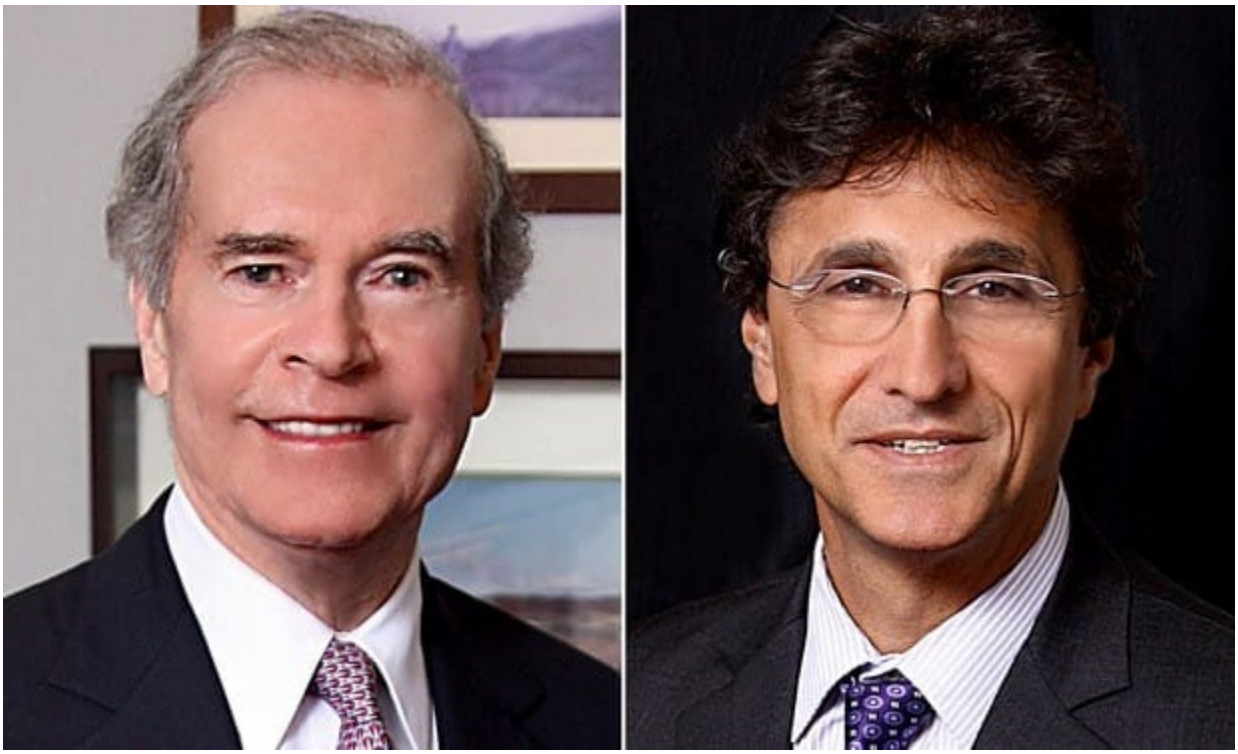
New York State Medical Indemnity Fund Experience



Thomas A. Moore and Matthew Gaier, New York Law Journal April 5, 2016

This month marks the five-year anniversary of the passage of the legislation establishing the New York State Medical Indemnity Fund (MIF)-Public Health Law article 29-D, Title 4. That statute applies only to medical malpractice actions brought on behalf of children who sustain neurologic injuries around the time of their birth.

It comes into play at the very end of the litigation process of those cases, either at the time the case is settled or when a judgment is being entered after a trial and a verdict in the plaintiff's favor. The effect of the statute is that children who sustain such injuries no longer receive monetary payments for their future health care requirements.
Instead of getting the cash awards to pay for that care, those children and their families must enroll in the MIF and must apply to the Fund administrator for approval of expenditures for their specific health care needs. That is the case regardless of whether the case resolves pursuant to a settlement or a verdict and judgment. Children whose cases are covered by this legislation do, however, continue to receive cash awards (via either settlement or judgment) for their pain and suffering and their lost earnings.
During the time since the MIF came into operation in October 2011, it has had significant impact on the courts, on defendants in cases covered by the Fund, and, most of all, on the children and families who must rely on the Fund to pay for important health care needs. This column

examines the various impacts and effects of the MIF, and makes suggestions for improving its effectiveness and its ability to serve the injured children for whom it was established.

