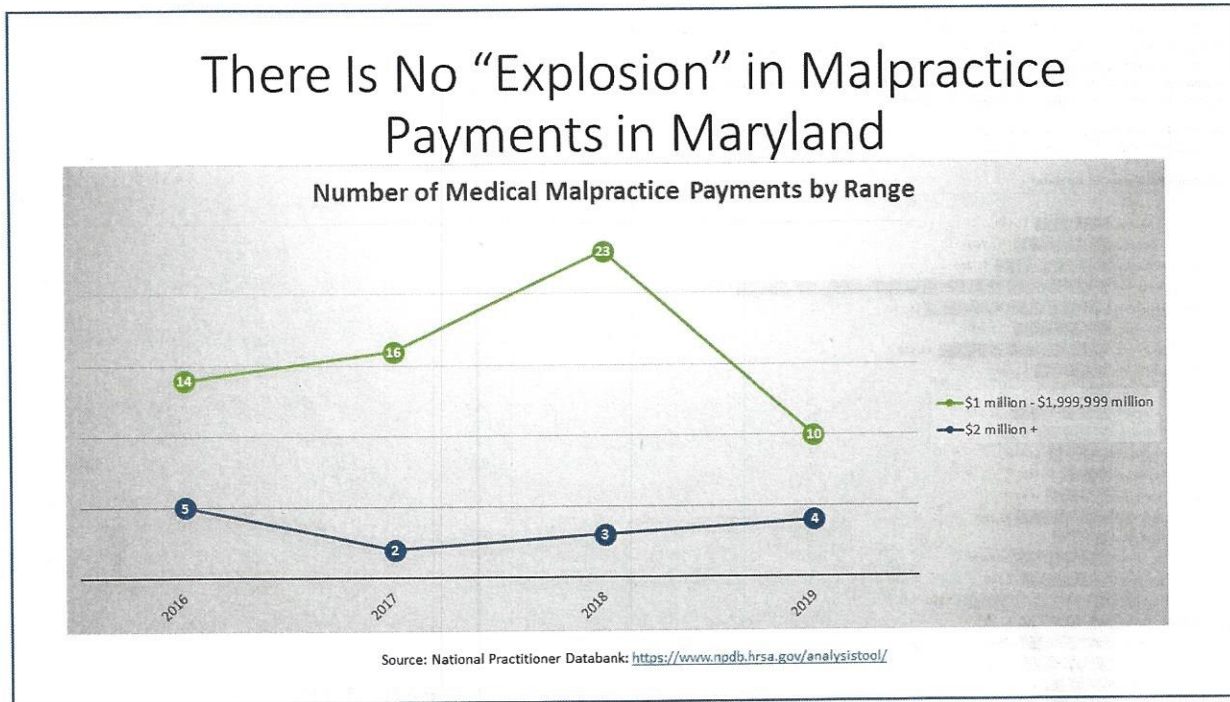
MARYLAND ASSOCIATION FOR JUSTICE

SB 879 Fact Sheet #1

Why the Maryland Infant Lifetime Care Trust is a Bad Bill

THERE IS NO "EXPLOSION" IN MALPRACTICE PAYMENTS IN MARYLAND

According to the National Practitioner Databank, there has been only one malpractice payment over $10 million in the past 10 years, and only a handful over $2 million. There is no "explosion" in malpractice payments in Maryland.



In fact, the most recent version of a study by Dietrich Healthcare has Maryland seeing payouts drop 6% since 2016.

Source: Dietrich Healthcare 2018 Medical Malpractice Payout Analysis, p 6

NORTHEASTERN UNITED STATES

Taking a closer look at the northeastern United States of America, in regard to medical malpractice payouts.

CONNECTICUT TOTAL PAYOUT AMOUNT: $104,766,250 | PER CAPITA: $29.20 | +67.64% IN TOTAL PAYOUTS FROM 2016

DELAWARE TOTAL PAYOUT AMOUNT: $8,253,250 | PER CAPITA: $8.58 | +38.95% IN TOTAL PAYOUTS FROM 2016

DISTRICT OF COLUMBIA TOTAL PAYOUT AMOUNT: $11,408,500 | PER CAPITA: $16.57 | +78.72% IN TOTAL PAYOUTS FROM 2016

MAINE TOTAL PAYOUT AMOUNT: $26,112,000 | PER CAPITA: $19.55 | +121.38% IN TOTAL PAYOUTS FROM 2016

MARYLAND TOTAL PAYOUT AMOUNT: $86,585,550 | PER CAPITA: $14.31 | -6.3% IN TOTAL PAYOUTS FROM 2016

MASSACHUSETTS TOTAL PAYOUT AMOUNT: $117,461,500 | PER CAPITA: [illegible] | -34.51% IN TOTAL PAYOUTS FROM 2016

NEW HAMPSHIRE TOTAL PAYOUT AMOUNT: $30,348,000 | PER CAPITA: $22.60 | -41.43% IN TOTAL PAYOUTS FROM 2016

NEW JERSEY TOTAL PAYOUT AMOUNT: $267,913,250 | PER CAPITA: $29.75 | -10.3% IN TOTAL PAYOUTS FROM 2016

NEW YORK TOTAL PAYOUT AMOUNT: $617,973,000 | PER CAPITA: $31.13 | -11.72% IN TOTAL PAYOUTS FROM 2016

PENNSYLVANIA TOTAL PAYOUT AMOUNT: $342,093,300 | PER CAPITA: $26.71 | +8.4% IN TOTAL PAYOUTS FROM 2016

RHODE ISLAND TOTAL PAYOUT AMOUNT: $32,152,250 | PER CAPITA: $30.34 | +10.53% IN TOTAL PAYOUTS FROM 2016

VERMONT TOTAL PAYOUT AMOUNT: $1,536,500 | PER CAPITA: $2.46 | -65.87% IN TOTAL PAYOUTS FROM 2016

For questions regarding this fact sheet, please contact MAJ's Legislative Chair George S. Tolley, III at gtolley@medicalneg.com or (410) 308-1600

MARYLAND ASSOCIATION FOR JUSTICE

SB 879 Fact Sheet 2020

The most recent Aon/ASHRM Hospital and Physician Professional Liability (2019) shows Maryland below the benchmark rate projected by the reinsurer for medical malpractice claims[1]. The OBE stands for "number of non-zero claims per occupied bed equivalent."

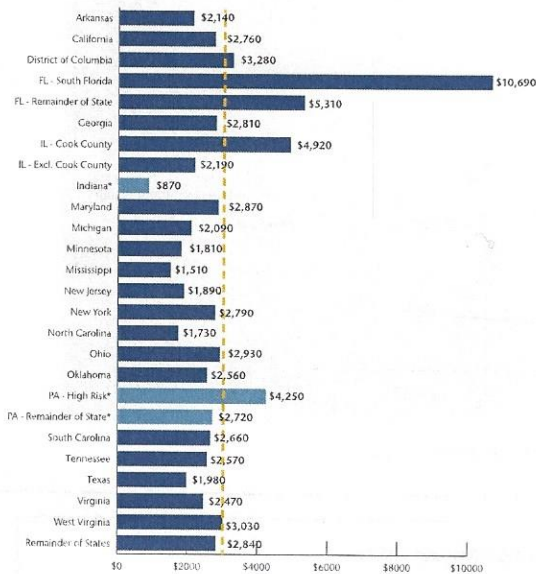
The previous year (2018) it was slightly above average, so it's decreasing.

State Findings for Hospital Professional Liability

The hospital professional liability benchmark database includes claims from 48 states, including the District of Columbia. In this report, we provide benchmark statistics for states having the necessary volume of experience to make the resulting benchmark statistics credible. In measuring credibility, we review bed counts, claim counts, and the volatility of the year-over-year results.

The following table provides the benchmark statistics by state for the individually reviewed states in the database. The yellow dashed line represents the 2020 countrywide advisory loss rate ($2,960).

2020 Loss Rates per OBE by State*



8 2019 Aon/ASHRM Hospital and Physician Professional Liability Benchmark Analysis

ABOUT US

Founded in 1954, Maryland Association for Justice (MAJ) represents over 1,300 trial attorneys throughout the state of Maryland. MAJ advocates for the preservation of the civil justice system, the protection of the rights of Marylanders, and the education and professional development of its members. *Learn more at mdforjustice.com*

MAJ's legislative advocacy is led by MAJ's lobbying team at Compass Government Relation Partners and lobbyist Frank Boston, Esq., in addition to an active volunteer Legislative Committee under the leadership of George S. Tolley, III; MAJ PAC Chair Bruce M. Plaxen; and MAJ President Ellen B. Flynn.

1 Aon/ASHRM Hospital and Physician Professional Liability Benchmark Analysis, October 2019, Executive Summary - Abridged Version, p 9

MARYLAND
ASSOCIATION
FOR JUSTICE

SB 879 Fact Sheet #2

Hopkins has a BIG Problem in Florida

DON'T PUNISH MARYLAND TAXPAYERS FOR FLORIDA'S PROBLEM

A Tampa Bay Times federal investigative report[1] from January 2019 identified extreme deficiencies in care at Johns Hopkins All Children's Hospital in Florida[2]. Hopkins now faces record fines in Florida, $40M from a few families alone. The report below shows an excerpt from a January 2019 Department of Health and Human Services Report that makes it clear that Hopkins ignored complaints and knowingly put patients at risk. Marylanders should NOT take the blame for Hopkin's rising insurance costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	103300	A. BUILDING ______ B. WING ______	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNS HOPKINS ALL CHILDREN'S HOSPITAL	501 SIXTH AVENUE SOUTH SAINT PETERSBURG, FL 33701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 043	Continued From page 1 ensure Emergency Services were provided in compliance with the Medical Staff Bylaws, failed to provide oversight and accountability for the Medical Staff (refer to A49), and failed to provide oversight and monitoring for the Infection Control Program (refer to A747, A749, and A756). Despite the facility's knowledge of complaints that alleged patient deaths due to a lack of oversight and accountability, the facility continued to implement ineffective strategies to ensure safe care. These failures resulted in a finding of ongoing Immediate Jeopardy beginning on 9/20/2018, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate corrective action on the part of the facility.	A 043		
A 049	MEDICAL STAFF - ACCOUNTABILITY CFR(s): 482.12(a)(5) [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.	A 049		

For questions regarding this fact sheet, please contact MAJ's Legislative Chair George S. Tolley, III at gtolley@medicalneg.com or (410) 308-1600

1 https://projects.tampabay.com/projects/2018/investigations/heartbroken/

2 https://www.tampabay.com/investigations/2019/08/23/johns-hopkins-agrees-to-pay-nearly-40-million-to-two-families-hurt-by-all-childrens-heart-surgeries/

MARYLAND ASSOCIATION FOR JUSTICE

SB 879 Fact Sheet 2020

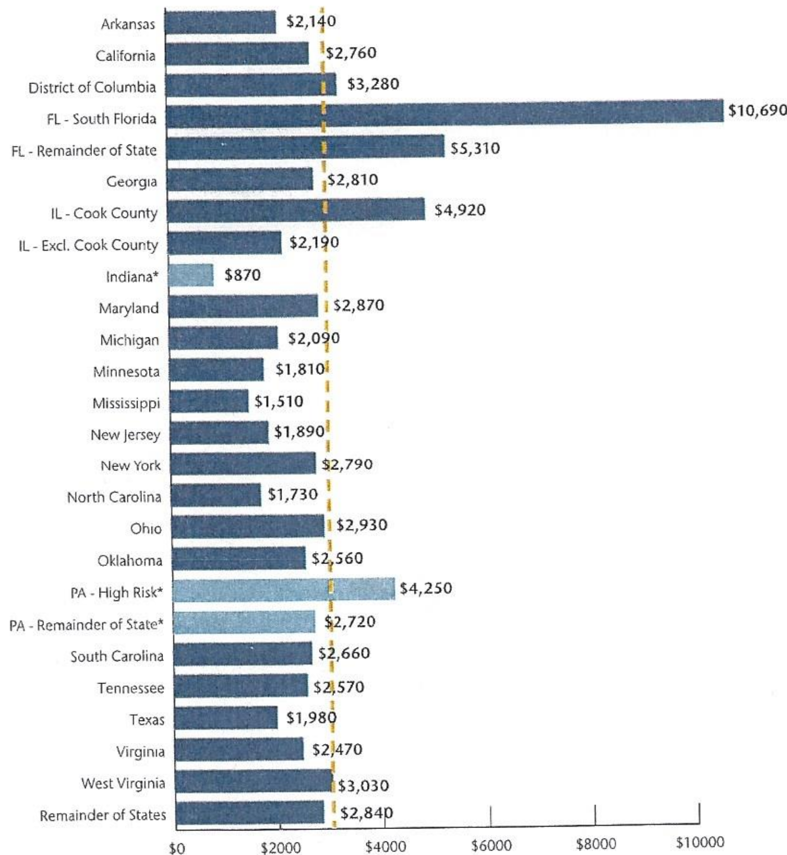
The most recent Aon/ASHRM Hospital and Physician Professional Liability (2019) shows Maryland below the benchmark rate projected by the reinsurer for medical malpractice claims[1].

State Findings for Hospital Professional Liability

The hospital professional liability benchmark database includes claims from 48 states, including the District of Columbia. In this report, we provide benchmark statistics for states having the necessary volume of experience to make the resulting benchmark statistics credible. In measuring credibility, we review bed counts, claim counts, and the volatility of the year-over-year results.

The following table provides the benchmark statistics by state for the individually reviewed states in the database. The yellow dashed line represents the 2020 countrywide advisory loss rate ($2,960).

2020 Loss Rates per OBE by State*



*All states limited to $2 million per occurrence except IN and PA are limited to PCF primary limits:
IN limits indemnity to $500K plus unlimited expense; PA limits indemnity to $500K plus unlimited expense

6 2019 Aon/ASHRM Hospital and Physician Professional Liability Benchmark Analysis

1 Aon/ASHRM Hospital and Physician Professional Liability Benchmark Analysis, October 2019, Executive Summary - Abridged Version, p 9

MARYLAND
ASSOCIATION
FOR JUSTICE

SB 879 Fact Sheet 2020 #4

The Byrom Verdict is an Outlier

THE STORY OF *BYROM V. JOHNS HOPKINS BAYVIEW MEDICAL CENTER*

On July 1, 2019, a jury in the Circuit Court for Baltimore City returned a unanimous verdict, including about $229,640,000.00 in monetary damages, in a medical negligence case brought by the mother of Zubida Byrom, a minor child, against Johns Hopkins Bayview Medical Center and other defendants.

Zubida suffered catastrophic brain damage during labor and delivery because, for days while her mother was admitted to the hospital, the hospital staff miscalculated Zubida's gestational age and weight and, when the staff realized their mistake, they withheld the truth from Zubida's mother.[1]

The jury's verdict included $25,000,000 in non-economic damages (which is subject to a statutory cap), and $200,000,000 in future economic damages. The future economic damages represents the present cost of medical care that the jury found the minor plaintiff likely will need in the future to treat the injuries caused by the defendants' negligence, for the rest of her life expectancy.

The trial itself came at the end of more than a year of discovery, during which time the plaintiffs and the defendants exchanged documents and other evidence and took testimony from witnesses. In a civil action such as this, the purpose of discovery is so that all of the parties and their lawyers have a clear understanding of all of the evidence that might be offered at trial.

