by the insurance and medical lobbies, as well as politicians like Rick Perry, George W. Bush, and Newt Gingrich. The goal of ending insurance price-gouging is something we have always supported. That is the entire purpose of our project, Americans for Insurance Reform. But this resolution is full of baseless claims and suggestions that are both offensive and false.

As a national consumer organization that has, for years, been fighting the insurance and medical lobbies who want to continually strip patients of their legal rights, we know exactly how issues of "access to care," such as those contained in Proposed Res. No. 84-A, tend to be discussed – couched in fear-mongering, not facts; anecdotes, not academic studies. Despite what is written in Proposed Res. No. 84-A, we hope the City Council rejects this approach.

Some physicians leave New York, many after just completing their training. In fact, in December 2009, the Center for Health Workforce (Center), part of the School of Public Health, University at Albany, State University of New York – an academic institution that monitors physician supply – published a paper called, "Less than Half of New Physicians Stay in New

York after Completing Training."[1] But the single biggest reason these new doctors list for leaving New York is to be closer to their family, followed by better jobs and salary elsewhere. Of the reasons listed, "Cost of Malpractice Insurance" is practically dead last on the list of possible reasons for their leaving New York State. Even the general category "Other" outranks "Cost of Malpractice Insurance." Notably, New York's legal system is *not even listed* as a reason.

And when it comes to OB/GYNs, just looking at the last three "Physician Profile" reports from the Center it appears that the number of active patient care physicians practicing both obstetrics and gynecology in New York State has been completely stable (2,585 physicians in 2008; 2,554 physicians in 2009; 2,595 physicians in 2010) – all while birth rates are dropping in New York State.[2] Specifically, "demographic changes appear to be contributing to a reduction in demand for some obstetrical services in New York. Between 1995 and 2003, the total number of births declined in New York and at the same time, the number of hospital obstetrical days and hospital obstetrical beds also declined."[3]

In terms of geographic regions, the Center also found that New York State as a whole had more than 55 OB/GYNs per 100,000 women of childbearing age in 2004 and that three regions had higher than the state average: Long Island (65.4 OB/GYNs), Hudson Valley (63.8 OB/GYNs) and New York City (59.4 OB/GYNs)[4] – areas that tend to have the highest malpractice insurance rates.[5] On the other hand, upstate regions showed a more dramatic decline – areas of the state with the cheapest malpractice insurance.

Attracting physicians to underserved areas is a long-standing problem having nothing to do with insurance rates but everything to do with lifestyle factors. Back in 1998, Oswego County reported great difficulty attracting physicians because of the "weather factor" and other lifestyle issues, including "boredom." Another problem was the lack of professional jobs in the area for spouses. Officials also noted that "because the large hospitals offer the latest in technology and research, physicians are often lured to the major cities."[6] In 2009, another report showed more than twice the number of doctors per capita in White Plains, NY than Bakersfield, CA (despite California's "cap" on compensation for injured patients).[7] "Quality of life" issues explain this disparity:

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[1] Armstrong DP, Forte GJ, and Moore J. *Less than Half of New Physicians Stay in New York after Completing Training*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. December 2009.

[2] Martiniano R, Moore J, Armstrong D, Continelli T, McGinnis S, and Forte G. *Changing Practice Patterns of Obstetricians/Gynecologists in New York*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. April 2006.

[3] *Ibid.*

[4] *Ibid.*

[5] The industry's underwriting process and models used to price certain specialties and geographic areas are secret. It is an area that demands more transparency (see later section.)

[6] Carol Thompson, "Recruiting and Retaining Physicians Not an Easy Task," *Oswego County Business*, April/May 1998.

[7] Chris Baltimore, "SPECIAL REPORT: Are doctors what ails healthcare?" *Reuters*, Nov. 6, 2009, found at http://www.reuters.com/article/companyNews/idUKTRE5A524720091106?pageNumber=1&virtualBrandChannel=11564.

> Doctors have been flocking to [the White Plains area] since the 1970s, drawn....[by] quality of life issues that any professional would consider when deciding where to live – climate, schools, and perhaps most importantly, income.
>
> It's no mystery why doctors avoid Bakersfield. The summer heat is oppressive, the air quality is poor and the Valley has been pegged by congressional researchers as one of the nation's most depressed regions, on par with the Appalachia region stretching across West Virginia and other coal-mining states.

This finding is consistent with those of the Harvard School of Public Health[8] (and many other researchers[9]), showing that the supply of OB/GYNs in a given state has no relationship to either doctors' malpractice premiums or a state's liability laws. Harvard researchers report:

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[8] Y. Tony Yang, David M. Studdert, S.V. Subramanian, Michelle M. Mello, "A Longitudinal Analysis of the Impact of Liability Pressure on the Supply of Obstetrician-Gynecologists," *Journal of Empirical Legal Studies*, Vol. 5, Issue 1, 21-53, March 2008.

[9] Suzanne Batchelor, "Baby, I Lied," *The Texas Observer*, Oct. 19, 2007, found at http://www.texasobserver.org/article.php?aid=2607 ("The [Texas] campaign's promise, that tort reform would cause doctors to begin returning to the state's sparsely populated regions, has now been tested for four years. It has not proven to be true.... [D]octors are following the Willie Sutton model: They're going, understandably, where the better-paying jobs and career opportunities are, to the wealthy suburbs of Dallas and Houston, to growing places with larger, better-equipped hospitals and burgeoning medical communities."); Katherine Baicker, Amitabh Chandra, "The Effect of Malpractice Liability on the Delivery of Health Care," 24-25, Nat'l Bureau of Econ. Research, Working Paper, No. 10709, 2004, found at http://www.dartmouth.edu/%7Ekbaicker/BaickerChandraMedMal.pdf ("The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt."); Tim Bonfield, "Region Gains Doctors Despite Malpractice Bills," *The Cincinnati Inquirer*, October 10, 2004, found at http://www.enquirer.com/editions/2004/10/10/loc_doctor.day1.html ("[There are] more doctors in the state today than there were three years ago...'[T]he data just doesn't translate into doctors leaving the state,' says Larry Savage, president and chief executive of Humana Health Plan of Ohio."); Matt Richtel, "Young Doctors and Wish Lists: No Weekend Calls, No Beepers," *The New York Times*, January 7, 2004, found at http://www.nytimes.com/2004/01/07/us/young-doctors-and-wish-lists-no-weekend-calls-no-beepers.html ("Today's medical residents, half of them are women, are choosing specialties with what experts call a 'controllable lifestyle.'"... 'I want to have a family. And when you work 80 or 90 hours a week, you can't even take care of yourself.'" said Dr. [Jennifer C.] Boldrick, explaining her decision to specialize in dermatology over plastic surgery."); "Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care, " 16-17, General Accounting Office, GAO-03-836, Released August 29, 2003, found at http://www.gao.gov/new.items/d03836.pdf (To the extent that some physician supply problems existed, many explanations could be established "unrelated to malpractice," and that such problems "did not widely affect access to health care." Moreover, GAO found evidence that some members of the AMA and state medical societies had purposely left certain states for the purpose of manufacturing a physician supply problem as part of a larger campaign to pressure lawmakers into severely limiting injured patients' rights."); Eleanor D. Kinney, Malpractice Reform in the 1990s: Past Disappointments, Future Success?, 20 J. Health Pol. Pol'y & L. 99, 120 (1995) ("Despite anecdotal reports that favorable state tort environments with strict...tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong...reforms have done so."); Eleanor D. Kinney & William P. Gronfein, Indiana's Malpractice System: No-Fault by Accident?, 54 Law & Contemp. Probs. 169, 188 (1991), *cited in* Marc Galanter, Real World Torts," 55 *Maryland L. Rev.* 1093, 1152-1153 (1996) (Indiana has "the most comprehensive and severe set of insurance and tort reforms in the nation." But the "data indicate that Indiana's population continues to have considerably lower per capita access to physicians than the national average.")

> Our results suggest that most OB/GYNs do not respond to liability risk by relocating out of state or discontinuing their practice, and that tort reforms such as caps on noneconomic damages do not help states attract and retain high-risk specialties.

If the medical groups would like to discuss anecdotes or biased surveys of members, we can certainly point the Council to other, more constructive kinds of anecdotes – the thousands and thousands of individual stories of medical negligence in New York City and New York State. These injured patients are always the forgotten faces in the debate over medical malpractice. You see no reference to any of their stories in the Proposed Res. No. 84-A or any reference to the epidemic of medical negligence in this state. Every injured victim, or parent of a dead child, will tell you that they had *access* to medical care – their access was to inept physicians or dangerous hospitals. If given the choice, each would have gladly given up convenience for competence.

We urge the Council to firmly reject information from medical groups and their insurers about access that is grounded in anecdotes, secret information and fear. While I could provide entire papers about why virtually every premise of Proposed Res. No. 84-A is substantively wrong, I'll concentrate on a few areas where I believe City Council should focus: insurance transparency and failure of "caps" to fix insurance problems while having a devastating impact on patients, particularly women; medical errors and the impact on racial and ethnic minorities in New York; and litigation and patient safety-related issues. But before doing this, I would like to point out some background information about New York's medical malpractice insurance situation.

NEW YORK'S MEDICAL MALPRACTICE INSURANCE – RECENT HISTORY

In the mid-1980s, New York was one of the many states that succumbed to pressure from medical and insurance lobbies to restrict the rights of injured patients after being told by these lobbyists that this was the only way to reduce skyrocketing insurance rates for doctors. As a result, New York State enacted three out of four "medical liability reform" agenda items pushed by the corporate-backed American Tort Reform Association: a sliding scale limit on attorney's contingent fees; prohibition of lump sum compensation payments to victims; and abolition of the collateral source. These laws added to legal obstacles that New Yorkers already faced, which residents in most other states do not: a restrictive statute of limitations law that begins to runs from the date of a patient's injury as opposed to its discovery; and an archaic "wrongful death" law dating from the 1800s that does not allow compensation for emotional loss of a child who is killed by medical malpractice.

These "tort reform" laws had such a significant impact on reducing medical malpractice payouts that the State, at the direction of Governor Pataki (and earlier Governor Mario Cuomo), appropriated close to a billion dollars from the reserves of the Medical Malpractice Insurance Association (MMIA) – established by the State as the medical malpractice insurer of last resort – to close gaps in the State's operating budget.

In 2001, the State finally dissolved MMIA, replacing it with the Medical Malpractice Insurance Plan (MMIP), an assigned risk plan in which all medical malpractice insurers participate. Unfortunately, because the State had drained MMIA's money, MMIP had accumulated a deficit

that, by law, had to be shouldered by the few companies selling malpractice insurance in the state.

In July 2007, Governor Spitzer established a Medical Malpractice Advisory Task Force to come up with ways to resolve this MMIP problem. I served on this Task Force. In October 2007, state insurance department representatives testified before the Task Force that the "frequency of medical malpractice insurance claims against doctors, nurses and other medical professionals are at a new low and has been stable for the third straight year. Severity is increasing at just 3 percent annually." The Center for Health Workforce also testified that New York is "the most richly supplied state in the nation in terms of the number of physicians in practice relative to the state population."[10] So while it was clear that the MMIP problem had nothing to do with any lawsuit or claims "crisis" but rather with MMIA's money being drained,[11] the hospital, medical and insurance lobbyists began using this process as an opportunity to argue for more limits on patients' legal rights, using fabricated analysis and scoring by their own paid insurance firms, like Milliman, to justify their position.

Yet virtually all of their insurance data were secret. Our own studies showed great reason to be skeptical that the crisis was anywhere near what MLMIC and the state insurance department were claiming at the time. For example, the MMIP deficit was said to be $1.5 to $2 billion in 2007, but we said this was calculated by use of unknown data and assumptions including Incurred But Not Reported (IBNR) reserves, which are essentially guesses about what they might pay out in the future on claims they don't even know about yet and tend to be highly exaggerated. (History shows that during certain parts of the insurance cycle – "hard markets" – insurers vastly overstate their IBNR losses by increasing reserves – money set aside to pay them – despite experiencing no increase in payouts or any trend suggesting large future payouts. This "over-reserving" seems often to be politically-inspired, used by insurers as a way to show poor income statements, which in turn is used to justify imposition of large premium increases.)

We recommended in 2007 that there was no need for quick action as, even if the deficit were real, insurers had large cash available in reserves – $8 billion. ***We were right.*** A rate freeze for two years and only two small increases of 5% since, and the situation has now eased and stabilized. What's more, according to MLMIC's most recent annual report, the company has *released* over three-quarters of a billion dollars of loss and LAE (loss adjustment expense) reserves, a whopping $788 million to be precise. So it appears that we were correct that reserves were excessive in 2007.

We also noted at that time that to properly analyze overall trends in frequency, severity and premiums – including by specialty and geographic area – we must have data from all carriers showing paid losses by quarter, number of doctors insured by quarter and number of paid claims by quarter. We never got these data, and we still do not have them.

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[10] Physician Supply and Demand Indicators in New York, 2000-2005: A Summary of Trends for 35 Medical Specialties. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany.

[11] See also, Public Citizen Study, "A Self-Inflicted Crisis: New York's Medical Malpractice Insurance Troubles Caused by Flawed State Rate Setting and Raid on Rainy Day Fund" (November 2007).

NEW YORK STATE SUFFERS FROM AN EXTREME LACK OF DATA ON MEDICAL MALPRACTICE INSURANCE

When it comes to the insurance industry and claims data, New York State is one of the least transparent states in the nation. Even Texas has better disclosure laws than New York.[12] The impact of this goes far beyond simply harming public confidence in city and state government and major institutions. This secrecy also has serious public safety implications, since the public and lawmakers never learn the reason claims arise and are paid. Moreover, experience in states like Illinois[13] shows how insurer reporting and transparency can result in significant enhancements to the insurance market, lower premiums, increased competition and other improvements that can benefit all health care professionals.

Late last year, eight health insurers in New York State, with 90 percent of the market of small group and individual insurance plans, formally ended their fight to keep secret documents supporting their requests for rate hikes. The companies said that "the filings were no longer due confidentiality under a 'trade secrets' exception to freedom of information laws." As the *New York Times* noted, "Some of the insurers have argued that disclosure would hurt their competitive position, and that the filings were too technical to be understood by consumers."[14]

While health insurers have now given up this argument and their fight to keep documents from public disclosure, the medical malpractice insurance carriers in New York State have not. Meanwhile, public officials are asked to make policy recommendations based on outlandishly inaccurate information that cannot be analyzed, if history is any guide. The following are some examples of the most critical medical malpractice insurance data needs in New York State:[15]

Full "closed claims" study for each med mal insurer for at least a ten-year period, and continuing on an ongoing basis.

- These data would be used to determine, at a minimum: (1) the major causes of New York medical malpractice claims; (2) causal factors that underlie trends in loss costs; and (3) ways to help physicians practice safer medicine.[16]
- We understand that DOH already collects some of this information. However, there are concerns about its completeness and the lack of analysis.

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[12] See, e.g., http://www.tmlt.org/newscenter/closedclaimstudies.html.

[13] "Illinois Department of Insurance Encourages Insurers to Comply with 2005 Medical Malpractice Reforms; Department observed increased competition, 10% decrease in premium paid since 2005 reforms," February 20, 2010, found at http://www.insurance.illinois.gov/newsrls/2010/02202010_a.asp

[14] Nina Bernstein, "7 More Insurers End Objections on Rate Filings," *New York Times*, October 27, 2011.

[15] Based on Testimony of J. Robert Hunter, Director Of Insurance, Consumer Federation of America before the Medicaid Redesign Team Medical Malpractice Reform Working Group, October 27, 2011. Hunter is co-founder of Americans for Insurance Reform. He was formerly the Commissioner of Insurance for the State of Texas, the Federal Insurance Administrator under both Presidents Carter and Ford, and President and Founder of the National Insurance Consumer Organization.

[16] See, e.g., http://www.tmlt.org/newscenter/closedclaimstudies.html (Texas); http://www.facs.org/fellows_info/bulletin/2007/griffen0107.pdf

- The State should invest sufficient resources to audit compliance with closed claim reporting requirements and create the analytic capacity to both track root causes over time and to develop and disseminate that information in ways that promote improvements in patient safety.
- There should be public access to closed claim information necessary for analytics and other research purposes.

Frequency and severity trends for the entire med mal industry and for each company, going back for at least six years, as well as going forward, including particular analysis of the Neurologically Impaired Infant Fund's impact.

- Even before the NII Fund was created in 2011, all parties agreed that claims frequency had been down in New York for years. However, certain parties had been claiming that severity was increasing, *even though data from the state's second largest insurer, Physicians Reciprocal Insurance (PRI) – which it was willing to share – shows that paid losses ("severity trend") were at 2%, growing at a rate less than medical inflation.* The amount of severely contradictory information permeating this issue must be resolved.
- That said, the impact of the 2011 NII Fund on hospitals payouts is enormous and must be examined as well. The NII Fund established a new liability and compensation system for the families of newborns who suffer brain damage at birth due to negligence, to cover costs for their future medical care. This process, which denies such families the same kind of rights and recourse that every other negligence victim has in the state, is not a "no-fault" fund. The Fund kicks in after a jury verdict or settlement, in other words, *after* the family endured the time and expense of proving their case in court (or settled), and the health care provider was found negligent. It is also a reimbursement fund, so the family may only recover money after they have actually incurred expenses for their child's care. In other words, the child and his/her family are forced to deal with a burdensome and humiliating struggle to get bills paid from an unaccountable state entity, adding additional burdens on families who already face unimaginable challenges caring for a profoundly disabled child. Clearly, despite their prior complaints about these cases, hospitals are now spending far less money compensating these victims.

Careful study of reserves (including "Incurred But Not Reported" claims or IBNR) of all New York State medical malpractice insurers.

- The study should include a review of Statutory Page 14s and full Schedule Ps, which must be made available from all insurers, including MMIP. Reserves in New York should also be compared to those of carriers in other states.
- Insurers estimate IBNR reserves, which are essentially guesses about what they might pay out in the future on claims they don't even know about yet. At least as of 2008, reserves were remarkably high and likely excessive. As we noted earlier, according to MLMIC's annual report, the company has recently released over three-quarters of a billion dollars of loss and Loss Adjustment Expense reserves, a whopping $788 million to be precise, raising questions as to whether they have been excessive.

Analysis of the real financial status of MMIP, with full data disclosure; an annual statement should be required, going back to 2005.

- The current MMIP deficit is said to be in the $470 million range, but data on how this figure was calculated are publicly unavailable as MMIP currently issues no annual statement. In fact, there is almost a complete lack of public data on MMIP. All we know for sure is the unreliability of the MMIP deficit figures over time.
- PRI says that the surplus deficit that appears on its books (as opposed to reserves, which are plentiful) is due primarily to MMIP and how it is carried on its books. Simply correcting how this figure is carried on the books of carriers could reduce this number significantly. Specifically, like the State Guarantee Fund, the expected payouts *in the near term* should be on the books of the carriers, not the expected payout in the infinite term, as it currently is.
- We also do not know if the reserves for MMIP are anywhere near accurate, since they are in a black box the public cannot see and analyze. If MLMIC, which administers MMIP, sets the reserves in MMIP the way they set them in their own books, it is certainly possible reserves are inflated. These data should be disclosed.

All recent rate filings (*e.g.*, from 2005) – with full information, unrestricted by overbroad "trade secret" assertions – should be made available for study and analysis as they have in other states[17] and by New York's health insurers; there must be an analysis of rate comparisons between specialties, areas within New York State, areas with similar demographics in contiguous states and all other factors about the causes of higher medical malpractice insurance rates in New York.

- For example, per occupied bed costs in New York State are estimated by Zurich North American Insurance to be $4,522, which is higher than most states. In addition, according to the U.S. census, New York ranks #3 in the nation in terms of the number of doctors per 100,000 population (392 while the U.S. figure is 267, or one and a half doctors in New York for every doctor in the nation), behind only Massachusetts and Maryland. The ranking of each of these states reflects that doctors are attracted to states with teaching hospitals, which also causes cost increases because of the use of cutting-edge technology. New York also has 30% higher inpatient day hospital utilization rates than the national average and 25% more outpatient visits, as well as higher income, higher medical care costs and higher Medicare costs than the nation. In addition, patient safety is problematic here and, as mentioned before, insurance reserves may be excessive compared to the rest of the country. Meanwhile, in terms of medical malpractice claims, "Inflation-adjusted payouts per doctor in New York State have been stable, have failed to increase in recent years, and are comparable to what they were in the early 1980s."[18] How all of these data factor into ratemaking is completely unavailable to lawmakers or the public.[19]

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[17] In California, for example, "All information provided to the commissioner pursuant to this article shall be available for public inspection." Section 1861.07 of the CA Insurance Code.

[18] Americans for Insurance Reform, "Medical Liability and Malpractice Insurance in New York State" (2011); http://insurance-reform.org/AIRNYMRTF.pdf.

[19] Based on Testimony of J. Robert Hunter, Director Of Insurance, Consumer Federation of America before the

- It also should be noted that inflation-adjusted premiums per doctor in New York State are among the lowest they have been in over 30 years, comparable to what they were in the mid-1970s.[20] This should be examined as well.

In sum, it would be simply unforgivable for public officials to consider taking any action regarding med mal insurance – let alone stripping patients' rights – without obtaining this basic information and opening it up to public inspection.

CAPS ON NON-ECONOMIC DAMAGES DO NOT SOLVE INSURANCE PROBLEMS – THEY ONLY DEVASTATE VICTIMS

Non-economic damages compensate injured patients for intangible but real "quality of life" injuries, like the loss of a reproductive system, permanent disability, disfigurement, trauma, loss of a limb, blindness or other physical impairment. As University of Buffalo Professor Lucinda Finley has written, "certain injuries that happen primarily to women are compensated predominantly or almost exclusively through noneconomic loss damages. These injuries include sexual or reproductive harm, pregnancy loss, and sexual assault injuries."[21] When President Clinton vetoed a products liability bill on May 2, 1996, he said, "The legislation would make it impossible for some people to recover fully for non-economic damages. This is especially unfair to senior citizens, women, children, who have few economic damages, and poor people, who may suffer grievously but, because their incomes are low, have few economic damages."

Caps on non-economic damages not only discriminate, they also keep the most severely injured patients from getting adequate compensation,[22] destroying yet another safety net for many vulnerable children and families. Moreover, according to Professor Finley, "[J]uries consistently award women more in noneconomic loss damages than men ... [A]ny cap on noneconomic loss damages will deprive women of a much greater proportion and amount of a jury award than men. *Noneconomic loss damage caps therefore amount to a form of discrimination against women and contribute to unequal access to justice or fair compensation for women.*"

Medicaid Redesign Team Medical Malpractice Reform Working Group, October 27, 2011. Hunter is co-founder of Americans for Insurance Reform. He was formerly the Commissioner of Insurance for the State of Texas, the Federal Insurance Administrator under both Presidents Carter and Ford, and President and Founder of the National Insurance Consumer Organization.

[20] Americans for Insurance Reform, "Medical Liability and Malpractice Insurance in New York State" (2011); http://insurance-reform.org/AIRNYMRTF.pdf.

[21] Lucinda M. Finley, "The 2004 Randolph W. Thrower Symposium: The Future Of Tort Reform: Reforming The Remedy, Re-Balancing The Scales: Article: The Hidden Victims Of Tort Reform: Women, Children, And The Elderly, Emory Law Journal," 53 Emory L.J. 1263, Summer, 2004.

[22] A survey by the RAND Corporation found that the "most significant impact" of California's three decades-old $250,000 cap "falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes." Source: "RAND Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps," Consumer Watchdog, July 13, 2004.

It should also be noted that racial and ethnic minorities receive inferior medical treatment by the health care industry and are being subjected to high rates of preventable medical errors.[23] As a result, limits on the rights of patients who have been killed or injured due to medical malpractice will disproportionately hurt racial and ethnic minorities as well. Complicating these issues is the fact that minorities are uninsured more often than non-Hispanic whites, a status that frequently results in less than adequate care and poor health consequences.

Despite the enormous hardships on innocent patients caused by "caps," or the fact that they shift compensation burdens onto others (like taxpayers through Medicaid), insurers argue that caps are worth enacting since they will bring down insurance rates. This is absurd. This argument is based entirely upon a false predicate – that the U.S. civil justice system is to blame for insurance price-gouging. We have already shown this to be untrue for New York, but also, history repeatedly shows that capping damages will not lead to lower rates because what drives rate hikes has nothing to do with a state's "tort" law. It is driven primarily by the insurance economic and underwriting cycle and remedies that do not specifically address this phenomenon through better regulation will fail to end price-gouging. Indeed, Proposed Res. No. 84-A entirely ignores the insurance industry's major role in the pricing of medical malpractice insurance premiums – an industry that is also exempt from anti-trust laws under the federal McCarran-Ferguson Act. See much more in Americans for Insurance Reform's study, *Repeat Offenders; How The Insurance Industry Manufactures Crises And Harms America,*[24] which exposes how the property/casualty insurance industry creates periodic insurance crises ("hard markets"). (Notably, contrary to Proposed Res. No. 84-A's findings, the country is not in a "crisis" period. We have been in a soft insurance market since 2006; nationally, medical malpractice premiums, inflation-adjusted, are nearly the lowest they have been in over 30 years and low med mal rates are continuing.[25])

Maryland and Missouri are both examples of states that enacted severe caps on damages in the mid-1980s, only to be hit with huge rate hikes later.

- **Maryland.** In the mid-2000s (during the last "hard market"), Maryland was called an American Medical Association (AMA) "problem state"[26] and a "crisis state" according to the American College of Obstetricians and Gynecologists.[27] Yet Maryland had had a cap on non-economic damages since 1986, originally $350,000 but later increased somewhat.[28] Despite the cap, the state experienced premiums that "rose by more than 70 percent in the last two years."[29] This caused lawmakers to push for, once again, even

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[23] See., Statement by Joanne Doroshow, Executive Director. Center for Justice & Democracy, Before the Assembly Standing Committee on Health Black, Puerto Rican and Hispanic Legislative Caucus, Health Care Disparities Between Minorities and Non-Minorities, April 22, 2004.

[24] See., http://centerjd.org/content/study-repeat-offenders-how-insurance-industry-manufactures-crises-and-harms-america

[25] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html

[26] AMA, *American's Medical Liability Crisis: A National View*, http://www.ama-assn.org/ama1/pub/upload/mm/450/med_liab_20stat.pdf (June 2004).

[27] Mary Ellen Schneider, *Maryland: A State in 'Crisis' for Ob.Gyns*, OB/GYN NEWS, Oct. 15, 2004.

[28] MD. CODE ANN., CTS. & JUD. PROC. §11.108.

[29] James Dao, "A Push in States to Curb Malpractice Costs," *New York Times*, Jan. 14, 2005.

more restrictions on patients' rights in a special session called by the Governor in 2004 ostensibly "to combat the high cost of malpractice insurance."[30]

- **Missouri** was also identified by the AMA as a so-called "crisis state,"[31] yet had had a cap on non-economic damages since 1986. The cap started at $350,000 and was adjusted annually for inflation, reaching $557,000 in 2003.[32] "New medical malpractice claims dropped 14 percent in 2003 to what the [Missouri Department of Insurance] said was a record low, and total payouts to medical malpractice plaintiffs fell to $93.5 million in 2003, a drop of about 21 percent from the previous year." And "the National Practitioner Data Bank, a federally mandated database of malpractice claims against physicians, found that the number of paid claims in Missouri fell by about 30 percent since 1991. The insurance department's database found that paid claims against physicians fell 42.3 percent during the same time period." *Yet doctors' malpractice insurance premiums rose by 121 percent between 2000 and 2003.*[33]

Other experience – rate *hikes,* not decreases

- **Florida:** "When Gov. Jeb Bush and House Speaker Johnnie Byrd pushed through a sweeping medical malpractice overhaul bill ... the two Republican leaders vowed in a joint statement that the bill would 'reduce ever-increasing insurance premiums for Florida's physicians . . . and increase physicians' access to affordable insurance coverage.'" But, insurers soon followed up with requests to increase premiums by as much as 45 percent.[34]

- **Ohio:** Almost immediately after "tort reform" passed, all five major medical malpractice insurance companies in Ohio announced they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.[35]

- **Oklahoma:** After "caps" passed in 2003, the third-largest medical malpractice insurer in the state raised its premiums 20 percent, followed by an outrageous 105 percent rate hike in 2004.[36] The largest insurance company, which is owned by the state medical association, requested an astounding 83 percent rate hike just after "tort reform" passed (which was approved on the condition it be phased in over three years).[37]

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[30] *Id.*

[31] AMA, *American's Medical Liability Crisis: A National View*, http://www.ama-assn.org/ama1/pub/upload/mm/450/med_liab_20stat.pdf (June 2004).

[32] Missouri Dep't of Ins., *Medical Malpractice Insurance in Missouri; The Current Difficulties in Perspective* 7 (2003).

[33] "State report says malpractice claims fell," *Associated Press,* November 5, 2004.

[34] Julie Kay, "Medical Malpractice; Despite Legislation that Promised to Rein in Physicians' Insurance Premiums, Three Firms File for Big Rate Increases," *Palm Beach Daily Business Review*, Nov. 20, 2003.

[35] *E.g.* "Despite New Law, Insurance Companies Won't Lower Rates Right Away," *Associated Press*, Jan. 9, 2003.

[36] "Hike Approved for Premiums," *Daily Oklahoman*, April 8, 2004.

[37] *E.g.* "Oklahoma's Largest Medical-Liability Company Gets 83% Rate Increase Over Three Years," *BestWire*, Dec. 2, 2003.

- **Mississippi:** Four months after "caps" passed, investigative news articles reported that surgeons still could not find affordable insurance and that many Mississippi doctors were still limiting their practice or walking off the job in protest.[38]

- **Nevada:** Within weeks of enactment of "caps" in the summer of 2002, two major insurance companies proclaimed that they would not reduce insurance rates for at least another year to two, if ever. The Doctors Company, a nationwide medical malpractice insurer, then filed for a 16.9 percent rate increase. Two other companies filed for 25 percent and 93 percent rate increases.[39]

- **Texas:** During the 2003 campaign for Prop. 12 – the "tort reform" referendum that passed – ads promised rate cuts if caps were passed. Right after the referendum passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.[40] In April 2004, after one insurer's rate hike request was denied, it announced it was using a legal loophole to avoid state regulation and increase premiums 10 percent without approval.[41] In a 2004 filing to the Texas Department of Insurance, GE Medical Protective revealed that the state's non-economic damage cap would be responsible for no more than a 1 percent drop in losses.[42]

Strong insurance regulatory laws – which New York does not have – are the only way to control insurance rates for doctors and hospitals.

There are only two states in the nation where it is possible to compare the impact on insurance rates of both "caps" on non-economic damages and strong insurance rate regulation (which New York State lacks): California and Illinois. The following describes the experience of both states. It is clear – caps do not solve doctors' insurance problems. Rather, strong insurance regulatory laws are the only effective and fair way to control insurance rates for doctors and hospitals.

- **California - Caps:** In 1975, California enacted a severe $250,000 cap on non-economic damages, the first in the nation. This cap has severely reduced the number of genuine malpractice cases brought in California.

  The impact of this "cap" on cases and payouts has been clear, because caps on non-economic damages make many legitimate cases economically impossible for attorneys to bring: those involving seniors, low wage earners (including women who work inside the

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[38] *E.g.* "Miss. Tort Reform Effort Falls Short," *Commercial Appeal*, Feb. 18, 2003; Reed Branson, "Doctors In Oxford Shut, Cite Insurance," *Commercial Appeal*, Feb. 14, 2003; Ben Bryant, "Tort Reform Has Done Little to Ease Malpractice Crisis," *Biloxi Sun-Herald*, Feb. 2, 2003.

[39] *E.g.* Joelle Babula, "Medical Liability Company Requests Premium Increase," *Las Vegas Review-Journal*, Feb. 11, 2003; Babula, "State Insurance Program Holds Off on Lowering Rates," *Las Vegas Review-Journal*, Aug. 14, 2002.

[40] *E.g.* Darrin Schlegel, "Some Malpractice Rates to Rise Despite Prop. 12," *Houston Chronicle*, Nov. 19, 2003; Darrin Schlegel, "Malpractice Insurer Fails in Bid for Rate Hike," *Houston Chronicle*, Nov. 21, 2003; (Oct. 2003 rate filing from Texas Medical Liability Insurance Assoc. (JUA) to Texas Dep't of Insurance).

[41] "Insurer Switching to Unregulated Product to Raise Premiums," *Assoc. Press*, April 10, 2004.

[42] The GE Medical Protective filing can be found at: http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf.

home), children and the poor, who are more likely to receive a greater percentage of their compensation in the form of non-economic damages.

Insurance defense attorney Robert Baker, who had defended malpractice suits for more than 20 years, told Congress in 1994, "As a result of the caps on damages, most of the exceedingly competent plaintiff's lawyers in California simply will not handle a malpractice case ... There are entire categories of cases that have been eliminated since malpractice reform was implemented in California."[43]

Despite the reduction of legitimate cases (while deaths and injuries due to malpractice have increased), between 1975 and 1988, doctors' premiums in California increased by 450 percent, rising faster than the national average.[44]

Today, as a result of the cap, California's medical malpractice insurance industry has become so bloated that "as little as 2 or 3 percent of premiums are used to pay claims" and "the state's biggest medical malpractice insurer, Napa-based The Doctors Company, spent only 10 percent of the $179 million collected in premiums on claims in 2009." This led Insurance Commissioner Dave Jones to say that "insurers should reduce rates paid by doctors, surgeons, clinics and health providers while his staff scrutinizes the numbers."[45]

California - Insurance: In 1988, California voters passed a stringent insurance regulatory law, Proposition 103, which ordered a 20% rate rollback, forced companies to open their books and get approval for any rate change before it takes effect and allowed the public to intervene and challenge excessive rate increases.