The initial topic of discussion addresses the manner in which cases subject to the Fund are settled. The remainder of the column focuses on substantive and procedural issues concerning whether the Fund applies to a particular case and the Fund's performance in providing for the health care needs of the children. The Fund administrator has taken on a significant role with regard to both of the latter issues. The New York State Department of Financial Services (DFS) serves as the Fund administrator, and since the second year of the Fund's operation, Alicare, Inc., has been the third-party administrator.

The defendants (and their liability insurers), who avoided liability for the cost of the health care necessitated by the neurologic injuries caused by their malpractice, have by far been the greatest beneficiaries of the MIF. As of last September, 331 children had enrolled in the Fund, and it is anticipated that by the end of the current fiscal year it will have 373 enrollees.1 Since the future health care costs in such cases are generally millions of dollars, it is safe to assume that defendants and insurance companies have saved hundreds of millions of dollars.

The MIF has had significant impact on the courts in the manner in which these cases are settled. Traditionally, the courts are required merely to approve settlements on behalf of injured children under CPLR article 12, and must occasionally decide whether a portion of the settlement proceeds should be allocated to a Medicaid lien. See, e.g., Lugo v. Beth Israel Med. Center, 13 Misc.3d 681 (Sup. Ct., N.Y. Co. 2006). The court's role has changed in cases subject to the Fund.

Settlement of Cases

Under the MIF, the court must make an allocation of the settlement proceeds between "Fund damages" (all health care costs) and "non-Fund damages" (pain and suffering and lost earnings). Once this allocation is made, pursuant to PHL §2999-j[14], the attorney fees attributable to all damages, including those covered by the Fund, are calculated and paid by the defendant to the plaintiff as part of the cash settlement.

The process was set forth in Mendez v. New York and Presbyterian Hospital, 34 Misc3d 662 (Sup. Ct., Bronx Co. 2011), shortly after the Fund became operational. In that opinion, Justice Douglas E. McKeon, who has had extensive involvement in cases under the MIF, observed that the statutory scheme requires the parties to agree upon a lump sum settlement, a portion of which must be allocated to damages covered by the Fund. That portion of the settlement is excluded from the payment made by the defendant, except for the attorneys' fees attributable to those damages.

As described by Justice McKeon, "[t]he allocation process seeks to determine, based on facts known at the time of settlement, the extent to which an award is meant to compensate for future medical expenses distinguished from other categories of damages." This allocation is the determinative factor in how much actual cash the plaintiff receives under the settlement. The greater the allocation to Fund damages, the smaller the actual cash received by the plaintiff.

In Mendez, the parties agreed upon a settlement of $5.5 million, and allocated 50 percent to Fund damages and 50 percent to non-Fund damages, which the court approved. McKeon then determined the cash amounts payable by the defendant under the settlement by applying the following calculations:

1. The attorney's fee is calculated pursuant to Judiciary Law §474-a (as the statute requires). The fee in this action is $700,000.
2. The non-Fund portion of the settlement (based on a 50-50 allocation) amounts to $2.75 million

(50 percent of $5.5 million).
3. From the non-Fund portion of the settlement ($2.75 million) is deducted that portion of the attorney's fee allocable to non-Fund damages (50 percent of $700,000 or $350,000), based on a 50/50 allocation. Thus $350,000 is deducted from non-Fund damages of $2.75 million and plaintiff receives $2.4 million in cash and enrollment in the Fund.
4. The balance of the attorney's fee allocable to Fund damages (50 percent of $700,000 or $350,000) is paid by the medical provider or insurance company.
As Justice McKeon observed, although the statute describes the allocation as occurring after the settlement amount is agreed upon, "in reality, the allocation and settlement are discussed at the same time." In fact, in practice, the parties often agree upon the actual cash amount to be paid by the defendants, and then work backwards to determine the total settlement amount and the allocation. This enables the plaintiff's lawyer to get the client the most money that the defendant or insurer is willing to pay.
McKeon further observed in Mendez that while the appellate precedent in cases of this nature would generally support allocations to Fund damages substantially greater than 50 percent, "the Fund changes the dynamics of the settlement process, requiring the courts to combine precedent with a healthy dose of practicality." This protects against a circumstance of too great a portion of the cash payment going toward the attorney fees. This practicality often warrants an allocation of less than 50 percent to Fund damages in smaller settlements.
Since Mendez, larger cases settled under the MIF have typically applied a 50 percent-50 percent allocation, while smaller ones often allocate less than 50 percent to Fund damages-sometimes substantially less. A small apportionment to Fund damages is particularly appropriate in cases where the child's injuries do not require extensive lifetime health care. This is the case with actions involving Erb's palsy, which results from injury to the brachial plexus during delivery.