As required by statute, the parties engaged in settlement discussions (called mediation, which is mandatory in medical negligence cases because hospitals claimed that mediation resolves cases more quickly and less expensively).

Settlement discussions continued after the mediation, and the parties continued negotiating even during the trial, until Deb Parraz, Esq., Senior Counsel at Johns Hopkins Health System, informed lawyers for Zubida that Hopkins was no longer interested in negotiations. Ms. Parraz' e-mail, dated June 26, 2019 (five days before the verdict) is reproduced on the other side of this fact sheet.

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[1]Cynthia Argani, M.D., the Director of Labor and Delivery at Johns Hopkins Bayview Medical Center, testified at trial that the truth about the medical errors in this case was shared in real time with other physicians throughout the Hopkins Health System "could potentially get hospital-wide attention or media attention," but it "wasn't important" for [Zubida's mother to be told the truth, even as she was asked to make decisions about operative delivery based on the same misinformation.

Of course, there is much more to the story than we can fit on one page. **MAJ and the lawyers who represented Zubida at trial are available to meet with any legislators or their staff who want to learn more about the negligent medical care in this case, the evidence and testimony at trial, the settlement negotiations that ended – in the middle of trial – when the Hopkins administration announced that they "need to be willing to take some verdicts," the status of the appeal, or the status of post-verdict settlement negotiations.**

Hopkins and MHA seem to want to make the facts of this case relevant to legislative policy during the 2020 Session. **MAJ believes that legislators should have the right to hear the whole story from both sides.**

For questions regarding this fact sheet, please contact MAJ's Legislative Chair
George S. Tolley, III at gtolley@medicalneg.com or (410) 308-1600

MARYLAND ASSOCIATION FOR JUSTICE

Medical Negligence Fact Sheet 2020

From: parrazd@gmail.com
Sent: Wednesday, June 26, 2019 8:14 AM
To: Keith Forman
Subject: Re: Byrom

Keith, it just occurred to me that I never responded to your $14 million demand. I am sorry for the delay. I ran this case all the way up the flagpole at Hopkins and the admin there really believes in the care rendered by our providers in this case. They feel that if we are going to try more cases we need to be willing to take some verdicts. I believe they are tired of paying on non-meritorious cases. I said all that to say that they really would like to see this case through to its trial conclusion. So, I do not have any more money to offer you at this time. I will certainly let you know if that changes.
Best,

Deb

Sent from my iPhone

Of course, Hopkins is a sophisticated consumer of legal services, and the administration at Hopkins had the benefit of legal advice from at least three (3) large law firms full of smart and capable lawyers when it decided that they "really believe[d] in the care rendered by our providers in this case," and that "we need to be willing to take some verdicts."

After trial, Hopkins and its defense team filed post-trial motions, asking the trial judge, the Hon. Audrey J. Carrion, for several things:

1. Arguing that the plaintiff did not prove negligence, Hopkins asked Judge Carrion to overturn the verdict and enter judgment for the defendants. Judge Carrion refused, finding that the evidence was sufficient to prove the defendants' negligence caused the minor plaintiff's injuries.

2. Arguing that the amount of the jury's verdict was not supported by the evidence at trial or otherwise "shocked the conscience" because it was so large, Hopkins asked Judge Carrion to reduce the verdict.

   Judge Carrion reduced the non-economic damages portion of the verdict to the statutory cap, but refused to reduce the future economic damages. This decision reflects a judicial finding that the verdict was supported by the evidence at trial and did not shock Judge Carrion's conscience.

3. Finally, Hopkins asked Judge Carrion to order that the future economic damages could be paid out slowly, over Zubida's lifetime.

Applying a statute enacted more than 30 years ago to deal with cases just like this, Judge Carrion agreed. She also ordered the lawyers for both sides to negotiate an appropriate payment schedule; those negotiations have been continuing ever since (and Hopkins has retained the services of a fourth large law firm to assist in those negotiations).

Hopkins has taken an appeal, which can be expected to take more than a year to resolve (and perhaps even longer). Of course, the parties also may negotiate a settlement at any time.

MAJ will keep interested legislators fully apprised of the ongoing status of the *Byrom* case.

For questions regarding this fact sheet, please contact MAJ's Legislative Chair
George S. Tolley, III at gtolley@medicalneg.com or (410) 308-1600

JOHNS HOPKINS
MEDICINE

High-Risk Births in Maryland and the Facts About the Byrom Case

Introduction

In a small number of complex cases, an infant may require long-term medical care as a result of neurological injuries that occur at birth. In a widely publicized 2019 case, a young mother named Erica Byrom sued Johns Hopkins after her baby experienced a neurological injury during her high-risk childbirth. Johns Hopkins is confident in the care and advice provided to the mother and was stunned when the case resulted in one of the largest jury awards in US history.

This case, and others like it, are driving up health care costs in Maryland and making it increasingly difficult for doctors and hospitals to get the insurance they need to be able to treat complex high-risk births in our state. The judgment also highlights the guessing game juries engage in when seeking to determine the costs of future medical care. The jurors in this case awarded nearly five times as much as Ms. Byrom asked for, far more than any reasonable estimate of the child's lifetime medical expenses.

The case has generated many questions, which we answer below, based on publicly available information.

Note: Federal privacy laws limit what may be shared publicly about this or any other case. All of the information below regarding the case is publicly available from trial testimony.

Q: What can you tell us about what happened in this case?

A: In this case, a young mother in medical distress was helicoptered to Johns Hopkins Bayview Medical Center from another hospital in Maryland that was not equipped to handle her care.[1] As described at trial, the mother was 25 weeks pregnant,[2] had no prior prenatal care, and had developed severe preeclampsia – a complication of pregnancy characterized by dangerously high blood pressure – which can be life-threatening for both mother and baby. When she arrived at Johns Hopkins, the mother had reduced amniotic fluid, and the prognosis of the fetus was poor, with a significant chance of death or disability.[3]

Multiple Johns Hopkins physicians strongly and repeatedly advised the mother to deliver the baby via C-section, but she declined each time, citing the potential for pain from the procedure.[4]

1 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/24/19

2 Due to a number of factors, including in part Ms. Byrom's lack of prenatal care, the gestational age when she arrived under emergency circumstances at Johns Hopkins Bayview Medical Center was uncertain and initially believed to be approximately 23 weeks.

3 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/24/19; Trial transcript, Byrom v. Johns Hopkins Bayview, 7/1/19

4 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/21/19; Trial transcript, Byrom v. Johns Hopkins Bayview, 6/20/19; Trial transcript, Byrom v. Johns Hopkins Bayview, 6/24/19

At the mother's insistence and against the advice of the Johns Hopkins team, the baby was delivered by a vaginal birth.[5] Weighing less than 1.5 pounds and with a heart the size of a quarter, she had to be resuscitated and treated and will require continued medical care.[6]

Q: What is the current status of the Byrom case?

A: Ms. Byrom sued Johns Hopkins and was awarded $229 million by the jury, which was nearly five times the $43 million she asked for. The court then reduced the jury award to $205 million (to fall within state limits), but it remains one of the highest jury awards in US history and far exceeds every reasonable estimate of the cost of the child's continued medical care.

Q: Did the young mother have a guardian or advocate available to support her while she made medical decisions?

A: Yes. According to trial transcripts, Ms. Byrom's mother accompanied her at the hospital, was present for multiple discussions with her care team, and was closely involved in her daughter's decision-making throughout the delivery.[7]

Q: Was Ms. Byrom advised to undergo a C-section, rather than attempt a vaginal birth?

A: Yes. As the trial record shows, given the severity of Ms. Byrom's case, and the unusual nature of her refusal to have a C-section, multiple Johns Hopkins physicians strongly and repeatedly advised her to deliver the baby via C-section, which she declined each time, citing the potential for pain from the procedure.[8]

At the insistence of Ms. Byrom, Johns Hopkins proceeded with a vaginal birth.[9] Following delivery, the baby was treated and resuscitated, but her challenges were immediately evident – she weighed less than 1.5 pounds and had a heart the size of a quarter.[10]

Q: What happens next? Where do we go from here?

A: Medical circumstances like this one are tragic and our hearts go out to this child, her family, and those who are caring for her. But these cases also are driving up health care costs in Maryland and making it increasingly difficult for doctors and hospitals to get the insurance they need to be able to treat complex high-risk births in our state.

Johns Hopkins is committed to providing world-class care and advice for Maryland patients facing high-risk medical situations. And if a hospital or doctor makes a mistake, they should be held accountable. But excessive jury awards put our entire Maryland health care and insurance system at risk and could cause even more Maryland hospitals to close maternity wards, discourage obstetricians from practicing in Maryland, and reduce access to obstetrical care in our state.

Legislation currently being considered by the Maryland General Assembly to create an Infant Lifetime Care Trust is a crucial step in the right direction. The bill establishes a trust - funded through hospitals that deliver babies - to cover the cost of care for infants who suffer neurological injury at birth.

5 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/21/19; Trial transcript, Byrom v. Johns Hopkins Bayview, 6/24/19

6 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/19/19; Trial transcript, Byrom v. Johns Hopkins Bayview, 7/1/19

7 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/24/19

8 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/21/19; Trial transcript, Byrom v. Johns Hopkins Bayview, 6/24/19

9 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/21/19; Trial transcript, Byrom v. Johns Hopkins Bayview, 6/24/19

10 Trial transcript, Byrom v. Johns Hopkins Bayview, 6/19/19; Trial transcript, Byrom v. Johns Hopkins Bayview, 7/1/19

The Johns Hopkins Medicine "Fact Sheet" about the *Byrom* case is factually wrong and misleading. Below are corrections to the "Fact Sheet" issued by Johns Hopkins Medicine:

Erica had prenatal care before she arrived at Johns Hopkins.

By the time Erica Byrom was admitted at Johns Hopkins, her adoptive parents had taken her to a pediatrician on August 21, 2014 who confirmed she was pregnant.[1] Erica's pediatrician referred her to an OB/GYN, and her adoptive parents took her to 3 prenatal appointments, on October 6, October 13, and October 20, 2014 before Erica ever went to Johns Hopkins.[2]

The doctors at Johns Hopkins never thought the baby was 23 weeks.

On October 6, 2014 (2 weeks before she arrived at Johns Hopkins), Erica's first prenatal ultrasound showed that her baby, according to her measurements, was approximately 23 weeks and 2 days old, and weighed about 546 grams.[3] On October 13, 2014, Erica's baby was about 24 weeks and 3 days according to the measurements from the second prenatal ultrasound.[4] On October 20, 2014, doctors at Johns Hopkins Bayview wrote in Erica's "History and Physical Chart" that her baby was 25 weeks and 3 days.[5]

The prognosis for Erica's baby was "fair" when she first got to Johns Hopkins.

When Erica arrived at Johns Hopkins on October 20, she signed an informed consent form that had been prepared by one of the residents:

> The indications, benefits and probability of success of the operation(s), treatment(s) or procedure(s) have been explained to me in a manner that I understand. These include:
> Indication: preeclampsia
> Benefit: maternal/fetal well-being
> **Probability of Success: Fair**[6]

At trial, the resident who filled out the informed consent with Erica testified that "probability of success" meant the probability of "...healthy mom and baby."[7]

Erica's medical records from Johns Hopkins Bayview also show that her baby was doing well on October 20, 2014—Erica's baby scored a 10 out of 10 on a biophysical profile, and the fetal heart rate monitoring was reassuring.[8]

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[1] Cambridge Pediatrics Medical Records, Joint Trial Exhibit 1B at pp. 1-4, admitted as evidence on June 18, 2019.
[2] Clinton Women's Prenatal Records, Joint Trial Exhibit 1B, admitted as evidence on June 18, 2019.
[3] Clinton Women's Prenatal Records, Joint Trial Exhibit 1B, at p. 1, admitted as evidence on June 18, 2019.
[4] Clinton Women's Prenatal Records, Joint Trial Exhibit 1B, at p. 9, admitted as evidence on June 18, 2019.
[5] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at p. 35, admitted as evidence on June 18, 2019.
[6] Joint Trial Exhibit 1A at pp. 3-4, admitted as evidence on June 18, 2019.
[7] Trial testimony of Rebecca Adami, M.D., at pp. 52:21-53:3.
[8] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at pp. 204-205, admitted as evidence on June 18, 2019.

Erica never "insisted" on a vaginal birth against the advice of the doctors at Johns Hopkins.

When Erica first arrived at Johns Hopkins, she gave the doctors consent to perform a cesarean section if her or her baby's health was at risk.[9] The choice of declining a cesarean section is not mentioned in the medical records until October 21, 2014.[10]

Beginning on October 21, 2014 the doctors at Johns Hopkins told Erica that: (1) her baby would probably not survive childbirth; (2) the NICU would not try to save her baby if she were born alive; (3) her baby had "zero" chance of having a normal brain; and (4) she could terminate the pregnancy.[11]

The doctors at Johns Hopkins also told Erica that if she had a cesarean section, she would never be able to deliver vaginally and had an increased risk of uterine rupture even if she never went into labor.[12]

Erica eventually withdrew her consent for a cesarean section for her baby's health later that day on October 21, 2014.[13]

Johns Hopkins always had Erica's permission to perform a cesarean section if her own health was at risk.

The doctors at Johns Hopkins always had Erica's permission to perform a cesarean section if her health was in danger.[14, 15] At trial, an expert hired by Erica and Zubida testified that it was unsafe for the doctors at Johns Hopkins to even attempt a vaginal delivery because it put Erica's health at risk, since her condition could deteriorate at any moment—**it would have been safer for Erica to do a cesarean section** when it came time to deliver her baby.[16]

Johns Hopkins violated their own patient safety policies when they induced Erica's labor.

In October 2014, Johns Hopkins had patient safety polices that governed induction of labor in patients like Erica.[17] According to Johns Hopkins' policies, an induction of labor begins with 25 micrograms Cytotec—**Johns Hopkins' doctors gave Erica a double dose of Cytotec 4 times.**[18, 19] Also according to

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[9] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at p. 3, admitted as evidence on June 18, 2019.
[10] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at p. 211, admitted as evidence on June 18, 2019.
[11] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at pp. 19, 129-130, 134-135, 211, 212, admitted as evidence on June 18, 2019.
[12] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at p. 211, admitted as evidence on June 18, 2019.
[13] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at p. 212, admitted as evidence on June 18, 2019.
[14] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at p. 3, admitted as evidence on June 18, 2019.
[15] Trial Testimony of Donald Garland, D.O. at pp. 92:3-19.
[16] Trial Testimony of Michael Cardwell, M.D. at p. 89:7-21.
[17] Trial Testimony of Donald Garland, D.O. at pp. 103:8-104:11.
[18] Trial Testimony of Donald Garland, D.O. at pp. 107:1-17.
[19] Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at p. 228, admitted as evidence on June 18, 2019.

Johns Hopkins' policies, the baby is continuously monitored during the induction of labor—Zubida was not monitored for more than 63 hours, including the entire 22 hour induction of labor.[20, 21]

Johns Hopkins does not, and will not, have to pay Zubida Byrom $205 million dollars.