During the period when every other state was experiencing skyrocketing medical malpractice rate hikes in the mid-2000s (during the last "hard market"), California's regulatory law led to public hearings on rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in two years,[46] saving doctors $66 million.

Today, if the California medical malpractice insurance industry does not lower rates on its own, as the Insurance Commissioner has requested, Prop. 103 will allow the Commissioner to take action and do so.

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[43] See, http://www.multinationalmonitor.org/mm2003/032003/court.html

[44] See, Consumer Watchdog, "Insurance Rate Regulation, Not Medical Liability Limits, Lowered California Malpractice Insurance Premiums," http://www.consumerwatchdog.org/newsrelease/house-republicans-have-their-talking-points-california-backwards-insurance-rate-regulati, *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California and How Malpractice Caps Failed* 1 (March 7, 2003), http://www.consumerwatchdog.org/healthcare/rp/rp003103.pdf.

[45] Shaya Tayefe Mohajer, "Calif regulator: Malpractice insurance too pricey," *Associated Press,* February 17, 2011; http://www.mercurynews.com/news/ci_17414760?nclick_check=1

[46] Consumer Watchdog, "California Group Successfully Challenges 29.2% Rate Hike Proposed by California's Ninth Largest Medical Malpractice Insurer; Proposition 103 Invoked to Slash Medical Protective Company's Requested Increase by 60%," Sep 16, 2004, http://consumerwatchdog.org/insurance/pr/pr004625.php3.

- **Illinois - Caps and Insurance:** In 2005, Illinois enacted a non-economic damages cap on compensation for injured patients ($500,000 for doctors and $1,000,000 for hospitals) and a very strong insurance regulatory law. In February 2010, the Illinois Supreme Court struck down the cap as unconstitutional. Because of a non-severability clause, the insurance regulatory law was struck down as well. However, in the five years these laws were in place, the following occurred:

  Cap: The cap never really affected settlements or insurance rates in Illinois during the five years it existed. This was acknowledged in a May 2010 webinar sponsored by A.M. Best, where a Chicago-based insurance attorney said: "It may be headlines in other places but here in Cook County [Illinois] I think that the Supreme Court's decision in *Lebron* was fully anticipated and discounted. None of the settlements that I've been involved in for the last couple of years paid the slightest attention to the caps anymore. There was almost a universal acceptance that it would be overturned by the Supreme Court. In fact it was overturned in Cook County two years ago. Lebron was a Cook County case going up, so the caps haven't been law here for quite some time."[47]

  Insurance: The strong insurance regulatory reforms *did* take effect and had an impact. In October 2006, the Illinois Division of Insurance announced that an Illinois malpractice insurer, Berkshire Hathaway's MedPro, would be expanding its coverage and cutting premiums for doctors by more than 30 percent. According to state officials and the company itself, this was made possible ***because of new insurance regulatory law*** enacted by Illinois lawmakers in 2005, and expressly ***not the cap*** on compensation for patients.[48] The new law ***required malpractice insurers to disclose data on how to set their rates.*** This, according to Michael McRaith, director of the state's Division of Insurance, allowed MedPro to "set rates that are more competitive than they could have set before."

  In February 2010, the Illinois Division of Insurance released data showing that insurance regulation had greatly improved the medical malpractice insurance environment with expanded coverage and lower premiums for doctors.[49] Specifically, the Insurance Division said:

  > The 2005 Reform Laws imposed changes to the Illinois Insurance Code that improved insurer reporting and transparency requirements and enhanced the Department's rate oversight authority. Since 2005, the Department has observed improvements in the medical malpractice insurance market. In particular, the Department observed:

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[47] "State of the Medical Professional Liability Market," *Best's Review*, May 2010.
[48] Adam Jadhav, "Minor insurer is cutting malpractice rates for doctors," *St. Louis Post-Dispatch,* October 13, 2006.
[49] "Illinois Department of Insurance Encourages Insurers to Comply with 2005 Medical Malpractice Reforms; Department observed increased competition, 10% decrease in premium paid since 2005 reforms," February 20, 2010, found at http://www.insurance.illinois.gov/newsrls/2010/02202010_a.asp

A decrease in medical malpractice premiums. Gross premium paid to medical malpractice insurers has declined from $606,355,892 in 2005 to $541,278,548 in 2008;

An increase in competition among companies offering medical malpractice insurance. In 2008, 19 companies offering coverage to physicians/surgeons each collected more than $500,000 in premiums, an increase from 14 such companies in 2005; and

The entry into Illinois of new companies offering medical malpractice insurance. In 2008, five companies collected more than $22,000,000 in combined physicians/surgeons premiums – and at least $1,000,000 each in premiums – that did not offer medical malpractice insurance in 2005."

Industry insiders have repeatedly admitted that capping damages will not lower insurance rates.

- **American Insurance Association:** "[T]he insurance industry never promised that tort reform would achieve specific premium savings." (American Insurance Association Press Release, March 13, 2002)

- **Sherman Joyce, President, American Tort Reform Association:** "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." (*Liability Week*, July 19, 1999)

- **Victor Schwartz, General Counsel, American Tort Reform Association:** "[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'" (*Business Insurance*, July 19, 1999)

- **Connecticut State Lawmaker:** "[T]he insurance industry now says [tort reform] measures will have no effect on insurance rates. We have been disappointed by the response of the insurance industry. The reforms we passed should have led to rate reductions because we made it more difficult to recover, or set limits on recovery. But this hasn't happened." (*UPI*, March 9, 1987)

- **State Farm Insurance Company (Kansas):** "[W]e believe the effect of tort reform on our book of business would be small. ... [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses....." (Letter from Robert J. Nagel, Assistant Vice President, State Filings Division, to Ray Rather, Kansas Insurance Department, Oct. 21, 1986, at 1-2.)

- **Aetna Casualty and Surety Co. (Florida):** After Florida enacted what Aetna Casualty and Surety Co. characterized as "full-fledged tort reform," including a $450,000 cap on non-economic damages, Aetna did a study of cases it had recently closed and concluded that Florida's tort reforms would not effect Aetna's rates. Aetna explained that "the review of the actual data submitted on these cases indicated no reduction of cost." (Aetna

Casualty & Sur. Co., Commercial Ins. Div., Bodily Injury Claim Cost Impact of Florida Tort Law Change, at 2, Aug. 8, 1986)

- **Allstate Insurance Company (Washington State):** In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage awards, the company said, "our proposed rate would not be measurably affected by the tort reform legislation." (*Seattle Times,* July 1, 1986)

- **Great American West Insurance Company (Washington State):** After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, "it does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform' law." (Letter from Kevin J. Kelley, Director of Actuarial, to Norman Figon, Rate Analyst, Washington Insurance Department, April 23, 1986, at 1)

- **Vanderbilt University:** A regression analysis conducted by Vanderbilt University economics professor Frank Sloan found that caps on economic damages enacted after the mid-1970s insurance crisis had no effect on insurance premiums. (Sloan, "State Responses to Malpractice Insurance Crisis of the 1970's: An Empirical Assessment," 9 *Journal of Health Politics, Policy & Law* 629-46 (1985))

ALARMING AMOUNTS OF MEDICAL MALPRACTICE IN NEW YORK; IMPACT ON RACIAL AND ETHNIC MINORITIES

It has been over a decade since the Institute of Medicine's seminal study, *To Err is Human: Building a Safer Health System,*[50] was published, which found that between 44,000 and 98,000 patients are killed in hospitals each year due to medical errors. The statement in Proposed Res. No. 84-A that "90% of which are the result of failed systems and procedures rather than the negligence of individual practitioners" is a complete fabrication. IOM'S 98,000 figure was an extrapolation of the 1990 Harvard Medical Practice Study, which evaluated New York hospitals and used stringent criteria in choosing which adverse events to consider. The report notes, "Some maintain these extrapolations likely underestimate the occurrence of preventable adverse events because these studies: 1) considered only those patients whose injuries resulted in a specified level of harm; 2) imposed a high threshold to determine whether an adverse event was preventable or negligent (concurrence of two reviewers); and 3) included only errors that are documented in patient records." In other words, the authors of the IOM study made special care to ensure that only incidents that were preventable or negligent were examined.

The Harvard Medical Practice Study actually found that in the year studied – 1984 – 6,895 patients died and 27,177 patients were injured due to negligence by doctors and hospitals. Moreover, of these deaths and injuries, "there were significant differences between hospitals that serve a predominantly minority population and other hospitals. That is, blacks were more likely

[50] Kohn, Corrigan and Donaldson, eds., *To Err Is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, D.C. (1999).

to be hospitalized at institutions with more AE's [adverse events] and higher rates of negligence."[51]

In 2002, the National Academy of Sciences Institute of Medicine (IOM) published its landmark study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which was conducted at the request of Congress. According to Dr. Brian Smedley, Director and Co-Editor of the report:

> Importantly and perhaps foremost, we found that the health care playing field is not level. It is not level for minorities, many populations of color who, on average, receive a lower quality and intensity of health care. These disparities are found with consistency across disease areas, clinical services and settings.... Importantly, these disparities are associated with higher mortality among racial and ethnic minorities.[52]

In *To Err is Human*, IOM reported on one study which found that "[m]ore than two-thirds (70 percent) of adverse events...were thought to be preventable, with the most common types of preventable errors being technical errors (44 percent), diagnosis (17 percent), failure to prevent injury (12 percent) and errors in the use of a drug (10 percent)."[53] Highly technical surgical specialties, such as cardiac surgery, contributed to higher rates of medical errors.[54]

In *Unequal Treatment,* after reviewing the most recent data available, IOM researchers found racial and ethnic differences in cardiovascular care and significant racial differences in the receipt of appropriate cancer diagnostic tests, treatments and analgesics, all of which led to higher death rates among minorities.[55] Racial and ethnic disparities were also evident in diabetes care, end-stage renal disease and kidney transplantation, pediatric care, maternal and child health services and many surgical procedures.[56] In some cases, minorities were more likely to receive less desirable procedures, such as amputation, than non-Hispanic whites.[57]

Other credible studies have uncovered evidence that race and ethnicity influence a patient's chance of receiving specific procedures and treatments. For example, according to the Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services, the length of time between an abnormal screening mammogram and the follow-up diagnostic test to determine whether a woman has breast cancer is more than twice as long for Asian-American, African-American and Hispanic women as it is for white women.[58]

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[51] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).
[52] Testimony of Dr. Brian Smedley during hearing with U.S. Representative Eddie Bernie Johnson (D-TX.) and the Asian-Pacific-American and Hispanic Caucuses on Health Disparities, April 12, 2002.
[53] Kohn, Corrigan and Donaldson, eds., *To Err Is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, D.C. (1999), p. 30.
[54] *Ibid.*
[55] Smedley, Stith and Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), Institute of Medicine, National Academy Press: Washington, D.C. (2002), p. 5.
[56] *Ibid* at 5-6.
[57] *Ibid.*
[58] Agency for Healthcare Research and Quality, "Addressing Racial and Ethnic Disparities in Health Care" (February 2000), found at http://www.ahrq.gov/research/disparit.htm.

Moreover, as discovered by AHRQ, relative to non-Hispanic whites, racial and ethnic minorities are less likely to receive appropriate cancer care, cardiac care, diabetes care, pediatric care and many surgical procedures.[59] In one AHRQ study, white patients were more likely than Hispanic and African-American patients to "receive invasive cardiac procedures in hospitals performing a high volume of such procedures, a factor strongly associated with the quality of cardiac care."[60] In other words, white patients are more likely to be treated in hospitals with experienced surgeons who are less likely to commit errors.

Racial prejudice may influence how minorities are treated by the health care industry. IOM researchers discovered that stereotyping, biases and uncertainty might play a role in medical disparities. Data showed that one-half to three-quarters of white Americans believe that minorities – particularly African-Americans – are less intelligent, more prone to violence and prefer to live off welfare compared to whites.[61] "In the United States, because of shared socialization influences," says the IOM, "there is considerable empirical evidence that even well-meaning whites who are not overtly biased and who do not believe that they are prejudiced typically demonstrate unconscious implicit negative racial attitudes and stereotypes."[62] (This group of "well-meaning whites" necessarily includes white healthcare providers, who, according to the IOM, may fail to recognize manifestations of prejudice in their own behavior.[63])

It is clear that whatever the cause, racial and ethnic minorities are receiving inferior medical treatment by the health care industry and are being subjected to high rates of preventable medical errors.

Following the IOM study, several New York newspapers ran extensive series on the degree and cost of malpractice in New York. In March 2000, a *New York Daily News* week-long investigative series found that "hundreds of New York State doctors, dentists and podiatrists – ranging from modest practitioners to prominent surgeons – have amassed extensive hidden histories of malpractice yet continue to treat patients." Moreover, "making even three malpractice payments is rare – only 1% of the nation's doctors have crossed that line, according to the national database. But those doctors account for 24% – or $5.6 billion – of the money paid to aggrieved patients.... The effect of failing to crackdown on the tiny percentage of doctors with the worst malpractice records is stunning, because they are a powerful driving force behind medical misfeasance nationwide."[64]

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[59] Agency for Healthcare Research and Quality, "Fiscal Year 2003: Research on Health Care Costs, Quality of Outcomes (HCQO)," found at http://www.ahcpr.gov/about/cj2003/hcqo03d.htm; Agency for Healthcare Research and Quality, "AHRQ Focus on Research: Disparities in Health Care" (March 2002), found at http://www.ahrq.gov/news/focus/disparhc.htm; Agency for Healthcare Research and Quality, "Addressing Racial and Ethnic Disparities in Health Care" (February 2000), found at http://www.ahrq.gov/research/disparit.htm.

[60] Agency for Healthcare Research and Quality, "Addressing Racial and Ethnic Disparities in Health Care" (February 2000), found at http://www.ahrq.gov/research/disparit.htm.

[61] Smedley, Stith and Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, National Academy Press: Washington, D.C. (2002), p. 10.

[62] *Ibid.*

[63] *Ibid.*

[64] Russ Buettner and William Sherman, "The 15 Most Sued Doctors In New York; Operating In The Dark," *New York Daily News*, March 5, 2000.

These conclusions are similar to those found by Public Citizen's Health Research Group, which found that just 7 percent of New York's doctors are responsible for 68 percent of malpractice payouts, according to the group's examination of National Practitioner Data Bank data.[65]

Since then, the statistics have only gotten worse. According to a November 2010 study by the Office of Inspector General of the U.S. Department of Health and Human Services, about 1 in 7 hospital patients experience a medical error, 44 percent of which are *preventable.*[66] The study concludes, "Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events."[67] In addition, the cost to Medicare of these errors was $4.4 billion a year.[68] Moreover, it noted, "These Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations."[69]

Meanwhile, Public Citizen called the New York Department of Health's record of disciplining clearly bad doctors "shameful."[70] In 2007, they wrote:

> Between September 1990 and December 2006, 6,186 New York doctors made two or more malpractice payments. For comparison purposes, that figure represents only 7.7 percent of the 80,681 licensed physicians in New York in the first half of 2007, and probably far less than 7.7 percent of doctors practicing in the time period. (New York almost certainly had significantly more than 80,681 licensed physicians since 1990 because the 2007 data represent only a snapshot in time.) But that small share of doctors was responsible for a whopping 71 percent of dollars paid out for medical malpractice in the time period. Barely one-in-twelve (8.5 percent) of physicians with two or more payments has experienced any license-related disciplinary actions by the state.
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> Just 3,052 physicians made three or more malpractice payments in the time-frame studied. Yet these physicians, who represent no more than 4 percent of the state's doctors in the time period and likely significantly less than that, have been responsible for nearly half (49.6 percent) of dollars paid for malpractice incidents since 1991. Of these doctors, only 10.8 percent have received licensure actions. Even more troubling is the fact that less than a third (31.5 percent) of the doctors who made *ten or more* payments have had a reportable licensure disciplinary action.

For example:

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[65] "Just 7 Percent of New York's Doctors Are Responsible for Two-Thirds of Malpractice Payouts, Study Shows," March 10, 2003.
[66] U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.
[67] *Id* at iii.
[68] U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.
[69] *Id* at ii-iii (emphasis in original).
[70] Public Citizen Study, "A Self-Inflicted Crisis: New York's Medical Malpractice Insurance Troubles Caused by Flawed State Rate Setting and Raid on Rainy Day Fund" (November 2007).

Physician number 59877 made 14 payments totaling $10.6 million between 1994 and 2005. These included three obstetrics payments totaling $2.7 million for "failure to monitor" and a $325,000 surgery-related payment for "wrong body part."

Physician number 27991 made 12 payments totaling $9.8 million between 1994 and 2006. These included nine obstetrics payments totaling $8.8 million.

Physician number 118288 made nine payments totaling $8.1 million between 1998 and 2005. Five of the payments were obstetrics-related. In 2003, the physician made a $1.9 million payment for "improperly performed c-section."

Physician number 25575 made nine payments totaling $8 million between 1992 and 2005. All but one of the payments was obstetrics-related. The physician made five payments for $4.3 million for "improper performance," and one payment of $995,000 for "improper choice of delivery method."

Physician number 24027 made five payments between 1994 and 2004, totaling $7.8 million, including 2 payments for "improper choice of delivery method" and one payment of $5.3 million for "delay in performance."

FEAR OF LITIGATION IS NOT THE MAIN REASON DOCTORS FAIL TO REPORT ERRORS

- A January 2012 report from the U.S. Department of Health and Human Services (HHS) found that massive error underreporting at hospitals is caused by widespread employee failure to recognize patient harm.[71] According to the HHS Inspector General, "[T]he problem is that hospital employees do not recognize 'what constitutes patient harm' or do not realize that particular events harmed patients and should be reported. In some cases, he said, employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or 'suspected that the events were isolated incidents unlikely to recur.'"[72]

- According to a 2006 study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of Internal Medicine*, "Comparisons of how Canadian and U.S. doctors disclose mistakes point to a 'culture of medicine,' not lawyers, for their behavior."[73] In Canada, there are

[71] Robert Pear, "Report Finds Most Errors at Hospitals Go Unreported," *New York Times*, January 6, 2012, found at http://www.nytimes.com/2012/01/06/health/study-of-medicare-patients-finds-most-hospital-errors-unreported.html (citing U.S. Department of Health and Human Services, Office of the Inspector General, *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm* (January 2012), found at http://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf).

[72] *Ibid.*

[73] Carol M. Ostrom, "Lawsuit fears aren't reason for docs' silence, studies say," *Seattle Times*, August 17, 2006, found at http://seattletimes.nwsource.com/html/health/2003204605_apologies17m.html (citing from Thomas Gallagher, M.D. et al, "Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients," *Archives of Internal Medicine*, August 14, 2006).

no juries, non-economic awards are severely capped and "if patients lose their lawsuits, they have to pay the doctors' legal bills...yet doctors are just as reluctant to fess up to mistakes."[74] Moreover, "doctors' thoughts on how likely they were to be sued didn't affect their decisions to disclose errors."[75] The authors believed "the main culprit is a 'culture of medicine,' which starts in medical school and instills a 'culture of perfectionism' that doesn't train doctors to talk about mistakes."[76]

- Research by George J. Annas, J.D., M.P.H. "found that only one quarter of doctors disclosed errors to their patients,"[77] but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance"[78] (*i.e.*, no litigation against doctors) for decades. In other words, "[t]here are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."[79]

FAR FROM BEING "BROKEN," EXPERTS SAY THAT THE CURRENT MEDICAL MALPRACTICE SYSTEM WORKS

While hype about "out-of-control" verdicts and frivolous lawsuits tends to dominate discussion around this issue, the facts and objective studies tell a different story. For example, "[s]ome of the largest medical malpractice awards in New York that made national headlines ultimately resulted in settlements between 5 and 10 percent of the original jury verdict actually being paid."[80]

Last year, Americans for Insurance Reform produced a study called "Medical Liability and Malpractice Insurance in New York State," which examined over 30 years of New York insurance data. AIR found, "Inflation-adjusted payouts per doctor in New York State have been stable, have failed to increase in recent years, and are comparable to what they were in the early 1980s."[81]

In an October 2011 study, California State University, Northridge Economics Professor and Cato Institute Adjunct Scholar Shirley Svorny analyzed existing empirical data and found that the medical malpractice system works just as it should. As Svorny explained,

- "The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs' attorneys, paid on a contingency basis, filter

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[74] *Ibid.*
[75] *Ibid.*
[76] *Ibid.*
[77] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.
[78] *Ibid.*
[79] *Ibid.*
[80] Valerie P. Hans and Neil Vidmar, *American Juries: The Verdict.* Amherst, NY: Prometheus Books (2007) at 333.
[81] See, http://insurance-reform.org/AIRNYMRTF.pdf.

out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements."[82]

- "The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court."[83]

- "Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims."[84]

- "Critics of the medical malpractice system point to its high administrative costs. ...Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice."[85]

Similarly, in its 2006 closed claims study, the Harvard School of Public Health reported that legitimate claims are being paid, non-legitimate claims are generally not being paid and "portraits of a malpractice system that is stricken with frivolous litigation are overblown."[86] Among the researchers' more significant findings:

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.[87]

- Eighty percent of claims involved injuries that caused significant or major disability or death.[88]

- "The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."[89]

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[82] Shirley Svorny, "Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?" *Cato Institute*, October 20, 2011 at 3, found at http://www.cato.org/pubs/pas/pa685.pdf.
[83] *Ibid.*
[84] *Ibid.*
[85] *Ibid.*
[86] David M. Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," 354 *N Engl J Med* 2024, 2025, 2031(2006), found at http://www.hsph.harvard.edu/faculty/michelle-mello/files/litigation.pdf.
[87] *Id.* at 2027-2028.
[88] *Id.* at 2026.
[89] *Id.* at 2030-2031 (2006).

- "[D]isputing and paying for errors account for the lion's share of malpractice costs."[90]

- "Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. ...[F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims."[91]

LITIGATION IMPROVES PATIENT SAFETY

David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice.[92] They confirm, "The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. ... [T]wo major factors forced their hand: malpractice claims and negative publicity.... Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it."[93] As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious: Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.[94]

In a breakthrough article by George J. Annas, J.D., M.P.H., the *New England Journal of Medicine* confirmed that litigation against hospitals improves the quality of care for patients. The author wrote, "In the absence of a comprehensive social insurance system, the patient's right to safety can be enforced only by a legal claim against the hospital. ... [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.... Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000."[95]

Numerous other medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.[96] As a result of such lawsuits, the lives of countless other patients have been saved.

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[90] *Id.* at 2031.
[91] *Ibid.*
[92] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," *90 Cornell L. Rev.* 893, 917 (2005).
[93] *Ibid* at 920, 921.
[94] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid,* 59 Vand. L. Rev. 1085, 1131 (2006).
[95] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.
[96] Meghan Mulligan & Emily Gottlieb, "Hospital and Medical Procedures," *Lifesavers: CJ&D's Guide to Lawsuits that Protect Us All,* Center for Justice & Democracy (2002) at A-36 *et seq.*, B-12 *et seq.*

The Harvard Medical Practice Study also acknowledged, "[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system."[97]

THE BEST WAY TO REDUCE MALPRACTICE LITIGATION IS TO REDUCE THE AMOUNT OF MALPRACTICE

NY Presbyterian Hospital-Weill Cornell Medical Center Obstetric Safety Initiative

- In the February 2011 *American Journal of Obstetrics & Gynecology*, three physicians published an article about a comprehensive obstetric patient safety program that was implemented in the labor and delivery unit at NY Presbyterian Hospital-Weill Cornell Medical Center, beginning in 2002.[98] This program initially came at the recommendation of the hospital's insurance carrier, MCIC Vermont. The authors wrote, "Our experience supports the recommendation that: '. . . Malpractice loss is best avoided by reduction in adverse outcomes and the development of unambiguous practice guidelines.'" Specifically, they say:

> After an external review of our obstetric service, we undertook comprehensive system changes beginning in 2003, to improve patient safety on our service. Among these patient safety changes were significant eliminations in practice variations as well as significant improvements in communication methods between staff. The main goal of these changes was to improve patient safety and decrease adverse outcomes.
>
> For example, they used team training and other methods to improve communication, electronic medical record charting, improved on call scheduling, established new drug protocols, premixed and color coded solutions, hired full time patient safety obstetric nurses funded by the carrier, made better use of physicians assistants and put a laborist on staff, required certification in electronic fetal monitoring and held obstetric emergency drills.
>
> They found that "that implementing a comprehensive obstetric patient safety program not only decreases severe adverse outcomes but can also have an immediate impact on compensation payments." For example, they reported that "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

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[97] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing Paul C. Weiler, Joseph P. Newhouse, & Howard H. Hiatt, *A Measure Of Malpractice: Medical Injury, Malpractice Litigation, And Patient Compensation* 133 (1993).

[98] Amos Grunebaum, MD; Frank Chervenak, MD; Daniel Skupski, MD . Effect of a comprehensive obstetric patient safety program on compensation payments and sentinel events, *American Journal of Obstetrics & Gynecology*, February 2011. http://www.scribd.com/doc/49879103/Columbia-Presbyterian-Patient-Safety-Study

compensation payment in the 3 years from 2007 to 2009 was $2,550,136 as compared with an average of $27,591,610 in the previous 4 years (2003-2006), a yearly saving of $25,041,475 (total: $75,124,424) during the last 3 years."

Beth Israel Deaconess Medical Center

I served on a New York State Medical Malpractice Task Force in 2007 and 2008, which among other things, discussed ways to improve patient safety as the best means of reducing injuries, claims, lawsuits and costs to the system. The presentation by Dr. Ronald Marcus, Director of Clinical Operations, Department of OB/GYN at Beth Israel Deaconess Medical Center and Assistant Professor of the Harvard Medical School, was instructive. His presentation not only acknowledged the extent of birth injuries caused by OB error but also discussed the reasons for this and proven methods to correct the situation.

As did the NY Presbyterian Hospital-Weill Cornell Medical Center authors, Dr. Marcus also specifically discussed the concept of team training or crew resource management that was developed by NASA to deal with pilot error. Dr. Marcus found that with crisis management training in OB emergencies, patient outcomes dramatically improved, with a 50 percent decrease in low Apgars, neonatal encephalopathy. With crew resource management in place, there was a 23 percent decrease in frequency and 13 percent decrease in severity of adverse events, and a 50 percent decrease in OB malpractice cases. It should be noted that if medical errors were not the cause of a certain birth-related injuries, as some doctors insist, clearly these kinds of statistics would not exist.[99]

Rand Institute for Civil Justice

- In 2010, the Rand Institute for Civil Justice released a new report funded, in part, by insurance companies, which examined whether successful patient safety efforts lead to reductions in medical malpractice claims, since apparently no study had yet looked at this issue.[100] Rand looked at California hospitals from 2001 to 2005 and found that indeed it does. Specifically, the authors found:

    - [There is a] highly significant correlation between the frequency of adverse events and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims.

[99] See also, Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 (An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care.").

[100] Greenberg, Michael D., Amelia M. Haviland, J. Scott Ashwood and Regan Main. Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California. Santa Monica, CA: RAND Corporation, 2010. http://www.rand.org/pubs/technical_reports/TR824.

- We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant.

- These findings are consistent with the basic hypothesis that iatrogenic harms are a precursor to malpractice claims, such that modifying the frequency of medical injuries has an impact on the volume of litigation that spills out of them. Although this is an intuitive relationship, it is not one that has been well validated previously. It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers.

- [N]ew safety interventions potentially can have positive effects on the volume of malpractice litigation—a desirable result to seek out, even beyond the immediate impact of medical injuries avoided.

- Presumably, the one thing that all parties to the debate can agree on is that reducing malpractice activity by reducing the number of iatrogenic injuries is a good idea. Arguments about the merits of statutory tort intervention will surely continue in the future, but to the extent that improved safety performance can be shown to have a demonstrable impact on malpractice claims, that offers another focal point for policymakers in seeking to address the malpractice crisis. Based on the results of the current study, we would suggest that that focal point may be more immediately relevant than has previously been recognized.

CONCLUSION

For many years, we have assisted families from around the nation who have traveled to Albany and Washington, D.C. to voice their strong opposition to bills and documents like Proposed Res. No. 84-A. These families are the forgotten faces in the debate over how to reduce health care and insurance costs, and I hope that, at some point, City Council decides to hear from them.

Dr. Lora Ellenson, a pathologist at NY Presbyterian Hospital-Weill Cornell Medical Center, is one. Her now 13-year-old son, Thomas, was brain-damaged from a birth injury due to negligence. She spoke to the *New York Daily News* last year[101]:

> "My son cannot walk or talk. He is not able to carry out activities of daily living – eating, dressing, toileting, bathing – without constant assistance from an adult. He also needs a motorized wheelchair, a speech output device and a wheelchair-accessible van, just to name a few."

[101] Denis Hamill, "Doctor with disabled son is no fan of governor's plan to cap malpractice suits," *New York Daily News*, March 13, 2011.

Had the Ellenson's not won a malpractice award well above the proposed $250,000 she would have had to quit her job to stay home with her son every day.

"Even with all the support, my son will face huge challenges throughout his life including his ability to move freely in the everyday world, to have a profession, to build friendships. Many of the things created for nondisabled individuals will never be available to him – climbing simple stairs, eating with utensils, swimming at a beach, rearranging the covers on his bed....

"As a physician, I have also had to grapple with the implications for my profession. I have had to come face-to-face with the knowledge that mistakes are made. Like most physicians, I live with the reality that we might one day make an error and be sued. When that day comes, I will be grief-stricken, not because of the process – although I am sure that won't be pleasant – but due to the fact that I may have caused someone irreparable damage.

"My only hope is that the damaged person can get what they need to live in the best way that they are able. As a physician, I want to know that there will be compensation to rebuild a life that has been diminished. Yet, as a mother, I also know that no typical physician, nor the system within which they operate, can possibly understand the true depth of these mistakes."

Meanwhile, New York's insurance laws do not force medical malpractice insurance companies to disclose even basic information to lawmakers or the public that could substantiate or refute their allegations about the financial health of the industry, why doctors are being charged certain premiums or the impact of New York's civil justice system. The need for data disclosure is urgent. We also believe the State Insurance Department must take a far more active role controlling insurance rates.

The state should also review its programs that help place physicians in underserved areas. New York has had a program to provide financial assistance to encourage physicians to practice in underserved areas. A review of this program must examine what reforms, or expansions, are needed.

History is clear on one thing, however: Taking away the rights of the most seriously injured New Yorkers has been and continues to be a failed public policy. Laws and proposals that increase the obstacles sick and injured patients face in the already difficult process of prevailing in court are certainly the wrong way to respond to the important problems that face this city and state. Our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights. Indeed, our goal must be to reduce medical negligence. Moreover, effective insurance reforms are the only way to stop the insurance industry from abusing its enormous economic influence here, which it uses to promote a legislative agenda that bilks taxpayers and severely hurts New Yorkers.

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THE BLACK INSTITUTE

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Testimony of Bertha M. Lewis
President and Founder
The Black Institute

Before the New York City Council Committees on Health and Women's Issues

Re: Proposed Resolution No. 84-A

January 31, 2012

Good afternoon, Chairs Arroyo and Ferreras, and thank you for the opportunity to testify before this joint hearing of your committees today.

My name is Bertha Lewis, and I am the founder of the Black Institute. The Black Institute, based here in New York City, is an "action tank" whose mission is to shape intellectual discourse and impact public policy from the perspective of Black people in America and people of color throughout the diaspora.

I'd like to begin by commending Council leaders for their decision to focus on barriers to women's health care providers. I applaud your effort to seek new and innovative ways to improve access to women's health care across the City. Women of color in New York City, and across the country, are disproportionately affected by limited access to quality health care, particularly the primary care they need to live health lives.

Black doctors providing women's health care also face unique challenges and obstacles, both because of the communities they serve and their place within the medical profession.

However, I take great exception to the resolution under consideration here today. Addressing only malpractice insurance premiums ignores the many complex issues standing in the way of providing first-class health care to all New York City's women, and particularly women of color. Bringing clinics and hospitals back to low-income communities and ensuring that everyone receives quality care demands far more than improving the bottom-line for insurance companies.

The committee is right to address the issue of access to women's health care. Low-income communities of color do face significant barriers to adequate women's health care, including proper ob-gyn care. However, this resolution addresses only malpractice premiums, which are insignificant when compared with the greater challenges facing our communities.

For example, low-income communities of color rely heavily on Medicaid; up to three quarters of all births in the Bronx are funded by Medicaid or Family Health Plus. Historically, New York's Medicaid reimbursement rates have been far too low – as recently as 2008, New York had the 47th lowest Medicaid obstetrical care fees among the 50 States, according to the Kaiser Foundation.

Since 2008 New York has increased its Medicaid obstetrics reimbursement rates somewhat, but many years of having among the lowest rates in the nation has exerted enormous financial pressure on clinics and other women's health care providers in low-income communities of color.

And reimbursement rates for obstetric care are still way too low; reimbursement for a routine delivery, including postpartum care, is still only $1,720. Reimbursement rates paid by private health care plans for the same services in more privileged communities are many thousands of dollars more. How can doctors and clinics be expected to maintain their services in low-income communities under these financial circumstances?

Improving access to women's health care in our communities depends on increasing State and Federal investment in healthcare, particularly primary care and women's health providers, and increasing Medicaid reimbursement rates; tinkering with insurance premiums will do little or nothing to address long-standing under-investment in our communities' health care systems.