Erb's Palsy Cases
Shortly after the MIF was created, a question arose as to whether Erb's palsy qualifies as a "birth related neurological injury" under PHL §2999-h[1], which is a prerequisite for the Fund to apply. That subdivision provides:
"Birth-related neurological injury" means an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both.
Although we are aware of no published decision on point, the courts have been finding Erb's palsy injuries to qualify as a spinal cord injury for the purpose of this definition if there was an avulsion or complete tearing of the nerves, as opposed to a mere stretching. It appears that the Fund administrator has gone along with this approach. The most recent actuarial report on the MIF indicates that slightly over 10 percent of the participants in the Fund are identified as having injuries described as Erb's palsy or brachial plexus.2

Whether the MIF Applies
The courts are required to make findings pertaining to whether the MIF applies. In Joyner-Pack v. State of New York, 38 Misc.3d 903 (Ct. Cl., 2012), the court sua sponte raised the question of

whether the infant claimant was a "qualified plaintiff" for the purpose of the MIF when presented with an infant's compromise order calling for his admission to the Fund. The child was born at the defendant's hospital in February 2002 with a condition known as tracheobronchomalacia, which causes a disruption of airflow to and from the lungs, and as a result he remained in the hospital for several months after the delivery.

Approximately four months into the admission, an MRI was performed with sedation, during which he suffered severe respiratory distress and cardiorespiratory arrest, resulting in brain damage. The court found that although the malpractice and injury did not occur until four months after the delivery, the child suffered a birth-related neurological injury, such that he was a qualified plaintiff and "therefore, properly belongs in the MIF."

More recently, in Matter of K.O. v. Lawsky, 50 Misc.3d 742 (Sup. Ct., Kings Co. 2015), the Supreme Court overruled a finding by the Fund administrator that an infant was not a qualified plaintiff. The child in the underlying medical malpractice action was born at home and suffered neurologic injuries during the delivery. The case was settled before Justice Marsha L. Steinhardt, who signed a compromise order finding that the child sustained a birth related neurological injury and qualified for the Fund. However, the plaintiffs' subsequent application for enrollment was denied on the ground that the child was not a qualified plaintiff because he was not injured during the hospital admission.

The plaintiffs and defendants then brought an Article 78 proceeding in Supreme Court, Kings County, against DFS and Alicare. The proceeding was assigned to Justice Steinhardt, who found that the respondents acted arbitrarily in denying the infant enrollment in the Fund. The case highlights two issues concerning the Fund, one substantive and the other procedural.

The substantive question is whether the MIF only applies to malpractice or injuries that occur during a hospital admission in which the child is delivered. As Justice Steinhardt observed, the venue of the delivery is mentioned in neither the statute nor its legislative history. The operative statutory provision is PHL §2999-h[1], as set forth above. It defines a birth-related neurological injury as "an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission...." It seems obvious from its context that the phrase "or by other medical services provided or not provided during delivery admission" was intended to expand the application of the statute beyond labor, delivery and resuscitation to include other malpractice that may occur during the newborn admission -- for example, failing to respond to problems that develop while the baby is in the nursery. The Fund administrator nevertheless read the phrase as a restriction rather than an expansion of the MIF.

Matter of K.O. v. Lawsky also raises procedural issues concerning admission to the Fund that warrant legislative attention. The malpractice plaintiffs and defendants brought an Article 78 proceeding arguing that the initial determination of eligibility for the MIF by the court that signed the compromise order is binding, and that the Fund administrator's role in the admission process is merely to determine whether the proper paperwork was submitted.