The jury awarded Zubida Byrom $200 million dollars for the cost of her future medical care.[22] After trial, the trial judge granted Johns Hopkins' request to purchase financial instruments called annuities, instead of paying a lump sum.[23, 24] According to the Order, Johns Hopkins Bayview's upfront costs are less than half of the jury's original award of $229 million.[25] Furthermore, at the time of Zubida's death, **unused money will be returned to Johns Hopkins Bayview**.[26]

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20 Trial Testimony of Donald Garland, D.O. at p. 106:9-14.

21 Johns Hopkins Bayview Medical Records, Joint Trial Exhibit 1A at pp. 40, 135, admitted as evidence on June 18, 2019.

22 Verdict Sheet, Circuit Court for Baltimore City, No. 24-C-18-002909.

23 Defendant's Motion to Annuitize Judgment for Future Economic Damages, Docket No. 173/0, dated July 15, 2019.

24 Order of Baltimore City Circuit Court, Docket No. 173/4, dated September 25, 2019.

25 Order of Baltimore City Circuit Court, Docket No. 222/1, dated January 17, 2020.

26 Order of Baltimore City Circuit Court, Docket No. 222/1, dated January 17, 2020.

Keith Forman

From: Deb Parraz <dparraz1@jhmi.edu>
Sent: Tuesday, June 18, 2019 7:55 PM
To: Keith Forman
Subject: Re: Byrom

Keith, my response is $2.5.

Thanks,
Deb

Sent from my iPhone

On Jun 17, 2019, at 4:57 PM, Keith Forman <kdf@malpracticeteam.com> wrote:

> Hi Deb,
>
> Sorry for the delayed response. I have authority to drop to $15,000,000.00.
>
> Thanks,
> Keith
>
> ______________________________
> Keith D. Forman, Esq.
> Wais, Vogelstein, Forman & Offutt, LLC
> (410) 998-3600
> (410) 591-7967
>
> -------- Original Message --------
> Subject: Re: Byrom
> From: Deb Parraz
> To: Keith Forman
> CC:
>
> Keith, I am responding with an offer of $2 million. I know that is probably not what you want to hear but let's just try to get some momentum going. Thanks.
>
> Sent from my iPhone
>
> On Jun 17, 2019, at 6:16 AM, Keith Forman <kdf@malpracticeteam.com> wrote:
>
>> Deb,
>>
>> Thank you for taking the time to talk yesterday afternoon. I appreciate it.
>>
>> In an effort to get settlement talks back on track I have been given authority to make a new demand of $15,500,000.00.

Thanks,
Keith

____
Keith D. Forman, Esq.
Wais, Vogelstein, Forman & Offutt, LLC
(410) 998-3600
(410) 591-7967

-------- Original Message --------
Subject: Re: Byrom
From: Deb Parraz
To: Keith Forman
CC:

Thank you for your response. I am not going to bid against myself. If you decide to respond, that's fine. Otherwise, I will consider negotiations closed.

Deb

Sent from my iPhone

> On Jun 14, 2019, at 12:16 PM, Keith Forman <kdf@malpracticeteam.com> wrote:
>
> Deb,
>
> Thank you for your email. I have had an opportunity to discuss same with my client and my partners. Unfortunately, we do not think your latest bracket is reflective of the seriousness and strength of this case, nor is it reflective of what transpired with the motions. As such, we are not in a position to respond.
>
> You can of course call me if you wish to discuss this further.
>
> Thanks,
> Keith
>
> ________________________________
> Keith D. Forman, Esquire | Partner
> Wais, Vogelstein, Forman & Offutt, LLC
> 1829 Reisterstown Road | Suite 425
> Baltimore, Maryland 21208
> Office: (410) 998-3600
> Cell: (410) 591-7967
> kdf@malpracticeteam.com
> Admitted in MD, MN & DC
>
> -----Original Message-----
> From: parrazd@gmail.com <parrazd@gmail.com>
> Sent: Friday, June 14, 2019 10:16 AM
> To: Keith Forman <kdf@malpracticeteam.com>
> Subject: Byrom
>
> Keith,
> I know that you have spoken with Mike. I want him to focus on trial so I am going to take over discussing potential for resolution. While we are going full steam ahead for trial and have an appellate team in full gear, I am also willing to explore settlement in a reasonable range to avoid dragging folks through trial. To that end, I am offering a settlement bracket in the range of $1.5

and $2.5. Please let me know your response.
>
> Deb
>
> Sent from my iPhone

Keith Forman

From: parrazd@gmail.com
Sent: Wednesday, June 26, 2019 8:14 AM
To: Keith Forman
Subject: Re: Byrom

Keith, it just occurred to me that I never responded to your $14 million demand. I am sorry for the delay. I ran this case all the way up the flagpole at Hopkins and the admin there really believes in the care rendered by our providers in this case. They feel that if we are going to try more cases we need to be willing to take some verdicts. I believe they are tired of paying on non-meritorious cases. I said all that to say that they really would like to see this case through to its trial conclusion. So, I do not have any more money to offer you at this time. I will certainly let you know if that changes.
Best,

Deb

Sent from my iPhone

> On Jun 14, 2019, at 12:16 PM, Keith Forman <kdf@malpracticeteam.com> wrote:
>
> Deb,
>
> Thank you for your email. I have had an opportunity to discuss same with my client and my partners. Unfortunately, we do not think your latest bracket is reflective of the seriousness and strength of this case, nor is it reflective of what transpired with the motions. As such, we are not in a position to respond.
>
> You can of course call me if you wish to discuss this further.
>
> Thanks,
> Keith
>
> ______________________________
> Keith D. Forman, Esquire | Partner
> Wais, Vogelstein, Forman & Offutt, LLC
> 1829 Reisterstown Road | Suite 425
> Baltimore, Maryland 21208
> Office: (410) 998-3600
> Cell: (410) 591-7967
> kdf@malpracticeteam.com
> Admitted in MD, MN & DC
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explore settlement in a reasonable range to avoid dragging folks through trial. To that end, I am offering a settlement bracket in the range of $1.5 and $2.5. Please let me know your response.
>
> Deb
>
> Sent from my iPhone

Solution: Patient Safety

EXPERT REVIEWS ajog.org

PATIENT SAFETY SERIES

A comprehensive obstetric patient safety program reduces liability claims and payments

Christian M. Pettker, MD; Stephen F. Thung, MD, MSCI; Heather S. Lipkind, MD; Jessica L. Illuzzi, MD; Catalin S. Buhimschi, MD; Cheryl A. Raab, RNC; Joshua A. Copel, MD; Charles J. Lockwood, MD, MHCM; Edmund F. Funai, MD

decreased in the 5-years after program inception. Compared with before program inception, median annual claims dropped from 1.31 to 0.64 ($P = .02$), and median annual payments per 1000 deliveries decreased from $1,141,638 to $63,470 ($P < .01$). Even estimating the monetary awards for the 2 remaining open cases using the median payments for the surrounding 5 years, a reduction in the median monetary amount per case resulting in payment to the claimant was also statistically significant ($632,262 vs $216,815, $P = .046$). In contrast, the Connecticut insurance market experienced a stable number of claims and markedly increased cost per claim during the same period. We conclude that an obstetric safety initiative can improve liability claims exposure and reduce liability payments.

TABLE 2
Comparison of outcomes before and after program inception

Variable	1998-2002	2003-2007	P value
Deliveries; n	23,499	23,372	—
Annual deliveries; mean (±SD)	4699 (± 159)	4674 (± 58)	.70[a]
Liability cases			
Total cases; n	30	14	—
Total cases per 1000 deliveries; n	1.28	0.60	—
Annual cases, median (range)	6 (4–7)	3 (1–5)	.02[b]
Annual cases per 1000 deliveries; median (range)	1.31 (0.88-1.45)	0.64 (0.22-1.06)	.02[b]
Closed case analysis			
Total payments	$50,721,033	$2,239,173	—
Annual payments; median (range)	$632,262 (2293–15,421,842)	$81,714 (13,505–1,579,496)	.03[c]
Total payments per 1000 deliveries	$2,158,434	$95,806	—
Annual payments per 1000 deliveries; median (range)	$1,141,638 (264,352–4,536,653)	$63,470 (0–335,349)	< .01[b]
Combined (open + closed) case analysis (estimated)			
Total payments	$50,721,033	$2,878,937	—
Annual payments; median (range)	$632,262 (2293–15,421,842)	$216,815 (13,505–1,579,496)	.046[c]
Total payments per 1000 deliveries	$2,158,434	$123,179	—
Annual payments per 1000 deliveries; median (range)	$1,141,638 (264,352–4,536,653)	$63,925 (13,353–403,264)	.08[b]

[a] Student's t test; [b] Mann-Whitney U test; [c] Median test.

Pettker. Obstetric safety program reduces liability claims and payments. Am J Obstet Gynecol [illegible].

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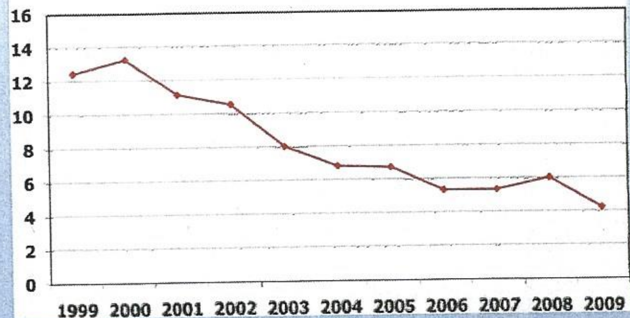
Solution: Patient Safety

REVIEWS www.AJOG.org

PATIENT SAFETY SERIES

Patient safety in obstetrics–the Hospital Corporation of America experience

Steven L. Clark, MD; Janet A. Meyers, RN; Donna K. Frye, RN; Jonathan A. Perlin, MD, PhD



8

PATIENT SAFETY SERIES

A comprehensive obstetric patient safety program reduces liability claims and payments

Christian M. Pettker, MD; Stephen F. Thung, MD, MSCI; Heather S. Lipkind, MD; Jessica L. Illuzzi, MD; Catalin S. Buhimschi, MD; Cheryl A. Raab, RNC; Joshua A. Copel, MD; Charles J. Lockwood, MD, MHCM; Edmund F. Funai, MD

Begun in 2003, the Yale-New Haven Hospital comprehensive obstetric safety program consisted of measures to standardize care, improve teamwork and communication, and optimize oversight and quality review. Prior publications have demonstrated improvements in adverse outcomes and safety culture associated with this program. In this analysis, we aimed to assess the impact of this program on liability claims and payments at a single institution. We reviewed liability claims at a single, tertiary-care, teaching hospital for two 5-year periods (1998-2002 and 2003-2007), before and after implementing the safety program. Connecticut statute of limitations for professional malpractice is 36 months from injury. Claims/events were classified by event-year and payments were adjusted for inflation. We analyzed data for trends as well as differences between periods before and after implementation. Forty-four claims were filed during the 10-year study period. Annual cases per 1000 deliveries decreased significantly over the study period ($P < .01$). Claims (30 vs 14) and payments ($50.7 million vs $2.9 million) decreased in the 5-years after program inception. Compared with before program inception, median annual claims dropped from 1.31 to 0.64 ($P = .02$), and median annual payments per 1000 deliveries decreased from $1,141,638 to $63,470 ($P < .01$). Even estimating the monetary awards for the 2 remaining open cases using the median payments for the surrounding 5 years, a reduction in the median monetary amount per case resulting in payment to the claimant was also statistically significant ($632,262 vs $216,815, $P = .046$). In contrast, the Connecticut insurance market experienced a stable number of claims and markedly increased cost per claim during the same period. We conclude that an obstetric safety initiative can improve liability claims exposure and reduce liability payments.

Key words: medical liability, medical malpractice, obstetric adverse outcomes, patient safety

The health care safety and quality movement has multiple goals, including (1) improvement of quality of care for individual patients, (2) reduction in the incidence of and exposure to adverse events, and (3) control of health care spending through accountable and value-based care. Preventable medical errors and mishaps diminish the ability to achieve all 3 goals, and thus efforts to control their occurrence are taking center-stage in health care improvement discussions.

Patient safety interventions have demonstrated remarkable improvements in quality indicators and reductions in adverse outcomes. However, less is known about how such interventions impact health care costs. Reducing waste and the spending required to respond to adverse outcomes is one way to reduce costs. It is also presumed that improvements in safety culture and the resultant enhanced collaboration and teamwork results in staffing efficiencies, such as less staff turnover and fewer staff vacancies. Finally, quality improvement efforts may alleviate some medicolegally-motivated defensive medicine practices complicating health care.

The contribution of medicolegal concerns to direct and indirect health care costs is a subject of debate. However, with obstetrics in a chronic professional liability insurance crisis, and with liability insurance and defense consuming a considerable amount of financial resources in obstetrics, demonstrating an impact on medicolegal outcomes, in addition to adverse outcomes, is an important goal in this field. Fewer lawsuits may be a surrogate marker of improved outcomes, but are probably a valuable indicator on their own. Decreasing claims also would reduce the overhead costs associated with legal defense and should also reduce overall payments for awards and settlements.

In 2002, Yale-New Haven Hospital (YNHH) partnered with its liability insurance carrier (MCIC Vermont, Inc., New York, NY) to introduce a comprehensive obstetrics safety initiative aimed at improving quality of care and reducing liability costs. We have

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MCIC Vermont, Inc. (New York, NY) provided partial financial support for this project as a quality assurance activity.

The authors report no conflict of interest.

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previously demonstrated reductions in adverse outcomes and improvements in safety culture/climate associated with this program.[1,2] More than 3 years after the maturity of this program, we now aim to describe the changes in our liability profile, namely the number of and payments for obstetric legal cases.

Materials and methods

We incrementally introduced multiple patient safety interventions from Dec. 2002 to Nov. 2006 at a university-based obstetrics service at YNHH. The details of this program have been previously described.[1] Briefly, the core elements of this project included:

(1) Outside Expert Review: we began in 2002 with a review of our obstetric services by 2 independent consultants. This site visit culminated in recommendations that focused on principles of patient safety, evidence based practice, and consistency with standards of professional and regulatory bodies.

(2) Protocols and Guidelines: protocol and guideline development began in 2004 with the aim to codify and standardize existing practices. Over 40 documents were produced during the study period.

(3) Obstetric Safety Nurse: an obstetric safety nurse was hired in 2004 to facilitate planned interventions and assist in data collection.[3] This nurse was in charge of educational efforts—including team training and electronic fetal heart rate (FHR) monitoring certification—and operations relating to patient safety activities.

(4) Anonymous Event Reporting: we initiated in July 2004 a computerized and anonymous event reporting tool (Peminic Inc, Princeton, NJ) that allows any member of the hospital to report an event or condition leading to harm (or potential harm) to a patient or visitor. Reports were reviewed and investigated.

(5) Obstetric Hospitalists: resident supervision and leadership of the inpatient activities was assumed by our Maternal-Fetal Medicine team to provide 24-hour, 7-day a week in-house coverage, beginning in 2003.

(6) Obstetric Patient Safety Committee: established in 2004 this multidisciplinary committee of physicians, midwives, nurses, and administrators provides quality assurance and improvement oversight. In particular, this group met monthly to review adverse events and address the needs for protocols and policies.