I also strongly condemn the suggestion raised by this resolution that women and children of color harmed by medical malpractice, whether in the delivery room or the radiologist's lab, are unjustly compensated for their injuries. Children injured by malpractice during childbirth face terrible injuries that last a lifetime; women die when a radiologist misreads a mammogram. The costs of compensating women and children of color gravely harmed by malpractice are small when compared to the harm done by negligent doctors and hospitals.

Sadly, people of color are disproportionately impacted by medical malpractice. They suffer more missed diagnoses, more instances of medically needed procedures and emergency interventions not done or delayed or important medications that are not timely administered, and, as a result, more medical errors and poorer outcomes.

According to a report of the Institute of Medicine, research has consistently demonstrated what people of color, especially women of color, have known all along: minorities and people of color experience lower quality health services, and are less likely to receive even routine medical procedures regardless of their income-level or insurance status. The Institute of Medicine documented consistently lower quality care received by people of color in cancer testing, pediatric care and all kinds of surgical procedures.

And do not make the mistake of thinking that this type of medical discrimination could not be a problem here in liberal New York. The U.S. Agency for Healthcare Research and Quality found that the quality of care provided to minorities and people of color in New York, measured by deaths and adverse events, was "weak" or below average. Worse still, minorities were found to be much more likely to die from complications during hospitalization.

According to a Harvard Medical Practice Study of hospitals in New York, people of color not only experience lower quality care, but they are also much more likely to be treated in hospitals with higher rates of negligence.

In other words, access to high quality health care is a life-or-death issue for people of color; this resolution's repetitive focus on premiums does nothing to address this critical issue.

Improving the quality of health care for people of color and all New York City's health care consumers, is vital, achievable, and coincidentally would do much to bring down the cost malpractice for hospitals and insurance companies.

Hospitals nationwide have had great success in reducing medical errors, particularly in the field of obstetrics. At the Hospital Corporation of America, a wholesale redesign of patient safety measures in obstetrics more than halved the number of malpractice claims against their hospitals, and resulted in "nearly a 5-fold reduction in the cost of claims" according to an article in American Journal of Obstetrics and Gynecology.

One New York City hospital has done an excellent job of replicating this success. New York-Presbyterian Hospital implemented a comprehensive safety program, including enhanced communications amongst staff, improved medical record charting, standardized staffing requirements, proper training and supervision, and controlled medication usage. The hospital reduced yearly obstetric-related malpractice payments by 99% and eliminated maternal deaths and other injuries during labor and delivery. If New York-Presbyterian can do this, so can other New York hospitals.

Women of color have for too long suffered and died as a result of medical malpractice. This committee should be focused on encouraging and implementing measures such as those adopted by New York-Presbyterian throughout New York City's hospitals, to ensure that all New Yorkers receive the high standard of care they deserve.

It is an affront to frame the issue of women's access to the health care they deserve as simply a matter of malpractice insurance premiums. As a voice for the black community, I respectfully ask that you reconsider this resolution in its entirety.

Thank you once again for the opportunity to testify today.

Testimony of Deborah Axt, Make the Road New York

Good afternoon, Chairperson Arroyo, Chairperson Ferreras, and members of the Health and Women's Issues. Let me begin by thanking you for the opportunity to testify here today.
My name is Kraig Cook and I am here reading the testimony of Deborah Axt, the deputy director of Make the Road New York. Make the Road promotes economic justice, equity and opportunity for all New Yorkers through community and electoral organizing, strategic policy advocacy, leadership development, youth and adult education, and high quality legal and support services. For many years Make the Road has actively campaigned for legislation and other initiatives that promote equal access to health care and tackle health problems that disproportionately impact low-income communities.
The proposed Resolution is a distraction from the real healthcare issues that confront our communities – the issues of access not just to women's health services, but to quality healthcare for all.

Medical malpractice insurance premiums are not one of the reasons why in lower-income communities too many women do not have adequate access to obstetrical services and to primary care generally. After all, medical malpractice insurance premiums are higher on Long Island than they are in New York City, yet Long Island has far more doctors per capita than does New York State overall.

The real reasons are chronic underfunding of primary care in lower-income communities. According to the Kaiser Family Foundation, as of 2008 New York ranked 47th in obstetrical services fees and 48th in primary care fees paid to Medicaid physicians. It's no wonder that, according to the Resolution, there are primary care shortage areas in the Bronx.

It's true that New York spends more than any other state on Medicaid, but in New York 43% of Medicaid spending goes to long-term care compared to 33% for the U.S. overall, according to Kaiser. This has meant that our clinics that serve low-income women are barely holding on. It has also meant that several hospitals that served primarily a low-income population recently closed and others are on the verge of closure. Most of these hospitals had or have obstetrics departments.

St. Vincent's Hospital is a case in point. Although it was located in Greenwich Village, St. Vincent's treated mostly Medicaid and other low-income patients. A *New York Magazine* article

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in 2010 that examined why the hospital closed reported that inadequate Medicaid funding was a major factor, noting, "... the hospital industry complains that since 2007 the New York State Legislature has cut Medicaid funding nine times, at a cost of $900 million to local hospitals."

Health care providers in New York City's low-income communities also bear a heavy financial burden for treating uninsured women. In 2007, the Office of the NYC Comptroller released a study on healthcare disparities in New York that included a disturbing table listing communities where at least 30 percent of the residents were uninsured. In Sunset Park, for example, 40 percent were uninsured, in East Harlem 37 percent were uninsured, in Hunts Point-Mott Haven 36 percent were uninsured. Hospitals and community health clinics that treat the uninsured have to subsidize uninsured patients with funds from other important parts of their budget or by unsustainable levels of borrowing. The City has been trying to enroll more Medicaid-eligible uninsured New Yorkers, but there is still a long way to go.

The growth in New York's foreign-born population has been a major driver of these high uninsured percentages. According to the City's health department, in 2007, 52% of births in New York City were to foreign born women, an increase from 48% in 1998.

Unless Medicaid funding and payments for treating the uninsured are increased substantially, we can expect even more hospital closures in lower-income communities. Earlier this month we spoke out against the possible closure of Wyckoff Heights Medical Center. We said it would be disastrous for our community. I now add that it would eliminate needed obstetrical services -- in 2009, 1,675 babies were delivered there. Other endangered Brooklyn hospitals with maternity departments include Brooklyn Hospital, which delivered 2,829 babies, and Brookdale Medical Center, with 1,686 deliveries.

The possible closures and mergers of these hospitals are a serious threat to obstetrics services in Brooklyn. But the reasons these hospitals are threatened have nothing to do with their medical malpractice payments, which are a minute fraction of operating expenses. As the New York Magazine article on St. Vincent's explained, New York City's hospitals serve more uninsured patients, face higher costs and receive lower Medicaid and Medicare payments for services than hospitals elsewhere in the country. As one chief operating officer of a Bronx community hospital: "We're asked to do a dollar's work for 70 cents." Executive compensation is another burden on hospital finances; while many hospitals face financial ruin, in 2008 the president and CEO of New York–Presbyterian, Herbert Pardes, received $9.8 million in pay and compensation. As a result of so many financial pressures, many New York hospitals are saddled with unsustainable debt that can lead to bankruptcy and closure.

One of the clauses in the proposed Resolution is especially disturbing. It recommends a Michigan program that would disproportionately hurt people of color. In this program, the heath care provider that made a serious medical mistake apologizes to the injured patient and offers "fair compensation" -- outside of the civil justice system, with no judge, jury or lawyer to protect the patient's interests. Patients are pressured to settle for less than they could get if they filed a legal claim. It is an unfortunate reality that people of color in the U.S. are disproportionately harmed by substandard medical care. Numerous major studies have documented that they more frequently experience delayed treatment, missed diagnoses,

medications that are not administered, and higher rates of death or adverse incidents as a result of malpractice. For people of color this is already a matter of life or death; replicating the Michigan program in New York would strip patients of their legal rights and protections in a system that already discriminates against minorities.

This proposed resolution does nothing to address the real barriers to quality care that exist in New York City communities. Therefore, Make the Road must respectfully ask that the Health and Women's Issues committees reject the resolution in its entirety.

Thank you again for granting Make the Road New York the opportunity to testify today.

Christie Rich Testimony

Joint Committee on Health and Women's Issues Hearing - Tuesday, January 31, 2012

Good afternoon and thank you for allowing me to speak here today today. I am not an expert in health care, and I don't have any statistics to tell you, I am just a mother here to share my family's story with you.

When I was pregnant I had unexplained bleeding. I was discharged on 5 separate occasions from the hospital. When I was only 26 weeks pregnant I gave birth to premature twins, a boy and a girl. It was mothers' day. My daughter passed away 2 months later, and my son, John, suffers from Cerebral Palsy. John is now 8 years old and can't eat, talk, walk or do anything on his own. He uses a feeding tube and sometimes needs oxygen. He requires around-the-clock care and I wasn't able to return to work for years.

I suspected that my childrens' premature birth, my daughter's death, and my son's condition was caused by the negligence of the doctors who saw me during pregnancy. The case is still pending and right now all expenses are either through insurance or out of pocket.

Presently we are being told that we don't qualify for a full-time Nurse through the insurance company. John Jr.'s father and I take turns watching him. I work nights as a corrections officer.

Although we are very lucky to have John Jr., the rest of our lives will be extremely difficult.

I am here to ask you only one thing: please do not do anything that would make the lives of families such as my own any more difficult. John Jr. will need care for the rest of his life and it should not be the taxpayers who pay for it -- it should be the people whose negligence caused his condition.

Thank you.

Christie Rich

Testimony of Elizabeth Colin
Joint Committee on Health and Women's Issues Hearing
January 31, 2012

Good afternoon. Thank you for allowing me to share my story with the Committee. I am someone who has been affected by medical malpractice and I know how it can turn a family's life upside down.

In 2004 I saw 3 doctors after feeling a lump in my breast. I had a mammogram but the doctors assured me that everything was fine and I should come back in a year for a routine visit. After a few months the lump got bigger and I went back to my doctor, who finally referred me to a breast surgeon. By that point there was also a spot on my spine and I was told I may have stage IV cancer.

Because of the concern about the advanced stage of the cancer, the doctors were not sure that I was even a candidate for chemotherapy. I never thought I would be praying to be able to have chemotherapy.

What I went through next I would not wish on my worst enemy. Throughout the next 9 months, I endured surgery, radiation, and chemotherapy. My singular focus was getting through these enervating treatments, anxiously hoping that they were not in vain. It wasn't until I finished months of chemo, followed by 6 weeks of radiation therapy that I thought I may be the victim of malpractice.

I hope that I'll have years ahead to enjoy my wonderful family, but know that I am fortunate to have at least reached 60. I know, however, that not everybody is so lucky. I can't fathom what it would be like to have gone through what I did and have a young family to take care of - and worry that I might not be there for them. Many women younger than I am do not make it because they are treated negligently by their doctors, and it is unimaginable to think that they and their families may not have any recourse.

I hope that whatever the outcome of this hearing, it does not include further injustice to those who have already suffered terribly from malpractice.

Thank you.

Elizabeth Colin

Medicaid Redesign Team Medical Malpractice Work Group Recommendations from Dr. Lee Goldman, Executive Vice President and Dean, Columbia University Medical Center

The Work Group should strive to meet three very important goals (1) increase patient access to health care, (2) protect and improve patient safety, and (3) reduce costs for providers and to the health system overall. These goals are not mutually exclusive. Too often the debate is cast as one of malpractice reform vs. patient safety. This is a false choice. We need and can reduce both the number of preventable medical errors and the malpractice premiums that providers pay.

No one is seeking to deny just, prompt, and reasonable compensation to patients who suffer harm as the result of the negligence of a hospital or doctor. But the system as it exists in New York today is out of control, with our State having among the highest, if not the highest, costs in the nation. Perhaps even worse, there is also often a disconnect between the quality of care and the likelihood of patient recovery of damages. The tort system should compensate for and punish bad medicine, but all too often it seems to do so merely for bad outcomes. During the course of his or her career, 99% of physicians practicing in a high risk specialty, like obstetrics or neurosurgery, will face a malpractice claim. We can argue about what percentage of these types of doctors practice bad medicine, but I would hope that we could agree that it is nowhere near 100%.

One other theory often espoused is that somehow the real villains are the insurance companies who are using the medical malpractice reform movement as a way to increase profits and who will not return any savings to the doctors. Whatever the case may be in other states, this is not so in New York. An overwhelming majority of the physicians and hospitals are insured by non-profit organizations, provider-owned companies, or other forms of cooperatives. They do not get their insurance from traditional for-profit companies, so if there are savings to be had, they are normally distributed to the providers in the form of dividends or the reduction in future premiums. We are insured through MCIC Vermont, which we, along with several other academic medical centers, control. If the problem was greedy for-profit insurance companies, our rates from our own insurer would be significantly less than we could get elsewhere. They are not.

Along these lines, I am very wary of any solution which looks at the medical malpractice issue as just an insurance problem. We must reform the system and not just attempt to regulate or subsidize premiums. That would miss the point and not be fair to taxpayers and ratepayers.

Recommendations

Caps on Non Economic Damages: Caps have been demonstrated to be the best and quickest way to lower medical malpractice costs. They are however very controversial. In order to achieve consensus, perhaps we could explore ways to provide some flexibility or even rare exceptions to the caps.

Strengthening and Expanding the Medical Indemnity Fund: Although it is still early, preliminary indications are that the Medical Indemnity Fund is a successful tool to lower costs and ensure the patient receives quality health care throughout the course of his or her life. The work group should look at ways to ensure the fund is adequately funded and perhaps expand it to cover other types of cases.

Safe Harbor: As mentioned earlier, too often the system awards damages for bad outcomes, not bad medicine, and even providers who meet and exceed the standard of care incur large medical malpractice costs. This should not be. Providers who practice according to accepted guidelines should be exempt from liability, and we need to develop a system under which the guidelines are more clearly set forth and can be fairly applied by a judge or jury.

Expert Witness Testimony: Expert witness testimony should be subject to discovery and deposition. This is just basic fairness and, to the best of my knowledge, New York is the only state which disallows this common sense approach, and it does so only in medical malpractice cases. The federal courts also provide for expert witness discovery. The purpose of a trial is to determine a just result based on the law and the facts. The outcome should not be based on surprising the other party, who is then unprepared to question a witness. In addition, legitimate expert disclosure gives greater information to all litigants and provides both sides with greater opportunities to evaluate their cases. Broader pretrial expert disclosure also would aid the courts in identifying legitimate opportunities for pretrial resolution. As such, many believe that it will promote settlements. The argument that experts would somehow be subject to intimidation or peer pressure is simply specious. With all the advances in evidence based medicine, physicians often testify against other doctors when they feel the situation warrants it.

Joint and Several Liability Reform: As with non-economic damages, defendants, especially those who were minimally responsible for the plaintiff's harm, should be held

responsible only for their share of the economic damages. This is simple fairness and will lead to quicker and more efficient disposal of cases against certain defendants.

Current New York law limits a joint tortfeasor's liability for non-economic losses to its proportionate share provided if he/she is 50% or less at fault. However, the joint and several liability rule remains in full effect for economic damages. In many cases, economic damages are by far the largest portion of the award, meaning that a defendant who is found to be only partially or even minimally at fault could be responsible for most, if not the entire damage award, if other, more culpable defendants are insolvent or cannot satisfy their allotted shares of the award. The perverse result of the current law is a system that rewards limited insurance coverage and penalizes those who are fully insured. New York needs to adopt a "fair share" rule such that, unless a defendant's liability exceeds 50% or is based upon willful, reckless, or malicious conduct, damages are tied to the appropriate share of liability. The joint and several liability limitations applicable to non-economic damages need to be applied in the same way to economic damages.

Affidavit of Merit: The Certification of Merit requirement should be strengthened to require an affidavit from an appropriate qualified provider stating that the case against each defendant has merit before an action can be commenced. This will cut down on the number of frivolous lawsuits and the number of defendants sued simply because they were someone how involved in providing care to the plaintiff.

Currently, in order to satisfy this requirement, a plaintiff's attorney need only provide a certificate saying that he/she has consulted with a physician who believes the case has merit. The attorney does not have to provide the physician's name nor any other information. Certainly if a physician believes a case has merit, he/she should be required and willing to attach his/her name to that statement. There is also no requirement that the consulting physician practice in the field or area of the case at hand or that he/she still be in practice and knowledgeable about the current state of clinical practice and science. Under New York's current law, a retired dermatologist who hasn't seen a patient or read a medical journal in five years and who practiced in a completely different setting can be the basis for a certification in a complex OB/GYN case. Furthermore, the consulting physician can base his/her her opinion solely upon the information provided by the plaintiff's attorney without even reviewing the medical records. The Certificate of Merit requirement was designed to guarantee that a physician would review a case prior to its even being brought in order to support a good faith basis for bringing the lawsuit, but the current law falls far short of that goal.

Apology and Quality Assurance Statements Protections: Statements made by providers apologizing to a patient should not be able to be used against the provider in future

litigation. Doing so inhibits doctor-patient communication and forces the doctor and patient to take on adversarial roles. Allowing the doctor and patient to work together to solve problems and resolve disputes will, in many cases, lead to a quicker resolution that is better for both parties. Furthermore, statements made to review or quality assurance committees should be absolutely protected from discovery. The best way to ensure safety is to allow providers to be open and honest with each other and have free, frank, and often difficult conversations concerning adverse events. This will allow all providers to learn from experience and mistakes. This is not possible if those statements can be used in a future litigation. In the event a provider makes a medical error, the first thoughts should be how to fix it and prevent it from happening again, not how to limit the chances of getting sued.

Early Settlement: The efforts in the Bronx and other courts to encourage early settlements have been fruitful and should be continued and expanded. Judges should be further encouraged to dispose of cases earlier on in the process, especially where the defendant played only a tangential role in a patient's care. Judges should also be more aggressive, as is the case in federal court, in imposing sanctions against litigants and their attorneys who bring meritless cases or raise unreasonable defenses and claims.

Expert Discipline: It is fundamental to American jurisprudence that the jury hear expert opinion only from those who are both responsible and truly qualified. Nonetheless, in too many cases juries are allowed to hear from those whose views are not justifiable. It should be a form of professional misconduct for a doctor to give false expert testimony. The problem of irresponsible "experts" is compounded by the fact noted above that experts do not need to be disclosed and are not deposed prior to trial, minimizing the availability of motions designed to challenge the legitimacy of the expert's theory. Currently, the only recourse available is to report such a physician to his professional society, a number of which now have specific requirements for legitimate expert testimony. However, the enforcement is highly variable among societies, and the penalties too light. A professional misconduct charge by the Office of Professional Medical Conduct would be much more effective, particularly if it could have some jurisdiction over physicians from other jurisdictions who testify in New York.

Specialty Courts: One of the best, and fairest, methods of controlling the costs and delays inherent in our current medical malpractice system would be to have all such disputes settled by specialized courts where the judges are specially trained in medical malpractice issues. Estimates are that as little as 46% of premium dollars are ultimately received by plaintiffs. These "Specialized Courts" would shorten the time taken to

resolve such disputes, decrease the costs of such disputes and result in more accurate and fairer results for both sides.

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TESTIMONY OF

MILTON HAYNES, M.D., F.A.C.O.G.

BEFORE THE

NEW YORK CITY COUNCIL

COMMITTEES ON HEALTH AND WOMEN'S ISSUES

TUESDAY, JANUARY 31, 2012

HEARING ON

PROFESSIONAL AND FINANCIAL BARRIERS

FACING WOMEN'S HEALTH CARE PROVIDERS:

RESOLUTION 84-A

Good afternoon. My name is Dr. Milton Haynes. I am a Board Certified Obstetrician – Gynecologist and I have been practicing in New York City since 1974. I am a Senior Attending in the Department of Obstetrics and Gynecology, Lenox Hill Hospital; Clinical Associate Professor of Obstetrics and Gynecology, New York University School of Medicine; Chairman, Committee to Eliminate Health Care Disparities, Medical Society State of New York; Member, Committee to End Health Care Disparities, American Medical Association; and Past President, New York County Medical Society, which represents more than 6000 physicians who practice in New York City.

I welcome this opportunity to appear before your committee today and present testimony in support of Resolution 84-A. This resolution addresses a critical issue that has a monumental impact on all physicians who practice in this great city and state, and that is of utmost importance for the future of healthcare for the men and women, boys and girls, babies and the elderly who live in our city and state.

Over the past 37 years in the practice of Obstetrics and Gynecology, I have witnessed the steady rise of liability premiums. Resolution 84-A seeks to address the high cost of malpractice insurance for Obstetricians, Gynecologists, General Practitioners and Radiologists. However, issues related to malpractice liability are felt throughout all areas of the medical profession. Between 2003 and 2008, there was a 55-80% increase in premiums, and there was an additional increase of 5% in 2010. For some physicians this increase was greater. The following represents the current liability premiums for Ob-Gyn physicians for the policy year July 1, 2011- June 30, 2012:

$171,275.00 for physicians practicing in Bronx and Staten Island

$166,243.00 for physicians practicing in Brooklyn and Queens

$135,964.00 for physicians practicing in Manhattan

Other specialists also face the enormous burden of high liability premiums. For the current year, a Neurosurgeon in Nassau and Suffolk Counties will pay $206.393.00 for malpractice insurance, while his colleague in Brooklyn and Queens will pay $281, 225.00. A General Surgeon in Brooklyn and Queens will pay $116,989.00 and a Vascular Surgeon in the Bronx and Staten Island will pay $109,019.00. When you add the additional costs of running a medical practice -- office rent, staff salaries, supplies, equipment, etc. - the annual costs are extremely high. If this fact is coupled with the very low reimbursement obtained from Medicare, Medicaid and the HMOs and other managed care organizations, you can perhaps begin to fully appreciate why many physicians practicing in New York are literally struggling for survival.

The obvious question that is likely to be asked in light of what has been presented so far is this: Are physicians practicing in other states facing the same problems as physicians in New York? It would perhaps be somewhat consoling to be able to answer "Yes" to the question. However, the reality is that physicians in many other states are no longer facing the financial and liability hazards that physicians in New York face daily. In Texas, 90% of physicians have seen a minimum 30% reduction in their liability premiums since 2003. In California, which is similar to New York in many demographic areas, an Obstetrician-Gynecologist in Los Angeles pays less than 1/3 the premium that a physician in New York City pays. Why the difference? It is because

both of these states (Texas and California), along with others, have enacted comprehensive medical liability reforms. Consequently, while the liability rates in New York have been increasing, premium rates in Texas and California have been decreasing. Given the malpractice milieu, malpractice rates and the economic pressures on physicians - and given a choice to practice in New York, California or Texas - where would you decide to practice? According to the Texas Alliance for Patient Access, more than 1200 physicians who had trained in New York answered that question by relocating to Texas since that state enacted comprehensive medical liability reform legislation in 2003.

In the August 17, 2011, issue of the New York Post, there is an article about a Brooklyn female Obstetrician-Gynecologist who closed her practice and took her family and her best friend, also an Obstetrician-Gynecologist, to Houston, Texas. These two former practitioners in Brooklyn opened two offices and their practice is reported to be "thriving." They, like many others, moved to a state with a more favorable malpractice climate. In the last year, North Carolina, Oklahoma and Tennessee enacted laws to provide limits on non-economic damages in medical liability cases. This brings to over 30 the number of states that now have a cap on non-economic damages in medical liability cases

What does that Texas statistic mean to New York? It means that the residents of New York now have at least 1200 fewer physicians to address their health care needs. It means that access to care in New York has been affected by the sensible actions of another state. Multiply that reality by the 29 other states in which former New York State physicians are now practicing, or may consider practicing, and a picture emerges that, if allowed to continue, can have a deleterious impact on both access to care and quality of care. As fewer physicians try to see greater numbers of patients in a shorter period of time, this increases the risk of errors being made that would not normally be made. This increases the number of lawsuits, and a vicious cycle is activated that both perpetuates and exacerbates the crisis. Current insurance statistics show that every 5 years, 65 % of Neurosurgeons and about 50% of surgical specialists and Obstetrician-Gynecologists are sued. These are physicians who treat the most high-risk patients in New York.

Physicians at both ends of the medical practice spectrum – older physicians and physicians who are just starting out - are more significantly affected by the high overhead costs of practice in New York that are driven largely by malpractice premiums and awards. Older physicians are retiring earlier than they had planned, or are dropping the obstetrical portion of their practice. Younger physicians who are being trained in New York, and are facing repayment of high medical school debt and the malpractice climate in New York, are opting to begin their practice careers in other states. The percentage of residents staying in New York State after going to medical school in this state decreased from 53% in 2010 to 44% in 2011.

According to New York City Corporation Counsel Michael Cardoza, in his testimony to the Medicaid Re-design Team Work Group last year, the $561 million that is spent on tort cases could be better spent in providing needed services to New Yorkers. I agree, and so do all of my professional colleagues. The malpractice crisis in New York has a negative impact not only on individual physicians, but on city and state budgets as well. I, like all physicians in this state, was profoundly disappointed that New York State's 2011-2012 Executive Budget that was presented by Governor Andrew Cuomo did not include the proposed comprehensive medical liability reforms that were similar to those in Texas-- a state that many New York trained physicians now find to be an attractive place to practice. An editorial in the September 14, 2011, issue of *Buffalo News* stated, "After Texas imposed a $250,000 cap on non-economic damages, malpractice rates fell and the state was inundated with applications for licenses to practice there."

As a Black physician, I would like to add a dimension to this dialogue that may not be on the radar of others who appear before this committee today. According to a report by the joint Center for Political and Economic Studies that was published in 2009, over 30% of direct medical expenditure for patients who were African-American, Hispanic and Asian-American were excess costs linked to health inequalities. Between 2003 and 2006, these excess costs were $229.4 billion. Indirect costs of racial inequalities associated with illness and premature deaths accounted for more than a trillion dollars over the same period. Eliminating these inequalities would have saved the US economy a grand total of $1.25 trillion, according to the report.

There is a large body of evidence that documents the disparity in health care that exists today. The death rates from diabetes, heart disease, hypertension, nutritional deficiency, and all types of cancer in the Black/African-American and Hispanic/Latino population are significantly higher than in the White population. Maternal death rates and infant mortality rates in the minority population are also higher. There is also a lack of diversity on the professional level, with Black, Hispanic and Asian-American physicians comprising only about 6% of physicians in the US. And yet, projections from the latest Census Bureau statistics indicate that by 2042 there will no longer be a White majority population in the United States.

A 2004 Association of American Medical Colleges (AAMC) study revealed that 51% of African-American, 41% of Native American and 33% of Hispanic medical school graduates planned to practice in underserved areas. Only 18% of White graduates had similar intensions. Available data indicate that nearly half of the patients seen by Black physicians and one-third of the patients seen by Hispanic physicians are on Medicaid or uninsured.

Albany University's Center for Health Workforce Studies (CHWS) published a report in March 2010 that looked at the under- represented minority (URM) population and physicians

(Blacks/ Hispanic/ American Indian/ Alaska Native) in New York State. In 1995 the URM population was 28% and in 2008 it was 33%. In 1995, the percentage of URM physicians was 7%, and in 2008 it was 8%. About 30% of these minority physicians reported patient case loads of at least 50% Medicaid patients, compared to 12% of all other physicians. It is generally recognized that compliance and outcomes are better when patients and physicians share the same racial/ethnic background and physicians can provide culturally competent care. The director of CHWS, Jean Moore, stated, "These findings suggest that URM physicians, who improve the diversity and cultural competency of the physician workforce, can potentially increase access to care and quality of care for underserved populations in New York."

Given the monumental amount of money that is wasted on direct and indirect costs as a result of the disparity in healthcare, and given that this disparity can be reduced by an increase in the diversity of physician providers who are more likely to serve minority populations, it is imperative that every effort should be made to make it viable for minority physicians to practice in New York. It is clear from the Albany University study that while the under-represented minority population increased by 5%, the minority physician population only increased by 1%. The large overhead costs, including the exorbitant malpractice premiums, are having a disproportionate impact on the ability of minority physicians to practice and serve the communities that need them most. Every effort should, and must, be made to make New York an attractive state in which to practice medicine. With our many outstanding hospitals, top-rated medical schools and superbly trained physicians, our health care providers should be able to remain in New York and practice both the science and art of our profession without having to practice defensive medicine that contributes to additional billions of dollars being wasted.

The physicians of New York and the New York County Medical Society are strongly in support of Resolution 84-A. However, we also believe that maximum benefit will only be achieved if and when a comprehensive reform of the medical tort system is addressed, and re-consideration is given to the medical liability proposals that were recommended by the Medicaid Redesign Team (MRT) and supported by the Medical Society of the State of New York.

Please accept my thanks, personally and on behalf of the New York County Medical Society, for this opportunity to speak in support of this important Resolution. The physicians of New York are anxiously awaiting any assistance that can be obtained in reducing the high cost of malpractice premiums and in making the necessary statutory changes to reform our current medical liability system.

An Overview of the Testimony
of
Hon. Ann Pfau
Statewide Coordinating Judge for Medical Malpractice Matters

and

Hon. Douglas E. McKeon
Administrative Judge for Civil Matters 12th Judicial District

before

The Council of the City of New York's Committees on Health and Women's Issues

Chairpersons Arroyo and Ferreras and Members of
the Committees on Health and Women's Issues:

Thank you for the opportunity to speak with you today to describe what is happening in the Judiciary in the important area of the Committee's focus. We are pleased to describe to you one initiative that has resulted in significant strides in reducing medical malpractice premiums while, at the same time, lowering Medicaid costs because of a unique partnership between the Executive and Judicial branches of New York State Government. As part of a collaborative effort between the New York State Department of Health (DOH) and the Office of Court Administration (OCA) (the Judiciary's administrative arm) programs to enhance patient safety have been implemented, a Judge Directed Negotiation (JDN) Program has been expanded and a recently enacted Medical Indemnity Fund (MIF)

has been integrated by courts into pending obstetrical actions.

By way of background, New York's current Chief Judge Jonathan Lippman and the prior Chief Judge Judith Kaye have been visionary in creating problem solving courts that marry administering the law with responding to societal needs. In furtherance of that philosophy, OCA has utilized specialized programs which promote the early resolution of medical malpractice claims without - and this is critical - diminishing the Judiciary's role as a neutral magistrate or depriving litigants of their right to a trial by jury.

A good example is the highly successful judge directed negotiation program created in cooperation with the New York City Health and Hospitals Corporation (HHC), which originated in the Supreme Court, Bronx County, to deal with municipal hospital malpractice claims. Because of its success in the Bronx, the JDN/HHC Program was expanded to other counties in New York City. Thereafter, crediting the JDN Program, Crain's Health Pulse reported on June 23, 2009 that HHC's malpractice indemnity costs had dropped from a "highwater mark [of] $190,000,000 in 2003 to $144,000,000 in 2008." According to the AMA News, posted October 31, 2011, HHC's average expense per medical liability case dropped from $567,000 in 2003 to $428,000 in 2010. By comparison, Montefiore Medical Center's malpractice indemnity costs rose from $53,000,000 in 2005 to $115,000,000 in 2009.

On June 10, 2010, OCA was awarded a grant, in the amount $2,973,600,

from the Obama Administration (the Agency for Healthcare Research and Quality [AHRQ]) to expand its JDN Program and to work in conjunction with DOH to implement patient safety and early disclosure and resolution programs at five private New York City hospitals. Outside of New York City, a JDN Program was developed in conjunction with the Westchester County Medical Center, a municipal hospital, in the Supreme Court, Westchester County, and OCA was awarded a grant from the New York State Health Foundation to establish a JDN Program in the Supreme Court, Erie County (the Buffalo, New York area) to deal with medical malpractice claims involving three major health systems.

Dr. James Battles, who oversees the grant for AHRQ, has acknowledged, in various newspaper accounts, that the agency is "excited about [JDN] . . . . . because it uses the existing court system and [doesn't] require any special legislation." JDN is a judicially inspired and created settlement tool and method of medical malpractice case management. Since 2006, when HHC established its own Law and Claims Departments, there were 695 HHC medical malpractice dispositions in the Supreme Court, Bronx County, only four of which required jury selection. Of those four only two resulted in a jury verdict. The JDN model has, at its core, a rather basic philosophy: If you promote discussion about a case, analyzing its legal and medical pros and cons, and create an environment where lawyers view the court as credible, fair and willing to become actively involved in the settlement process, you will settle cases. Its aim is to establish a process where

meritorious claims are promptly identified and resolved and, just as importantly, where meritless claims against physicians and health providers are just as promptly identified and just as promptly resolved.

Our experience with the program supports the notion that suits which settle sooner generally settle for less; moreover, there is the additional benefit to all parties that litigation costs are significantly reduced. Under the JDN method, once a suit is commenced, a single Judge supervises the case from inception to jury selection. This permits the Judge to become invested in the case and use every court appearance as an opportunity to explore settlement. If the facts warrant settlement (or the discontinuance against a blameless medical provider) even before discovery commences, discussions among the parties are initiated. In any event, each case is closely monitored to reduce court appearances and lower defense costs. This is significant since researchers estimate that as much as 54% of medical malpractice indemnity costs go to the "administration of the system."