The court did not address this issue or the administrator's authority, and the pertinent statutory provisions (PHL §2999-j[6] and[7]) are less than pristinely clear on that subject. If the administrator has authority to make independent substantive decisions regarding eligibility, that sets up the potential for inconsistent determinations. This creates uncertainty for courts and litigants attempting to settle lawsuits.

An amendment to the statute expressly making the administrator's role in the admission process

purely ministerial would avoid this problem. Alternatively, if the Legislature perceives a salutary purpose in having the administrator pass on the plaintiff's eligibility for the MIF, there is no reason why a new proceeding should have to be brought under Article 78 to challenge a negative finding. It would be simpler, more expedient and more efficient for the litigants to move in the malpractice action before the court that signed the compromise order. This assures that the issue is resolved by the court most familiar with the litigation, enables that court to consider the administrator's viewpoint, and avoids the potential of one Supreme Court justice having to decide whether another justice's determination was correct.

The Needs of the Children

Perhaps the most important issues concerning the Fund relate to its performance in providing for the health care requirements of the children who are forced to rely upon it. As noted in Mendez, this is "a program charged with safeguarding the future of seriously sick children." As further noted in Mendez, "[t]he Fund substitutes services for upfront cash." Therefore, these children should be afforded the care they would have been able to pay for with a monetary award.

While the actuarial reports on the Fund provide general statistics on money spent and the types of care on which it is spent, there is no published data or surveys of which we are aware regarding the experiences and perspectives of the participants in the Fund and whether they are satisfied. For this we must rely on anecdotal evidence as related by our clients and those of other lawyers who have placed children in the Fund. In this regard, the families of children in the Fund have consistently raised two areas of criticism: (1) limits on rates of payment for services; and, (2) the process for appealing denials of services by the administrator.

Reimbursement rates are addressed in the statute. PHL §2999-j[4] provides:

The amount of qualifying health care costs to be paid from the fund shall be calculated: (a) with respect to services provided in private physician practices on the basis of one hundred percent of the usual and customary rates, as defined by the commissioner in regulation; or (b) with respect to all other services, on the basis of Medicaid rates of reimbursement or, where no such rates are available, as defined by the commissioner in regulation.

Pursuant to subdivision (a) above, the commissioner has defined the usual and customary rates as "the eightieth percentile of the usual and customary charges for services in private physician practices, as reported by FAIR Health, Inc., in its Usual, Customary and Reasonable (UCR) database at the time of billing." 10 NYCRR §69-10.21(a). FAIR Health was established in 2009 as part of a settlement of an investigation by New York State (through then Attorney General Andrew Cuomo) into health insurance industry reimbursement practices.3

FAIR Health has since compiled an independent database of information containing health care claims contributed by payers nationwide, and it is utilized to determine reimbursement rates by health insurers. FAIR Health's UCR rates are categorized by percentiles. The 80th percentile means that only 20 percent of the service providers charge higher rates than that rate in a geographic area. As such, the 80th percentile of FAIR Health UCR is not an unreasonable basis for usual and customary. However, that is only paid for physicians' services.

Pursuant to subdivision (b), all other health care providers receive only Medicaid rates, where Medicaid has a rate for the service. That is the most common complaint by parents of children in the Fund, and it is the impediment to Fund participants receiving the care they require. That is because some of the most vital care and services required for the health and well-being of physically disabled children-including nurses, therapists and home health aides-are subject to Medicaid rates of reimbursement.

Many of these health care providers refuse to accept Medicaid rates because they are often radically less than usual and customary rates. As a result, parents of children who require these services must either try to find a provider willing to accept Medicaid rates, which greatly limits their choice of provider, or pay for the difference in rates from their own pockets or from the portion of their child's award for non-Fund damages (pain and suffering or lost earnings). None of these alternatives are fair or reasonable.

The Fund is not a government entitlement. It is not health insurance. It is compensation for the care necessitated by medical negligence. There is no reason why the children who must rely upon it should be relegated to those health care providers willing to accept Medicaid rates. Notably, where Medicaid rates are unavailable for a service, the commissioner's regulations provide for payment of "a reasonable rate for that type of service in that geographic area," and state that rates are deemed reasonable "if they are sufficient to provide the enrollee with access to services and are not in excess of the prevailing rates paid by other payers in the region." 10 NYCRR §69-10.21(e).