(7) Safety Attitude Questionnaire: to assess employee perception of teamwork and safety, we annually surveyed our teams with this tool, adapted from the aviation field.[4]

(8) Team Training: we implemented crew resource management seminars, based on those of airline and defense industries. These 4-hour classes included videos, lectures, and role-playing with the goal of integrating obstetric staffing silos (physicians, midwives, nurses, administrators, assistants) and teaching effective communication. Completion of the seminar was a condition for employment and/or clinical privileges.

(9) Electronic FHR Certification: teaching for this included dissemination and review of NICHD guidelines, review of tracings, allocation of study guides, and voluntary review sessions, culminating in a standardized, certified examination. All medical staff and employees responsible for FHR monitoring interpretation were obligated to pass this exam at program inception or within 1 year of employment.

Events, claims, and suits related to obstetric cases at YNHH were collected prospectively by the liability carrier (MCIC Vermont, Inc.) for the hospital and all of its employees and providers, and classified according to event year. MCIC Vermont, Inc. covers all care at YNHH, including professional liability insurance for all obstetricians and midwives. For the purposes of this study, only formal claims and suits filed against the hospital or a hospital provider were designated as 'cases.' A case consisted of a claim or suit requesting financial compensation of the patient for alleged harm and resulting in legal involvement and/or response by the liability carrier.[5] This includes cases dropped by the plaintiff or settled with or without payment before the filing of a formal lawsuit. Events noted by the legal or medical liability teams to be at risk for legal action were not included.

Cases were categorized according to high, moderate, or low severity, as described in Table 1, by the liability carrier using the industry standard National Association of Insurance Commissioners Index.[6] Cases were also categorized according to the nature of the case/issue (eg, prenatal diagnosis, fetal monitoring, improper obstetric management, nonobstetric, and other).

Closed cases were defined as those resolved by withdrawal, court judgment, or settlement. Open cases were claims or suits filed in court but still unresolved at the time of performing the analysis. Connecticut state law (CGS § 52-584) requires that a medical malpractice lawsuit must be initiated within 2 years from the date the injury is first sustained or discovered (statute of limitations), or 3 years from the date of the act or omission causing the injury (statute of repose).[7] Thus, a malpractice claim must be initiated within 3 years of the act/omission even if the injury is not discovered until after 3 years have passed. There is no law extending the statute of limitations for injured minors. Thus, obstetric cases up to Dec. 2007 must have been filed before Jan. 2011, ensuring complete accounting for all possible cases in this study. Study completion date of Dec. 2007 was chosen to allow for the statute of repose as well as a subsequent 18-month period to allow any open cases to resolve.

Indemnity payments were identified by our liability carrier and include all compensation to claimants of plaintiffs. Payments do not include costs of investigating or defending the case or other allocated loss adjustment expenses. As events that did not lead to claims or suits were not included, dollars held in reserve for possible future actions were not included. All monetary values are

expressed in dollars and adjusted for inflation to reflect 2007 values, according to the Consumer Price Index.

There were no concurrent changes in malpractice law on caps or noneconomic damages in Connecticut during this study period. A statute requiring a 'certificate of merit' from a qualified health care provider for medical liability cases was passed in 2005 (CGS § 52-184c and 52-190a). There were no institutional changes in mediation or adverse event disclosure policies during the study period.

Analysis was performed tracking the number of liability cases per 1000 deliveries, per year. Cases were normalized per 1000 deliveries to control for any variation in volume across study years or periods. Comparisons were made for 2 5-year periods (before study inception [Jan. 1998-Dec. 2002] and after study inception [Jan. 2003-Dec. 2007]) using Student's *t* test, the median test, Mann-Whitney *U* test and χ^2 or Fisher exact test where appropriate. Poisson regression was used to analyze annual trends in numbers of claims per 1000 deliveries. In addition, analysis of differences and trends in annual liability payments was performed on closed as well as open and closed (combined) cases. For combined case payment analysis, we used the overall median liability payment for the 5 surrounding years as the estimate for each open claim, assuming each open case resulted in payment. Cases that did not result in payment were not included in payment analyses. We performed the additional analysis of combined cases because a closed claim analysis may bias results in favor of the second epoch, given that it is likely to have more open claims. When claims remained open we performed worst-case and best-case scenario analyses when estimating the numbers of claims settled without payment. Worst-case scenarios designated open cases as being settled with payment, whereas best-case scenarios designated them as settled without payment. *P* values $< .05$ were considered statistically significant. Analysis was performed using commercially available software (SPSS version 18.0; SPSS, Inc., Chicago IL).

TABLE 1
Severity classifications with descriptions and examples

Severity	Injury description	Example of injury
High	Death, permanent major	Maternal or neonatal death, cerebral palsy
Moderate	Permanent minor, temporary major, temporary minor	Erb's palsy, bowel perforation, preventable infection
Low	Temporary insignificant, emotional	Retained vaginal sponge, scalp laceration, improper management without physical harm

Pettker. Obstetric safety program reduces liability claims and payments. Am J Obstet Gynecol 2014.

This project was reviewed by the Chair of the Yale University Human Investigations Committee and was deemed a quality assurance activity and thus not required to undergo review by the Committee.

Results

Our unit averaged approximately 4600 deliveries annually, with no statistically significant difference between both epochs (Table 2). We identified 44 cases overall during the entire 10 year study period, with 30 of those associated with events before initiation of our safety initiative and 14 after. Twelve (12) cases resulted in no payment made, with 7 of these in the 5 years before our patient safety project and 5 cases after the initiation of our intervention (Table 3). There were 2 open claims remaining at the time of this report, both being in the second 5-year epoch.

Annual cases per 1000 deliveries decreased significantly over the study period (Poisson regression, $P < .01$; Figure 1). Compared with the rates before initiation of our program, median annual rates of cases per 1000 deliveries were significantly lower after study inception (1.31 before vs 0.64 after, $P = .02$; Table 2 and Figure 1). Distribution of cases by severity and distribution of cases by type, however, did not significantly change after inception of our patient safety program (Table 2). The number of cases resolved without payment did not significantly change, both in the closed case analysis (n = 7 [23%] vs n = 5 [42%]; $P = .27$) and in worst-case and best-case scenarios in the combined case analysis (worst-case: n = 7 [23%] vs n = 5 [35%]; $P = .48$; best-case n = 7 [23%] vs n = 7 [50%]; $P = .19$).

Closed-case analysis revealed that payments were drastically reduced after the patient safety effort, from $50.7 million to $2.2 million (Table 2). Median annual payments, per 1000 deliveries, were significantly lower in the second time period as well ($1,141,638 vs $63,470; $P < .01$); this statistically significant result held true when performing the combined (open and closed) case analysis as well (Table 2). However, annual trends towards reduced payments, both in the closed case and combined case analyses, were not statistically significant. Figure 2 represents a graphic depiction of the yearly trend for the combined case analysis; the closed case analysis does not appear different.

To determine whether the patient safety program had any impact on payments to claimants, we analyzed how payments differed across both time periods. The median monetary amount per case resulting in payment to the claimant was statistically significantly different in the combined case analysis ($632,262 vs $216,815; $P = .046$) and in the closed case analysis ($632,262 vs 81,714; $P = .03$). Furthermore, there was much less variability in payments, as reflected in a narrowing of the interquartile ranges after initiating our safety program (interquartile range before $2,996,068, vs after $270,361 [combined cases] and $267,280 [closed cases]).

Comment

This analysis demonstrates a strong association between introduction of a comprehensive obstetric patient safety

TABLE 2
Comparison of outcomes before and after program inception

Variable	1998-2002	2003-2007	*P* value
Deliveries; n	23,499	23,372	—
Annual deliveries; mean (±SD)	4699 (± 159)	4674 (± 58)	.70[a]
Liability cases			
Total cases; n	30	14	—
Total cases per 1000 deliveries; n	1.28	0.60	—
Annual cases; median (range)	6 (4–7)	3 (1–5)	.02[b]
Annual cases per 1000 deliveries; median (range)	1.31 (0.88-1.45)	0.64 (0.22-1.06)	.02[b]
Closed case analysis			
Total payments	$50,721,033	$2,239,173	—
Annual payments; median (range)	$632,262 (2293–15,421,842)	$81,714 (13,505–1,579,496)	.03[c]
Total payments per 1000 deliveries	$2,158,434	$95,806	—
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Combined (open + closed) case analysis (estimated)			
Total payments	$50,721,033	$2,878,937	—
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[a] Student's *t* test; [b] Mann-Whitney U test; [c] Median test.

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initiative and a dramatic reduction in liability claims and liability payments. We have estimated a 95% reduction in direct liability payments and a savings of $48.5 million over a 5-year period. We also see a consistent pattern of statistically significant trends in reduced payments and in the variability of these payments. Furthermore, during this patient safety intervention there was a 53% reduction in liability claims and lawsuits compared with the 5 years prior. The mean number of annual cases consistently dropped over the 10-year period. We were unable to see differences in the distribution in the quality (severity and types) of the cases, which may be due to small sample sizes, though there were absolute decreases in each category.

There are several limitations to this study. It is important to note that our 2 remaining open claims are in the second study period, and this may bias the results toward showing a difference between the 2 study periods when there is not one in reality (ß-error). Increasing time from injury to case closure (the 'age of the claim') is also typically associated with a larger final payment. However, there is not an association of age of claim and whether any payment at all is made. In Connecticut, approximately 50% of malpractice claims result in payment and there is no association with the age of the claim.[8] As a result, nonpayment for either claim still open in our study would strengthen our results. We believe that our estimate for this report is fair, and that the timely reporting of these results (ie, not waiting until all cases have been finalized, which on average in Connecticut is 5 years after the date of injury) is important for the obstetrics, medicolegal, and patient safety communities.[8]

Our study is also limited by an inability to directly compare with a control group. In our case, we chose the time period before our safety initiative as a comparison. Our institution overall did not experience a statistically significant reduction in claims in nonobstetric fields (eg, surgery, emergency department, medicine, etc), when comparing the same 2 epochs ($P = .16$), suggesting that this was a change specific to our program rather than a generalized institutional phenomenon. Controls outside of our institution would be

difficult to find and/are problematic. First, there is the issue of reporting; institutions are generally very guarded with respect to reporting their liability experiences to outside entities. To put our report into context, however, the Connecticut State Insurance Commissioner has reported that from 2005-2009 the values of claims either awarded or settled actually increased.[8] Moreover, Connecticut juries awarded 2 record judgments of $38.5 million and $58.6 million for obstetrics cases in the time after implementing our program.[9] In terms of claim numbers, closed claim data from the Connecticut State Insurance Commissioner has reported that the total number of medical liability claims in Connecticut closing in 2010 (693) was only negligibly different from those closing in 2006 (714); more discrete data such as those focused on obstetric claims or those sorted by event year are not available.[8] Though not definitive proof, these data suggest that the certificate of merit statute passed in our state had little effect on numbers of claims submitted by plaintiffs. Comparisons to institutions outside of Connecticut are also limited, as other states will have different malpractice environments and few have statutes with such short conditions of repose. However, national rates of claims, as well as the severity of claims, have been reported as increasing, with obstetrics playing a key hospital risk area in this rise.[10,11]

A major strength of this paper lies in its analysis by event year, rather than policy year. Although neither method allows for strict conclusions to be made about causation, analyzing by event year allows us to make stronger temporal associations. Policy year analysis would not necessarily reflect adverse events from a particular time period, as it is a measure of claims filed in a particular year without regard to when they actually occurred. This is further enhanced by Connecticut's short statute of limitations, which makes an analysis 3 years after the final claim year possible. Thus, we are able to analyze a nearly completed dataset of actual claims and payments, rather than an experience based on reserves,[12] sentinel events, or claims during periods with open statutes of limitations.[13,14]

Prior reports have demonstrated this program's impact on reduced adverse outcomes and improved patient safety

TABLE 3
Liability case characteristics

Cases	1998-2002	2003-2007	*P* value
Total cases	30	14	—
Cases without payment	7 (23%)	5 (42%)[a]	.27
Case severity			
High	16 (53%)	8 (57%)	.97
Moderate	9 (30%)	4 (28%)	
Low	5 (17%)	2 (14%)	
Case type			
Improper management	13 (43%)	7 (50%)	.91
Fetal heart rate monitoring	5 (17%)	2 (14%)	
Failure to diagnose	3 (10%)	2 (14%)	
Other	9 (30%)	3 (21%)	

All values reported as: n (%). All comparisons made using Fisher exact test.

[a] Indicates that 2 additional cases remain open.

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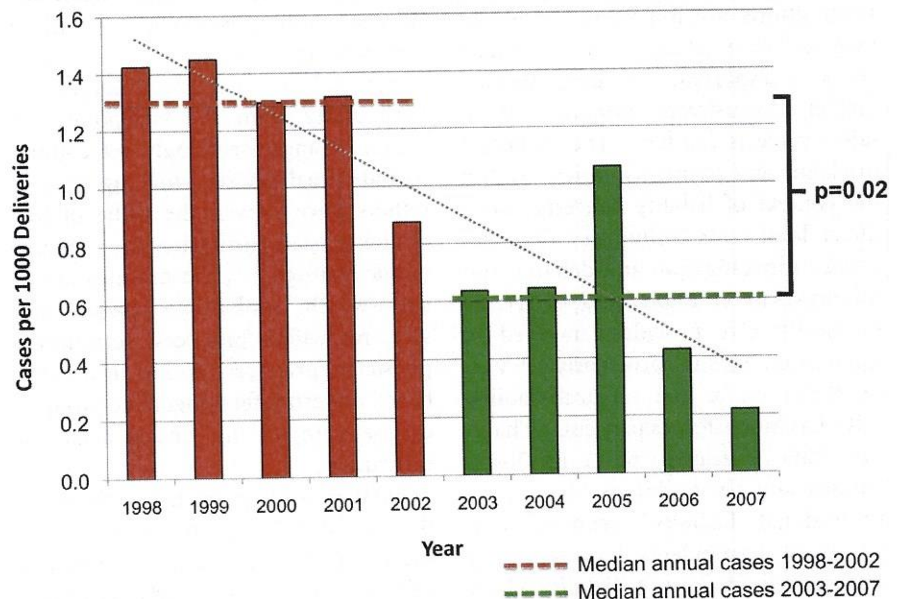
FIGURE 1
Annual cases per 1000 deliveries, classified by event year



Comparison of the two 5-year epochs demonstrates a statistically significant reduction in liability cases ($P = .02$, Mann-Whitney *U* test). Trend in reduction of annual cases per 1000 deliveries (*shaded line*) is also significant ($P = .01$, Poisson regression).