By the way of background information, there are approximately 4,000 medical malpractice actions commenced in New York courts each year (3,807 in 2011). The overwhelming majority of filings (3040 in 2011) occur in the eight downstate counties: Westchester, Bronx, New York, Kings, Richmond, Queens, Nassau and Suffolk (the downstate region). At the end of 2010 there were five hospital/hospital systems each paying in excess of $100,000,000 in medical liability indemnity costs. All five were in the downstate region. Of the five, two were paying in excess of

$130,000,000 and two were paying in excess of $120,000,000. Montefiore Hospital was experiencing a loss of $8,000 each time it delivered a baby whose medical expenses, inclusive of mothers, were paid by Medicaid. Malpractice premiums for an obstetrician practicing in Suffolk or Nassau Counties averaged $186,772 while premiums in Bronx County averaged $176,573 and Kings County averaged $171,430.

According to Crain's New York Business, "about 50% of Med-Mal costs" in New York are due to suits involving neurologically impaired infants; in other words infants allegedly damaged due to a mishap at birth. Medicaid is the insurer for an estimated 50% of New York State deliveries and pays for about 70% of baby deliveries in the Bronx and Brooklyn.

Last year, the Governor's Medicaid Redesign Team proposed a Medical Indemnity Fund (the Fund) to pay the cost of future medical expenses for youngsters who settled or received judgment in a medical malpractice action for neurological injuries suffered at birth. The Legislature enacted the Fund into law, effective April 1, 2011. Since then, several obstetrical actions have been resolved in our courts and the infant-plaintiffs enrolled in the Fund.

Prior to the enactment of the Fund, youngsters damaged at birth could settle lawsuits yet remain eligible for Medicaid benefits under a device known as a Supplemental Needs Trust (SNT). The creation of the Fund renders the need for an SNT obsolete because the Fund pays for the same care and treatment as

Medicaid. Hence, the Fund relieves Medicaid of that expense and reduces the cost of a medical malpractice settlement or judgment by the amount attributable to future medical expenses.

Based on the template in Mendez v. New York and Presbyterian Hospital, the first published opinion interpreting the Fund, and actual savings achieved in post-April 1, 2011 Fund settlements, we have been advised that major hospitals in New York are projecting significant reductions in medical malpractice premium costs. By way of illustration, the $5,500,000 settlement in Mendez actually costs the hospital $3,100,000 because the Fund pays for future medical damages, an expense which, prior to the Fund, would have been paid by the hospital or its insurer. This constitutes a savings of $2,400,000. The Fund appears at this early stage to be effective in achieving its goals - provide for appropriate care while generating significant savings to those hospitals and/or insurers whose disproportionately high malpractice costs are due to obstetrical malpractice claims.

Judge Directed Negotiation and New York's Medical Indemnity Fund are two practical programs that address economic realities while adhering to the fundamental right of victims of medical malpractice to be fairly compensated, preferably sooner rather than later. They represent new approaches to deal with old problems, innovative methods that seem to be working.

Mindful as we are that several New York City hospitals confront a difficult economic future, we look forward to working cooperatively with all stakeholders and

fashion approaches that balance the needs of patients with hospitals' medical liability culture and financial circumstances to create efficient and economically feasible models to resolve medical malpractice litigation. Thank you.

TESTIMONY OF
JESSE LAYMON, DOWNSTATE CAMPAIGNS DIRECTOR
CITIZEN ACTION OF NEW YORK

BEFORE THE COMMITEES ON HEALTH AND WOMEN'S ISSUES OF THE NEW YORK CITY COUNCIL

ON PROPOSED RESOLUTION 84-A: CALLING ON THE STATE TO ADDRESS THE HIGH COST OF MEDICAL MALPRACTICE INSURANCE

January 31, 2012

For more information, contact:

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which has restricted the availability of certain critical medical services, including those performed by obstetricians, gynecologists and radiologists. On the contrary, the physician-to-population ratio in New York has been steadily *increasing* in recent decades, rising almost 30% from 1990 to 2009: slightly higher than the national average. And, the SUNY Albany Center for Health Workforce Studies has found that from 2004 to 2009, the number of practicing ob-gyns in New York remained unchanged while the number of pregnancies declined. The Center projects that the supply of ob-gyns in the state will increase at a faster rate than demand until at least 2030.

The facts also demonstrate that there have not been dramatic increases in medical malpractice premium rates. According to Public Citizen, the average medical malpractice rate hike in New York between 1991 and 2007 was only 3.5%, far less than the national medical rate of inflation (6.5%). In 2008 and 2009, malpractice premiums did not increase in New York, and in 2010, the state approved an increase of 5% -- quite small considering the rate freeze of the previous two years. Further, some steps have recently been taken to address increases in medical malpractice premium rates, including the creation last year of a Medical Indemnity Fund for Neurologically Impaired Newborns.

And even if medical malpractice rates are too high, this doesn't mean that high rates have caused the problems highlighted in the resolution, including doctor shortages. Despite an extensive public process, the provider representatives serving on the state Medical Liability Insurance Task Force were not successful in making the case that either medical malpractice lawsuits or malpractice rates adversely affected the availability of medical providers in the state. The state needs to continue to monitor medical malpractice rates, but proposed Resolution 84-A presents a distorted picture of the reasons for medical liability rate increases.

Without a doubt, certain neighborhoods of our city and many rural areas of the state have inadequate numbers of providers -- particularly as to certain medical specialties -- or otherwise have inadequate health care services. For example, from 1995 to 2005, 8 out of 12 hospital closures in New York City were in communities

where people of color predominate. However, there is no demonstrable connection between allegedly high medical liability insurance rates and the availability of doctors and other health practitioners. For example, Long Island has the highest medical malpractice premiums in the state but has a ratio of ob-gyns to population that is the same as the state as a whole. Meanwhile, upstate counties have among the lowest medical malpractice premiums in the nation, yet the New York State Board of Regents has designated 11 upstate rural counties as ob-gyn shortage areas.

The SUNY Albany Center for Health Workforce Studies has found that medical residents ranked malpractice premium rates as an extremely small factor in their plans to leave New York State to practice elsewhere. Only 1% blamed malpractice premiums, ranking malpractice rates below better jobs for their spouses or partners at 5%, better jobs in desired practice settings at 8%, better salaries at 10%, better jobs in desired locations at 12% and desires to be near their families at 32%.

II. The City Council Should Focus Attention on Patient Safety and the Availability of Medical Care in Underserved Regions of the State

Instead of claiming that lack of access to quality care, including in the area of women's health, is caused by high malpractice premiums, we instead recommend that the City Council urge the state Department of Health to greatly increase its focus on patient safety. The best way to reduce malpractice costs is to reduce medical errors.

Patient safety measures have proven to be highly successful in reducing medical errors, particularly in obstetrics. The Hospital Corporation of America provides a perfect example of this. HCA implemented a comprehensive redesign of patient safety processes in obstetrics in over 200 HCA-affiliated hospitals nationwide, resulting in a 5-fold reduction in the cost of claims. And here in New York City, New York Presbyterian Hospital introduced a safety program that improved staff communications, staff training and record keeping and standardized staffing requirements. The success of this safety program reduced New York Presbyterian's obstetric malpractice costs by fully 99% from 2003 to 2009 -- yes, 99% -- and more importantly eliminated maternal deaths and other injuries during labor and delivery.

Addressing patient safety is not just the right thing to do, but a critical factor in reducing medical liability insurance costs. Since 1991, just 4% of New York doctors have accounted for half of all malpractice incidents, yet only one in ten of this small number has ever been punished by the state Office of Professional Medical Conduct. It stands to reason that addressing the costs imposed on the system by the least competent doctors would help cut premiums.

The national and state focus on health reform also provide a golden opportunity for state and city leaders to address issues as to shortages as to the availability of care for some medical specialties in some regions of the state. Under the federal Affordable Care Act, New York State must establish a health insurance "exchange" -- a marketplace for health insurance for individuals and small businesses -- by January 1, 2013. Governor Cuomo has proposed legislation to establish an exchange in the 2012-13 Executive Budget. Once a state exchange is established, health insurers, particularly those serving New York City and other large population centers in the state will have strong incentives to gain access to the hundreds of thousands that are expected to enroll. This provides an opportunity for the state to negotiate strong terms for consumers, including a mandate that health insurers that operate in the state exchange have strong provider networks with sufficient numbers of specialty providers in each geographic region they serve, including providers of reproductive as well as maternal and infant care.[3] Other steps should also be considered, such as improving Medicaid reimbursement rates for deliveries.

In closing, I once again ask you to broaden the proposed resolution beyond a narrow focus on medical malpractice rates. We should instead focus the state's attention on more fundamental concerns to consumers, including patient safety and the availability of quality health care services for all New Yorkers in every region of the state. Thank you once again for holding this hearing and for the opportunity to testify today.

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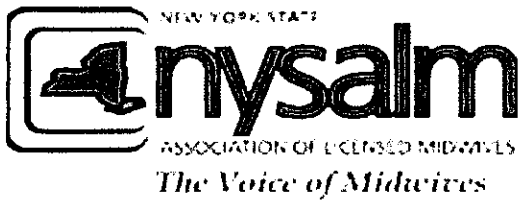
[3] See Health Care for All New York, Comments to Proposed Rules on Establishment of Exchanges and Qualified Health Plans, CMS-9989-P (October 31, 2011), http://hcfany.files.wordpress.com/2010/10/hcfany-cms-9989-p_establishment-of-health-insurance-exchanges-for-qualified.pdf.



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President
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January 31, 2012

Thank you for inviting the New York State Association of Licensed Midwives (NYSALM) to present testimony to you today. My name is Patricia Burkhardt. I am a midwife licensed in NYS, certified by the American Midwifery Certification Board and I hold a doctorate in Public Health. I returned to the US in 1987 and became involved in the work needed to pass the New York State Midwifery Practice Act of 1992, a law that has enabled the profession to grow to more than 1000 licensed and practicing midwives in NY State. In my 'real' job at that time I directed the midwifery practice of Columbia-Presbyterian Medical Center for 8 years. I was recruited and moved south to join the faculty of NYU's Division of Nursing to develop and direct the Midwifery Education Program, a position I held for 14 years. I am currently the president of NYSALM, the NY state midwifery professional organization that engages in activities to assure access to midwives and choices for women in their health care.

Resolution 84-A is critically important in what it seeks to accomplish. However, the formal goal, "to devise a comprehensive solution to address the financial and professional barriers to women's access to obstetric care" is very exclusive in its approach. Only obstetricians appear to be affected by financial barriers that negatively impact women's access to obstetric care. In reality, there are other providers in the NY city and NY state who share the excess burden of costs, some in more disproportionate ways than obstetricians.

I will speak to the situation of licensed midwives, who attended 11% of New York births in 2010. Although the malpractice rates for obstetricians are high in comparison to those of midwives, the salaries are equally disparate. Midwifery salaries range from $75,000 to 100,000 in NY. Malpractice premiums range from $20,000 - $37,000. The best case calculation between these two elements has a midwife paying 20% of her gross salary for malpractice. Worst case she is paying 49%. In addition, midwives are often reimbursed significantly less doing exactly the same procedure or care as a physician. Unfortunately, the current health care system rewards the doing of procedures rather than the support and maintenance of health.

Midwives have been forced to make concessions in practice as have the obstetricians because of the high cost. Some midwives choose to practice without insurance in which case they lose hospital privileges or cannot get them in the first place. Or they stop delivering babies and function solely as if they are nurse-practitioners, or lose their jobs to nurse-practitioners or physician-assistants who do not have the same training in obstetrics that midwives do, but whose malpractice insurance cost is significantly less.

The cost of malpractice insurance has impacted access to care especially in rural areas. One of our former members, who was one of only 3 obstetrical providers in her upstate county, closed her practice and moved to North Carolina when she could no longer afford malpractice insurance with the proceeds from her mostly Medicaid clientele.

In addition to focusing on malpractice insurance premiums, strategies that reduce the likelihood of a suit should be explored to facilitate this resolution's goal of removing financial barriers to women's access to obstetrical care. These strategies include:

- incorporation of shared decision-making as a basic component of care for all women so that they are treated with respect and given an opportunity to be real partners in their care
- family-centered care that supports physiological birth needs to be supported by institutions and providers so that it is available for those women who choose it,; medical intervention is only warranted when there are developing complications
- if an untoward outcome occurs, disclosure and apology by health care practitioners and institutions needs to occur. One program that provides education and training for this approach is "Sorry Works". They address patient harm in a thoughtful, expeditious way and have had excellent results in lowering the incidence of malpractice suits.

Most critically, licensed midwives must be included in any efforts to remove financial barriers to women's access to "expertise in pregnancy, childbirth... including preventive care, prenatal care, detection of sexually transmitted diseases, pap test screening and family planning," all areas in which midwives are as skilled as physicians.

Thank you for this chance to further the well being of the women of New York.

GREATER NEW YORK HOSPITAL ASSOCIATION

Hospital Malpractice coverage Costs: Causes and Impact

Committees on Health and Women's Issues
New York City Council
January 31, 2012

1

GNYHA And Hospital Goals

With respect to the health care system

- Improve quality, efficacy, and efficiency of care
- Improve patient safety/ reduce adverse events
- Improve patient satisfaction
- Reduce unnecessary costs in general and medical malpractice costs in particular

With respect to the tort system

- Improve efficiency and efficacy of the claims/ judicial system for patients and providers alike
- Reduce unnecessary costs of the system while also ensuring fair compensation of those injured due to negligence of the medical system

GREATER NEW YORK HOSPITAL ASSOCIATION

2

Med Mal Coverage Costs, Causes, and Impacts

Significant costs related to OB services, often due to NI newborns; many cases not caused by negligence

Overall severity, not frequency is the problem: severity in NY is among highest in U.S.

"Exorbitant overhead:" equal to 54% of compensation paid

High med mal costs

- Hospitals:
  - > $1.6B/year
  - High losses/bed
- Physicians: $200,000 for OBs

Wrong use of health care resources

Negative impact on access and quality: hospital losses, service curtailments, and closures

Defensive medicine: $25B-$210B/year nationwide; costs all payers

GREATER NEW YORK HOSPITAL ASSOCIATION

NYS Hospital Malpractice "Coverage"

Many types of "coverage" and funding due to unavailability/unaffordability of commercial insurance

- Self-insured (self-pay)
- Self-insured with recommended reserves
- Self-insured trusts or RRGs with premium structures
- Commercial insurance (if so, most often the initial layer)
- Reinsurance
- Layers of the above

Involves actuarial analyses and input

No motivation to "over charge" or over reserve

4

NYS Hospital Malpractice Coverage Costs

GNYHA surveyed hospitals re 2010 med mal coverage costs (2011 costs not yet available for some hospitals)

Hospitals surveyed represent 50% of Statewide hospital operating costs

- Total coverage costs of surveyed hospitals: $1 billion
- By extrapolation, GNYHA estimates hospital costs Statewide exceed $1.6 billion

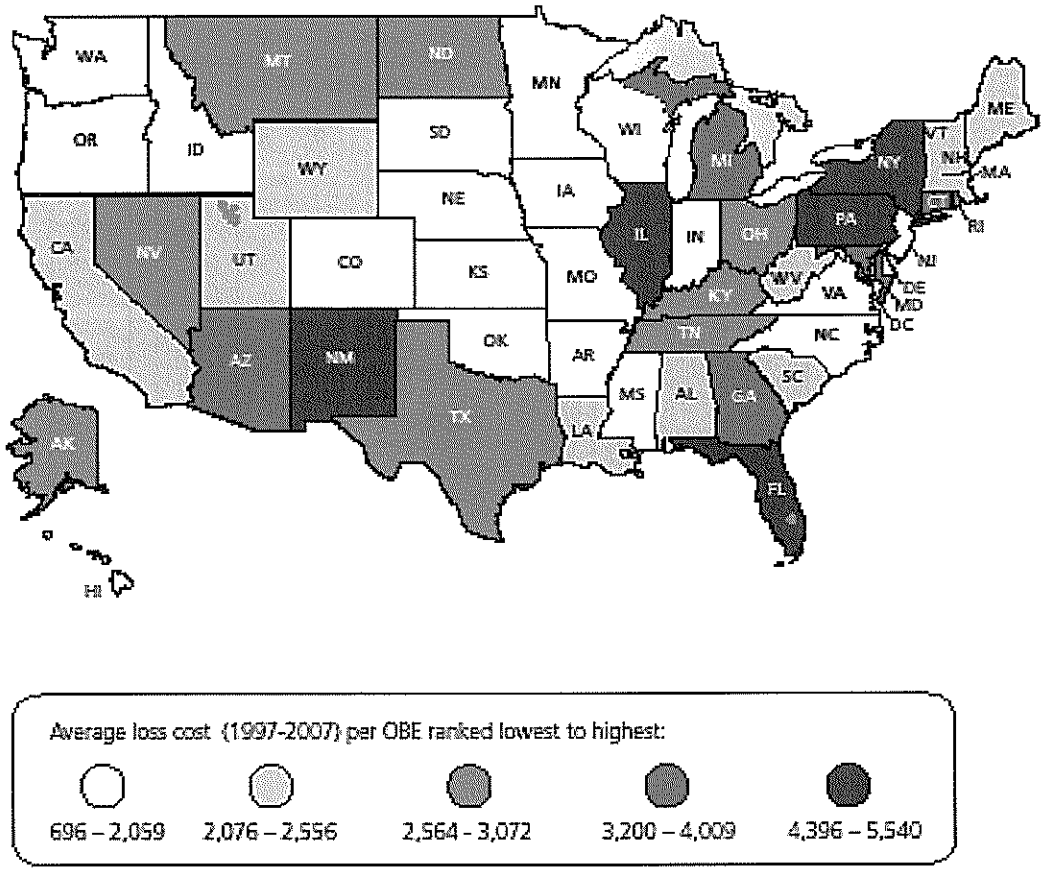
Five hospitals/systems had costs in excess of $100 million each

- Of those, four had costs of $120 million or more each
- Of those, two had costs in excess of $130 million each

CHART 5

New York's Average Loss Costs Per Occupied Bed Equivalent is Fourth Highest in the Country

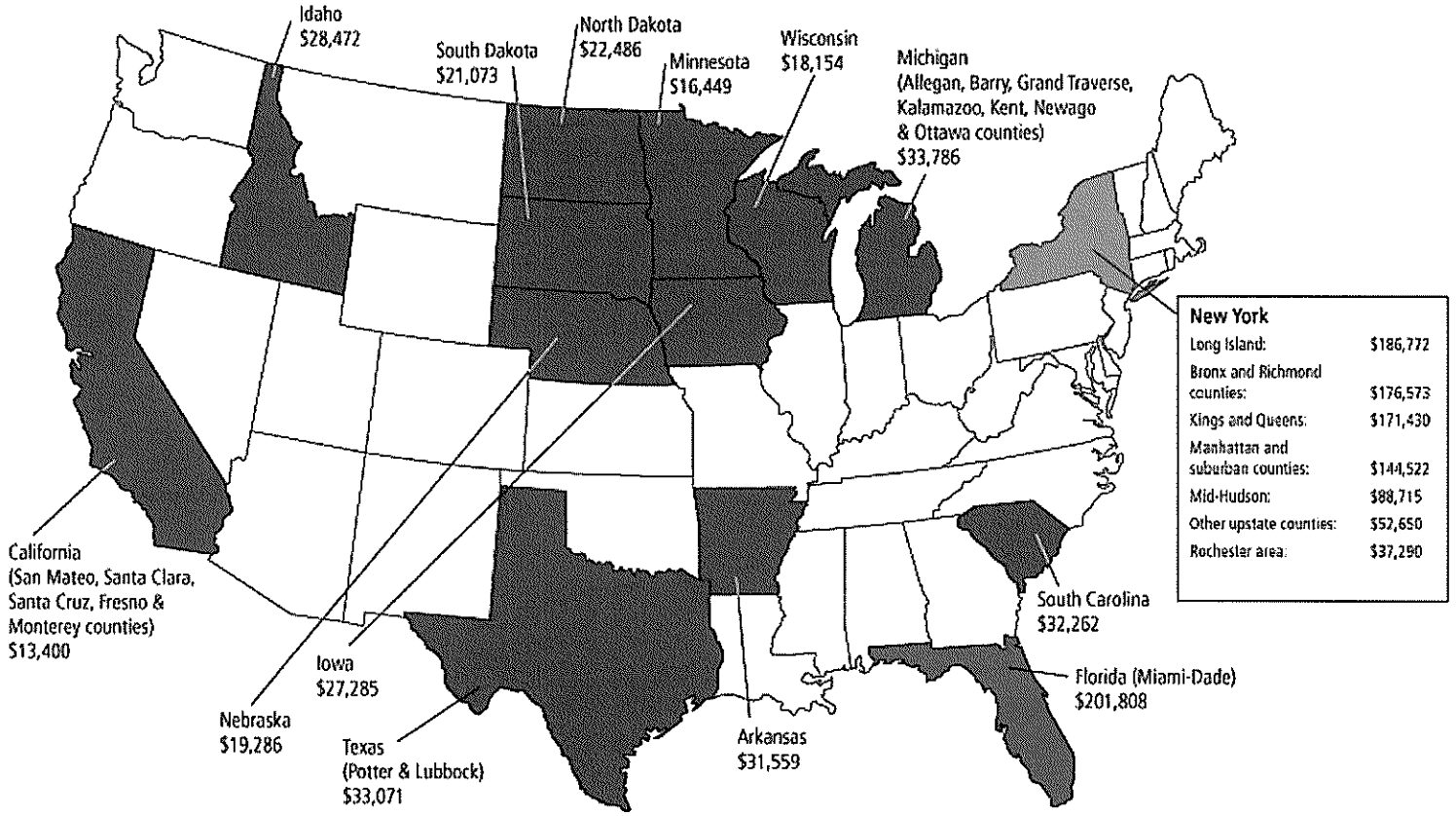
Loss costs by state



Source: Zurich Annual Benchmarking Report on Claims Trends in the Healthcare Industry, Fall 2010

exhibit 6

Obstetrics & Gynecology – Sample Medical Malpractice Rates, 2010

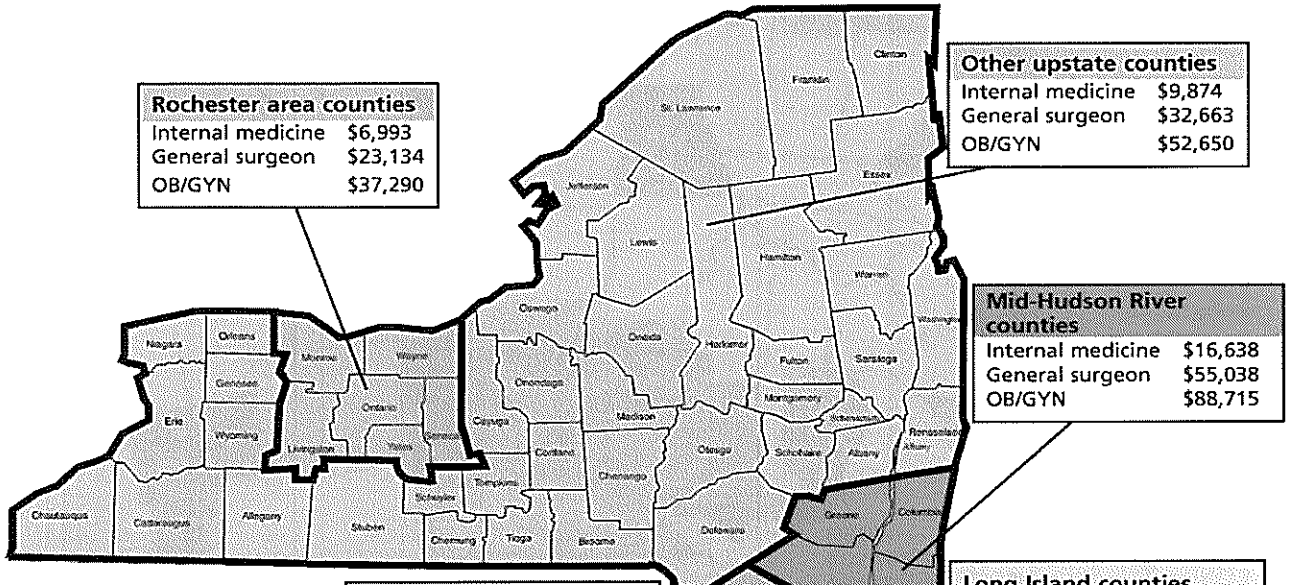


Source: Medical Liability Mutual Insurance Company. Internist premiums cited exclude cardiac catheterization. Rates effective from July 1, 2010, through June 30, 2011; Medical Liability Monitor, October 2010, Vol. 35 No. 10.

Excellus

EXHIBIT 7

Standard Medical Malpractice Premium Rates in NYS (July 2010-June 2011)



Source for Map and Data: Medical Liability Mutual Insurance Company

Excellus

Addressing Cost Drivers: OB Coverage Costs

Perinatal Safety Initiatives

- GNYHA Perinatal Safety Collaborative (44 hospitals)
- Collaborative to be part of NYS Partnership for Patients
- Hospital and hospital system initiatives
- Professional society activities (ACOG- NY)
- Insurer initiatives with hospitals and physicians
- NYS Department of Health programs, workgroups, and hospital quality initiative

Medical Indemnity Fund

- Provides lifetime of care for eligible plaintiffs
- Helps reduce the cost of coverage for OB services by
  - Reducing overpayments and double payments
  - Sharing future medical costs
- Reduces Medicaid costs
- More narrow than requested
- Hospitals are assessing impact on coverage costs
- Little impact on physician rates

Addressing Cost Drivers: Focus on Reducing Adverse Events and Claims Overall

Reducing adverse events accrues to everyone's benefit, but foremost of course to the benefit of patients

A lot of effort is being devoted to reducing adverse events and is reflected in part by reduced frequency of claims

Key elements of successful efforts to reduce adverse events:

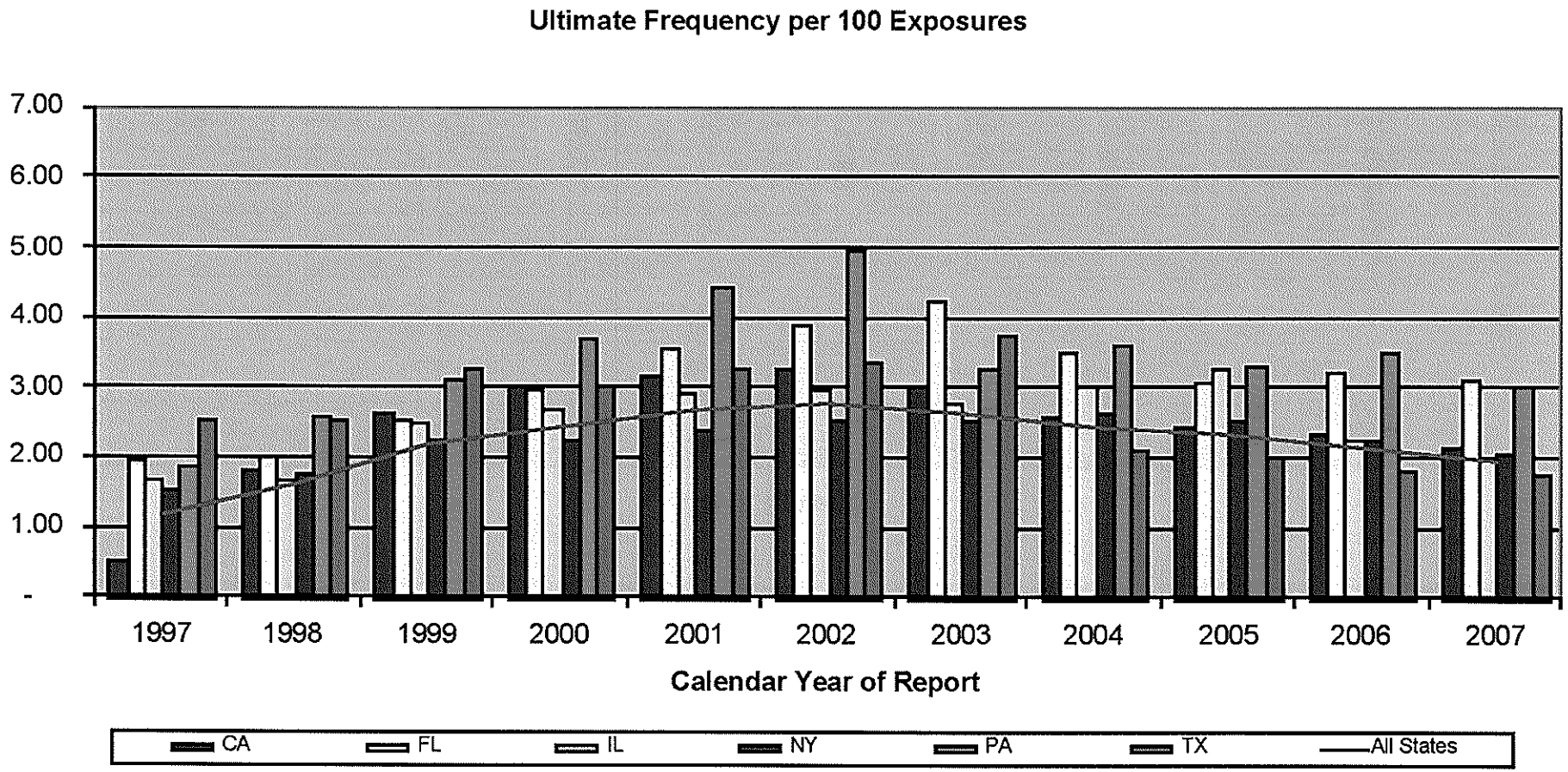
- Culture of safety/just culture
- Collaborative approach—across institutions/organizations/regions
- Development of best practices/practice guidelines
- Team training/psychological safety and respect
- Transparency, disclosure, and reporting
- System redesign

Some adverse outcomes cannot be avoided

10

ADDRESSING COST DRIVERS: CLAIMS

Frequency in NY is Declining and Reflects National Average



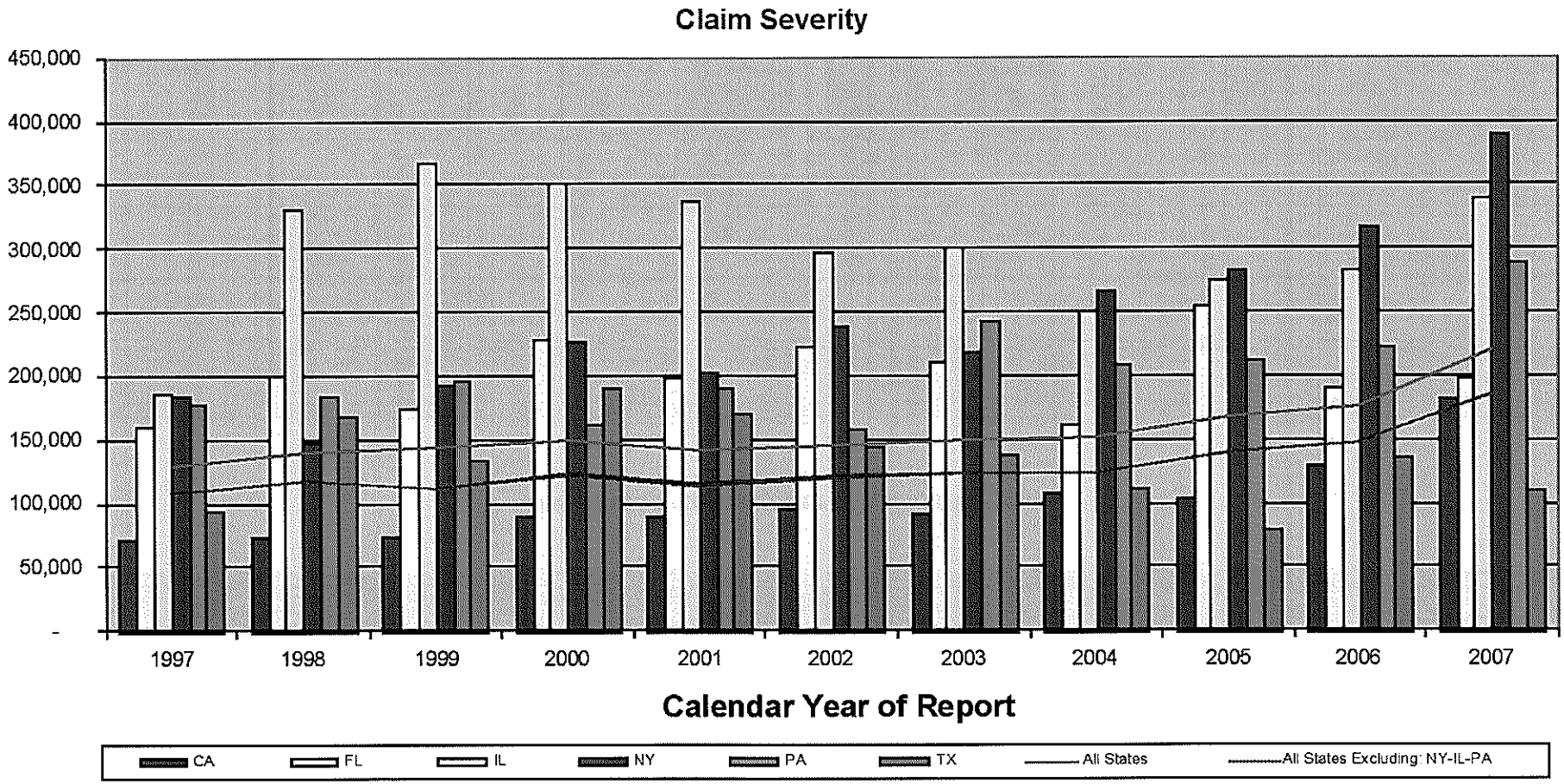
Source: Zurich Annual Benchmarking Report on Claims Trends in the Healthcare Industry, Fall 2010

GNYHA

11

ADDRESSING COST DRIVERS: CLAIMS

Yet "Severity" in NY is Among Highest in the Country



Source: Zurich Annual Benchmarking Report on Claims Trends in the Healthcare Industry, Fall 2010

Addressing Cost Drivers: Cost and Efficacy of Tort System

Harvard Medical Practice Study (as discussed through the decades)

- Requested by NYS and evaluated 1984 claims data
- Many patients with injuries stemming from negligence do not assert claims
- Only 17% of claims asserted appeared to involve negligent injury
- Key predictor of payment was patient's degree of disability, not the presence of negligence
- Tort system is "tremendously inefficient"
  - Approximately 60 cents of every dollar expended goes to administrative costs, predominantly legal fees

Studdert, Mello, and Brennan, "Medical Malpractice," NEJM (Jan. 15, 2004): 283

Addressing Cost Drivers: Cost and Efficacy of Tort System

"There is a deep-seated tension between the malpractice system and the goals and initiative of the patient-safety movement. At its root, the problem is one of conflicting cultures: trial attorneys believe that the threat of litigation makes doctors practice more safely, but the punitive, individualistic, adversarial approach of tort law is antithetical to the nonpunitive, systems-oriented, cooperative strategies promoted by leaders of the patient-safety movement."