The rule goes on to provide, "[w]hen FAIR Health, Inc.'s UCR database specifies a rate for a particular service, the Fund Administrator shall pay at the 80th percentile of such rate." 10 NYCRR §69-10.21(e). There is no reason why those rates should not be used to reimburse for the services of all health care providers for Fund enrollees.

PHL §2999-j[4] should be amended to remove Medicaid rates as the basis for reimbursement for services other than physicians, and require that all qualifying health care costs be reimbursed at a rate of at least the 80th percentile of FAIR Health's UCR database, where the database specifies a rate for the particular service. If FAIR Health's database does not specify a rate for the service, the reimbursement rate should be, as provided in the regulation, a rate sufficient to provide the enrollee with access to services that is not in excess of the prevailing rates paid by other payers in the region.

If there is a concern about the increased cost of providing Fund enrollees health care at the usual and customary rate for such services, there should not be. DFS has indicated, pursuant to a FOIL request, the following year-end balances for the MIF special account for each of the first five years of the Fund's operation: Dec. 31, 2011, $30.0 million; Dec. 31, 2012, $28.2 million; Dec. 31, 2013, $61.1 million; Dec. 31, 2014, $99.5 million; and, Dec. 31, 2015, $132.8 million.

In short, the MIF is not only flush with money, it is accumulating it at a consistent and substantial rate. At the same time, it is not adequately providing for the needs of the neurologically damaged children for whom it was created. If the statutory requirement of Medicaid rates was initially adopted out of fear of insufficient funding, the Fund's balance sheets more than allay any such concern. The Fund legislation should be fixed to provide its enrollees the care that they deserve.

The final area in which there have been significant complaints expressed by parents of children in the Fund is the procedure for obtaining a review of, or appealing, the administrator's denial of a health care request. It must be borne in mind that under PHL §2999-h[3], any requested health care cost must be determined by a doctor, physician assistant or nurse practitioner to be necessary to meet the child's health care needs. Where a child's doctor has made that determination, and the administrator denies the request, 10 NYCRR §69-16 sets forth an involved process for reviewing the denial. It involves evidentiary hearings before Department of Health administrative law judges (ALJs), which may take on an adversarial quality, with sworn testimony, the admission of exhibits in evidence, and cross-examinations of witnesses.

The ALJs make recommendations in the form of a written decision with findings of fact,

conclusions of law and the reasons for their determination. The commissioner or his or her designee then issues a similar decision based upon the hearing record and the ALJ's recommendations. The enrollee's only recourse from an adverse decision by the commissioner is to bring an Article 78 proceeding.

Each and every enrollee in the Fund has already litigated in Supreme Court to a successful outcome. They have all obtained either jury verdicts in their favor or settlements paid by defendants. It is unfathomable and unconscionable that successful litigants should have to litigate all over again just to get services that their doctors have expressly determined to be necessary for their health care.

The statute should be amended to permit a denial by the administrator to be challenged directly by a motion brought in court before which the child's case was settled. For decades, Supreme Court justices have entertained applications on behalf of injured children to release portions of prior settlement proceeds to pay for health care or other needs of the child. The process of reviewing a request for care that was denied by the Fund administrator should not be much more involved. Since the Fund replaces the money the defendant would have paid, this procedure makes perfect sense, and it is much more fair and expedient and less costly than the adversarial process required by the MIF regulations.

In sum, the MIF has saved money for defendants and insurers, and has been handled well by the courts, but it needs substantial improvements if it is going to safeguard the future of the injured children it was created to serve. The Legislature ought to reflect on the five years of experience of this unique program and make the adjustments necessary for it to fulfill its mission and provide these children with the care they require.

Endnotes:

1. See Report to the New York Department of Financial Services, New York State Medical Indemnity Fund, 3rd Quarter 2015 Actuarial Analysis, January 2016 ("Jan. 2016 Report"), pp. 2, 6.
2. Jan. 2016 Report, p. 12.
3. See http://www.fairhealth.org/About-FH.