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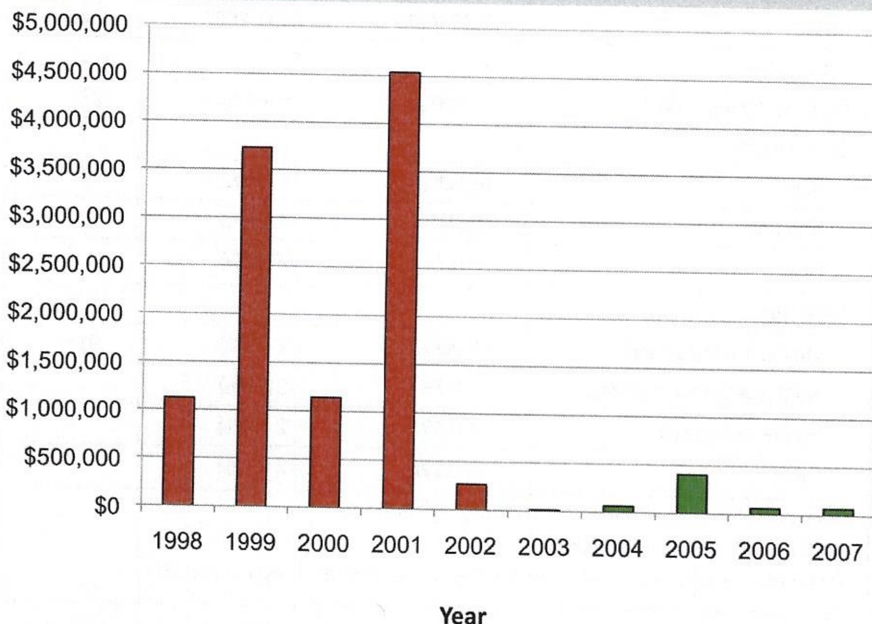
FIGURE 2
Annual liability payments per 1000 deliveries



Annual liability payments per 1000 deliveries, classified by event year (inflation adjusted to 2007 dollars) (open and closed case analysis).

Pettker. Obstetric safety program reduces liability claims and payments. Am J Obstet Gynecol 2014.

culture.[1,2] The results from this analysis document a third benefit of initiating a comprehensive obstetric patient safety effort: possible cost savings. Although the primary motivations driving patient safety efforts are improving quality of care and eliminating harm, these data are also important for demonstrating further downstream impacts patient safety projects can have. The reduction in claims and payments, strictly within the context of liability concerns, saves direct legal costs, minimizes time devoted to investigation and defense, and minimizes the emotional and social costs on health care providers involved in these cases. This is particularly relevant in obstetrics, as the medical liability crisis has hit obstetrics particularly hard. The 2009 American College of Obstetricians and Gynecologists "Survey on Professional Liability" reported that 90.5% of respondents indicated they experienced at least 1 liability claim during their careers, with an average of 2.69 claims per physician.[15]

The significance of these results outside of the narrow medicolegal context should not be underestimated. A reduction in liability claims is likely a hallmark of an environment with improved quality. In fact, coupling these results with our prior report demonstrating reduced adverse outcomes suggest a direct association, as others have reported.[5] Initial resistance to such programs is common, if not ubiquitous, particularly from the viewpoint that system changes seemingly act counter to individual decision-making or skill. Others have proven the value of formalizing standardization in nonacademic settings[14,16]; the findings at our site—which combines a resident service, midwifery practices, community physician practices, and a university-based maternal-fetal medicine group—can have impact in a diverse academic institution.

Furthermore, given the striking reductions in liability payments seen one cannot ignore the economic relevance of this report, particularly in today's health care environment of accountable and value-based care. Savings in legal costs beyond direct payments to plaintiffs are likely. Legal defense costs in Connecticut average from $58,000 to $70,000 per claim, including for claims that result in no payments to claimants.[8] A study involving a random sample of 1452 closed malpractice claims from 5 insurance carriers estimates that the administrative costs of litigating claims increases the cost of these claims by an additional 54% of the compensation paid to plaintiffs.[17] It is difficult to say that projects like this will have an impact on overall health care spending, however. Some experts estimate that legal fees, payments, and insurance premiums contribute to only 0.5% of US health care costs[18]; however, the contribution may be as much as 10% when taking into account broader phenomena related to the liability atmosphere, such as defensive medicine practices.[19] Our study does not address the cost or efficiency of the services that were rendered over the study period. Although we did not specifically encourage any defensive practices during the study period, we did note that our cesarean delivery rate increased over time, in step with national trends.[1] We have no information as to whether this increase affected the risk of adverse outcomes, but we are sure that it did increase costs to patients and their insurers. Furthermore, few of these efforts can be provided at no cost, although the simplicity of many tools (such as checklists) challenges any arguments against them. Whether patient safety projects provide a net cost benefit is difficult to calculate and not known at this time. Initial costs of our program, supported by our liability carrier, are estimated at $210,000, with ongoing yearly costs of $150,000, giving a 5-year estimate of $810,000. Thus, we may estimate a substantial return on investment from the view of our medical liability carrier, on the order of 58:1.

Certainly, our effort is not the only approach to quality and safety with possible impacts on the medical liability climate in obstetrics. For instance enhanced communication skills may improve provider-patient relations after an adverse event or medical error. In fact, formal implementation of a disclosure program that also offers compensation for medical errors has shown a decrease

in claims.[20] Others have demonstrated that most payments for obstetric malpractice cases are a result of substandard care resulting in *preventable* injury, adding that over 50% of litigation costs could be avoided with practices such as 24-hour obstetric coverage, adherence to medication protocols, and improved documentation, particularly in cases of shoulder dystocia.[16] Unfortunately, we are unable to conclude which of the core elements of our patient safety project had the most impact in achieving the results reported here.

Although improving the medical liability climate has generated much discussion, little clinically based work has actually impacted this serious problem. President Obama and the Department of Health and Human Services made patient safety projects an important part of health care reform, explicitly connecting them to improving the medical liability environment.[21] A first step toward this end is for the medical profession to put effective interventions in place that reduce events that result in liability. We believe this report is an important advance toward this end and is particularly important because it impacts the point of care, rather than the political or statutory structures of the medical liability machine. However, whereas we have been able to demonstrate that patient safety efforts can have a significantly positive effect on liability exposure, we do not believe that it can happen without a broad effort to improve the general liability environment. We believe a patient safety program can be even more successful in regions that have embraced meaningful tort reform, when the threat of suit is less likely to be a principle driver of the desire to reduce harm to patients. ∎

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Date: March 5, 2020

Testimony of Michele Stevener, mother of a child with a birth injury
Fairfax, Virginia
Before the Senate Finance Committee

Senate Bill 879
Position: Opposed

Madam Chair Kelley and members of the Senate Finance Committee, my name is Michele Stevener and I am a mother opposed to Senate Bill 879. I very much appreciate the opportunity to share why I am opposed to this bill, as a mother of a daughter with a birth-related brain injury. I have direct experience with a state birth injury fund, the Virginia Birth-Related Neurological Injury Compensation Program, and here is our story.

My daughter, Caroline, was born on Christmas Day in 1998. Both of us almost died that night. I was thrilled to be expecting a daughter and dreamed about so many adventures we would have one day. I had a healthy pregnancy and I delivered her full term, just ten days before my due date. I didn't know at the time that you shouldn't have a child on a holiday. The physician checked on me early in the day, saw that I was fully dilated, then disappeared until just before I delivered – but the damage was already done. The nurse, who had only been in labor and delivery for two months, was not monitoring my daughter nor me close enough. She just didn't know enough about fetal monitoring. When my baby arrived, she was a dark blue color and had no tone. She was virtually dead and had to be intubated. I remember asking why she wasn't crying. They did what they could, but Caroline was left with severe and permanent brain damage. Our lives were forever changed.

The fetal monitoring strip from my daughter's delivery was only provided by the hospital after required by a subpoena. It was clear that my daughter went into distress shortly after 5 pm and remained in distress until her delivery at 5:50. No one did anything to help her. She experienced a lack of oxygen during birth, and would have been born healthy if not for the lack of medical care during a dangerous labor and delivery. The theory is that I had a terminal placental abruption – which explained Caroline's lack of oxygen, my blood in her lungs, and my near fatal hemorrhage. From that day on, I had to focus on keeping my daughter alive.

We weren't aware of the extent of Caroline's brain injury until July 1999. It was a full year from her birth that I actually heard about a birth injury fund in Virginia. I didn't realize that, in the Commonwealth of Virginia, if there is a birth-related neurological injury so severe that the baby meets the statute's eligibility, it must be treated as a bureaucratic inconvenience due to a law passed ten years before Caroline was born. Virginia calls it a no-fault program, and it's supposed to pay for medical care and other expenses for the children who are admitted to the program.

But the fund doesn't work as intended. They made it very difficult for me to get the best care for my daughter.

They reneged on critical benefits that were in place as of my daughter's birth, but denied because of a perceived lack of funding after they forgave assessments for years from the physicians and hospital. The fund only protects hospitals, and by my daughter qualifying to be in the fund, I was not allowed to seek

litigation on Caroline's or my behalf. My separate right of action was also abrogated in favor of this exclusive remedy.

Interpretation of the covered benefits is subject to a conflicted board of directors, represented by the interests who pay into the fund. For example, if I were to take Caroline to an out-of-network physician, I would have to seek approval first or the program would not pay for the difference in in-network costs.

When my daughter needed care that the fund said was outside of its limited coverage, I would have to appeal the decision, and this usually went on for months. But the fund was managed by a board of directors that would only meet once a month, sometimes canceling their meetings for a month, meaning board decisions for Caroline's care threatened our ability to keep her healthy. And, then when I lost to the board of directors, I had to face the Attorney General's office.....alone.

Then, there is the issue that the fund wants to pay for 2019 expenses with 1987 dollars. The Virginia program only covers expenses at the rate that was originally decided when it passed into law in 1987. Therefore, when I needed to pay for insurance for a van to take my daughter to doctor appointments, I had to pay almost half of it out-of-pocket. My complaints fell on deaf ears. And, even though the state requires backup cameras in vehicles such as her van, since it wasn't in the approved expenses list within the fund, my family had to pay for this safety feature.

My daughter's life was complicated, but I never expected that I wouldn't be able to provide her with the best care possible due to a bureaucratic, self-serving fund that was supposed to help children like her. It added injury to a catastrophic injury. The program has one clear goal: protect the hospital's and doctor's money, at the expense of these children.

Senate bill 879 in Maryland would take away the rights of parents just like me and hide hospitals and physicians from being held accountable. I am told by many experts that most, if not all, of these catastrophic injuries are avoidable based on the warning signs during labor or delivery. If hospitals – the very institutions we trust to keep our children healthy – continue to put profit over lives and bills like this one pass, more families will face a heartless system like I did. Hospitals should be focused on fixing their problems, not removing themselves from being at fault and forcing others to pay for the harm inflicted during their oversight in giving quality medical care.

Tragically, my Caroline passed away last October. She aspirated on her formula, went into septic shock and died in my arms a couple of days later. Another expense that is approved with 1980's prices is the funeral costs. We'll have the funeral later, once I can afford the costs myself for a proper send off for my daughter.

Advocating for my daughter involved a fight against the program, its board of directors, the attorney general's office and the medical lobby. While Caroline battled for life, I was battling with people who didn't know a thing about her needs. It pains me to think more families would experience this if this bill in Maryland turns into law.

I recommend that members of the committee oppose the bill. Caroline was among Virginia's youngest and most defenseless victims, and was among Virginia's most disabled citizens. Do not throw out a child's constitutional rights to a jury trial, due process or equal protection, just to mention a few, in favor of such a program. Do not make the same mistake as your neighboring state.

Reducing Malpractice Injuries And Deaths Should Be Highest Priority

By Robert E. Oshel, Ph.D

The real problem with medical malpractice in Maryland is with the amount of malpractice itself, not with too much money being paid out in damages to the most harmed victims. A birth-injury fund or other changes making it more difficult for victims to hold physicians and health care providers accountable won't reduce malpractice. The Maryland legislature should take action to reduce medical malpractice itself, not the amount of compensation paid to victims.

Following retirement from my position as Associate Director for Research and Disputes for the Division of the Practitioner Data Bank at the U.S. Department of Health and Human Services, I have often worked with Public Use Data File version of National Practitioner Data Bank (NPDB), the federal database that receives information about all malpractice payments for physicians and other practitioners. The NPDB also maintains records on all disciplinary actions taken by the state licensing boards for physicians and other providers, as well as records of disciplinary actions taken by hospitals and other facilities against practitioners. Before I retired, I designed the Public Use Data File for research use. It contains information from all NPDB reports but does not identify the reported practitioners.

In Maryland, my analysis of the Public Use Data File shows that over a 20-year period, only 1.68 percent of the state's physicians were responsible for half of all the money paid out for medical malpractice. Most of these physicians had multiple malpractice payments. If action were taken to restrict or retrain this very small proportion of Maryland physicians, Maryland malpractice payments could be substantially reduced, perhaps even cut in half.

Yet, action was rarely taken against this 1.68 percent of Maryland physicians causing half of the problem. Only 12 percent of them had ever had any reportable action -- not even a slap on the wrist reprimand -- taken against their license by the Maryland Board of Physicians. Only about 4 percent of them had ever had any reportable action taken against their clinical privileges by a Maryland hospital or other health care facility.

Obviously, something is wrong when only about 1/8 of the few physicians with the very worst malpractice records, responsible for half of malpractice dollars paid out, have had any action taken against their licenses and when only about 1/25 of them have had any reportable action taken against their clinical privileges.

There has been much debate recently over the specific issues related to medical malpractice in obstetrics and injuries to infants at birth leading to the proposal to create a birth-injury fund, this year called the Maryland Infant Lifetime Care Trust. While hospitals and physicians claim there is a crisis, over the 10-year period from 2010 through 2019 there were 119 obstetrics-related Maryland malpractice payments for physicians (including settlements and judgments). 103 physicians were responsible for these payments; 89 physicians had only one obstetrics-related payment; 12 had two obstetrics payments; and one physician was responsible for three obstetrics-related payments. The number of obstetrics judgment payments is so small, it would be impossible to say there is any trend either in numbers or payment amounts.

In fact, there were no obstetrics judgments against physicians resulting in payments in 2011, 2013, 2017, 2018, or 2019. There may have been obstetrics judgements rendered against physicians in those years, but they did not result in the judgment-ordered payment and presumably were negotiated down in subsequent settlement discussions or are still being negotiated or appealed with no payment yet made as of the last data of 2019.

It is also possible that there were judgments or settlements against hospitals which did not name physicians or other licensed practitioners and therefore were not reported. This should be rare since hospitals are required to report to the NPDB if a practitioner had any responsibility for the malpractice. It is unethical and potentially illegal for hospitals to require a plaintiff to remove named individuals from a suit, thereby protecting them from being reported, in order to negotiate a settlement.

The number of physician malpractice payments each year in Maryland varies, but has tended downward since 2010 and the fewest number of payments were reported in 2018 and 2019. It is also worth noting that 2018 and 2019 were also the years with the lowest total payments, with total payments of between $60,000,000 and $70,000,000. All the years except 2014 had totals under $100,000,000.

Based on my analysis of the data, I see no evidence of a medical malpractice "crisis" in Maryland for obstetrics or otherwise, as has been claimed. If recent data is indicative, there have been a downward trend in malpractice payments and lower total cost of payments in recent years.

If hospitals and others want to reduce malpractice payments, it would seem that a much more effective strategy would be to ensure the Maryland Board of Physicians has all the resources and legal authority it needs and to require the Board to take action when confronted with physicians who repeatedly have malpractice claims brought against them, especially if payments result. Maryland hospitals should also strongly be encouraged to ensure that peer reviewers take needed actions.

Malpractice isn't a chance or random event. Most physicians never have a malpractice payment. Having even one payment is unusual. The majority of Maryland physicians with obstetrics-related malpractice payments over the last 10 years had at least 2 malpractice payments, including non-obstetrics payments. One had as many as nine payments, most of which were non-obstetrics-related – but no actions against his license or clinical privileges. Only eight physicians in Maryland have worse malpractice records, yet no action has been taken against his license or clinical privileges. The licensing board and peer reviewers need to take action to protect the public from physicians with extremely bad malpractice records.