Studdert, Mello, and Brennan, "Medical Malpractice," NEJM (Jan. 15, 2004): 283

Addressing Cost Drivers: Cost and Efficacy of Tort System

Study of closed claims (83% closed 1995-2004) to determine whether

- Medical injury occurred
- If medical injury occurred, was injury due to "error"
  - Defined using IOM definition: failure of planned action to be completed as intended or use of wrong plan to achieve aim
  - *Definition of error broader than negligence*

Results

- 3% of claims had no medical injuries
  - 16% of those with no injury resulted in compensation
- *37% of claims with injuries did not involve errors*
  - 28% of those (with injury but no error) resulted in compensation
- Of those injury claims that did involve errors
  - 73% did involve compensation
  - (27% did not involve compensation)

Studdert, Mello, Brennan, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," NEJM (May 11, 2006): 2024

Addressing Cost Drivers: Cost and Efficacy of Tort System

Administrative costs of system

- "Overhead costs are exorbitant"
- Total cost of litigating claims equaled 54% of compensation paid to plaintiffs
  - 22% of administrative costs are attributable to claims with no error
- Average time between injury and resolution: 5 years
- Long periods for plaintiffs to await decisions about compensation
- Long periods for defendants to endure uncertainty, acrimony, time away from patient care
- High-value target: Streamline processing of claims

Studdert, Mello, Brennan, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," NEJM (May 11, 2006): 2024

Point of Agreement: The System Should Serve the Patient

All of us want to reduce adverse outcomes and provide safe patient care

- Significant patient safety efforts have been undertaken/are under way
- Must continue intensive focus on patient safety initiatives

The tort system should also do a better job of serving patients

- Streamline the process
- Ensure more accurate, efficient, and transparent process
- Promote less acrimonious process
- Promote more predictability and equity among plaintiffs
- Develop a system that more effectively promotes safe patient care

Expected Outcomes

- Safer patient care
- Lower costs of coverage for providers
- Less defensive medicine
- Reduced costs for all payers particularly the State Medicaid program

Specific Recommendations for Reducing Med Mal Costs

- Convert Medical Indemnity Fund to no-fault approach
- Establish caps (or guidelines) re non-economic injuries to eliminate unpredictability, inequities, and variability in awards
- Expand definition of MIF to include all neurologically-impaired persons
- Expand active case conferencing/judge-directed negotiation
- Create health courts with specially trained judges, neutral experts, guidelines
- Establish clinical practice guidelines
- Protect disclosures, apologies, and early offers of compensation

Published October 19, 2009

Malpractice System Needs Reform, Too

To truly achieve health care reform, medical malpractice costs must be addressed. In New York alone, tort reform could save hundreds of millions of dollars in unnecessary health care for patients, providers, and the State. This issue of *Health Care News In-Depth* explores the failures and costs of the current malpractice system and how it can better meet its goals.

The two main goals of the medical malpractice system are to deter unsafe health care delivery practices and to compensate individuals who have been injured by providers' negligent acts or omissions. By design, the current tort system is one that assigns blame, often through lengthy, acrimonious proceedings—thereby operating contrary to recommendations for promoting safety.[1] The most effective way to improve patient safety, experts say, is to create a "culture of safety" that promotes teamwork, transparency, and discussion of adverse events without blame in order to identify and address system failures and barriers to providing safe care.

The current system also fails to effectively compensate injured patients. The system's high costs and long delays dissuade many patients injured by negligence from filing claims. At the same time, studies indicate that 40% of claims involve no error, yet 28% of such no-error claims result in payments, with the degree of patient disability—not the presence of negligence—as the key predictor of payment.

Direct and Indirect Coverage Costs

The current malpractice system also diverts enormous resources from the health care system. According to a recent Congressional Budget Office study, providers nationwide will incur $35 billion, or about 2% of total health care expenditures, in direct costs of malpractice liability in 2009. In New York State, hospitals incur at least $1.6 billion annually in medical malpractice costs, representing more than 3% of their operating costs. Obstetricians in certain areas of New York pay medical malpractice premiums of close to $200,000 per year. Studies attribute an exorbitant share of the system's costs to "overhead," with litigation costs equaling 54% of compensation paid to plaintiffs, and 22% of these administrative costs being attributable to claims with no error.

Besides direct costs, the current malpractice system also encourages unnecessary tests and treatment to fend off potential claims. Studies indicate that a high proportion of physicians order diagnostic tests and consultations due to fears of litigation and that such behavior correlates with a physician's perceived burden of his or her premiums. While the projected cost of defensive medicine varies, the figures are staggering. McKinsey & Company estimates that defensive medicine may cost as much as $150 billion to $190 billion per year. Even conservative estimates put the annual cost of defensive medicine to be at least $25 billion, which translates to $350 billion over a decade, with inflation.

Huge Impact on OB

Obstetrical (OB) services often bear the highest share of these costs, due in great part to large settlements and awards related to neurologically impaired newborns. In New York, coverage for OB care can represent 35%–50% of a hospital's total coverage costs, regardless of declines in the frequency of OB-related claims or whether the hospital has implemented aggressive perinatal safety programs. These coverage costs contribute to significant operating losses for OB services at most hospitals. As a result, the availability of OB services in New York is in serious jeopardy. Most states and their Medicaid programs have a large interest and "investment" in resolving this problem. This is particularly true in New York, where Medicaid covers nearly 50% of the deliveries.

However, OB services may be unfairly targeted. More and more evidence suggests that the most expensive OB cases involving neurologically impaired newborns are often not sensitive to medical intervention or due to obstetricians' errors. Studies have concluded that the prevalence of cerebral palsy has not decreased though perinatal medicine has improved, suggesting that birth injuries do not necessarily equal medical negligence.[2,3]

PROPOSALS TO REDUCE NEW YORK HOSPITAL COVERAGE COSTS

PROPOSAL	% REDUCTION	COST DECREASE/ YEAR
No-fault fund for neurologically impaired newborns	40%	$640M
Fault-based medical indemnity fund for neurologically impaired newborns	20%–25%	$320M–$400M
$250,000 caps on non-economic damages	24%	$384M
Improved dispute resolution systems	5%	$80M

Ways to Improve the System

Given the high cost of OB coverage and the fact that many adverse outcomes are not caused by poor obstetrical care, it is necessary to consider an alternative compensation system for these cases. A no-fault system that would provide payment based solely on defined injuries and eliminate the adjudication of causation would permit injured parties to receive expedited payments without lengthy litigation. Such a system would reduce coverage costs for New York hospitals by 40%, or $640 million, annually. An alternative is to maintain the fault-based system, but create a medical indemnity fund to cover future medical care for any cases in which a settlement or award might be reached. Although this alternative would not eliminate litigation costs, it would avoid the overcompensation that often occurs now while also spreading the cost of care more broadly and fairly. This model would reduce New York hospitals' coverage costs by 20% to 25%, or $320 million to $400 million, per year.

PROPOSALS THAT WOULD INCREASE NEW YORK HOSPITAL COVERAGE COSTS

PROPOSAL	% INCREASE	COST INCREASE/YR.	BILL*
Eliminate graduated plaintiff attorney contingent fee schedule to permit 1/3 attorney fees across the board	25%–40%	$400M–$640M	S. 2040
Adjust current plaintiff attorney contingent fee schedule by increasing fee bands	15%	$240M	No bill introduced yet
Extend statute of limitations to run 2 1/2 years from when one knows/should have known of negligence and that negligence caused injury (vs. current 2 1/2 years from act or omission); includes one year revival of claims	15%–25%	$240M–$400M	S. 1729 and A. 4627-A
Prohibit ex-parte interviews of later treating physicians; overturns Court of Appeals decision in *Arons*	5%	$80M	A.1254-A/ S.3203-A
Amend General Obligations Law to require non-settling defendants to elect the method of calculating share of future recovery before trial	5%	$80M	A. 2579-A and S. 2390

*Bill numbers are current as of April 1, 2010.

Although controversial, one of the most effective ways to reduce coverage costs is to impose caps on non-economic damages, such as pain and suffering. Many states have enacted such caps to eliminate some of the unpredictability, variability, and inequities associated with large pain and suffering awards. A 2004 Milliman study estimates that a $250,000 cap on non-economic damages would reduce medical malpractice costs for New York hospitals and physicians by 24%, or $384 million, per year. Studies suggest such reforms would significantly reduce defensive medicine costs without negatively affecting the quality of care.[4,5]

Meaningful reforms to the dispute resolution system could also improve access and reduce coverage costs. The most compelling proposal is courts dedicated to medical malpractice, which would be administrative in nature but that could also operate in the Federal or state judicial systems. Such courts could have specially trained judges and apply identified clinical practice and compensation guidelines. Studies indicate that a more efficient, faster, and less rancorous system for adjudicating claims can reduce both costs and defensive medicine.

Regardless of the reforms pursued, providers should participate in meaningful initiatives to reduce adverse events. GNYHA and its members have undertaken initiatives designed to increase patient safety, improve outcomes, and identify best practices. For more information regarding these initiatives, please see the Quality Section of GNYHA's Web site, **www.gnyha.org**.

Proposals That Increase Costs

While the nation is trying to reduce health care costs, some New York State legislators have proposed bills that would increase malpractice costs. Among them is a bill that would eliminate the current graduated fee schedule so that plaintiff attorney fees can be one-third across the board. For example, an attorney winning a $6 million award for a plaintiff would be entitled to a $750,000 fee in the current system. As proposed, the attorney would be entitled to a 167% increase in that fee, or $2 million. This proposal, if enacted, would increase hospital coverage costs by 25%–40%, or $400 million to $640 million, per year.

Another proposal would amend the 2.5 year statute of limitations, which currently runs from the date of an act or omission, so that it would run from when one knows or reasonably should have known of the negligent act or omission and that the act caused an injury. This bill would increase hospital coverage costs by 15%–25%, or $240 million to $400 million, per year. Other states with such liberal discovery rules generally also cap damages.

A third bill would eliminate a defendant's right to interview, ex-parte, the plaintiff's later treating physicians, a right that plaintiffs have and that the State Court of Appeals has upheld. This would increase hospital coverage costs by 5%, or $80 million, per year.

None of these bills would improve the State's dispute resolution, and all would unnecessarily increase health care costs. GNYHA continues to advocate for meaningful tort reform that reduces unnecessary costs, improves patient care, and appropriately compensates patients who have been harmed. ■

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Published January 11, 2010

Neurologically Impaired Newborns

The current medical malpractice system—in many states and certainly New York—compensates individuals unevenly and inaccurately. The system is full of delays and diverts tremendous resources from the health care system in many ways, including through high premiums and other coverage costs. In a new *Health Care News In-Depth* series, GNYHA will explore a number of reform options in detail, starting with the process by which neurologically impaired newborns are compensated.

Cases involving neurologically impaired newborns are one of the principal drivers of high medical malpractice coverage costs for hospitals and physicians. While devastating, these cases often are not the result of provider negligence. And yet, the full cost of defending and paying for such cases is borne entirely by providers. Why? Research shows that the key predictor of compensation in malpractice cases is not the presence of provider negligence, but the degree of patient disability.[1]

Revising the system for compensating these individuals could greatly expedite payments for needed care, eliminate the unnecessary costs of litigation, and spread the cost of care more broadly in recognition of the fact that providers are not responsible for many of the impairments that occur.

Neurological Impairments and Their Causes

"Neurological impairment" describes an array of conditions or disabilities, but in the context of the high cost of medical malpractice coverage, it often refers to cerebral palsy (CP), neonatal encephalopathy, or other forms of substantial motor deficits occurring in newborns. The disabilities can be significant and require a lifetime of care. However, well-regarded studies and reports have concluded that the majority of such disabilities do not occur due to lack of oxygen during labor and delivery—as typically alleged in malpractice claims—but are most often attributable to events that occur during gestation (before labor begins).

MALPRACTICE COSTS FOR OB ARE A MEDICAID ISSUE

MEDICAID COVERS

- Nearly 50% of all deliveries in the State
- Nearly 60% of all deliveries in NYC
- Over 70% of all deliveries in Brooklyn and the Bronx

The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics in 2003 released one of the most significant reports on the subject, entitled, "Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology." Endorsed by the Centers for Disease Control and Prevention, March of Dimes Foundation, and National Institutes of Health, among others, the report stated advances in science and technology indicate that most cases of neurological impairment do not originate during labor and delivery, and are thus rarely caused by perinatal asphyxia. Rather, "It is now accepted that most neonatal encephalopathy and cerebral palsy have their origins in developmental abnormalities, metabolic abnormalities, autoimmune and coagulation defects, infection, trauma, or combinations of these factors."[2] Cerebral palsy is also linked to children with low birth weight or gestational age, other conditions unaffected by the process of labor and delivery, with nearly one-quarter of all cerebral palsy cases occurring in infants weighing less than 1,500 grams (3.3 pounds) at birth.[3]

More recent articles by Dr. Karin B. Nelson of the National Institute of Neurological Disorders and Stroke and others underscore that lack of oxygen during delivery causes only a small proportion of cerebral palsy cases. Dr. Nelson has written that a study of eight types of complications that can cause an acute interruption in oxygen to a fetus found that only one complication—the umbilical cord wrapped around the fetus's neck—was linked to cerebral palsy in children with normal birth weight.[4] Perhaps even more significant is the conclusion that, "despite serious efforts, CP due to birth asphyxia has not been shown to be preventable." Even when cerebral palsy risk factors are known, "in none of these problems has obstetric intervention been demonstrated to reduce the risk of CP, largely because useful and specific indicators of intrauterine events do not yet exist."[5]

In spite of the foregoing, in neurological impairment medical malpractice claims, plaintiffs' attorneys typically allege that delivery should have been more immediate. In response, Dr. Nelson has written that "there is no evidence of good quality

that [cesarean] delivery can prevent cerebral palsy."[6] In this regard, a study conducted in 10 countries, including the United States, concluded that "despite a five-fold increase in cesarean deliveries over recent decades driven in part by the use of fetal monitoring, the incidence of CP has remained steady at about 1 in 500 births..."[7] At the same time, major complications occur in about 2% of cesarean deliveries. According to the authors of the 10-country study, "Operative intervention based on [electronic fetal] monitoring has probably done more harm than good."[8]

High Coverage Costs

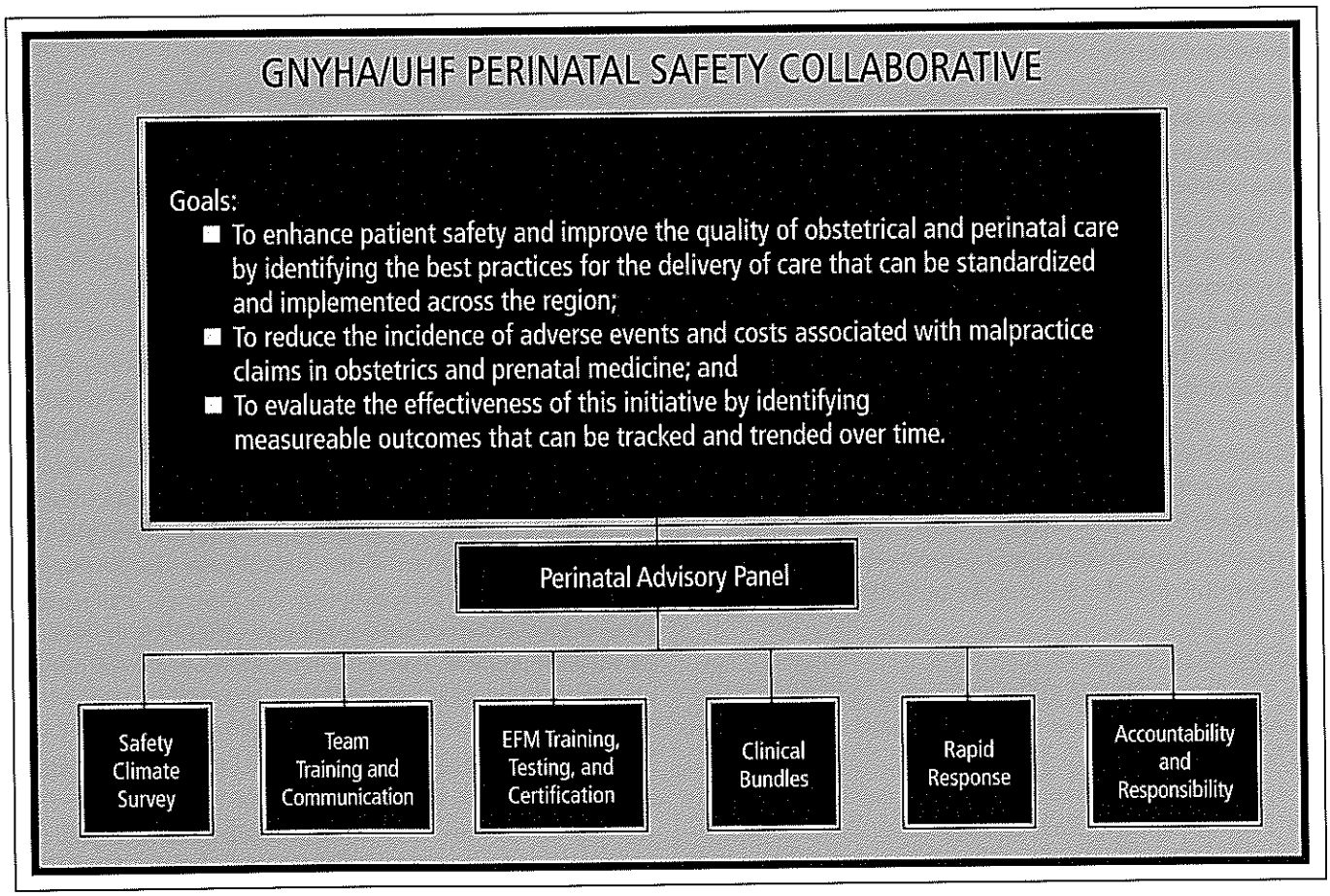
In spite of the fact that most cases of neurologically impaired newborns are not the result of provider negligence, GNYHA estimates that obstetrical (OB) services account for about 35% to 50% of hospital members' medical malpractice coverage costs, due in great part to the costs associated with claims involving such disabilities. GNYHA projects that its members' total coverage costs exceed $1.6 billion per year, meaning hospitals in New York spend between $560 million and $800 million each year for malpractice coverage for their OB services alone.

Recent GNYHA research suggests many hospitals suffer significant losses from their OB services, in most cases entirely attributable to the cost of their related malpractice coverage. One hospital in New York City has reported that its malpractice expense for each delivery is $9,400. Not including malpractice expenses, the hospital's net income for each delivery of a Medicaid-covered newborn would be $1,500; however, including the malpractice expenses, the hospital actually loses almost $8,000 each time it delivers a Medicaid-covered newborn. Because Medicaid covers 60% of this particular hospital's newborn discharges, it, like most others, is experiencing significant losses from providing OB services.

In this environment of spiraling costs and devastating payment cuts—particularly in Medicaid—hospitals are necessarily looking to reduce operating costs. In trying to preserve the whole hospital for the community's benefit, OB services are often targeted for reduction, as they are among the biggest sources of operating losses. Given that Medicaid covers so many deliveries in New York, the State has a particular interest and investment in this problem: Medicaid covers nearly 50% of the deliveries statewide. In New York City, the Medicaid program covers nearly 60% of deliveries, and in Brooklyn and the Bronx, more than 70% of all births are covered by Medicaid.

The Need for Alternative Compensation Approaches

Due to high coverage costs associated with neurologically impaired newborns and the fact that science and medicine have concluded that most such cases are not due to provider negligence, it is important that states, particularly New York, create alternative systems for handling and funding claims related to them. The systems should be designed to cover the reasonable costs of care for eligible children and funded



through a wider array of sources in recognition that the cost of caring for such individuals is society's obligation, rather than the sole responsibility of providers. The systems should also be designed to minimize, if not eliminate, the unnecessary costs and time required to litigate such cases. A no-fault system that would provide payments to children based solely on the disability or injury involved would best accomplish those goals. Funding could come from several sources, including:

- assessments on all types of insurers, many of which abandoned the malpractice market;
- Medicaid third-party recoveries; and
- government appropriations.

Such a system would reduce hospital malpractice costs in New York by an estimated 40%, or $640 million, annually.

In 2008, State Senators Kemp Hannon (R-Garden City) and Dale Volker (R-Depew) introduced S. 7748, which would establish a no-fault approach. Though the bill did not advance during the last legislative session, it is expected to be re-introduced in 2010.

One alternative to a no-fault system is to process cases through the existing litigation system, but create a medical indemnity fund to cover future medical care costs, as incurred, in the event of a settlement or award. Funding sources could be similar to those in the no-fault fund approach. The medical indemnity fund would not eliminate litigation costs and would still require providers to bear all non-medical costs, as well as pre-settlement/award medical costs. It would, however, reduce the cost of settlements and awards by requiring payment of future medical care from the indemnity fund only as required, and it would share medical care costs more broadly in recognition of the fact that most such adverse outcomes are not due to provider negligence. It is estimated that the medical indemnity fund approach would reduce hospital malpractice costs by 20%–25%, or $320 million to $400 million, per year. The establishment of a medical indemnity fund has been recommended in prior years and in particular during New York State's 2007 Medical Malpractice Liability Task Force proceedings.

Reducing Adverse Outcomes

Though evidence demonstrates that providers cannot currently prevent most cases of neurological impairment in newborns, GNYHA has devoted significant efforts toward reducing avoidable adverse events in the perinatal setting to the extent possible. Its most significant effort is its Perinatal Safety Collaborative, launched in 2007 in partnership with the United Hospital Fund (UHF). More than 40 hospitals are working to improve the quality of obstetrical and perinatal care by implementing a standard set of patient care practices, called the "perinatal safety bundle." GNYHA and UHF developed the bundle with input from an advisory panel that includes member hospitals, the American College of Obstetricians and Gynecologists (District II/New York), the New York State Department of Health, and the Healthcare Association of New York State. For more information, see GNYHA's May 18, 2009, *Health Care News In-Depth*, "Perinatal 'Bundles' Deliver Safety."

While the birth of a neurologically impaired newborn is devastating for patients, their families, and providers, New York State has an ethical—and financial—obligation to ensure that these cases are resolved in a way that provides appropriate care and support for patients while distributing costs across society at large, rather than holding providers solely financially responsible such that their ability to deliver care to entire communities is compromised. ■

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PROPOSALS TO COMPENSATE NEUROLOGICALLY IMPAIRED NEWBORNS

PROPOSAL	MAIN FEATURES AND BENEFITS	% REDUCTION IN HOSPITAL COSTS PER YEAR	HOSPITAL COST DECREASE PER YEAR
NO-FAULT FUND	Claims are made to administrative body and payments are made from no-fault fund based solely on impairment	40%	$640M
	Eliminates cost of, and delays related to litigating causation		
	Eligible persons would receive compensation/coverage swiftly and without acrimony		
	Shares the cost of care broadly, in light of low probability of provider negligence		
	Mechanism for reviewing care for quality improvement and oversight purposes		
Medical Indemnity Fund	Claims would proceed through judicial system	20%–25%	$320M–$400M
	Providers would, if found negligent, be responsible for the cost of past medical care, the cost of all non-medical care expenses related to injuries, and plaintiff attorney fees related to future medical care settlement/award		
	Future medical costs identified through settlement or award would be paid from medical indemnity fund, as incurred		
	Would not eliminate cost of, and delays related to litigating causation		
	Would reduce overall cost of medical care since future costs would be paid only as incurred, rather than being estimated in advance, which can result in greater compensation than may be required		
	Would spread the cost of medical care more broadly, in light of low probability of provider negligence		

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The Costs of Defensive Medicine

While the unsustainably high costs of medical malpractice coverage are often cited as a primary reason for malpractice reform, the cost of defensive medicine practiced due to fears of malpractice litigation probably dwarfs the direct costs of malpractice liability. In this installment of the *Health Care News In-Depth* series on medical malpractice, GNYHA looks at why policy makers attempting to address health care costs and inefficiencies should focus on reforming the medical malpractice system.

"Defensive medicine" has been defined as "a deviation from sound medical practice that is induced primarily by a threat of liability."[1] Most often, it is discussed in terms of providing additional testing or treatment, but it can also encompass "replacing" care—such as when a physician refers a case to another physician—or "reducing" care by a physician's refusal to treat certain types of patients. As the term is used with respect to providing additional services, it is sometimes called "assurance behavior" and involves delivering or ordering additional services "of marginal or no medical value with the aim of reducing adverse outcomes, deterring patients from filing malpractice claims, or persuading the legal system that the standard of care was met," according to a 2005 study published in the *Journal of the American Medical Association* by researchers from Harvard and Columbia universities.

Survey Finds Defensive Medicine Prevalent

In this study, David Studdert, Michelle Mello, Troyen Brennan, William Sage, and others examined the prevalence and characteristics of defensive medicine among physicians practicing in high-liability specialties in locations with unstable or high malpractice costs. They hypothesized that physicians' concerns "about the costs and availability of coverage may induce a wider array of defensive practices, affecting not only the cost of health care but also its accessibility and quality." The team surveyed hundreds of physicians practicing in high-risk specialties in Pennsylvania about their defensive medicine practices. The behaviors studied included: 1) ordering more tests than medically necessary; 2) prescribing more medications than medically necessary; 3) referring to specialists in unnecessary circumstances; 4) suggesting invasive procedures against professional judgment; 5) avoiding certain procedures or interventions; and 6) avoiding caring for high-risk patients. The researchers also inquired about a number of measures, including several related to physicians' perceptions of their medical malpractice coverage, e.g., its financial burden.

According to the study, 93% of the 824 respondents reported that "they sometimes or often engaged in at least one type" of defensive medicine. Nearly 60% of respondents "often ordered more diagnostic tests than medically indicated," the authors said. More than half of respondents said they referred patients to another specialist when it was unwarranted. The authors said this practice was "particularly common" among obstetricians and gynecologists. A third of respondents said they prescribed more medications than indicated, and a third of respondents also often suggested "invasive procedures which, in their professional judgment, were unwarranted." The survey also asked about the doctors' most recent encounter with defensive medicine. For more than 40%, that incident involved using imaging studies.

Studdert and his colleagues noted that medical malpractice insurance influenced many doctors' defensive medicine practices. The doctors surveyed who were concerned about the effectiveness of their medical malpractice insurance "were more than twice as likely as other specialists" to engage in defensive medicine behaviors. Those surveyed who reported that their medical malpractice premium burden was "extreme" were more than 1½ times as likely to engage in defensive practices such as ordering unnecessary tests and overprescribing medicines.

HOW PREVALENT IS DEFENSIVE MEDICINE?

In a 2005 study of physicians practicing in high-risk specialties,

- 59% said they often ordered more diagnostic tests than medically necessary
- 52% said they often referred patients to other specialists in unnecessary circumstances
- 33% said they often prescribed more medications than medically necessary
- 32% said they often suggested invasive procedures that were unwarranted

—Studdert, et al. (2006)

Other Studies Show Prevalence

Subsequent surveys by others support the wide scope of defensive medicine. For example, in 2007 and 2008, the Massachusetts Medical Society surveyed physicians practicing in Massachusetts

in eight specialty areas. Those surveyed reported that 22% of all x-rays, 28% of CT scans, 27% of MRIs, and 24% of ultrasounds were ordered for defensive reasons. Similarly, 28% of specialty referrals or consultations were motivated by liability concerns, with OB/GYNs reporting that 40% of their referrals and consultations were not driven by medical need. Finally, 18% of all laboratory tests and 13% of all hospital admissions were motivated by liability concerns.[2]

The Added Costs

How much defensive medicine costs the nation and how sensitive defensive medicine is to malpractice reforms have been called controversial questions. But over time there has been growing recognition that whatever defensive medicine costs, it is a significant amount. To provide a sense of numbers discussed, at the high end, McKinsey & Company has estimated that defensive medicine costs the nation as much as $150 billion to $190 billion each year.[3] A 2003 report from the U.S. Department of Health and Human Services pegged the cost of defensive medicine between $70 billion and $126 billion per year.[4] Even the most conservative estimates suggest that defensive medicine represents at least 1% of the nation's health care expenditures, or $25 billion each year. However, even this conservative estimate translates into $350 billion over the next ten years when accounting for projected inflation in national expenditures.

IS THERE A RELATIONSHIP BETWEEN FEARS OF MALPRACTICE LIABILITY AND DEFENSIVE MEDICINE?

Specialists who perceived their premium burden to be extreme were more than 1½ times as likely to overprescribe medications, refer patients unnecessarily, and order unnecessary tests.

– Studdert, et al.

Would Reform Reduce Defensive Medicine?

A recent Congressional Budget Office (CBO) analysis reflects the growing recognition of defensive medicine's impact on health care costs and its sensitivity to malpractice reform. The CBO examined how medical malpractice reforms could lead to potential reductions in malpractice premiums as well as reductions in health care utilization caused by defensive medicine practices. In an October 9, 2009, letter to Senator Orrin Hatch (R-UT), who had requested the study, the CBO stated that recent research has provided evidence that malpractice reforms do reduce the use of health care services. In light of the research, CBO included, for the first time, indirect savings from reduced utilization of health care services in its most recent analysis of the impact of malpractice reforms.

While not quantifying the cost of defensive medicine, the CBO estimated that if a package of specified malpractice reforms were adopted, Federal health care spending under Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program would decrease by $41 billion over the next ten years. The CBO stated that its estimate accounted for the fact that many states have already adopted a number of the suggested reforms, as well as the fact that some reforms might actually increase the volume of services provided. The lesson is clearly that the right mix of reforms in certain states could result in meaningful savings for state Medicaid and other health-related programs.

The CBO also calculated that the Federal government would enjoy an additional $13 billion in increased tax revenues due to related reductions in health care spending and health insurance costs and corresponding potential increases in taxable wages. Thus, the CBO estimated that the Federal deficit would be reduced by $54 billion over 10 years as a result of the reforms discussed.

West Virginia Senator John D. Rockefeller, IV, raised questions about the CBO's analysis. In a letter dated December 10, 2009, the CBO explained that its estimates of savings had increased over time because "the weight of empirical evidence now demonstrates a link between tort reform and the use of health care services."

Malpractice Reform Will Reduce Health Care Costs

The practice of defensive medicine to avoid litigation is pervasive and takes many forms. It is also closely correlated with providers' concerns about malpractice premiums and adequacy of insurance coverage. Although difficult to quantify, the costs of defensive medicine are significant, if not extraordinary. It has also been demonstrated that defensive medicine is sensitive to reforms that reduce the pressures of malpractice liability on providers. For the foregoing reasons, the Federal government and all states should seriously consider the savings that will accrue from reductions in health care utilization as a result of malpractice reforms. Such savings could be dedicated to creating special compensation funds for neurologically impaired newborns, supporting patient safety, or promoting other initiatives. Both health care and malpractice reform discussions must therefore consider the prevalence, causes, and costs of defensive medicine. ■

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Improving Dispute Resolution

The current system for resolving medical malpractice claims compensates individuals unevenly, often inaccurately, and typically after long delays. It is also unnecessarily expensive and diverts tremendous resources from the health care system. Improving the dispute resolution system will benefit patients, providers, and society. This issue of *Health Care News In-Depth* will explore one possible solution: courts dedicated to medical malpractice cases.

The current dispute resolution system falls short of its goals of deterring provider negligence and compensating those injured by it. It operates in direct conflict with safety experts' recommendations for improving the delivery of care. According to a 2004 *New England Journal of Medicine* article by Harvard medical malpractice experts David Studdert, Michelle Mello, and Troyen Brennan, "the punitive, individualistic, adversarial approach of tort law is antithetical to the nonpunitive, systems-oriented, cooperative strategies promoted by leaders of the patient-safety movement."[1] In fact, they wrote, "The clash between tort law and the patient-safety movement undermines efforts to improve quality."

With respect to its compensation goal, the system is often so lengthy, acrimonious, and expensive that many individuals injured by negligence never enter the system. These same factors undermine the benefits intended for those who do enter the system, create inequities and unpredictability in compensation, and result in unreasonable costs for all involved.