There are two ways to reduce malpractice payments – reduce malpractice injuries and deaths or cut compensation payments when people are injured or killed. The former is obviously the better solution. Policymakers should act to reduce malpractice-related injury and death rather than simply to cut compensation to injured patients. Reducing injury and death is a lot more important than saving money for malpractice insurance companies and their premium paying physicians and hospitals at the expense of not fully compensating injured victims for their injury.

Robert Oshel, Ph.D, retired as the Associate Director for Research and Disputes for the Division of the Practitioner Data Bank at the U.S. Department of Health and Human Services in 2008. While at HHS he designed the NPDB's Public Use Data File for research use. He can be reached at robert.oshel@gmail.com.

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PLEASE REPLY TO:
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March 2, 2020

Testimony of Michael W. Kessler in Opposition to the Enactment of **SB 879** to the Senate Finance Committee on Thursday, March 5, 2020

EXECUTIVE SUMMARY

- Because the Fund only applies to cases where liability and damages have already been *proven*, it has nothing to do with eliminating "frivolous" or unmeritorious claims.
- The Fund fails to provide for the care that has been proven in court to be required by birth injured children, and creates a bureaucratic quagmire for parents to try to get necessary care and services.
- The New York Fund has current *unfunded* liabilities of almost one billion dollars, and more than two billion dollars over the next eight years, with unfunded liabilities increasing by more than two hundred million dollars *per year* for the next ten years after that.
- There are serious constitutional and other questions of law about the legality of the Fund.

INTRODUCTION

My name is Michael Kessler and I am an attorney in New York State. It is my understanding that you are considering legislation modeled after the New York Medical Indemnity Fund (hereinafter the "Fund") created in 2011. The Fund legislation prohibits children who were injured by *proven* malpractice to recover costs of their care that was also proven and established in court, so that they and their families can make their own critical health care decisions under the guidance of their own physicians.

I am familiar with the proposed legislation before your committee and this legislative body. I have represented a number of the families of birth injured children in the New York Medical Indemnity Fund. In addition, because I have written extensively about the Fund,[1] dozens of families with children in the Fund have reached out to me for assistance in getting care that they require and were promised. Universally they describe the devastating impact that the New York Fund has had on the care provided to their children, and the quality of their lives. As someone who has significant knowledge of the New York Fund, its legal infirmities, how it works in practice, its extraordinarily high

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[1] Some of my writings on the New York Medical Indemnity Fund are attached to this submission. It is respectfully hoped that you will consider these materials in deciding whether to enact the very unfair, harmful, and costly proposal before you.

cost, and, most importantly, its harmful impact on the care that the children in the Fund actually receive, I have been asked to share that information with you as you consider this bill.

I am not a member of the Maryland Bar and have no cases pending in this state. However, when I learned that Maryland was considering legislation based on the New York Medical Indemnity Fund [Birth Injury Fund], I felt compelled to travel to Annapolis on my own time and at my own expense in order to help legislators better understand how harmful this legislative scheme has been to the families of catastrophically injured children in New York. I hope that you will not choose to follow the same tragic path taken in New York.

I understand that my time to speak to you is quite limited, so I have prepared these more complete written comments to supplement and give greater context to my testimony. I respectfully hope that you will make them part of the legislative record and consider these thoughts as you decide whether to follow the disastrous humanitarian and fiscal path that was undertaken in New York.

I know that others will speak to issues unique to Maryland, so I will limit my written comments to four key observations about the New York Fund, since our experience there serves as a warning about what will occur in Maryland should the proposed Legislation be enacted: (1) What does the Fund do, and how does it differ from other compensation schemes?; (2) What is the impact of the Fund on the rationing of care to these seriously disabled children?; (3) What effect the enormous insolvency of the Fund will have on those dependent on it for care, as well as on the taxpayers of New York?; and (4): What other fundamental legal issues are raised by the creation of the Fund?

1. **What Does the Fund Do and How Does it Differ from Other Compensation Schemes**?

It is critical to understand what the New York Fund model does, and how it changes the right to choose and pay for the extensive care that these catastrophically injured children need. It is equally important to understand what the Fund does *not* even purport to do.

There should be no misunderstanding: The Fund has absolutely nothing to do with practice weeding out "frivolous" or unmeritorious lawsuits. To the contrary, it *only* applies to those cases where the aggrieved family has *already proven* malpractice, the severity of the injury, and the need and cost of future care.[2] What the Fund does, however, is take those proven needs, and, at best, arbitrarily reduce the ability of families to choose and pay for care for these children. At its worst, it denies them much, if not all of the extensive care that they so critically need.

Under the Fund, the family of a catastrophically injured child has to hire a lawyer and go through all the steps, expense, and years of delay, to prove the malpractice that

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[2] It also applies to settlements, which by definition are only in situations where the health care providers agree to settle *because* they are concerned that they will be found negligent and will be ordered by a Court to pay even more after a trial.

caused their child's injury, and, among other things the nature and cost of their catastrophically injured child's future care needs. These include medical services and, more importantly, the cost of nursing or care aides when the child's parents or caregivers are unable to take care of the child, therapists, and special equipment.

After hearing all of the facts from both sides, the Court makes a determination, based on the evidence, as to the types and costs of care required, and how long it will be needed. Even then, this finding, based on evidence from expert physicians and rehabilitation specialists, is subject to reduction on appeal.

The system prior to the Fund, though perhaps not without flaws, was pretty fair in determining the nature and cost of the future care. It assured that the care necessary to maximize the brain injured child's quality of life was available, would be paid for, and, as described, there were, and are, numerous safeguards in place to protect the negligent doctor or hospital from "overpaying."

Under the Fund, however, the child's family still has to go through all of the steps described above. But now, instead of requiring the wrongdoer who caused the harm (or its insurance carrier) to pay the *actual* cost of providing care, the obligation to pay for future care is transferred to the Fund, and the *proven* wrongdoer's insurance carrier pays *nothing* for these expensive care costs.

If all that would occur when the law in New York changed, was to transfer the cost of needed future care to the Fund, there might have been no harm done to the child. But that's not what actually happened. Even though the cost of care and the need for it has already been established in Court, now the child and his family have to apply (beg) the Fund *to pay for the care that has already been determined by a physician to be medically necessary, vetted and determined by the Court to be essential.* As a result, a bureaucrat, who is not medically trained, without access to the expert testimony, and without the safeguards inherent in the fact-finding role of the Court, will now decide anew whether the previously determined essential care will be provided.

If the needed care is not approved by the Fund, the family has to go through another round of administrative hearings, in the hope of getting the care that they need *and which the Court already said was appropriate!* If the family's request for care is still denied, the family will be required to embark on yet another trip to Court to get what they have already previously established that their child needs.[3] There are, therefore, only two possibilities: (1) the child and his family gets exactly the same care as they would if the judgment was paid as required (in which case there is no cost saving to anyone -- plus the extra cost of administering the Fund); or (2) the child's care will be rationed and reduced by the Fund, which is exactly what is occurring in New York.

The Fund has taken health care decisions and the means to pay for them out of the hands of Courts, families, and their doctors -- even after they were proven and accepted by a Court -- and then places these critical life-altering decisions at the whim of a Fund bureaucrat who, because there are inadequate resources available to pay anticipated

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[3] *See* e.g. *Matter of Anson v. Zucker*, 162 A.D.3d 1179 (3d Dept. 2018) as an example of what families in New York must go through to get the care they need. This issue is discussed in more detail below.

claims, has every motivation to deny or reduce payments and services. Sadly, it is inevitable that children will suffer and even die because of this legislation.[4]

It should be noted that, unlike Maryland, New York State has no cap on non-economic damages. As a result, New York families are often compelled to use the money they have received for non-economic damages to pay for the *care* that their catastrophically injured child needs which should be paid by the Fund. This occurs because the Fund is unwilling to pay for the needed care that has already been proven in Court. Given the existence of the non-economic damage cap in Maryland, there will be insufficient funds to do even this, and the child will inevitably not receive the care required.

2. How Does the Fund Ration Care and Treat These Catastrophically Injured Children and their Families.

Because, as discussed in detail below, it is financially impossible to create adequate reserves to pay the benefits required (and actually judicially determined), there is no alternative but to deprive children of the care, services and equipment that they were found to require. [5]

Many, if not most of the children who sustained hypoxic brain injury at birth are severely neurologically impaired. Often, they are quadriplegic and require lifetime round-the-clock care, many times by highly skilled health professionals. Even with lesser impairments they usually require significant medical interventions and monitoring, physical, occupational, speech, aquatic, and other therapies, medications, specialized equipment, home modifications to accommodate wheel chairs, handicapped accessible vans, specialized transportation, and electronic equipment to communicate, among other things. The cost of caring for these severely impaired children routinely exceeds several hundred thousand dollars a year, and can be more than one million dollars per year.[6]

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[4] *See* e.g. Charlene Harrington et al., "Nursing Staff Levels and Medicaid Reimbursement Rates in Nursing Facilities, 42 HEALTH SERVICES RES. 1105, 1106–07 (2007). See Joanna Bisgaier & Karin V. Rhodes, Auditing Access to Specialty Care for Children with Public Insurance, 364 NEW ENG. J. MED. 2324, 2325, 2328 (2011) (describing a study which measures the impact of Medicaid coverage on the availability of medical specialty care). Danny Hakim & Russ Buettner, In State Care, 1,200 Deaths and Few Answers, N.Y. TIMES, Nov. 5, 2011, at A1, available at http://www.nytimes.com/2011/11/06/nyregion/at-statehomes-simple-tasks-and-fatal-results.html (describing a case of an individual drowning, because of an allegedly low staffing level due to inadequate funding).

[5] Indeed, if adequate reserves for the projected care cost liabilities were provided, there would be no savings at all.

[6] Already, in its short existence, the New York Fund has almost 50 enrollees who have been paid more than one million dollars in costs each. There are a number of enrollees whose *annual* cost is well into the hundreds of thousands of dollars, and, after a lengthy legal battle, one recipient is costing more than one million dollars *per year*. Since these costs are largely for required nursing care, the Fund's actuaries project that these costs will continue and increase in the future. As a result, as discussed below, the New York Fund will have more than two million dollars in unfunded liabilities over the next eight years. *Report to the New York New York Department of Financial Services, New York State Medical Indemnity Fund, 2nd Quarter 2019 Actuarial Analysis*, Pinnacle Actuarial Resources, August 2019. Excerpts of the report are attached, and the report can be found at: (https://www.dfs.ny.gov/system/files/documents/2019/09/mif_2nd_qtr_2019_report.pdf).

However, despite their proven care needs, many of the New York Fund's children receive no benefits whatsoever.[7]

I have dealt with a number of families who have been forced by law into the Fund instead of being able to collect their lawfully determined damages from the insurance carrier of the person who caused the harm. Without exception, and without prompting, every one of these parents uses the same word to describe their experience in trying to get the necessary services from the Fund: "*It's a nightmare*!"

One mother, whose experience is described below, told me that she devoted approximately 20 hours every week just battling with the Fund for services, and, although she eventually got some of what was needed, she had to use the portion of the child's own recovery for "pain and suffering" to pay for the medical services for which the Fund refused to pay. As noted above, this will not be an option for Maryland families given their statutorily limited recovery for "pain and suffering" damage.

The following is part of what this same mother wrote to the Ways and Means Committee Chair of the New York State Assembly last year. She understood firsthand how poorly the Fund had been treating her son and the families of other children forced into it. She was trying to do something about it. Make no mistake, if you choose to pass this ill-conceived and poorly thought out legislation in Maryland, you *will* hear from families who are denied needed care that they already won in Court and which they desperately need.

> "MIF [New York Medical Indemnity Fund] families have to constantly fight for every single item. Currently without an advocate, we juggle 24-hour caregiving with appeals and endless phone calls to claims. One Hundred percent (100%) of the time hiring a lawyer would cost more than the item we are fighting for.
>
> On June 14, 2017, the NYS Senate Health Committee held a Round Table for parents, attorneys and providers. I testified that fighting the MIF became a part time job. I am unusual MIF parent as I practiced law for a short time and know how to interpret government regulations. **Even with my background, I struggled.** Towards the end our construction appeal I had to hire a lawyer. I acted pro se for three years...How many other parents are also struggling, taking their children to the hospital, working full time, and spending any energy they have left fighting the MIF.
>
> **The MIF: A History of Abuse of Power**
>
> In the spring of 2016 during my request for environmental modification, the MIF **ordered** the independent evaluator, Accessible Options to **recommend nothing.** I got a call from the evaluator crying, as she did not

[7] Indeed, the Fund's actuaries highlight this point. However, recall that these were *all* children who were determined by a Court to have significant future care needs. The fact that many of these children are getting no services at all from the Fund, further underscores the hurdles that the New York Fund imposes on obtaining services.

> know what to do. I immediately filed a complaint with the Inspector General against the MIF administrator as this action was inappropriate.
>
> ...[T]he administrative judge awarded us 60% of our requested construction items. However, MIF refused to act and I was advised the only way to enforce the order was to file an Article 78 proceeding. It was at this point that the cost of the litigation in the NYS Supreme Court system would cost more than the construction....
>
> One of the benefits the MIF was looking to get rid of in the proposed regulations was recreational and therapeutic assistive technology. Since their attempt to amend the regulations failed, their current practice is to just outright deny items with no reasonable explanation....
>
> Since Luke was enrolled in the MIF in 2014, I had to fight for glasses, a handicapped rental van, dental bills, OTC laxatives, a wheelchair ramp, environmental modifications and most recently assistive technology." (Emphasis in original letter from Heidi Skau attached)

This is just one of dozens of similar experiences of families in the Fund. Many of them are forced to just give up and try to pay for services themselves. If they can't afford it, which is usually the case, the child must go without necessary services. As Ms. Skau notes in her letter, fighting with the Fund to get required care is an ongoing and time-consuming struggle, and "[o]ne Hundred percent (100%) of the time hiring a lawyer would cost more than the item we are fighting for."

Here are a few more examples of what these parents go through, many times to get even the most minimal care for children in the Fund:[8]

In the *Anson* case cited above, the child required a mechanical lift from his wheelchair to a pool for aquatic therapy. Both the therapy and the lift were ordered by his physician as medically necessary for continued home care, and the Fund conceded its medical necessity. Nevertheless, the Fund denied the lift, claiming that it "did not constitute a qualifying healthcare cost," and continued to deny it during an administrative appeal. The Fund arbitrarily determined instead that the child would have to go to a public pool a twenty minute drive away (which was only open one day a week). This public pool also lacked a lift and would have required two adults to be present to lift the child in and out of it. The family was forced to go to Court and, after three years of litigation -- and the legal costs associated therewith -- the Court ordered approval of the lift. The actions of the Fund demonstrate that, in practice, the Fund inevitably tries to unjustifiably ration care in the hope that families will simply give up.

A fifteen-year-old client of mine with a hypoxic brain injury, is functioning at the level of a five-year-old. He cannot be left unsupervised. Yet, the Fund refused payment for fencing and a security gate so that he could be allowed to safely be outside in his yard without an adult being present at all times to prevent him from wandering into the street.

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[8] Attached are comments to proposed New York Fund Regulations that I prepared on behalf of the New York Academy of Trial Lawyers and which describe in more detail both the roadblocks which the Fund imposes to getting services and the experiences of families trying to navigate them.

Many children with these disabilities are quite temperature sensitive, and require a constant environment within limited temperature ranges and oftentimes air filtration. For them, air conditioning is not a luxury but a medical necessity, and having it in a home helps prevent the need for institutionalization. Despite this, the New York Fund simply refused to pay for it because other family members may receive a collateral benefit. Similarly, many of the Fund children require constant access to electrically powered medical appliances, in some cases as a matter of life and death. Yet, one family whom I know was denied a backup generator to power life-critical equipment.

Another family who contacted me had a home with a small garage which would only fit a compact car. It would not fit a handicapped van, which the family required for their child's wheelchair. The Fund denied their request to increase the size of the garage to accommodate the van. Lacking the resources to make this basic logical and necessary accommodation, the family is required to stand outside to get the child and his wheelchair out of the van in the cold, rain, and snow. This unnecessarily exposes an already fragile child to the elements, and is dangerous. Similarly, another family was denied approval for a slight change to the grade of a driveway which, because of the length and configuration of the wheel chair van, was damaging its undercarriage and lift mechanism.

Yet another family was denied a wheelchair accessible path to enable access to the backyard, resulting in the child being stuck inside when at home. A recent decision by the Fund approved by the New York Commissioner of Health denied yard modifications necessary for wheelchair access, simply because they were outside.

The above examples are not merely anecdotal, but sadly are the norm of the life of a family who must rely upon the Fund for the care their child needs. Even when services are approved, the paperwork that the family is required to fill out to get them is overwhelming. Compounding matters further is that the rates of reimbursement make it impossible to find providers.

Providing care to a quadriplegic child is a twenty-four hour a day, seven day a week job. The level of burnout and stress on these families is enormous. The New York Fund arbitrarily restricts respite care to twenty hours a week, regardless of the child's actual needs. This adds to the difficulty of a parent's ability to be employed and imposes additional economic hardship on these families. Implicit in these care-rationing restrictions is the unfounded assumption that families alone have the unpaid responsibility to provide full time care, even to adult enrollees. As such, the child's primary caregiver is precluded from becoming employed to support themselves and their family. In addition, family members, including grandparents, aunts, and uncles -- the people, other than parents, who are most familiar with taking care of the disabled child's needs -- cannot be reimbursed for the time that they provide respite care for the child. Instead, the caregiver must find a stranger, with limited knowledge of caring for the child, who is available – often on short notice – and is willing to undertake this responsibility at the discounted reimbursement rate established by the Fund. Not even Medicaid imposes this restriction on close relatives providing paid respite services. Thus, not only are the number of hours of care limited by the Fund, but, because the reimbursement rates are so low, any caregiver which the family could find at those rates would unlikely have sufficient qualifications to safely care for the child.

Even to apply for equipment, modifications, or services, families must navigate a Byzantine process of contractors, estimates, physicians, and agencies. Many parents have told me that this process requires significant personal out-of-pocket expense. In addition, as Ms. Skau notes, it becomes essentially a job in itself. This is superimposed on the twenty-four hour care that the parents are providing. This extra time precludes them from attempting to supplement family income by being employed in any capacity.

One family who contacted me incurred the expense of a hiring a rehabilitation professional to prepare a detailed fifty-page report supporting their application for home modifications. Nevertheless, despite extensive documentation and proof of medical necessity, the Fund rejected the majority of the needed modifications.

These examples are hardly unique, but rather a consistent fact of life in dealing with the New York Fund. It is undeniable that in most instances the New York Fund is not providing the level of care, therapies, and equipment that these children had *proven* to require in Court, which, absent being forced into the Fund, they would have recovered from the malpractice insurance carrier of the wrongdoer who was *proven* to have caused their injury. Nor has the New York Fund even provided the care and services which its own enabling legislation and regulations require. Part of the reason for this is the nature of the Fund's bureaucracy. More critically, because the Fund is grossly under-reserved to pay for either the promised or necessary care, it has no choice but to dramatically ration and limit care, which is exactly what they have done.

3. The New York Fund Model is Actuarially Unsound, Grossly Underfunded, and Unsustainably Insolvent.

The New York Medical Indemnity Fund [Birth Injury Fund], and any legislation based on this model is structurally unsound, and destined to create massive and increasing unfunded liabilities both currently and over the next thirty years or more. The New York Fund is required to provide regular actuarial reports of its financial status. Excerpts of their most recent public report are attached hereto.[9]

Similar to what is proposed in Maryland, the New York Fund is supported by an increased tax on obstetric hospital services. This tax doesn't come close to funding either the financial obligations undertaken or the promises of future care made to children whose recoveries for such care were taken away from them by their legislators when the Fund was established. Even using the most wildly optimistic projections of payments, usage, medical cost inflation, and life expectancy, the New York Fund, after less than eight full years of existence, has currently amassed *unfunded* liabilities for future care of close to one billion-dollars discounted to present value. That means even under the best-case scenario, as of this moment, the New York Fund is obligated to pay one billion dollars more in in current benefits than it has the money to pay for. In undiscounted dollars, the *current unfunded* liabilities of the Fund are more than two billion dollars.

As bad as that is, the Fund is a ticking fiscal time bomb. This is because the number children in the Fund will continue to increase for the next twenty years. Thus, the

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9 https://www.dfs.ny.gov/system/files/documents/2019/09/mif_2nd_qtr_2019_report.pdf

unfunded liabilities alone–not the amounts to be paid, but the portion of the payments which are *unfunded*– is currently *increasing by than one hundred million dollars per year* in dollars discounted to present value. This deficit accelerates to increase by more than two hundred million dollars *per year of unfunded* liabilities over the next eight years. By 2028, the discounted *unfunded* liabilities will be $2.2 billion ($5.7 billion undiscounted) and will more than double again over the following ten years.[10]

Tragically, all of this was foreseeable at the time of the Fund's passage to anyone who was willing to actually think through the details and mechanism of how the Fund would be funded and operate. The New York legislature ignored the warnings that this insolvency would inevitably occur. Time has proven that predictions made at the time of its enactment regarding the Fund's inevitable insolvency and its inequitable and unjustified rationing of care to the children it was intended to provide for and protect, were true.[11]

The Fund is operated as a giant Ponzi scheme -- paying out current claims with the dollars it has on hand. Operating as it does, the Fund has no ability to reserve money for the future claims of its current recipients, let alone be able to fund the future obligations of the new, additional children who are forced into it each year. Sadly, this process will not start to level out for thirty years or more.[12]

There is a reason why states do not allow insurance companies to operate with unreserved commitments of billions of dollars.[13] Establishing a Fund for future care that does not have the means to fund its future obligations creates the inevitable need for taxpayer bailout and inequitable and unjustified rationing of care. Yet, that is exactly what is occurring in the New York Fund, and will inevitably occur in any other state that adopts this model. Sadly, there cannot, and will not, be a happy ending to this situation. It will inevitably result in more and more rationing of care, accompanied by eventual complete insolvency and abandonment or an enormous multi-billion dollar state bailout. The New York Fund is in a financial death spiral and will inevitably cease within the foreseeable future without a massive influx of funding. In the meantime, care will continue to be reduced, and eventually the children who are relying on it will be left without the services that they require and were promised.

4. Legal Infirmities of the Fund

It is beyond the scope of these comments to address all the legal and constitutional issues presented by the New York Medical Indemnity Fund, almost all of

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[10] Despite these critical and growing unfunded liabilities, and the fact that New York is receiving the proceeds from the new tax intended to finance the Fund, the New York Governor's 2020 budget makes *zero* appropriation for the Fund, instead pocketing the tax, and further undermining the Fund's insolvency.

[11] *See,* e.g., Kessler and Fahrenkopf, *The New York State Medical Indemnity Fund: Rewarding Tortfeasors Who Cause Birth Injuries by Rationing Care to Their Victims*; 22 Albany Law Journal of Science and Technology 173; http://www.albanylawjournal.org/Documents/Articles/22.2.173-Kessler-Fahrenkopf.pdf

[12] See Department of Financial Services Actuarial Report cited above.

[13] Even with their most optimistic actuarial assumptions, in order to make the Fund fiscally solvent, it would have to place in reserve the present value of all of the future care for each enrollee at the time of enrollment. Since this is at least the same amount as the Court had determined was necessary to provide care, there would be no cost savings under any actuarially stable Fund structure.

which remain unresolved. However, many of these constitutional issues will also be applicable to the proposed Maryland legislation. I am respectfully attaching for your consideration, my law review article which, in part, discusses these issues in more detail.[14] Some, but certainly not all of the Constitutional issues include

(a) Separation of Powers: The Fund interferes with the inherent judicial authority to enter judgment that conforms to the facts of the case as determined by the jury and accepted by the Court. Similarly, the Fund interferes with the Court's inherent judicial power to protect infant's rights and approve settlements in an infant's best interests.

(b) Jury Trial: The Fund infringes on the right of a party to have a jury determine his economic damages including care needs, and to enforce its findings under a judgment.

(c) Due Process: The Fund is an uncompensated taking of a property right to recover the cost of care and, at that, is not for a public purpose, but rather to relieve a private defendant from paying a private judgment.

(d) Equal Protection: The "Fund" improperly discriminates between the victims of obstetric malpractice and other victims of malpractice and other negligence.

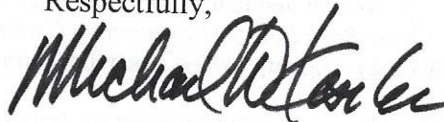
CONCLUSION

After representing dozens of parents of catastrophically impaired children, I can assure you that the last thing they think about before going to sleep each night, and the first thing that they think about each morning, is "how is my child going to be cared for, when I no longer can do so." Prior to the adoption of the Fund in New York, parents were able to rest a bit easier at night, knowing that the resources that they had proved their child needs would continue to be available to their child as long as needed. The adoption of the Fund in New York has robbed parents of that peace of mind, and turned the process of obtaining the care that their children require into an ongoing struggle.

The Hippocratic Oath mandates that the first obligation of a physician is to "do no harm." The creation of a Fund under the New York model does untoward harm to the most vulnerable children in society. It portends devastating consequences to children who have already been victimized by irresponsible medical care.

I hope that this information is helpful to you and I am happy to answer any questions that you might have.

Respectfully,



Michael W. Kessler

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[14] Kessler and Fahrenkopf, *supra.*

EXCERPTS FROM THE FUND ACTUARIAL REPORT

Report to the New York Department of Financial Services

New York State Medical Indemnity Fund

2nd Quarter 2019 Actuarial Analysis

As of June 30, 2019

August 2019

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Bloomington, IL 61704
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Commitment Beyond Numbers

Executive Summary

Based on our review of available information regarding the New York State Medical Indemnity Fund as of June 30, 2019, Pinnacle has arrived at a number of key conclusions:

- As of June 30, 2019, the Fund has accepted 629 participants (619 living) with expected future benefit payments of approximately $924.3 million and future administrative expenses of $186.3 million, assuming a discount rate of 2.0% and future medical inflation of 3.0%. With a Fund balance as of June 30, 2019 of approximately $229.4 million, this results in an unfunded liability for the Fund of approximately $881.2 million.
    - For the fiscal year prior to the impact of legislation signed on December 31 of 2016 (4/1/16-3/31/17, the 2016-17 fiscal year), the average benefit payments per participant were $12,310 per quarter for a total of $21.100 million paid in benefits during this fiscal year. Living participant counts increased from 400 to 455 over this period. See the Payments Per Participant Summary for more detail regarding these numbers.
    - On December 31, 2016, new legislation was signed expanding eligibility for the Fund to non-hospital births and significantly raising reimbursement rates for the period from July 1, 2017 through December 31, 2019. The period for these increased reimbursement rates was recently extended to December 31, 2020 as part of the recent New York State budget. For the most recent four quarters of the Fund (7/1/2018-6/30/2019), average benefit payments per participant were $17,199 per quarter, representing a 39.7% increase over the average payments in the 2016-17 fiscal year. Total benefits paid were $40.348 million for these four quarters, representing a 91.2% increase in payments over the 2016-17 fiscal period, while living participant counts increased from 556 to 619 over this period. Total annual benefit payments are anticipated to increase annually as more participants are added to the Fund.
    - Our analysis contemplates the "sunset" of the 2016 legislation expected to occur on December 31, 2020. Any legislative action to extend this sunset may have a significant impact on this analysis, similar to the impact of the recent extension noted in our report as of March 31, 2019.

- Total future lifetime benefits for the 619 living Fund participants without discounting is estimated to be $1.848 billion. See Exhibit 2, Page 2.
- The current present value of future benefit payments of $924.3 million does not consider any additional enrollees that may be admitted to the Fund in the future.
- Prior to the beginning of the fiscal year, the Fund was expected to have approximately eighty-four (84.40) additional participants accepted between March 31, 2019 and March 31, 2020. Historically, more participants are admitted in the first quarter of the fiscal year than in successive quarters of the fiscal year; we have incorporated this observation into our expected participant counts per quarter (see Exhibit 3).
  - There were twenty-five (25) new participants to the Fund in the first quarter of fiscal year 2019-20, approximately two (2) less than expected for this period at the beginning of the fiscal year but the largest group admitted since 2017 Q2. This difference is despite updated participant estimates evaluated at March 31, 2019. Prior to this quarter, new participant counts per quarter have varied between eleven (11) and twenty-nine (29) in the last two years.
  - The number of eligible participants is expected to continue increasing for at least thirty years as more eligible participants are admitted to the Fund each year.

- Actual benefit payments in the first quarter of the 2019-20 fiscal year (4/1/19-6/30/19) as of 6/30/19 were $10.605 million. This amount is $1.635 million lower than expected at the prior quarterly analysis. Based on modeled severities and an expected 57.39 additional participants, expected benefit payments in the remaining three quarters of the 2019-20 fiscal year are $39.310. Estimated total benefit payments for the 2019-20 fiscal year (4/1/19 – 3/31/20) are therefore $49.915 million. See Exhibit 3 for more detail regarding these numbers. It is important to recognize that these amounts can vary significantly each quarter due to the inherent uncertainty in benefit payments, the effect of the legislative change on payments, and the transition to a new third party claim administrator in the third quarter of the 2017-18 fiscal year.
- As of September 1, 2018, both the Fund's claims handling and enrollment services are now provided by Public Consulting Group (PCG) instead of Alicare. This change is ultimately

expected to decrease the administrative expenses of the Fund on a per month per member basis. Based on information from the Department, at the March 31, 2019 analysis we projected that $5.449 million would be spent in administrative costs for the 2019-20 fiscal year (see Exhibit 2, Page 1 of our report for 2019 Q1). This number was based on expected, not actual, participant counts. We expect the annual administrative expense to decrease on a per member basis over the next few years due to economies of scale.