High Overhead

In a 2006 study, the aforementioned Harvard experts, Atul Gawande, and others studied closed malpractice claims from five insurers to determine the merits and outcomes of malpractice claims.[2] The primary goal was to examine the prevalence of frivolous lawsuits. Presumably for that reason, they applied the Institute of Medicine's (IOM) definition of error: "the failure of a planned action to be completed as intended...or the use of a wrong plan to achieve an aim," which is broader than the tort system's term "negligence." Of the 1,452 claims reviewed, 3% had no adverse outcome from medical care. In cases that involved injuries, the researchers concluded that nearly 40% of the claims did not involve errors even though they applied the broader IOM definition.

Of the cases that involved injuries but no provider errors, 28% resulted in compensation. Of those cases that involved provider errors, 73% resulted in compensation. The authors concluded that the system's outcomes are reasonably in accordance with the merits of the claims when using the broad definition of error. Presumably, if the researchers had analyzed the claims applying the standard of "negligence," there would be more claims without "merit" and less correlation between merit and compensation.

However, the researchers expressed deep concerns about the system's costs. The average time between injury and resolution was five years, while one in three claims took at least six years to resolve. "These are long periods for plaintiffs to await decisions about compensation and for defendants to endure the uncertainty, acrimony, and time away from patient care that litigation entails," Studdert and his colleagues wrote. In terms of actual financial costs, they labeled the system's overhead costs "exorbitant." Researchers have noted that the combination of defense costs and plaintiffs' attorney contingent fees "brought the total costs of litigating claims in our sample to 54 percent of the compensation paid to plaintiffs." They therefore believed that substantial savings could result from improving the system's efficiency and urged that efforts be made to streamline the processing of claims.

DELAYS AND COSTS OF SYSTEM BENEFIT NO ONE

In a study of 1,452 closed medical malpractice claims, researchers found:

- The total cost of litigating claims equaled 54% of compensation paid to plaintiffs
- The average time between injury and resolution was five years
- One in three claims took six years or more to resolve
- Streamlining the processing of claims would result in substantial system-wide savings

—Studdert, et al. (2006)

Studies that have examined claims from the standpoint of negligence have shown far less correlation with compensation. The often-cited Harvard Medical Practice Study from 1990 found that only 17% of claims studied involved a negligent injury. In a 1996 follow-up study, Troyen Brennan, one of the Harvard Medical Practice Study authors, and others found that the severity of a plaintiff's disability, not the presence of negligence, was predictive of compensation.[3]

Impact on Defensive Medicine

Improving the dispute resolution process would also reduce the high costs associated with defensive medicine. According to a study by Daniel Kessler and Mark McClellan, reductions in the time spent and the amount of conflict involved in defending against malpractice claims can also reduce defensive practices substantially.[4] "[E]ven a modest reduction in the hassle of resolving a claim...would lead to a large change in the intensity of treatment" of the diagnoses they studied.

IMPROVING THE CURRENT RESOLUTION SYSTEM

To improve access, equity, and consistency and to reduce unnecessary costs, the system needs:

- Judges specially trained in handling medical cases and mediation
- Availability of neutral experts
- Clinical practice guidelines
- Compensation guidelines for certain injuries
- Patient safety data collection

Improving Dispute Resolution

Over the years, malpractice system experts have recommended developing courts dedicated to resolving malpractice claims expeditiously, efficiently, and accurately. Those same experts believe such courts could quite adequately meet injured patients' needs and rights by increasing access, improving consistency in decision-making, and enhancing equity in payments.[5]

Establishing specialized courts for certain types of cases is not new. New York State has separate probate and family courts, along with a number of "problem-solving courts" aimed at addressing special issues surrounding specific types of cases involving domestic violence, mental health, sex offenses, and drug treatment. At the Federal level, patent and bankruptcy courts address the specialized issues that may arise in those areas.

Advocates of dedicated courts often recommend they be administrative in nature, similar to New York State's system for processing worker's compensation claims, given that those systems often cost much less than judicial systems. However, a dedicated court could also be part of the judicial system as New York's existing specialized courts are.

Whether judicial or administrative, it is recommended that dedicated courts have certain features:

Judges With Special Training in mediation and adjudicating disputes about medical care. The practice of medicine and the operation of large health care providers are complex areas. It is important for plaintiffs and defendants that the judges overseeing such cases have special training and skills in this area.

Neutral Experts that could, when needed, assist the court by offering unbiased testimony regarding the appropriate standard of care. The current malpractice system is often criticized for being a battle of the experts, some of whom promote theories that do not have a strong foundation in medicine.

Clinical Practice Guidelines that are evidence-based, which the court can use to make decisions regarding liability. Developing and relying on guidelines will help improve care, drive appropriate early offers of compensation, and instill more confidence in the process, thereby encouraging patient safety efforts. Using the guidelines would also streamline the process and reduce the system's costs.

Compensation Guidelines for certain injuries that would assist the courts in ensuring fairness and equity in decision making. Currently, there can be wide swings in compensation, with some people winning huge awards while others are unable to enter the system due to its costs.

Collection of Data that can be used, without identifiers, for improving health care delivery systems and avoiding future errors.

A Fairer, More Efficient System

The current malpractice system is unreasonably lengthy and expensive. Attorney fees, expert fees, and related costs sap resources equal to 54% of the compensation paid to plaintiffs, while delays and acrimony drive up the costs of defensive medicine. Many individuals with injuries caused by provider negligence never enter the system, and those who do must often wait years for compensation. Courts specifically designed to handle malpractice cases expeditiously, efficiently, and equitably will serve patients and providers alike by improving the fairness and consistency of the proceedings while reducing unnecessarily high overhead costs. ■

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Disclosures, Apologies, and Early Offers of Compensation

A tenet of building a culture of safety is disclosing and discussing adverse events to improve systems and avoid future errors. It is also important—indeed required—for providers to disclose and discuss adverse outcomes with patients. However, litigation fears often discourage full disclosure, meaningful apologies, and early offers of compensation, when warranted. This issue of *Health Care News In-Depth* will explore disclosure requirements, the potential value of full disclosure and apology, and ways to encourage providers to undertake comprehensive disclosure programs.

The last decade has seen significant movement toward encouraging and assisting providers to disclose and discuss adverse outcomes with patients and families. Disclosure is not a new concept and is required by professional ethics, accrediting standards, and many states' laws and regulations. But it is unquestionably a hard thing to undertake, given natural feelings of denial and embarrassment, as well as concerns about loss of stature, punishment, and malpractice litigation. Many hospitals have therefore implemented programs to support their staffs, who must undertake disclosures. Over the years, GNYHA has facilitated these efforts by providing communication skills training to members.

Elements of Full Disclosure and Apology

More important—and certainly more difficult—than the act of disclosure is ensuring that it is complete and accompanied by a "full" apology, which has been defined as one that is an "acknowledgment of responsibility ... coupled with an expression of remorse."[1] In addition, it is also advised that the provider should offer appropriate compensation, when warranted. This approach is premised on the view that patients want and deserve certain basic information, respect, and, in some cases, recompense. The preface to Leonard Marcus's 15-year-old book, *Renegotiating Health Care*, outlines a seasoned health care mediator's observations as to what patients want.[2] Patients first want to know what really happened to them. They want to know the incident will not be repeated. They also want an apology or acknowledgement. Subsequent research has repeatedly reinforced these observations. Thus, while "disclosure" is required and important, the patient wants and deserves much more.

Impact on Claims Volume, Costs?

The question of whether such programs will or do trigger increased claims and costs remains controversial, although recent data suggest that costs might actually decrease when such programs are successfully implemented. First, to examine evidence supporting the idea of increased claims, a 2007 article written by malpractice experts David Studdert, Michelle Mello, Troyen Brennan, Atul Gawande, and Claire Wang concluded that more disclosures would likely lead to increases in litigation volume and costs.[3] For the purposes of the study, the authors assumed that, following a disclosure, the average cost per severe injury claim would decrease by 40%, on the basis that patients might be willing to accept reduced pain and suffering compensation for expeditious settlements.

The authors surveyed 78 "medico-legal experts" in 2005 for their predictions of how 100 patients would react to disclosure in the

RISK MANAGERS AND PHYSICIANS DIFFER ON DISCLOSURE, APOLOGIES

In an AHRQ-funded survey of risk managers and physicians:

- More risk managers than physicians strongly agreed that generally serious errors should be disclosed to patients.
- Risk managers were more likely than physicians to recommend that the errors specified in the study be disclosed and to provide full details about how the errors would be prevented in the future.
- Physicians were more likely than risk managers to provide a full apology, recognizing the harm caused by the error.

Source: David J. Loren, M.D., et al. "Risk Managers, Physicians, and Disclosure of Harmful Medical Errors." *The Joint Commission Journal on Quality and Patient Safety* 36 no. 3 (March 2010): 101-108.

context of four different situations. Based on 65 survey responses, the authors concluded that it was highly likely that claims volume would increase if there were more disclosures, and correspondingly that a net increase in costs was more likely than a decrease or change. The authors acknowledged the weaknesses of the study's theoretical nature, as well as the fact that the experts' survey assumed only a "typical disclosure situation in your institution or experience," which might not have assumed full apologies, offers of compensation, or other elements that reduce tendencies to litigate.

UMHS Reports Disclosure Success

Facilities with more comprehensive programs have found that disclosure and apology reduced their cost of claims. In a January 2009 *Journal of Health & Life Sciences Law* article, Richard Boothman, Chief Risk Officer, and others from the University of Michigan Health System (UMHS) outlined UMHS' proactive approach to responding to patient injuries and claims.[4] It includes acknowledging and apologizing for "true mistakes" and providing "a thorough explanation" of all unanticipated outcomes. UMHS is also committed to compensating patients quickly and fairly when "unreasonable" medical care causes injury, defending medically reasonable care vigorously, and reducing patient injuries by learning from patient experiences.

GNYHA'S COMMUNICATION SKILLS TRAINING

- Promotes improved care outcomes, and ultimately improved patient satisfaction.
- Helps staff develop and improve skills needed to accomplish effective disclosure following an adverse event.
- Prepares core group of skilled staff that can assist others with communicating about adverse events.
- Helps create more supportive environment for physicians and other caregivers following an adverse event.

Addressing the Studdert study's conclusions that open and honest disclosure would result in increased litigation, the Boothman article stated that UHMS "has not seen those floodgates swing open." New claims have fallen steadily from a high of 136 in 1999 to a low of 61 in 2006, without adjustment for increases in clinical activity over the same period. In that time (2001 to 2007) UHMS also reduced its average claims processing time from 20.3 months to about 8 months. In addition, its total insurance reserves dropped by two-thirds, and its average litigation costs were cut in half.

Others Satisfied With UMHS Program

Boothman, et al., acknowledged that more than just transparency had been at play, citing decreases in tort filings and efforts to improve patient safety nationally. But they also said physicians and the plaintiff's bar approve of the program. More than 87% of 400 UMHS physicians surveyed said the threat of litigation adversely affected the satisfaction they had in practicing medicine. But 98% of respondents fully approved of the UMHS approach to adverse events, and 55% said the approach was a "significant factor" in their decision to stay at UMHS. Among the 26 respondents to a survey of the plaintiff's bar, 71% stated settlement amounts with UMHS were less than anticipated; 81% said their costs were lower; and 87% agreed the transparency allowed them to make better decisions about claims to pursue. More than half of respondents stated they had declined to pursue claims they likely would have pursued before the system changed. The article also cited other hospitals and systems that have reported success with similar approaches, including the nationwide Kaiser Permanente network, Johns Hopkins in Maryland, Catholic Healthcare West in the Southwest, and COPIC Insurance Company in Colorado.

Need to Protect Disclosures, Apologies

Though UMHS and other systems have reported positive results in their approaches to adverse events, providers' fears of litigation are still an obstacle to comprehensive programs, particularly in states that are perceived to have less friendly litigation climates. To address this, the majority of states have enacted laws protecting apologies, and in many cases disclosures and early offers of compensation as well, from being introduced in court. The formulations vary, but all are aimed at ensuring that providers are more willing to undertake complete disclosures and full apologies without fear that those discussions will be used against them in any subsequent litigation. It is often argued that providers should not be protected from undertaking actions they are required to take or that are simply the right thing to do. But a proactive, full, and meaningful disclosure and apology may be more satisfying to patients and providers, and may be more apt to lead to an early and fair resolution. Among the states in which GNYHA members are located, unfortunately, only Connecticut offers such protections at this time. GNYHA urges the passage of such laws in every state.

Encouraging Comprehensive Programs

Proactively offering a full disclosure and apology following an adverse event, plus compensation, when warranted, may spare providers and patients long and often acrimonious litigation, potentially reduce costs, and certainly support a culture of safety. Given that litigation fears often impede providers from undertaking recommended comprehensive disclosures and full apologies, laws protecting such actions from admission in subsequent arbitration or litigation may be necessary to encourage providers to engage in these recommended activities. ■

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Limiting Contingent Fees

Many states, including New York and its neighbors, limit the contingent fees plaintiff attorneys can charge clients in medical malpractice cases to discourage non-meritorious cases, reduce malpractice coverage costs, and ensure more of the recovery goes to the injured plaintiff. This issue of *Health Care News In-Depth* explores the goals of contingent fee limits and the negative financial impact of increasing those limits.

Plaintiff attorney contingent fees are considered a way for individuals who might not be able to pay attorneys an hourly rate to access the courts. The fees are contingent on a settlement or award in the case and are based on a percentage of the amount actually recovered. Given the negative incentives created by such fees, some states have imposed across-the-board limits, while others have enacted sliding fee schedules under which the permissible fee percentage decreases as the size of the recovery increases.

Fee Limits: Goals & Impacts

A number of reports and articles discuss the benefits and perceived downsides of limiting contingent fees. According to the Congressional Budget Office, contingent fees "create incentives for attorneys to take on large numbers of cases, each with a low probability of success, with the expectation that the fees earned from the successful cases will be large enough to subsidize the unsuccessful cases."[1] Limiting contingent fees might therefore remove that incentive. Similarly, a 2004 National Association of Insurance Commissioners report states that limits on contingent fees help deliver "more of the award to the person who sustained the injury and thus [are] fairer to malpractice claimants."[2] In addition, such limits help "weed out non-meritorious claims, as attorneys are less inclined to take a chance on a doubtful recovery if their stake in the claim might be smaller." On the other side, both reports acknowledge the argument that contingent fee limits may deny injured individuals their day in court because attorneys might be less inclined to take cases with small dollar values, regardless of their validity.

EXAMINING THE CASE FOR CONTINGENT FEE LIMITS

"...contingent fees—which are typically a percentage of the amount awarded—create incentives for attorneys to take on large numbers of cases, each with a low probability of success, with the expectation that the fees earned from the successful cases will be large enough to subsidize the unsuccessful cases."

–Congressional Budget Office, The Effects of Tort Reform: Evidence from the States (2004)

Fee Limits, Settlements

A *Duke Law Journal* article on contingent fees discusses the fact that such limitations may not only decrease the number of claims but also increase the rate of malpractice claim settlements.[3] According to the article, insurance companies—and presumably providers—are "generally willing to settle meritorious claims for amounts that the plaintiffs and their attorneys find reasonable. By decreasing the amount that the plaintiff's attorney may charge in fees, contingent fee limitation statutes consequently increase the amount of a proposed settlement a plaintiff will retain." The article suggests that this result will lower the threshold settlement offer necessary to prompt plaintiffs to settle. The article argues that "[a]ttorneys will also have a greater incentive under sliding scale contingency fee limitations to accept a lower settlement offer." This is because the attorney will have "less incentive to risk sure money for the opportunity of a large jury award."

New York's Sliding Schedule

New York State enacted its existing limitations on plaintiff attorney contingent fees in malpractice cases in 1985 as part of a comprehensive package of reforms to limit increases in the costs of malpractice coverage. The Legislature replaced the one-third across-the-board fee limit with the current schedule that breaks down a plaintiff's recovery into tiers so that attorneys may receive fees equal to:

- 30% of the first $250,000 recovered;
- 25% of the next $250,000;
- 20% of the next $500,000;
- 15% of the next $125,000; and
- 10% of those portions of recoveries above $1,250,000.

The bill memorandum that accompanied then-Governor Mario Cuomo's proposal to move to a sliding scale stated that the limits were intended "to assure that the injured party will receive a sufficient share of the judgment and to target insurance premium dol-

lars primarily to the plaintiff's compensation." The memorandum also stated that limiting contingent fees would diminish awards that are often significantly increased to pay for attorney's fees.[4] Governor Cuomo's proposal was much less generous to attorneys than the one the Legislature ultimately enacted. His plan would have reduced the fee to 10% on recoveries as low as $500,000.

Higher Fees Available

New York permits attorneys to apply for compensation beyond the fee schedule when, due to extraordinary circumstances, the attorney can demonstrate that the schedule would not provide adequate compensation. In reviewing an application for a fee increase, the New York State Court of Appeals has stated that the test is whether the fee schedule "equitably compensates counsel for 'the amount of time reasonably and necessarily spent' in litigating the claim." In determining whether the statutory fee might be inadequate, the Court stated that factors that might be considered are "whether the case involves an extremely complicated procedural history or where plaintiff's counsel is required to expend an inordinate amount of time in pursuing the medical malpractice claim, thereby rendering the hourly rate of compensation exceptionally low or causing a loss of other income or some other financial detriment."[5] According to a 2005 *Forbes* article, some plaintiff attorneys in New York State have been very successful in applying for fees beyond the statutory schedule.[6]

PLAINTIFF ATTORNEY CONTINGENT FEES

SETTLEMENT/ AWARD	CURRENT: SLIDING FEE SCHEDULE	PROPOSED: 1/3 OF THE SETTLEMENT/AWARD ACROSS THE BOARD	% FEE INCREASE
$250,000	$75,000	$83,333	11%
$500,000	$137,500	$166,667	21%
$750,000	$187,500	$250,000	33%
$1,000,000	$237,500	$333,333	40%
$1,500,000	$300,000	$500,000	67%
$2,000,000	$350,000	$666,667	90%
$3,000,000	$450,000	$1,000,000	122%
$6,000,000	$750,000	$2,000,000	167%

Impact of Modifying Fees

As limitations on contingent fees are a mechanism to reduce malpractice coverage costs, it is not surprising that proposals to increase or even eliminate New York State's current sliding fee schedule would greatly increase such costs, an outcome that would make little sense during a time when all three branches of New York State's government are looking for ways to streamline the system and reduce costs. Actuaries have estimated that raising the fee tiers would increase hospital malpractice costs by 15%, or $240 million, statewide. Eliminating the sliding fee schedule entirely and returning to a one-third across-the-board cap would increase hospital costs by 25%–40% or $400 million–$640 million statewide while drastically increasing plaintiff attorneys' fees. For example, in the case of a $2 million recovery, the attorney's fee would increase from $350,000 to $666,667, a 90% increase. In the case of a $6 million recovery, the attorney's fees would increase from $750,000 to $2 million, a 167% increase.

While there is debate about exactly how much premiums and other coverage costs would rise if the limits were increased, any change would unquestionably result in harm to plaintiffs and providers. An increase in attorney fees must come from either the pockets of the attorneys' clients in the form of reduced shares of their recoveries and/or out of the pockets of hospitals and physicians in the form of increased coverage costs.

Plaintiff attorneys argue they are due an increase because the fee schedule has not been adjusted recently. However, the reason for the currently unsustainably high levels of coverage costs is that the severity of recoveries has increased significantly in recent years. Plaintiff attorneys have thus received increases in fees because the underlying recoveries have increased, and they have the ability to apply for larger fees if the complexity or demands of a particular case warrant it.

Schedule Should Remain

Rolling back the significant reform of limiting plaintiff attorney fees would likely result in both lower recoveries for plaintiffs and higher costs for providers. Such a move would be antithetical to the current policy goals of reducing the costs of malpractice coverage, streamlining the resolution of cases, and ensuring that a sufficient share of the recovery dollars goes to the injured parties. ■

SOURCES

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PATIENT SAFETY INTITIATIVES AND THE TORT SYSTEM

Hearing of the

New York City Council Committee on Health
Maria Del Carmen Arroyo, Chair

and

New York City Council Committee on Women's Issues
Julissa Ferreras, Chair

Tuesday, January 31, 2012

Testimony of Mary A. Walling, Esq.

"TEMPORAL TRENDS IN RATES OF PATIENT HARM RESULTING FROM MEDICAL CARE" NEJM, NOV 25, 2010

"In December 1999, the Institute of Medicine (IOM) reported that

medical errors cause up to 98,000 deaths and more than 1 million injuries each year in the United States.

In response, accreditation bodies, payers, nonprofit organizations, governments, and hospitals launched major initiatives and invested considerable resources to improve patient safety. Some interventions have been shown to reduce errors… However, many of these interventions have not been evaluated rigorously or implemented reliably on a large scale…"

"Our findings validate concern raised by patient-safety experts in the United States and Europe that harm resulting from medical care remains very common. Though disappointing, the absence of apparent improvement is not entirely surprising…the penetration of evidence-based safety practices has been quite modest…"

"…achieving transformational improvements in the safety of health care will require further study of which patient-safety efforts are truly effective across settings and a refocusing of resources, regulation, and improvement initiatives to successfully implement proven interventions."

Landrigan et al, "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," NEJM, Nov 25, 2010.

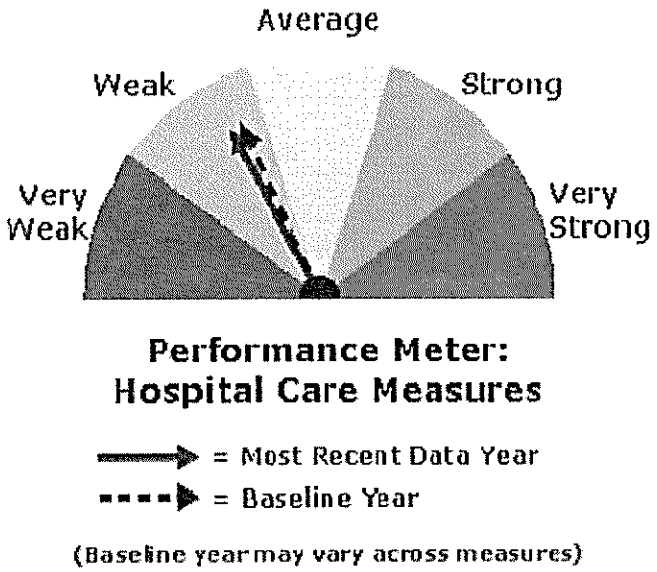
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The AHRQ compares how well hospitals perform on 31 key quality and patient safety measures. **The AHRQ 2010 hospital "performance meter" for New York as compared to that of all states:***

New York

What Is the Hospital Care Quality Performance Compared to All States?

How Has That Performance Changed?



*Accessed at http://statesnapshots.ahrq.gov/snaps10/settingsofcare.jsp?menuId=12&state=NY&level=5

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
PERFORMANCE OF ALL STATES ACROSS ALL MEASURES IN HOSPITAL CARE 2010

Rank	State	Meter Score for Hospital Care
1	OH	78.12
2	MI	76.09
3	ME	70.69
4	PA	70.59
5	FL	70.31
6	SC	70.31
7	NH	66.67
8	MN	66.13
9	MT	65.62
10	VA	65.62
11	VT	65.38
12	UT	63.79
13	WI	62.9
14	IA	61.29
15	NC	59.38
16	NJ	57.81
17	SD	56.25
18	CT	54.84
19	MA	54.84
20	ID	53.12
21	NE	51.61
22	ND	50
23	RI	48.28
24	DE	46.88
25	IL	46.88
26	CO	41.94
27	MO	41.94
28	AZ	40.32
29	WA	40.32
30	WV	40
31	AR	39.06
32	CA	37.5
33	IN	37.5
34	OR	37.1
35	KS	34.38
36	**NY**	**34.38**
37	MD	32.26
38	OK	32.26
39	GA	31.25
40	TN	31.25
41	WY	28.26
42	KY	28.12
43	HI	22.58
44	NV	22.58
45	TX	19.57
46	AK	17.86
47	AL	17.65
48	MS	11.76
49	DC	9.38
50	LA	5.88
51	NM	3.12

http://statesnapshots.ahrq.gov/snaps10/overall_quality.jsp?menuId=12&state=NY&sCol=speed&sDir=DESC&level=5&region=0&compGroup=N&compRegion=-1

HEALTHGRADES HOSPITAL PATIENT SAFETY RANKINGS

The annual *HealthGrades Patient Safety in American Hospitals Surveys* for both 2010 and 2011 scored **New York's "Overall Average"** for hospital safety to be among the **"Bottom 10 States".*** The rankings were based on risk-adjusted performance on 13 patient safety indicators developed by the U.S. Agency for Healthcare Review and Quality.

HEALTHGRADES®

*http://www.healthgrades.com/business/img/HealthGradesPatientSafetyInAmericanHospitalsStudy2011.pdf (Page 30)

http://www.healthgrades.com/media/DMS/pdf/PatientSafetyInAmericanHospitalsStudy2010.pdf (Page 32)

WSJ.com THE WALL STREET JOURNAL. ONLINE

"Once Seen as Risky, One Group Of Doctors Changes Its Ways

Anesthesiologists Now Offer Model of How to Improve Safety, Lower Premiums"

By JOSEPH T. HALLINAN - Staff Reporter of THE WALL STREET JOURNAL - June 21, 2005

"The rising cost of medical-malpractice insurance has hit many doctors, especially surgeons and obstetricians. But one specialty has largely shielded itself:

Anesthesiologists pay less for malpractice insurance today, in constant dollars, than they did 20 years ago. That's mainly because some anesthesiologists chose a path many doctors in other specialties did not. Rather than pushing for laws that would protect them against patient lawsuits, these anesthesiologists focused on improving patient safety. Their theory: Less harm to patients would mean fewer lawsuits.

Over the past two decades, anesthesiologists have advocated the use of devices that alert doctors to potentially fatal problems in the operating room. They have helped develop computerized mannequins that simulate real-life surgical crises. And they have pressed for procedures that protect unconscious patients from potential carbon-monoxide poisoning.

All this has helped save lives.

Over the past two decades, patient deaths due to anesthesia have declined to one death per 200,000 to 300,000 cases from one for every 5,000 cases,

according to studies compiled by the Institute of Medicine, an arm of the National Academies, a leading scientific advisory body.

Malpractice payments involving the nation's 30,000 anesthesiologists are down, too, and **anesthesiologists typically pay some of the smallest malpractice premiums around. That's a huge change from when they were considered among the riskiest doctors to insure**. Nationwide, the average annual premium for anesthesiologists is less than $21,000, according to a survey by the American Society of Anesthesiologists. An obstetrician might pay 10 times that amount, Medical Liability Monitor, an industry newsletter, reports.

http://www.saynotocaps.org/newsarticles/once_seen_as_risky.htm

HEALTHCARE-ACQUIRED INFECTION PREVENTION PROGRAMS: INFECTION RATE AND COST REDUCTIONS

• After adjusting for the range of effectiveness of possible infection control interventions, **the benefits of prevention range from a low of $5.7 billion (20% of infections preventable) to a high of $31.5 billion (70% preventable).**

Centers for Disease Control, *The Direct Medical Costs of Healthcare Associated Infections in the U.S. and the Benefits of Prevention*, March 2009.

• "Hand washing is considered vital in health care settings to prevent the spread of potentially-infectious pathogens, like Methicillin-resistant Staphylococcus aureus. **And close attention to such basic hygiene could be a way of reducing the nation's hospital bills by billions of dollars.**"

Kevin Sack, "A Hospital Hand-Washing Project to Save Lives and Money," *NY Times,* September 10, 2009.

• Each year central venous catheters cause an estimated 80,000 blood-stream infections and result in up to 28,000 patient deaths in ICUs. The average cost of a catheter-related blood stream infection is $45,000. The main components of the Michigan Keystone ICU Patient Safety Program implemented at 108 ICUs included measures like hand washing, removal of unnecessary catheters and using full-barrier precautions during the insertion of central venous catheters. **The program resulted in up to a 66% reduction in catheter-related bloodstream infection rates.**

Pronovost et al, "An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU," *New England Journal of Medicine*, December 28, 2006.

RESULTS OF OBSTETRICS SAFETY PROGRAMS IN OTHER U.S. HOSPITALS

Hospital Corporation of America:

"Comprehensive redesign of patient safety processes" in obstetrics more than halved the number of obstetrical claims against HCA facilities and resulted in

"nearly a 5-fold reduction in the cost of claims."

"In this large health system, with nearly 200 hospitals nationwide, obstetric malpractice claims currently rank behind `accidents on hospital grounds' in terms of litigation loss and cost."

Clark et al, "Improved outcomes, fewer cesarean deliveries, and reduced litigation: results of a new paradigm in patient safety," *American Journal of Obstetrics and Gynecology*, August 2008.

Catholic Healthcare Partners (Cincinnati):

"Comprehensive perinatal patient safety program" at 16 perinatal centers resulted in a 65% decline from 2003 to 2008 in obstetrical occurrences (a "birth-related event or injury that may lead to a claim"),

the average cost per obstetrical claim fell from $1 million to less than $500,000 and the number of new claims reported decreased by 48%.

Simpson et al, "A comprehensive Perinatal Patient Safety Program to Reduce Preventable Adverse Outcomes and Costs of Liability Claims," *The Joint Commission Journal on Quality and Patient Safety*," November 2009.

OBJECTIVE ANALYSIS. EFFECTIVE SOLUTIONS.

"Better Patient Safety Linked to Fewer Medical Malpractice Claims in California"

FOR RELEASE
April 15, 2010

"Reducing the number of preventable patient injuries in California hospitals from 2001 to 2005 was associated with a corresponding drop in malpractice claims against physicians, according to a study issued today by the RAND Corporation.

"Researchers studied both medical malpractice claims and adverse events such as post-surgical infections across California counties and found that changes in the frequency of adverse events were strongly correlated with corresponding changes in the volume of medical malpractice claims.

"'These findings suggest that putting a greater focus on improving safety performance in health care settings could benefit medical providers as well as patients,' said Michael Greenberg, the study's lead author and a behavioral scientist with RAND, a nonprofit research organization.

"The link between safety performance among health care providers and malpractice suits has been of central interest to policymakers in the ongoing debate over health care reform. **The RAND study is the first to demonstrate a link between improving performance on 20 well-established indicators of medical safety outcomes and lower medical malpractice claims."**

...

Source: Rand Corporation press release, April 15, 2010

New York Presbyterian Hospital

"Effect of a comprehensive obstetric patient safety program on compensation payments and sentinel events"

Amos Grunebaum, MD; Frank Chervenak, MD; Daniel Skupski, MD

Improving patient safety has become an important goal for hospitals, physicians, patients, and insurers. Implementing patient safety measures and promoting an organized culture of safety, including the use of highly specialized protocols, has been shown to decrease adverse outcomes; however, it is less clear whether decreasing adverse outcomes also reduces compensation payments and sentinel events.

Our objective is to describe comprehensive changes to our obstetric patient safety program and to report their impact on actual spent compensation payments (sum of indemnity and expenses paid) and sentinel events.

Materials and Methods

New York Presbyterian Hospital-Weill Cornell Medical Center is a tertiary academic referral center with a level 3 neonatal intensive care unit and serves as a New York State regional perinatal center. The labor and delivery unit performs about 5200 deliveries per year of which voluntary attending physicians manage approximately 25%, and 75% are managed by full-time faculty. The New York Weill Cornell Investigation
Research Board approved this report as exempt research.

Patient safety program

In 2002, we began to implement in a step-wise fashion a comprehensive and ongoing patient safety program. The date of implementation is included for each step.

Consultant Review (2002)

In 2002, as part of an obstetric initiative by our insurance carrier (MCIC Vermont, Inc., Burlington, VT), **2 independent consultants reviewed our department and assessed our institution's obstetric service. This review resulted in specific recommendations and provided a general outline for making changes and improvements in patient safety. Building on these findings, we implemented a comprehensive obstetric patient safety program.**

American Journal of Obstetrics & Gynecology, February 2011.

NEW YORK PREBYTERIAN HOPSITAL OBSTETRIC PATIENT SAFETY PROGRAM

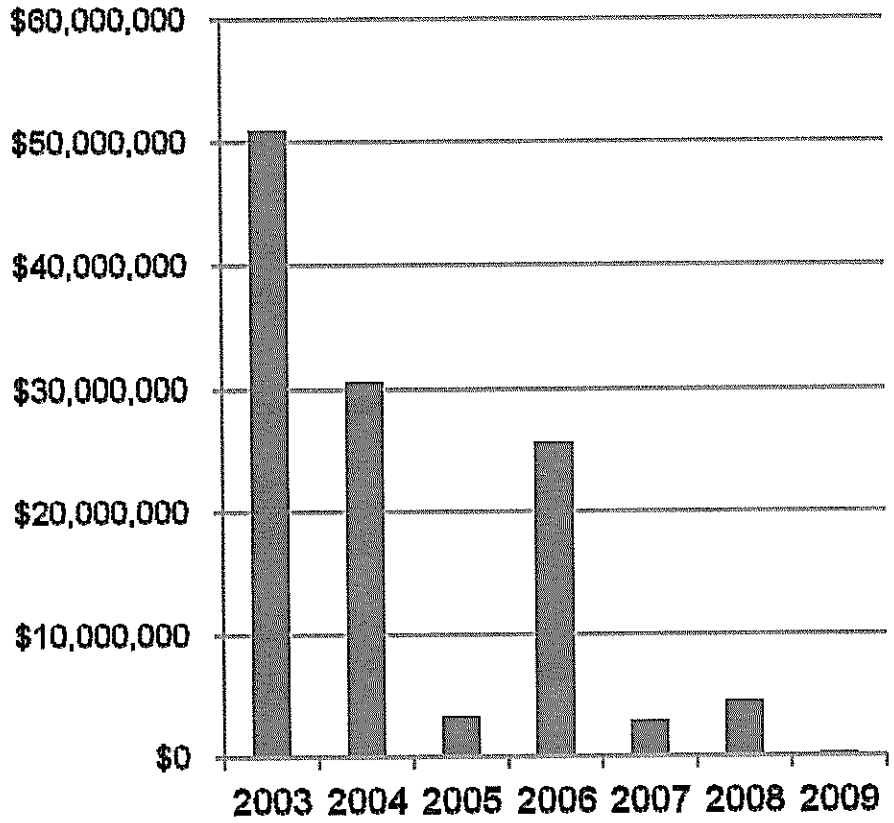
Key elements:

- Interdisciplinary team training, focusing on better communication
- Obstetric emergency drills
- Electronic medical record charting for all patients in labor and delivery
- Clear chain of communication, from nurse up to chairman of the department
- Standardized oxytocin labor induction and stimulation protocol and addition of an oxytocin initiation checklist and color-coding of magnesium sulfate and oxytocin solution labels
- Employment of an obstetric patient safety nurse who is involved in training, implementation of protocol changes, obstetric emergency drills, etc.
- Addition of three new physician's assistants and a laborist on nights and weekends
- Electronic fetal monitor interpretation certification required of staff
- Routine thromboembolism prophylaxis for all cesarean deliveries
- Retrospective review of obstetric compensation payments and new and ongoing lawsuits

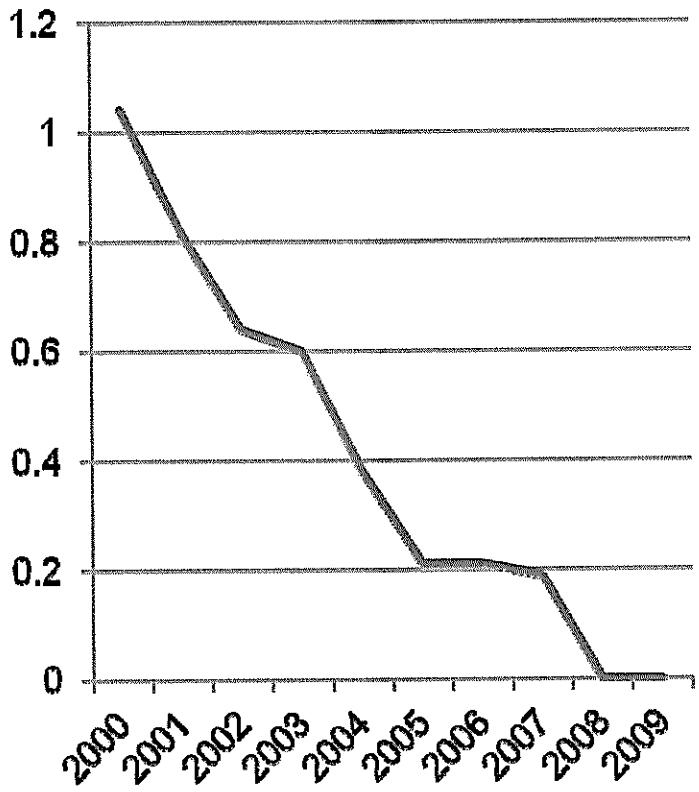
NEW YORK PRESBYTERIAN HOPSITAL OBSTETRIC PATIENT SAFETY PROGRAM "RESULTS"

"The 2009 compensation payment total constituted a 99.1% drop from the average 2003-2006 payments (from $27,591,610 to $250,000)."

Compensation payments by year



Sentinel events by year (per 1000 deliveries)*



Grunebaum et al, Effect of a comprehensive patient safety program on compensation payments and sentinel events," *American Journal of Obstetrics & Gynecology*, Feb 2011 et al.

*A sentinel event is "an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof."

NEW YORK PRESBYTERIAN HOSPITAL OBSTETRIC PATIENT SAFETY PROGRAM "COMMENT"*

"Our results show that implementing a comprehensive obstetric safety program not only decreases severe adverse outcomes but can also have an immediate impact on compensation payments."

"The $25,041,475 yearly savings in compensation payments for the last 3 years alone dwarf the incremental cost of the patient safety program..."

"Making significant changes on a labor and delivery unit including ... 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."

*Grunebaum et al, Effect of a comprehensive patient safety program on compensation payments and sentinel events," *American Journal of Obstetrics & Gynecology* , Feb 2011 et al.

CONTROLLED RISK INSURANCE COMPANY (CRICO)

Strategies for Patient Safety

"As the patient safety and medical professional liability provider owned by and serving the Harvard medical community for more than 30 years, CRICO is dedicated to providing industry-leading insurance coverage, expert legal and claims services, and **pioneering patient safety methodologies**..."

"CRICO is an internationally renowned leader in evidence-based risk management, proudly serving 21 hospitals, more than 12,000 physicians (including residents and fellows), and 207 other health care organizations."

http://www.rmf.harvard.edu/company/about-us.aspx

"CRICO/RMF Strategies...uses medical malpractice data to help hospitals across the nation dramatically reduce medical errors and minimize financial loss..."

"CRICO/RMF Strategies offers proven methodologies and data-driven insights that reveal hidden areas of risk and deliver actionable intelligence to drive fundamental change that transforms the safety of patient care..."

http://www.marketwire.com/press-release/crico-rmf-strategies-convenes-emergency-medicine-leadership-council address-crisis-americas-1514740.htm

CRICO/RMF: "PSAG CORE CURRICULUM FOR PATIENT SAFETY"

***Excerpts from Module 1: Introduction to Patient Safety*:**

"In the time it will take you to complete this module, 80 patients in the American health care system will be injured, and 10 will die, because of preventable medical errors..."

"This is a serious public health problem..."

"...Although the individual professional is the final pathway by which these errors happen, **errors designed into our systems are waiting to be made, if not by you, then by the next doctor or nurse**."

"What would it look like if leaders were to direct attention to the issue of medical error? ... Reported error rates would go up for awhile because we currently underreport errors and near misses by a factor of 10."

"...When errors occur, we would learn and prevent, rather than blame and hide... **Our patients would be injured less often, and health care costs would go down considerably."**

http://www.rmf.harvard.edu/education-interventions/materials-for-instructors/patient-safety/index.aspx#essay

CRICO/RMF ON FRIVOLOUS LAWSUITS AND PATIENT SAFETY

"NOT A FRIVOLOUS MATTER"

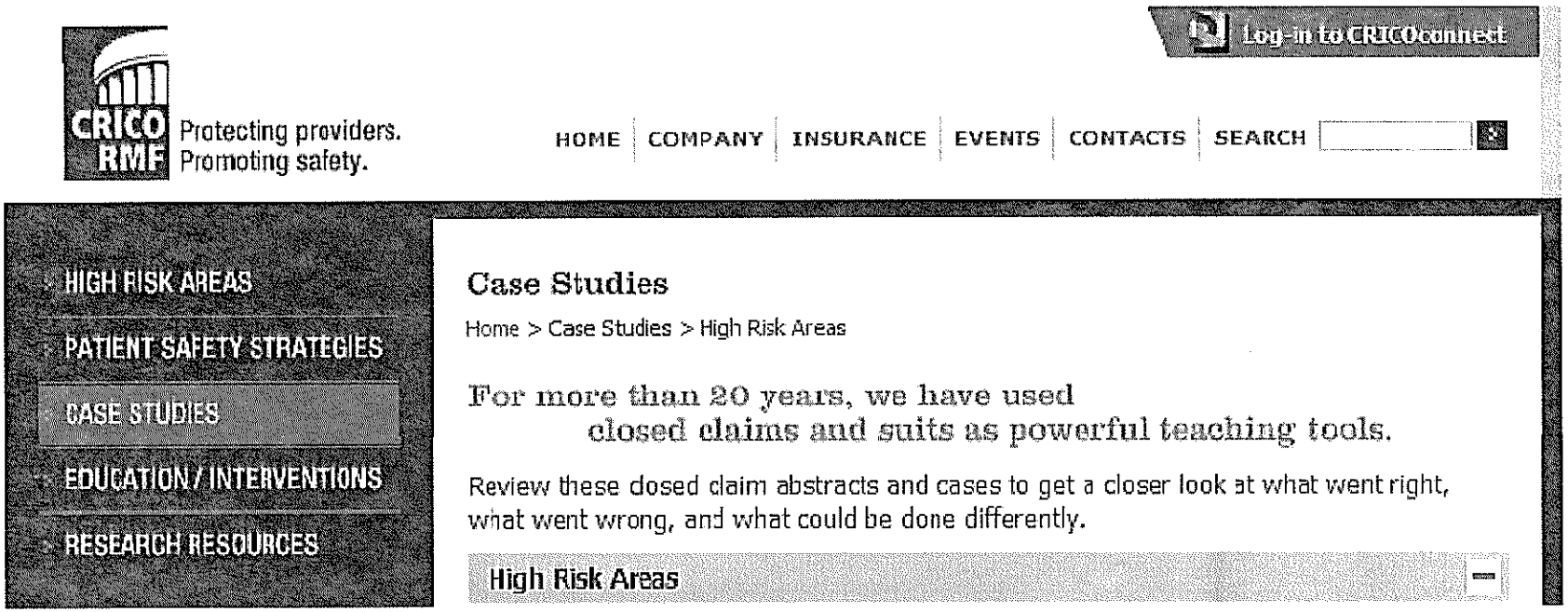
by Jock Hoffman, Patient Safety Education Program Director, CRICO/RMF
January 2011

"…`**frivolous' malpractice suits are less common than the politicians espousing them.** Plaintiffs whose claims lack the fundamental legal components are challenged to find an attorney willing to devote time and out-of-pocket resources, unlikely to find a tolerant court, and even less likely to receive compensation…"

"Rather than dwell on the frivolous bogeyman, politicians, and health care providers will likely be more successful at reducing patient injuries, costs, and lawsuits by studying the underlying causes of the malpractice cases that reflect suboptimal care and present opportunities to repair flaws in the health care delivery system. Seriously."

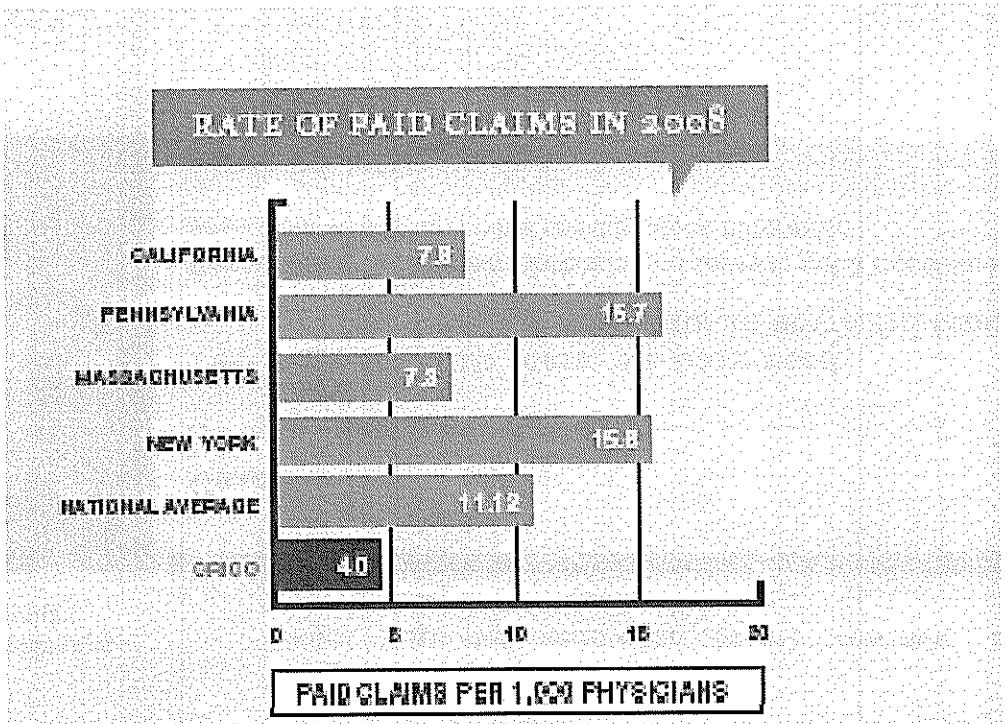
http://www.rmf.harvard.edu/education- interventions/sps/issues/SPS-1-2011.html

CRICO/RMF ON THE USE OF CASE STUDIES

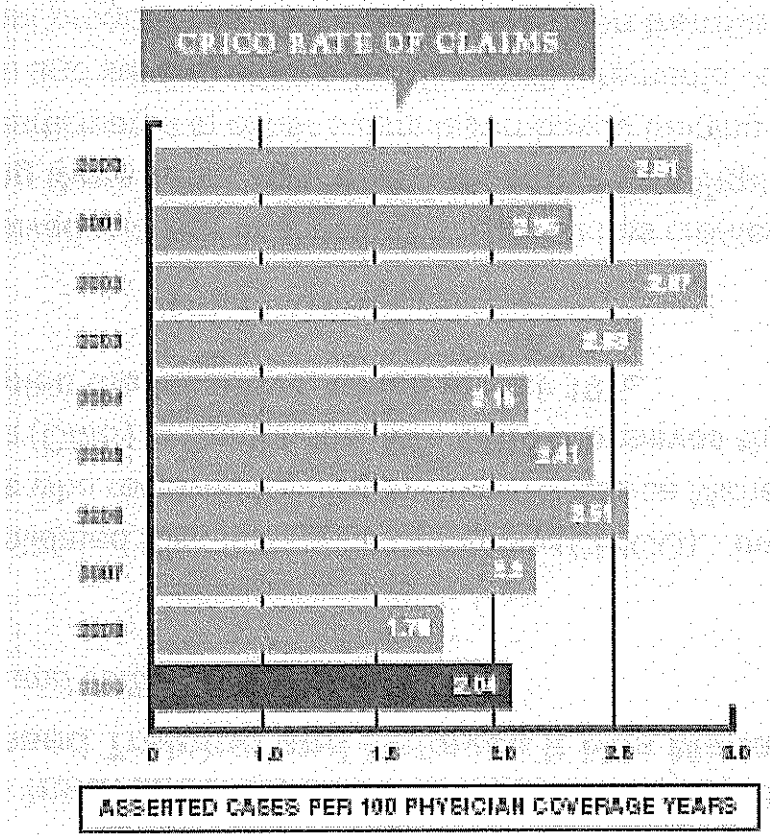


http://www.rmf.harvard.edu/case-studies/index.aspx

CRICO/RMF 2009: The Year in Review



http://www.rmf.harvard.edu/files/documents/Focus_2009_Year_Review.pdf



http://www.rmf.harvard.edu/files/documents/Focus_2009_Year_Review.pdf

ANESTHESIA PATIENT SAFETY FOUNDATION *NEWSLETTER*
THE OFFICIAL JOURNAL OF THE ANESTHESIA PATIENT SAFETY FOUNDATION, Spring 2007

"Malpractice Insurance Carrier Provides Premium Incentive for Simulation-Based Training and Believes It Has Made a Difference"

by Jack McCarthy and Jeffrey B. Cooper, PhD

In 2001, the Consolidated Risk Insurance Company (CRICO)...**introduced** an **incentive for anesthesiologists** who received training in Crisis Resource Management at the Center for Medical Simulation (CMS) in Cambridge, MA. **CRICO believes that this has made a difference and has since tripled the incentive, which is now 19%.**

Based on its perceived success in anesthesia, CRICO has created a similar incentive program in OB/GYN... **Starting three years ago, a 10% incentive was implemented for OB/GYN physicians** who participated in either a simulation-based training program or an organization wide teamwork program and several other educational requirements. Although there is not yet sufficient experience with that program, **CRICO claims have been trending lower at those institutions with active team training or simulation training. CRICO/RMF is now planning additional incentive programs in other specialties ...**

http://www.apsf.org/newsletters/html/2007/spring/17_malpractice.htm

RISK RETENTION REPORTER, JUNE 2007

"Risk Retention Group Offers Incentives to Reduce Claims Frequency"

Excerpts from a *Risk Retention Reporter* interview with Jack McCarthy, President of Risk Management Foundation of the Harvard Medical Institutions, the administrative organization for Controlled Risk Insurance Co. of Vermont (A Risk Retention Group):

"RRR: What results have you seen from the [OB] discount program?"

"McCarthy: ... **Our preliminary results at BIDMC** [Beth Israel Deaconess Medical Center], the location for the first team training, **are very encouraging**. In the three years prior to team training, BI had 7 OB claims and suits with 5 (71%) being high severity. In the three years post training, claims and suits dropped to 2 and high severity to 1. Another measure, **the Adverse Outcomes Index ...shows a 55% drop over the same period of study. This would tend to validate the claims experience."**

"RRR: What's next?"

"McCarthy: Office practice evaluations (OPE) are done by CRICO/RMF staff. These OPEs focus on test result handling, referral management, and quality of office records. We are piloting a discount program and providers will receive a 10% discount for a score of 85% or better on a range of evaluation factors... **Our assessment is that positive incentives can accelerate adoption of patient safety and risk management programs**. These incentives have had a positive payback for our program in the short run and we are interested in adding specialties and continuing to measure the impact on premium and bottom line results."

http://www.rmf.harvard.edu/files/documents/RRR_mcarthy_2006-07.pdf

CITY OF NEW YORK OFFICE OF THE COMPTROLLER
CLAIMS REPORT FISCAL YEARS 2009 & 2010

"Since FY 2001, HHC has been pro-active in the areas of risk and litigation management with impressive results. **The number of tort claims against HHC has dropped 26 percent since FY 2001."**

"[T]heir efforts have resulted in a decrease in overall medical malpractice claim filings from a high of 889 in FY 2000 to 650 in FY 2010, the lowest number of new filings in the last 11 years. **Settlement costs have also decreased significantly. In FY 2003, the City paid a 10-year high of $195.4 million for medical malpractice claims. In contrast, the City paid $130.1 million in FY 2010, the second lowest payout in the last 11 years."**

http://comptroller.nyc.gov/bureaus/bla/pdf/2011_Claims_Report.pdf

Massachusetts
Medical Law Report
AUTUMN 2008 / MMLR

Rx for Excellence Awards Ceremony and Breakfast • October 31, 2008 • Taj Boston

"CRICO/Risk Management Foundation Loss Prevention and Patient Safety Department ...has been very successful in defending claims. But its Loss Prevention and Patient Safety Department, through an innovative "reinvestment strategy," has moved CRICO beyond simple coverage and defense to helping fix the underlying conditions that threaten patient safety in the first place.

"When **Robert Hanscom** took over as **vice president of loss prevention and patient safety** in 1998, he instituted a push to analyze data in order to determine where patients were experiencing the greatest number of high-severity incidents, and then use money saved via successful claim defenses for generous grants to its organizations and providers to address these areas.

"Hanscom says the program has been a tremendous success.

" For example, the department identified obstetrics as an area of concern. By analyzing data and charts, they noticed that many losses were due to communications failure. So the department funded a grant for every labor-and-delivery department in the Harvard system to receive training in the team-based philosophy used in the aviation industry.

"'We saw an impact in a very short period of time,' Hanscom says. *'For example,* ***data from [Beth Israel Deaconess Medical Center] has shown a 50 percent reduction [in] malpractice cases in seven years.'*** ...

"The grant program has resulted in similar success in surgery and diagnosis, particularly in the area of breast cancer diagnoses, Hanscom adds, noting that the number of malpractice cases stemming from missed diagnoses has significantly diminished over the last few years.

"'[Many insurers] focus on tort reform to reduce malpractice costs, but I don't think that's the answer," says Hanscom. "The answer is prevention, which means making sure institutions provide as highly reliable an environment as possible.'"

MMLRRobert Hanscom –*Eric Berkman* http://www.affiliatedmonitors.com/Affmonitor-mmir.pdf

THE PERINATAL SAFETY NURSE: EXEMPLAR OF TRANSFORMATIONAL LEADERSHIP

MCN, THE AMERICAN JOURNAL OF MATERNAL/CHILD NURSING,

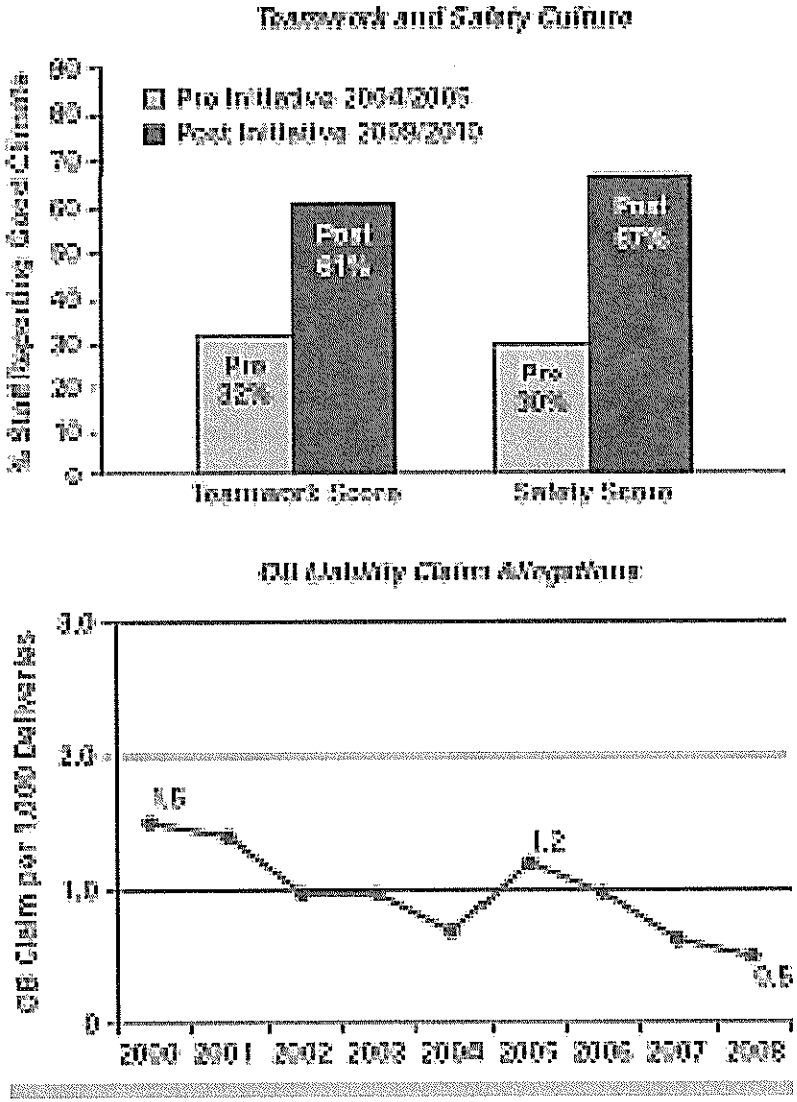
SEPTEMBER/OCTOBER 2011

"If success of a perinatal patient safety initiative can be measured by decreased obstetric adverse events, decreased liability claims, and an increased perception of the culture of safety, the experience over the 5 years of the initiative at Yale-New Haven Hospital and New York Presbyterian Weill Cornell Medical Center can be deemed successful ..."

http://www.nursingcenter.com/pdf.asp?AID=1209594

FIGURE 1. NYP-WCMC AND YALE NEW HAVEN HOSPITAL OB DATA

HTTP://WWW.NURSINGCENTER.COM/PDF.ASP?AID=1209594



KORN/FERRY INTERNATIONAL

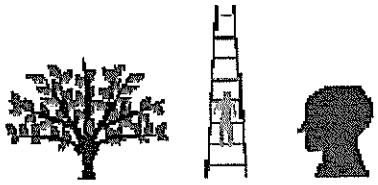
MCIC VERMONT, INC.

Confidential Position Specification

MCIC Vermont, Inc.

Chief Medical Officer and
Senior Vice President, Patient Safety and Loss Prevention

June 2011



THE ART SCIENCE OF TALENT

MCIC

KORN/FERRY PUBLICATION FOR POSITION O F CHIEF MEDICAL OFFICER AND SENIOR VICE PRESIDENT PATIENT SAFETY AND LOSS PREVENTION - JUNE 2011

Loss Prevention Program

The primary goal of the MCIC Loss Prevention program is to reduce the risks that cause medical malpractice claims. The focus of the program to date has been primarily concentrated on risk factors in Obstetrics, Pediatrics, Emergency Department, Neurosurgery, and Cardiothoracic Surgery clinical areas. Below is a brief description of the major multi-institutional initiatives, which have resulted in successful outcomes for its shareholders and are ongoing:

Obstetrics: This initiative began in 2004 and has been recognized by almost all of the institutions as having had a significant impact on malpractice claim losses and the department safety cultures. This approach succeeded through a collaboration of institutional obstetrics leadership and MCIC staff, and focused on identifying and implementing risk reduction projects of greatest impact. These projects have included: interdisciplinary communication and team training, adoption of best practice protocols, fetal monitoring certification and simulation training. In addition, a patient safety nurse is placed within each of the institution's departments.

Emergency Department: This risk reduction initiative began in 2009 and has focused on: triage, teamwork and communication, results reporting, managing interruptions and failure to diagnose issues. As with the obstetrics initiative, the approach has been to bring institutional emergency department clinical leaders together to define best practices and implementation strategies. MCIC is also funding patient safety nurses for this initiative. While a relatively new initiative, the claims in the Emergency Department have reduced significantly over the last two years.

The MCIC Loss Prevention team also works with individual institutions to perform risk assessments and provide risk profiles in specific clinical areas which pose a high liability risk in order to identify potential initiatives that can reduce malpractice risk. Currently, there are comprehensive risk assessments being performed at Johns Hopkins and NYP/Cornell in the neurosurgery area.

MEDICAL RISK *MANAGEMENT*, LLC HARTFORD, CT

"...founded in 2003...MRM works with hospitals, physician groups, residency programs, captive insurers and commercial insurance carriers that operate across the United States.

MRM has a proven track record of reducing malpractice claims, premiums, and improving patient safety through a comprehensive risk management education program and consulting services.

Reduce Claims

Beginning in 2006 MRM and Connecticut Surgical Group have worked together in reducing malpractice claims by 89%.

Premium Reductions

Since 2003 MRM and ProHealth Physicians have worked together to reduce their malpractice premiums by over 50%.

Improve Patient Safety

95% of all participants surveyed have stated they will change their practice after experiencing MRMs educational program.

Today, MRM is a growing organization with thousands of participants working in residency/fellowship training programs, large tertiary teaching hospitals and healthcare systems, specialty hospitals, small and mid-sized community hospitals, large to small multispecialty physician groups, commercial malpractice insurance carriers and healthcare facility sponsored captive insurance companies."

THE SULLIVAN GROUP

OAKBROOK TERRACE, IL 60181

WWW.THESULLIVANGROUP.COM

" A Revolutionary Approach to Emergency Medicine Patient Safety and Risk Management"

"The Sullivan Group (TSG) was founded to help emergency practitioners establish best practices, enhance patient safety, and reduce both medical errors and the resulting exposure to litigation."

"**Over 600 clients** have instituted The Sullivan Group's Emergency Medicine Risk Initiative (EMRI®), which includes web-based patient safety education, real-time risk management tools at the bedside, and web-based performance appraisal with feedback to the emergency department team. The results have been dramatic. **One client with over 180 hospitals has reduced its emergency medicine malpractice claims by 38% over a 3-year period and removed tens of millions of dollars from company malpractice reserves."**

ABRIDGED TESTIMONY OF JAY TARTELL, MD
PRESIDENT, MEDICAL SOCIETY OF THE COUNTY OF QUEENS
TO THE NEW YORK CITY COUNCIL
REGARDING RESOLUTION 84-A

Good afternoon. My name is Dr. Jay Tartell and I am a Radiologist and President of the Queens County Medical Society. I am Associate Director of Radiology at Mount Sinai Hospital of Queens and President of Advanced Radiological Imaging, Queens' oldest radiology practice, founded in 1958. On behalf of QCMS as well as the Medical Society of the State of New York, we very much appreciate the opportunity to present testimony to you today.

Resolution 84-A addresses only one small aspect of liability-related challenges facing health care in New York City. Physicians practicing in New York City and its surrounding suburbs pay medical liability insurance premiums that far exceed most other states, yet their ability to pay these extraordinary premiums shrinks daily due to ongoing payment cuts by public and private insurers. Large numbers of NY physicians are now closing or selling their practices due to years of unrelenting payment cuts. Since Medical Malpractice premiums comprise one of the largest overhead items for many physicians, cutting premiums is of utmost importance to maintain the viability of physician practice, especially for litigation prone specialties.

Resolution 84-A appropriately calls for action by the New York State Department of Health and Department of Financial Services, but action must actually come from the State Legislature and Governor Cuomo.

Liability premiums for New York physicians increased 55-80% from 2003 to 2008, and an average additional 5% in 2010 (for some specialties it was even significantly higher). While nominal rates were on average held steady for the 2011-12 policy year, the rates are now at extraordinarily high levels. Moreover, my specialty, Radiology, on average was hit with an 8% increase. Through additional surcharges, those in our group who do breast imaging pay premiums 50% higher than the others. It is critical to understand that "Failure To Diagnose Breast Cancer" has been the number one cause for medical lawsuits in NY State over the last five years.

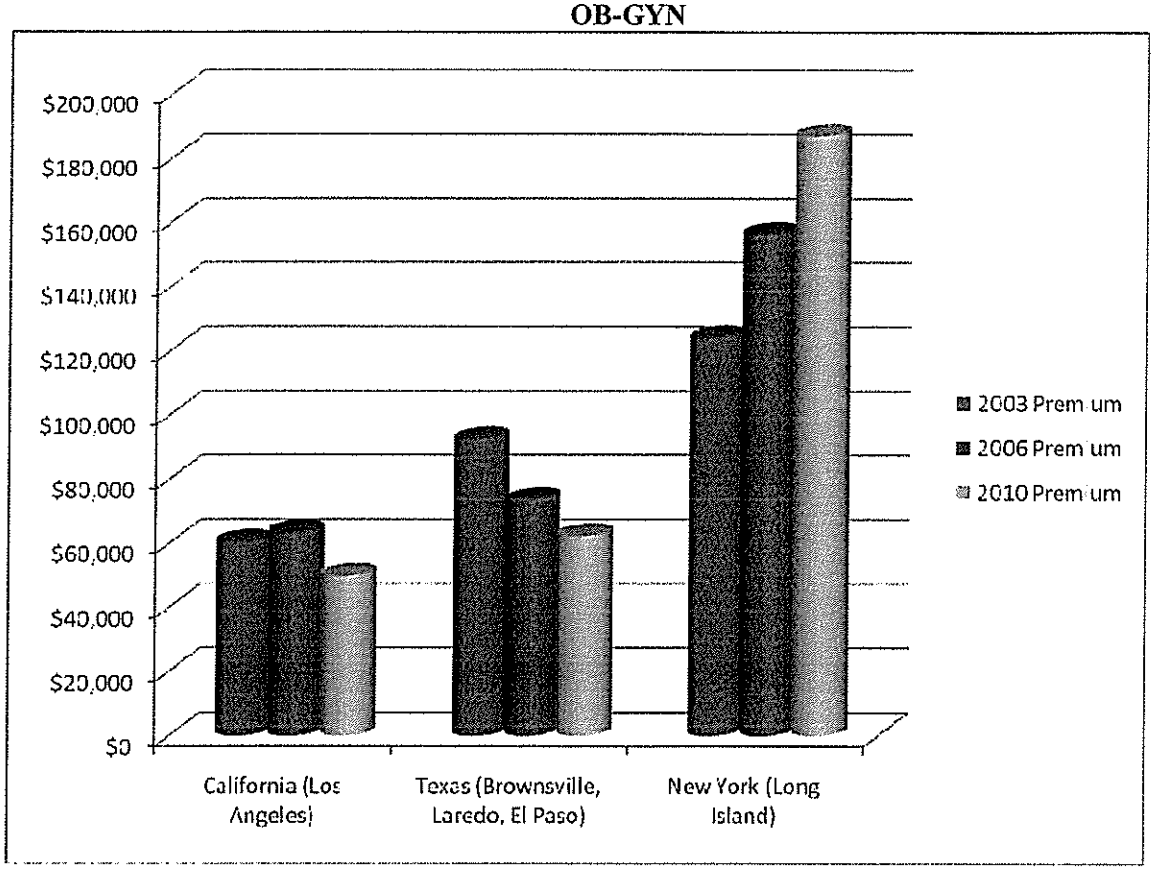
Many New York City physicians pay liability premiums over $100,000 and many exceed $200,000. For example, the yearly cost of coverage for 2011-12 was:

- $281,225 for Brooklyn and Queens neurosurgeons;
- $171,275 for Bronx and Staten Island Ob-GYN's;
- $116,989 for a general surgeon in Brooklyn /Queens; and
- $109,019 for vascular and cardiac surgeons in Bronx and Staten Island

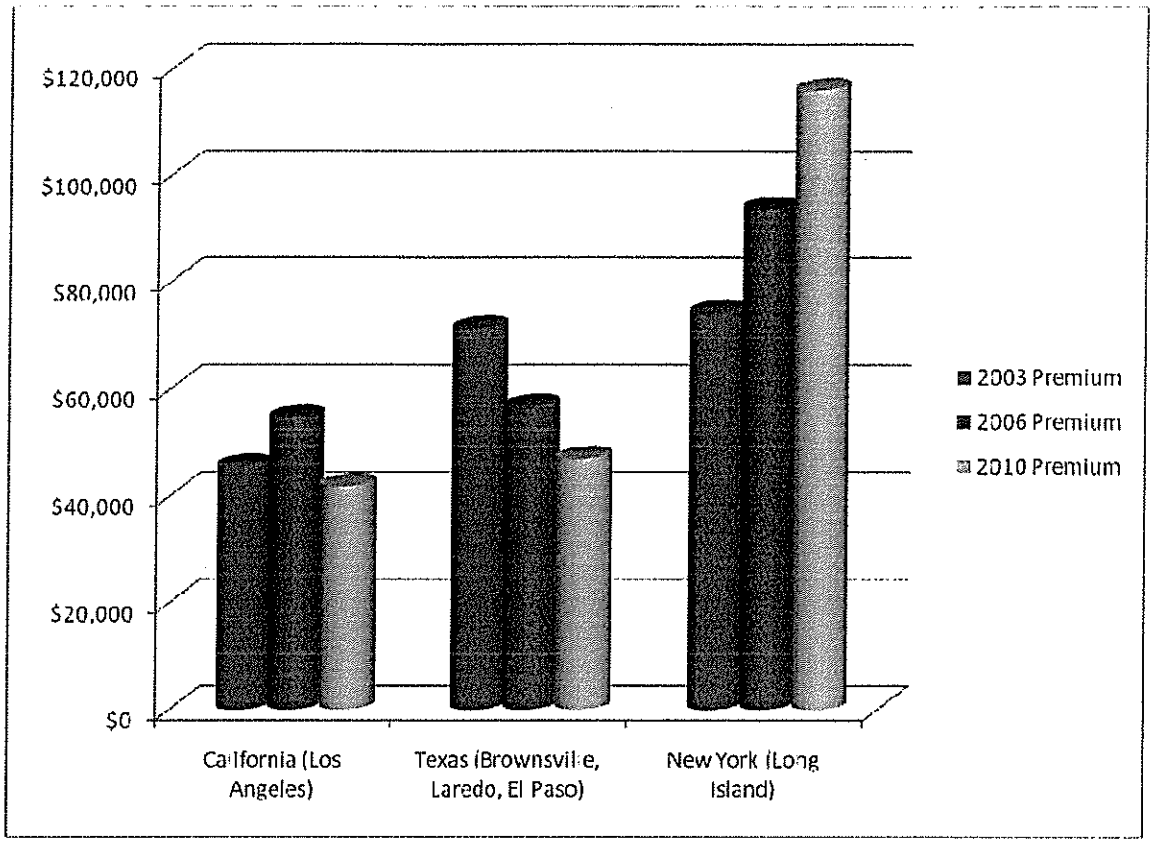
Since I am trying to keep my remarks concise, in the handouts which you have received, I have enclosed facts and figures as well as comparative graphs showing how true and meaningful medical malpractice reforms in Texas and California have driven down malpractice premiums markedly.

Not surprisingly, since Texas reformed its tort law in 2003, over 1,200 physicians who had trained in New York State have located to Texas according to the Texas Alliance for Patient Access.

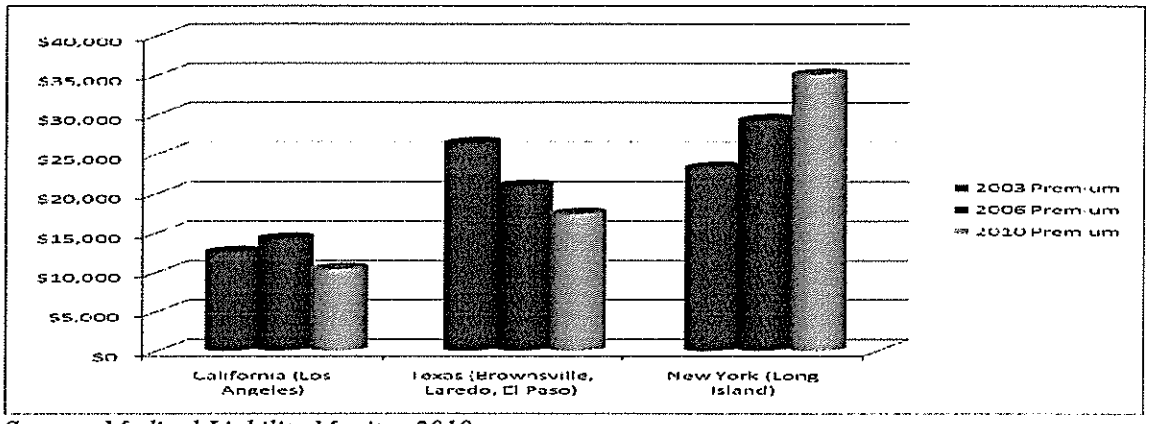
PHYSICIAN PREMIUMS: NEW YORK, CALIFORNIA, AND TEXAS



SURGERY



INTERNAL MEDICINE



Source: Medical Liability Monitor 2010

The issue is not just access to care, but fiscal as well. As New York State struggles financially, we can no longer afford the costs that arise from a deeply flawed and expensive medical liability adjudication system. NY physician practices are the sixth largest employer in NY State. However, the extremely difficult practice environment physicians face in New York State makes moving to other states (and taking jobs with them) an increasingly attractive option, particularly as more and more states enact legislation to reform their medical liability laws.

We appreciate how supportive New York City Corporation Counsel Michael Cardozo has been regarding the need for liability reform. I have quoted his recent remarks and accomplishments on this subject in your handouts.

As part of last year's Medicaid Re-design Team (MRT) proposals, Governor Andrew Cuomo proposed a package of comprehensive medical liability reforms similar to those enacted in Texas in 2003. To our extreme dismay, this package was excluded from the final State Budget. As New York reigns in its high Medicaid costs, hospitals and physicians are facing substantial payment cuts and increased administrative burdens. How can hospitals and physicians survive these burdens when key costs such as medical liability are not addressed as an offset?

More and more states are passing malpractice reform measures to help their physicians cope with cuts in the face of rising overhead. In just the last year, North Carolina, Oklahoma and Tennessee enacted laws to provide meaningful limits on non-economic awards in medical liability suits, bringing to over 30 the number of states who have enacted limitations on non-economic damages in medical liability actions. Why is New York in the minority?

The enormous liability costs are driven by an unpredictable medical liability adjudication system that numerous studies have concluded results in cases where awards and settlements are made despite the absence of negligence and conversely, patients who deserve payment often receive none.
Physicians who treat the most high-risk patients are sued with astounding regularity in New York State. Every 5 years, 65% of our neurosurgeons are sued, as well as nearly 50% of our surgeons and OB-GYNs. I find that the majority of the lawsuits in our radiology group are related to women's imaging--especially mammography. The best doctors in my group who take on high risk procedures, such as women's imaging have the highest malpractice premiums. The doctors in my group who are the most defensive in their practice style by avoiding high risk procedures and ordering additional tests are rewarded with the lowest premiums. There is a well known shortage of women's imaging Radiology specialists in New York State as a result of the same malpractice problems afflicting Ob/Gyn's. For this reason, my practice required an almost 3 year search before we were able to hire a women's imager. There has also been a well documented decrease in the number of mammography facilities in New York over the last decade. Women's imagers face the same crisis as obstetricians, but radiologists have inexplicably been dropped from the newest draft of your resolution.

The problems of the medical liability adjudication system do not just impact physicians. They impact the cost of all health care. Studies have shown that billions of dollars in health care costs are unnecessarily spent each year due to the practice of "defensive medicine", such as unnecessary tests and specialty referrals. The costs of this phenomenon vary based upon the studies, but are undoubtedly immensely significant. You have examples in your handouts citing the specific high costs of defensive medicine and the supporting studies.

We are grateful that a few positive steps have been taken in New York in recognition of the magnitude of our problems. In my handout, I mention pilot-tests of alternative medical liability adjudication models. Certainly, the enactment of the "Medical Indemnity Fund" for neurologically impaired infants by the State Legislature last year was also a step in the right direction. While these programs are promising, they have not driven down malpractice premiums as in other states and a shortage of high risk specialists remains a major issue. New York State is an increasingly unattractive state in which to practice most medical specialties, in large part due to its liability environment. The percentage of physician residents staying to practice in New York State after going to medical school here decreased from 53% in 2001 to 44% in 2010. To encourage young physicians to stay to practice in New York, to have enough physicians able/willing to practice high risk specialties, and to reduce the huge health care costs in our State Budget which are attributable to medical liability, we recommend that the following actions should be taken:

(I will list them with descriptions to be found in my handouts)

Litigation Reforms:

- **Alternate Dispute Resolution Forums** - MSSNY supports legislation to resolve medical liability claims in more objective, less expensive forums, such as special health courts and a No-Fault system for claims involving neurologically impaired infants

- **Medical Expert Witness Reform** - MSSNY supports legislation to require that an expert witness testifying in a medical liability action be identified and practice in the same or similar specialty as the physician against whom the suit has been filed

- **Certificate of Merit Reforms** - MSSNY supports legislation to require that a physician consulted for a Certificate of Merit be identified, be of the same specialty as the physician against whom the suit is filed, and be required to file a certification statement

- **Reasonable Cap on Non-Economic Awards** - MSSNY supports legislation to enact a meaningful cap on non-economic damage awards. This is well known as the key mechanism by which other states have been able to control malpractice premiums.

- **Reducing Frivolous Lawsuits** - MSSNY supports legislation or other regulatory action which would assure that penalties are imposed on those who bring frivolous medical liability actions.

- **Immunity for Apologies** - MSSNY supports legislation to protect health care providers who express sympathy to a patient for an unanticipated outcome from having such statement used against the health care provider in any subsequent litigation that may arise.

- **Peer Review** – To encourage physician participation in peer review and quality improvement committees, MSSNY supports legislation that assures that physician statements made as part of these proceedings are immune from discovery

Insurance/Structural reforms:

- **Subsidization** - MSSNY supports legislation to provide a state-funded subsidy and/or a tax credit to defray the cost of medical liability insurance.

- **Re-Creation of MMIA (the high risk indemnity pool)** - MSSNY supports legislation that would re-create the joint underwriting association, comprised of all insurance companies writing liability insurance in New York State, to cover the assigned risk pool for medical liability insurance in New York State.

- **Periodic Payments Structural Reform** - MSSNY supports legislation to revise the method for structuring medical liability awards.

- **Personal Asset Protection** - MSSNY supports legislation that provides greater protection of a physician's personal assets.

MSSNY and I thank you again for advancing this resolution and holding this hearing today. Since this resolution raises larger issues which are critical to all New York citizens' care and to our state's fiscal health, we ask that the City Council not to be short-sighted by focusing only on ob/gyns. It is imperative that efforts to control health care costs include malpractice premium relief which will ensure that New York's women (and hopefully men) have access to physicians in all specialties. Your resolution should be revised to include reduction of malpractice premiums for all physicians. After all, women don't just need gynecologists. The shortage of Radiologists to read their mammogram and sonogram is just as real. And don't women need surgeons, cardiac surgeons, neurosurgeons, and vascular surgeons too? We agree that New York State Departments of Health and Financial Services must address the high cost of medical liability insurance. However, this resolution should acknowledge that the over-riding need for reform of the dysfunctional tort system can only be addressed through statutory changes by the State Legislature.

By bringing these very critical issues to the attention of our citizens and our legislators in Albany, the New York City Council makes clear its relevance as a force for the public good. Thank you very much for your consideration.

TESTIMONY OF JAY TARTELL, MD
PRESIDENT, MEDICAL SOCIETY OF THE COUNTY OF QUEENS
TO THE NEW YORK CITY COUNCIL
REGARDING RESOLUTION 84-A

Good morning. My name is Dr. Jay Tartell and I am a Radiologist and President of the Queens County Medical Society. I am Associate Director of Radiology at Mount Sinai Hospital of Queens and President of Advanced Radiological Imaging, Queens' oldest radiology practice, founded in 1958. On behalf of QCMS as well as the Medical Society of the State of New York, we very much appreciate the opportunity to present testimony to you today.

Resolution 84-A discusses an issue of critical important to the future of health care in New York City. Physicians practicing in New York City as well as its surrounding suburban area pay medical liability insurance premiums that far exceed most other states, yet their capacity to pay these extraordinary premiums shrinks every day due to ongoing payment cuts by health insurance companies as well as public payers. As many of you know, large numbers of NY physicians are closing or selling their practices as a result of years of unrelenting payment cuts. Since Medical Malpractice premiums comprise one of the largest overhead items for many physicians, cutting premiums is of utmost importance to maintaining the viability of physician practice for all litigation prone specialties.

Resolution 84-A appropriately calls for investigation and action by the New York State Department of Health and Department of Financial Services, but action is also required by the State Legislature and Governor Cuomo.

Liability premiums for New York physicians went up 55-80% from 2003 to 2008, and went up an average additional 5% in 2010 (for some physicians it was even significantly higher). While nominal rates were on average held steady for the 2011-12 policy year, the rates are stabilized at extraordinarily high levels, Moreover, all the physicians in my specialty, Radiology, were hit with an 8% increase.

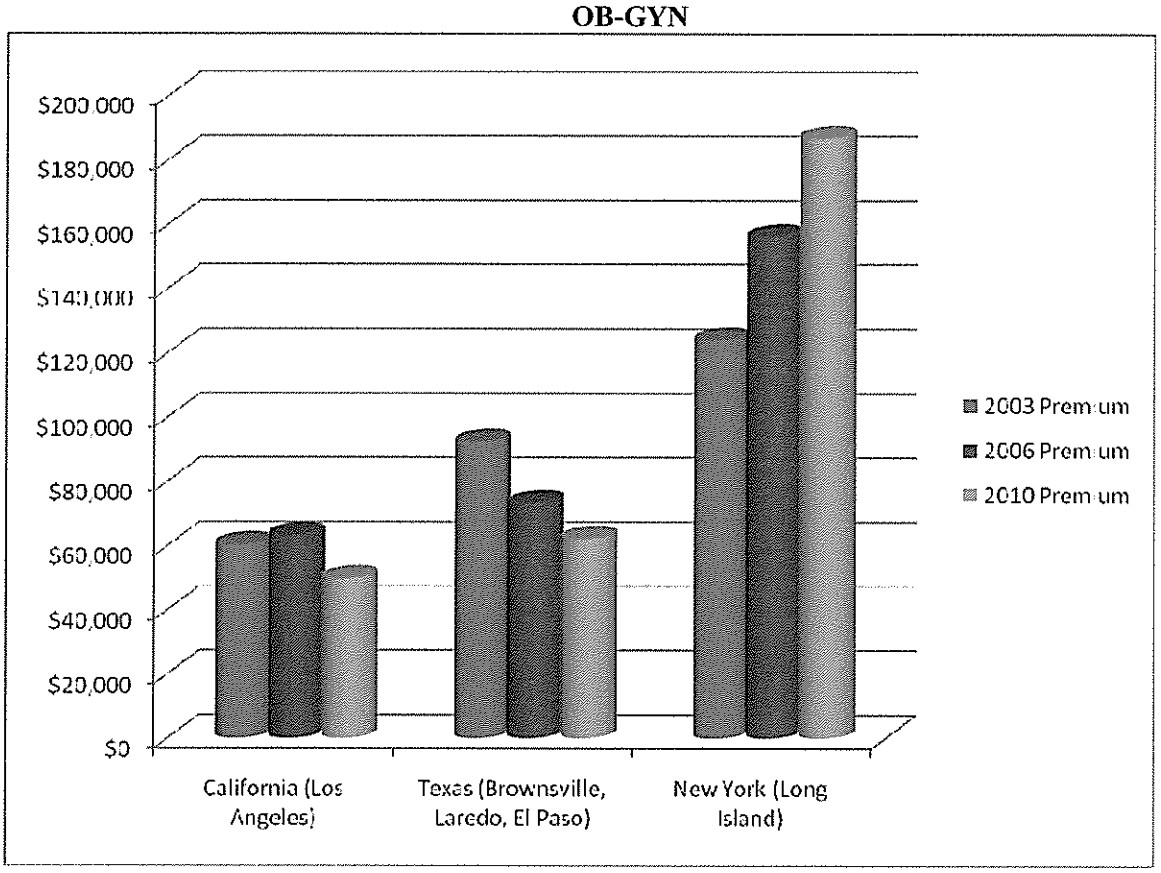
Many physicians practicing in the New York City metropolitan area pay liability premiums that far exceed $100,000 and in some cases even exceed $200,000. For example, for just a single year of coverage, the cost of medical liability coverage for the 2011-12 policy year was:

- $281,225 for a neurosurgeon in Brooklyn and in Queens;
- $171,275 for an Ob-GYN in Bronx and Staten Island;
- $116,989 for a general surgeon in Brooklyn and in Queens; and
- $109,019 for an vascular surgeon or cardiac surgeon in Bronx and Staten Island

It is notable that physicians pay far less in other states, particularly those where meaningful reform has been enacted. The Texas Medical Liability Trust, the largest medical liability insurer in Texas, just reduced premiums to physicians for the ninth straight year since the enactment of comprehensive medical liability reform legislation in Texas in 2003. 90% of Texas physicians have seen a minimum of 30% reduction in their premiums since 2003. In Los Angeles, California, in a state where strong medical liability reforms were enacted in the mid-1970s, Ob-GYNs pay less than 1/3 the premiums that New York physicians pay. In both these states, medical liability premiums have gone down significantly since 2003 while the opposite has occurred in New York. And please keep in mind that, unlike many other states, in New York State, the Superintendent of Insurance (now Financial Services) sets the premium rates, not the Insurance companies. We have included comparison charts below in our written testimony.

Not surprisingly, since Texas enacted its law in 2003, over 1,200 physicians who had trained in New York State have located in Texas since that state reformed its tort law, according to the Texas Alliance for Patient Access.

PHYSICIAN PREMIUMS: NEW YORK, CALIFORNIA, AND TEXAS



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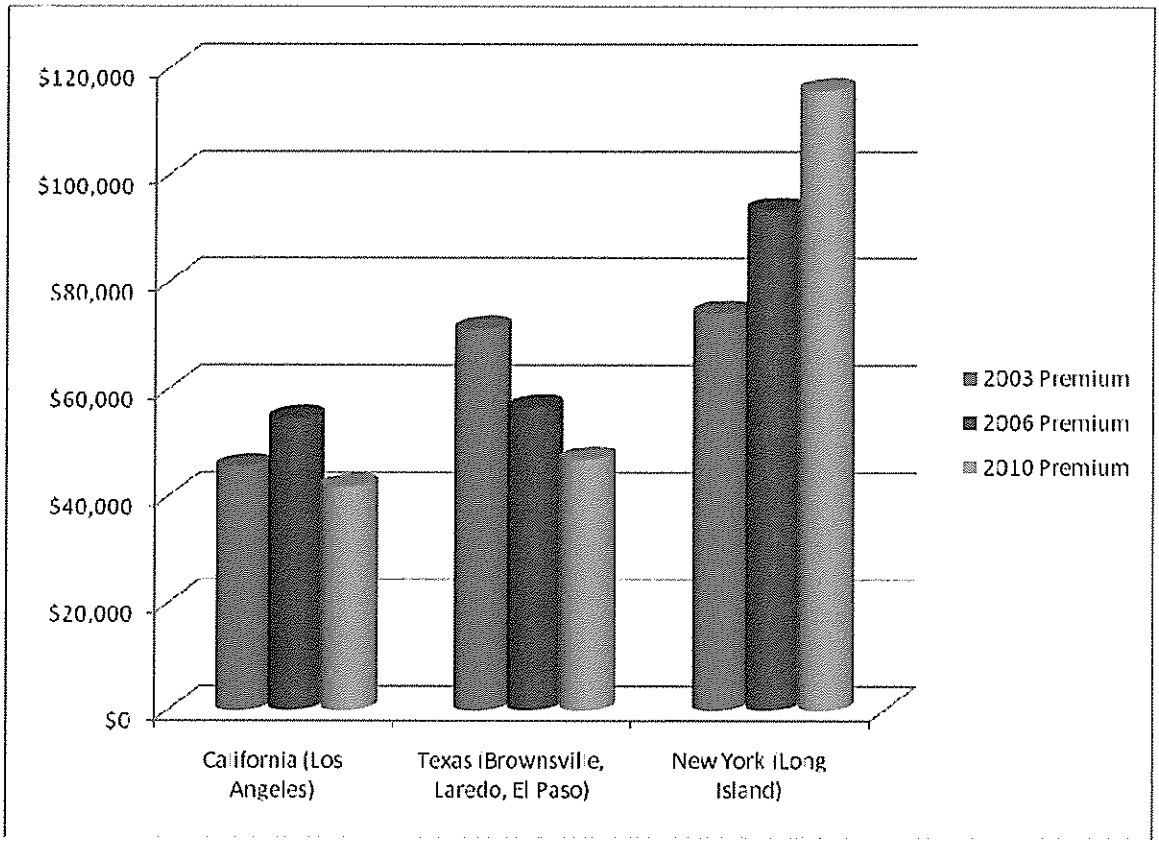

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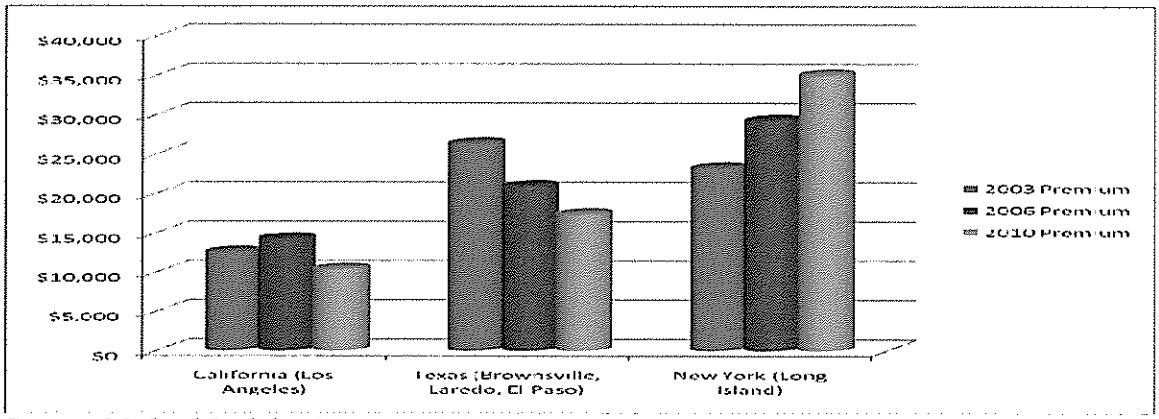

Source: Medical Liability Monitor 2010

With continuing cost cutting from health insurance companies and government payors to reduce physician payments for patient care, New York physicians' medical liability premiums are not sustainable. Something has to give.

This issue is not just access to care, but budgetary as well. As New York State struggles to balance its Budget and reduce the extraordinary tax burden placed upon its citizens, we can no longer afford the costs that arise from a deeply flawed and expensive medical liability adjudication system. Moreover, the extremely difficult practice environment physicians face in New York State makes moving to other states an increasingly attractive option, particularly as more and more states enact legislation to reform their

medical liability laws. To bring down the costs of health care in New York as well as to preserve access to New York's world-class but financially strained health care system, the State Legislature must work together with the Departments of Health and Financial Services to develop a package of recommendations to reduce medical liability insurance costs, including changes to our dysfunctional tort laws.

We appreciate how forceful New York City Corporation Counsel Michael Cardozo has been regarding the need for liability reform. In a September 2011 speech to the Citizens Budget Commission, he noted that "we must find a way to bring this $561 million tort number under control. In a time of financial crisis and budgetary cuts, this is not a huge number – it represents an unacceptable tradeoff in favor of individual plaintiffs at the expense of providing needed services to New Yorkers". He presented similar testimony to the Medicaid Redesign Team Work Group on Medical Malpractice Reform.

As part of the Medicaid Re-design Team (MRT) proposals advanced as part of the 2011-12 Executive Budget, Governor Andrew Cuomo proposed a package of comprehensive medical liability reform similar to what was enacted in Texas in 2003. To our great dismay, this package was excluded from the final State Budget. The inclusion of medical liability reform legislation in the MRT proposals was important because it sought to strike a balance between reining in the extraordinary costs of New York's Medicaid program while assuring that patients have access to needed care. As New York seeks to reign in its extraordinarily expensive Medicaid costs, hospitals and physicians are facing substantial payment cuts and increased administrative burdens to provide care. If hospitals and physicians are to survive in such an environment, costs related to medical liability must be decreased as an offset.

As New York physicians continue to drown in a sea of overwhelming overhead costs, other states are passing measures to assure patients can continue to access essential physician care. For example, in just the last year, three more states, North Carolina, Oklahoma and Tennessee, enacted laws to provide meaningful limits on non-economic awards in medical liability actions, bringing to over 30 the number of states who have enacted limitations on non-economic damages in medical liability actions. The time for change is now!

The enormous liability costs are driven by an unpredictable medical liability adjudication system that numerous studies have concluded results in cases where awards are made despite the absence of any negligence whatsoever. Moreover, under the current system studies have shown that often those truly injured by negligence do not sue. For example, in one recent review of closed claims in the *New England Journal of Medicine*, it was shown that nearly 30% of the time a patient was awarded payment where no negligence was committed, or a patient was not awarded payment where there was negligence.

As a result of the randomness and unpredictability of the current medical liability adjudication system, settlements are often made even where no negligence has occurred. Physicians who treat the most high-risk patients are sued with astounding regularity in New York State. Every 5 years, 65% of our neurosurgeons are sued, as well as nearly 50% of our surgical specialists and OB-GYNs. We find that the the majority of the lawsuits in our radiology group are related to women's imaging--especially mammography. The best doctors in my group who take on the high risk procedures, such as women's imaging have the highest malpractice premiums. The doctors in my group who are the most defensive in their practice style by avoiding high risk procedures and practicing defensively are rewarded with the lowest premiums. There is a well known shortage of women's imaging Radiology specialists in New York state as a result of the same tort problems afflicting Ob/Gyn. For this reason, my practice could not hire a women's imaging specialist for 2 ½ years. There has also been a well documented decrease in the number of mammography facilities in New York over the last decade.

The problems of the medical liability adjudication system do not just impact physicians. They impact the cost of all health care. Studies have shown that billions of dollars in health care costs are unnecessarily spent each year due to the practice of "defensive medicine", such as unnecessary tests and specialty referrals. The costs of this phenomenon vary based upon the studies, but are undoubtedly immensely significant:

- A 2010 study by Dr. Michelle Mello of the Harvard Public School of Health reported in *Health Affairs* concluded that defensive medicine cost the healthcare system $45.6 billion annually;
- A 2009 study by the Congressional Budget Office (CBO) showed that enactment of medical liability reforms would reduce the federal deficit by $54 billion over 10 years largely due to reducing defensive medicine;
- A 2008 study by the Massachusetts Medical Society of eight specialties indicated that $1.4 billion was spent annually in just the state of Massachusetts alone for defensive medicine;

Recognizing the enormity of this problem, we are pleased that some positive steps have been taken. The federal Department of Health and Human Services recently awarded a demonstration grant to the New York Office of Court Administration to pilot-test an alternative medical liability adjudication model. The New York program involves 5 New York City hospitals where identified adverse events will result in an early offer of compensation in an effort to save on the huge cost of taking cases through the courts. Where such early offer fails to prevent a claim from going to court, the case will be reviewed by a judge who has received significant clinical medical training that will better enable such judge to differentiate cases with merit from those without. Additionally, as part of the 2011-12 enacted Budget, the State Legislature enacted a "Medical Indemnity Fund" to help cover the medical costs of neurologically impaired (N/I) infants arising from a medical liability verdict or settlement.

However, while these programs are promising, they do not sufficiently address the medical liability crisis. My own practice required 3 years to find a women's imager-a result of a well known shortage in this litigation-prone subspecialty. New York State is an increasingly unattractive state in which to practice most medical specialties, in large part due to its excessive liability exposure. The percentage of physician residents staying to practice in New York State after going to medical school here decreased from 53% in 2001 to 44% in 2010. To encourage young physicians to stay to practice in New York, to have enough physicians able/willing to practice high risk specialties, and to reduce the huge health care costs in our State Budget which are attributable to medical liability costs, we recommend that the following actions should be taken:

Litigation Reforms:

- **Alternate Dispute Resolution Forums** - MSSNY supports legislation to resolve medical liability claims in more objective, less expensive forums, such as special health courts and a No-Fault system for claims involving neurologically impaired infants

- **Medical Expert Witness Reform** - MSSNY supports legislation to require that an expert witness testifying in a medical liability action be identified and practice in the same or similar specialty as the physician against whom the suit has been filed

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- **Re-Creation of MMIA** - MSSNY supports legislation that would re-create the joint underwriting association, comprised of all insurance companies writing liability insurance in New York State, to cover the assigned risk pool for medical liability insurance in New York State.

- **Periodic Payments Structural Reform** - MSSNY supports legislation to revise the method for structuring medical liability awards.

- **Personal Asset Protection** - MSSNY supports legislation that provides greater protection of a physician's personal assets.

MSSNY and I thank you again for advancing this resolution and holding this hearing today. It is an issue of critical importance to assuring New Yorkers' continued access to essential health care. It is also in the best interests of New York's fiscal health that this issue be addressed as quickly as possible. Again, while we agree that is incumbent upon New York State Departments of Health and Financial Services to work to address the high cost of medical liability insurance, the over-riding need for reform of the dysfunctional tort system can only be addressed through statutory changes by the State Legislature. It is also essential that these reforms apply to high risk women's specialties including Radiology.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☑ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: Ebony Constant

Address: 39 Broadway, Ste 1540 N.Y., NY 10006

I represent: Bertha Lewis, The Black Institute

Address: 39 Broadway Ste 1540 NY, NY 10006

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Krug Cook

Address: 210 Jefferson Ave Brooklyn, NY 11216

I represent: Make the Road New York

Address: 301 Grove St Brooklyn, NY 11237

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☑ in opposition

Date: 31 Jan., 2012

(PLEASE PRINT)

Name: Patrick Krug

Address: 9 Murray St., NY, NY

I represent: NYPIRG (in place of Rebecca Weber)

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: MILTON ~~HAYNE~~ HAYNES, MD

Address: _____

I represent: NY COUNTY MED. SOCIETY

Address: 12 E. 41, NYC 10017

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-2010

☐ in favor ☐ in opposition

☒ neither *Date:* 1/31/2012

(PLEASE PRINT)

Name: Sam Sanders

Address: 333 E. 80th St., 6D, NY NY

I represent: Nat'l Structured Settlement Association

Address: Washington, D.C. (NSSTA)

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 0084-2012

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: David A. Friedman

Address: _____

I represent: Self

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☑ in opposition

Date: 1/31/12.

(PLEASE PRINT)

Name: Jesse Laymon

Address: 36-50 Crescent St. L.I.C. NY

I represent: Citizen Action of New York

Address: 94 Central Ave, Albany NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☑ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: Rebecca J. Weber

Address: 9 Murray St, NY NY 10007

I represent: NYPIRG

Address: 160 W. 106 St. #2B 10025

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 84-A Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jay Tartell

Address: 29-16 Astoria Blvd, Astoria, NY 11102

I represent: Med Society of Queens, Med Society State of NY and Advanced Radiology

Address: 29-16 Astoria Blvd, Astoria, NY 11102

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☒ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: Joanne Doroshow

Address: 140 W. 92nd St, #2A NYC 10025

I represent: Center for Justice + Democracy

Address: 185 W. Broadway, NYC 10013

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: Susan Waltman

Address: 555 West 57th St, 15th Fl NY NY 10019

I represent: Greater NY Hospital Association

Address: 555 West 57th St, 15th Fl NY NY 10019

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 01/31/12

(PLEASE PRINT)

Name: DR. IFFATH ABBASI HOSKINS

Address: 150 55th St. Lutheran MC. Brooklyn NY 11220

I represent: Lutheran Med. Ctr + ACOG NY

Address: 150 55th St. Lutheran MC. Brooklyn NY 11220

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☐ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: PATRICIA BURKHARDT

Address: 49 STRONG PLACE

I represent: NY State Assoc. of Licensed Midwives (NYSALM)

Address: Same

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/26/12

(PLEASE PRINT)

Name: Carol Pittman

Address: 120 Wall St NY 10005

I represent: NYS Nurses Assoc.

Address: same

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Suzanne Blundi, Deputy Counsel

Address: NYC Health & Hospitals Corporation

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: Christie Rich & John Singleton

Address: 546 Tlyssa Way, S.I. NY 10312

I represent: My family: John Singleton, Jada Singleton

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: MARY ANNE CARROLL

Address: Sullivan Papain Block McGrath

I represent: [illegible]

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 8 Res. No. 84

☐ in favor ☒ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: Ross Frommer

Address:

I represent: Columbia University Medical Center

Address: 630 West 168th N.Y. N.Y. 10032

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/31/12

(PLEASE PRINT)

Name: JUDGE ANN PFAU

Address: 360 ADAMS St, BKLYN, NY

I represent: NYS Judiciary

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Leslie Kelmachter

Address: _____

I represent: New York State Trial Lawyer

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☐ in opposition

Date: 1-31-12

(PLEASE PRINT)

Name: Christie Rich + John Singleton

Address: _____

I represent: self

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☐ in opposition

Date: 1-31-12

(PLEASE PRINT)

Name: Elizabeth Colin

Address: _____

I represent: myself

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 84-A

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Maria Marsonet

Address: _____

I represent: NY Communities For Change

Address: _____

Please complete this card and return to the Sergeant-at-Arms