- Exhibit 1 summarizes Fund payments by benefit type since 4th quarter of 2012. Compared to the Virginia Birth Related Neurological Injury Compensation Fund, another state-run birth injury fund serviced by Pinnacle, the Fund is having a substantially higher percentage of overall costs in medical and hospital costs, medical equipment and prescription drug costs, and corresponding lower percentages in nursing and long term care costs.
- As of June 30, 2019, thirty-eight (38) participants have received more than $1 million in benefit payments, with eight (8) of these participants receiving more than $2 million in benefit payments. Based on current annual severities by individual member, we expect eight (8) more members to cross the $1 million threshold in the next twelve months. These benefit payments do not include prescription amounts handled in bulk by vendors; see Exhibit 7, page 8 for total prescription drug payments handled in bulk.

Background

"The Medical Indemnity Fund was established in 2011 to provide a funding source for future health care costs associated with birth-related neurological injuries. Enrollees of the Fund are plaintiffs in medical malpractice actions who have received either court-approved settlements or judgments deeming the plaintiffs' neurological impairments to be birth-related."[1] More specifically, a "birth-related neurological injury" is "an injury to the brain or spinal cord...that occurred in the course of labor, delivery or resuscitation, or by the provision or non-provision of other medical services during

[1] Provided by NY DFS

New York Department of Financial Services
Quarterly Analysis of New York Medical Indemnity Fund
Future Fund Balances by Fiscal Year (000s) as of June 30, 2019
With 2.00% Discount

BALANCE SHEET	At 6/30/19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29
		Projections as of Fiscal Year-End									
Assets											
Fund Balance	229,353.9	242,042.5	241,765.6	259,511.4	273,355.2	282,771.8	287,492.6	287,196.0	281,523.6	270,292.0	253,175.8
Liabilities											
Future Benefits for Current Participants	924,274.7	983,620.0	1,078,392.6	1,197,499.4	1,320,902.8	1,448,182.3	1,578,810.8	1,711,909.0	1,847,701.6	1,985,366.9	2,125,013.0
Future Administrative Expenses	186,260.4	182,279.1	201,192.8	220,050.8	238,759.8	257,030.2	274,756.0	291,798.2	308,214.1	323,871.2	338,811.0
Surplus/(Unfunded Liability)	(881,181.2)	(923,856.6)	(1,037,819.9)	(1,158,038.8)	(1,286,307.5)	(1,422,440.7)	(1,566,074.2)	(1,716,511.2)	(1,874,392.2)	(2,038,946.2)	(2,210,648.2)

INCOME STATEMENT	At 6/30/19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29
Initial Fund Balance		229,353.9	242,042.5	241,765.6	259,511.4	273,355.2	282,771.8	287,492.6	287,196.0	281,523.6	270,292.0
Annual Funding		52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0
Investment Income @ 2.00%		4,152.4	4,275.3	4,448.3	4,761.1	4,991.4	5,131.3	5,175.1	5,116.0	4,948.7	4,668.0
Benefit Payments		39,310.0	50,957.5	32,804.1	36,560.0	40,345.6	44,256.1	48,341.4	52,632.0	56,949.0	61,431.0
Administrative Expenses		4,153.8	5,594.8	5,898.4	6,357.2	7,229.1	8,154.4	9,130.4	10,156.4	11,231.3	12,353.2
Final Fund Balance	229,353.9	242,042.5	241,765.6	259,511.4	273,355.2	282,771.8	287,492.6	287,196.0	281,523.6	270,292.0	253,175.8
Change in Fund Balance		12,688.6	(277.0)	17,745.8	13,843.8	9,416.6	4,720.9	(296.7)	(5,672.4)	(11,231.6)	(17,116.2)
Benefit Payments as % of Initial Fund Balance		17.1%	21.1%	13.6%	14.1%	14.8%	15.7%	16.8%	18.3%	20.2%	22.7%
Number of Participants											
Initial		619	673	754	836	918	1,000	1,080	1,158	1,235	1,309
Expected New		57	86	88	89	91	91	91	92	91	91
Expected Deceased		4	5	6	8	9	11	13	15	17	20
Final	619	673	754	836	918	1,000	1,080	1,158	1,235	1,309	1,381

Notes

Balance Sheet - Assets	Calculated in Income Statement
Balance Sheet - Liabilities	Future Benefits from Exhibit 5, Pages 4-6 discounted to current evaluation
	Future Expenses based on current administrative costs
Balance Sheet - Surplus	= Assets - Liabilities
Income Statement - Initial Fund Balance	= Final Fund Balance of prior period
Income Statement - Annual Funding	Provided by MIF
Income Statement - Investment Income	Calculated based on 2.0% assumed investment return and assuming average date of benefit and expense payments is the middle of the fiscal period
Income Statement - Benefit Payments	From Exhibit 5, Pages 1-3
Income Statement - Admin Expenses	Calculated based on current and projected participant counts and administrative expense contracts provided by MIF
Income Statement - Final Fund Balance	= Initial Fund Balance + Annual Funding + Investment Income - Benefit Payments - Administrative Expenses
Income Statement - Change in Fund Balance	= Final Fund Balance - Initial Fund Balance
Income Statement - Benefit Payments as % of Initial Fund Balance	= Benefit Payments / Initial Fund Balance
Income Statement - Number of Participants	Initial from Exhibit 7
	Expected New from Exhibit 3
	Expected Deceased based on assumed increasing rate of deaths for current participants, up to 1.5%
	Final = Initial + Expected New - Expected Deceased

New York Department of Financial Services

Quarterly Analysis of New York Medical Indemnity Fund
Future Fund Balances by Fiscal Year (000s) as of June 30, 2019
Undiscounted

BALANCE SHEET

	At 6/30/19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29
		Projections as of Fiscal Year-End									
Assets											
Fund Balance	229,353.9	237,890.1	233,337.8	246,635.3	255,718.0	260,143.3	259,732.8	254,261.0	243,472.6	227,292.4	205,508.1
Liabilities											
Future Benefits for Current Participants	1,847,766.5	2,010,887.2	2,266,731.2	2,562,261.2	2,877,398.3	3,211,877.7	3,565,253.2	3,936,267.9	4,326,264.4	4,733,853.2	5,160,045.9
Future Administrative Expenses	352,907.0	348,925.8	392,138.0	436,319.6	481,408.3	526,974.4	572,779.6	618,494.4	664,212.9	709,595.4	754,691.3
Surplus/(Unfunded Liability)	(1,971,319.6)	(2,121,922.9)	(2,425,531.5)	(2,751,945.5)	(3,103,088.5)	(3,478,708.8)	(3,878,300.0)	(4,300,501.3)	(4,747,004.6)	(5,216,156.28)	(5,709,229.04)

INCOME STATEMENT

	At 6/30/19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29
Initial Fund Balance		229,353.9	237,890.1	233,337.8	246,635.3	255,718.0	260,143.3	259,732.8	254,261.0	243,472.6	227,292.4
Annual Funding		52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0	52,000.0
Benefit Payments		39,310.0	50,957.5	32,804.1	36,560.0	40,345.6	44,256.1	48,341.4	52,632.0	56,949.0	61,431.0
Administrative Expenses		4,153.8	5,594.8	5,898.4	6,357.2	7,229.1	8,154.4	9,130.4	10,156.4	11,231.3	12,353.2
Final Fund Balance*	229,353.9	237,890.1	233,337.8	246,635.3	255,718.0	260,143.3	259,732.8	254,261.0	243,472.6	227,292.4	205,508.1
Change in Fund Balance		8,536.2	(4,552.3)	13,297.5	9,082.7	4,425.3	(410.5)	(5,471.8)	(10,788.4)	(16,180.3)	(21,784.2)
Benefit Payments as % of Initial Fund Balance		17.1%	21.4%	14.1%	14.8%	15.8%	17.0%	18.6%	20.7%	23.4%	27.0%
Number of Participants											
Initial		619	673	754	836	918	1,000	1,080	1,158	1,235	1,309
Expected New		57	86	88	89	91	91	91	92	91	91
Expected Deceased		4	5	6	8	9	11	13	15	17	20
Final	619	673	754	836	918	1,000	1,080	1,158	1,235	1,309	1,381

Notes

Balance Sheet - Assets	Calculated in Income Statement
Balance Sheet - Liabilities	Future Benefits from Exhibit 5, Pages 1-3 discounted to current evaluation Future Expenses based on current administrative costs
Balance Sheet - Surplus	= Assets - Liabilities
Income Statement - Initial Fund Balance	= Final Fund Balance of prior period
Income Statement - Annual Funding	Provided by MIF
Income Statement - Benefit Payments	From Exhibit 5, Pages 1-3
Income Statement - Admin Expenses	Calculated based on current and projected participant counts and administrative expense contracts provided by MIF
Income Statement - Final Fund Balance	= Initial Fund Balance + Annual Funding - Benefit Payments - Administrative Expenses
Income Statement - Change in Fund Balance	= Final Fund Balance - Initial Fund Balance
Income Statement - Benefit Payments as % of Initial Fund Balance	= Benefit Payments / Initial Fund Balance
Income Statement - Number of Participants	Initial from Exhibit 7 Expected New from Exhibit 3 Expected Deceased based on assumed increasing rate of deaths for current participants, up to 1.5% Final = Initial + Expected New - Expected Deceased

New York State Academy of Trial Lawyers

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Comments on The New York Medical Indemnity Fund Proposed Amended Regulations

Introduction

On behalf of the NYS Academy of Trial Lawyers and myself, I am writing to comment on the proposed amendments to the New York Medical Indemnity Fund and urge that these proposed regulations be withdrawn. I am a practicing attorney, and I have studied both the Fund and its regulations. A number of families who have children in the Fund have shared their experiences with me, and therefore I am very familiar with how the Fund operates and how it has treated families since its inception. In 2012, I co-authored a law review article which extensively analyzed the Fund's enabling legislation, as well as what, at that time, were the "Emergency Regulations" under which it was operating.[1] Unfortunately, shortcomings of the Fund, and the difficulties it would impose on these severely disabled children which were predicted in that article, have been more than borne out. The Fund has made life unnecessarily difficult for these families–especially when compared to the compensation that was taken from them to create the Fund. It is respectfully submitted that the currently proposed amendments to the Fund regulations–by further unnecessarily restricting access to care and refusing to approve necessities which would provide therapeutic benefit and improve the quality of life of these severely injured children--will

[1]Kessler and Fahrenkopf, *The New York State Medical Indemnity Fund: Rewarding Tortfeasors Who Cause Birth Injuries by Rationing Care to Their Victims*; 22 Albany Law Journal of Science and Technology 173; http://www.albanylawjournal.org/Documents/Articles/22.2.173-Kessler-Fahrenkopf.pdf

make a bad situation even worse for the families who have been forced into obtaining services from the Fund.

The more than three hundred children now enrolled in the fund require extensive care, equipment, and services, and the effort required by their families to maintain these children twenty-four hours a day is already enormous. These families deserve our support to make their lives easier-- especially since they were forced by law to give up the compensation which would have enabled them to obtain the services themselves-- instead creating more obstacles to get the Fund to pay for necessary services and equipment. The proposed amendments to the regulations will make it more difficult to get the care that the children in the fund were promised, and to which they are entitled.

Because I have written about the Fund,[2] I am regularly contacted by parents of children who suffered neurologic impairment at birth, concerning their experiences in attempting to get the medical care, equipment and services that their children require to maintain their health and improve their quality of life. Based on my conversations with a number of parents, not only is the Fund depriving these children of what they need, but the hurdles imposed by the Fund and the effort required by these families to get even basic services is overwhelming. It is not an exaggeration to say that – without exception – every parent of a Fund child with whom I have spoken over the last several years has used the same one word to describe their Fund experience.

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[2] See e.g.
http://www.rrkslaw.com/Articles-Appearances/Obamacare-and-the-New-York-Medical-Indemnity-Fund-Where-is-the-Outrage-over-Rationing-Care-to-Innocent-Children-Injured-by-Negligent-Doctors-and-Hospitals/
http://www.disabled-world.com/news/america/newyork/indemnity-fund.php
http://www.rrkslaw.com/Articles-Appearances/Disabled-Individuals-Cared-For-by-New-York-State-A-Preview-of-Care-under-The-New-York-State-Medical-Indemnity-Fund/
http://www.rrkslaw.com/articles-appearances/new-yorks-death-panel-lottery-for-children-injured-by-medical-malpractice-at-birth/
http://www.rrkslaw.com/Articles-Appearances/The-Double-Secret-New-York-Medical-Indemnity-Fund-Where-is-the-Information-About-Fund-Operations-and-Where-are-the-Hearings-and-the-Fund-Regulations/
http://www.rrkslaw.com/Articles-Appearances/Challenging-The-New-York-Medical-Indemnity-Fund/

Each one of them calls it a "nightmare."

The new proposed regulations will unfortunately further restrict the care and equipment that these children will receive, lower the amount that the Fund will pay for services, and make the process to obtain equipment and improve handicapped accessibility even more burdensome than it is already. This Memorandum will briefly explore the impact of some of the proposed amendments.

Background

In addressing the impact of the proposed Fund regulation amendments it is important to recall why the Fund was created and what it was promoted to do by its advocates and, indeed, what persons not familiar with its day to day operations may believe that it is accomplishing.[3] Unlike, for example, workers compensation, which applies to all workers injured on the job without regard to the fault of the employer, the Fund is *not* universal to all children who suffered a neurologic injury at birth. To the contrary, the Fund *only* applies to that small number of children who were injured at birth *as the result of the proven medical malpractice* by a doctor or hospital. In order for the Fund to apply, these children must go through all the steps of malpractice litigation, and then *only* after they have either proven and obtained a verdict and judgment against a defendant confirming the deviations from accepted care *and* that such malpractice caused the neurologic injury, or they have convinced a defendant to settle their malpractice claim, does the Fund apply.

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[3] Among the promoted purposes of the Fund when it was enacted was the hope that it would reduce medical malpractice insurance costs by prohibiting children injured at birth from recovering damages for the cost of future care from the hospital or doctor who caused the injury that required care. Whether or not the reduction in medical malpractice insurance costs has been achieved is questionable, but well beyond the scope of these comments. However, one consequence of the Fund is indisputable: Assuming that the cost of future care for birth injured children is reduced by the Fund paying for it instead of the charging the negligent party who caused the injury, that cost reduction can *only* occur by either limiting (rationing) the amount of care, equipment and services that the child receives, or reducing the amount paid for it–which limits access to qualified providers-- or both. Unfortunately, that is exactly what has happened and the situation will be exacerbated by the proposed amendments to the regulations.

At that point, even after obtaining a verdict against the negligent defendant which establishes what future care is required and provides for a sum of money to be paid in installments into a trust to provide for the child's future care needs, the defendant's obligation to pay for that amount is extinguished, and the child is forced into the Fund which, using taxpayer money, is supposed to pay for his or her care.

Thus, even with a judgment against a defendant to compensate the child for the cost of future care, the child receives absolutely no compensation for this proven loss. Nor does the defendant pay any money into the Fund. This scheme is unique among any other malpractice or other tort victim in New York and, indeed, to my knowledge, any tort victim in the United States. It takes away an otherwise enforceable judgment against a defendant after it has been rendered, and in its place requires enrollment in the Fund which is supposed to pay for future care needs. The Fund is not bound by the Court determination of the amount required for future care or the services that the Court had found were required for the child's well-being. Rather, the child must get the Fund to approve the services that it will pay for under a time-consuming and burdensome administrative process. And, if the Fund denies a service, the appeals process is not only difficult and weighted against the child, but time-consuming and expensive. After enduring a successful malpractice litigation, these families are forced into a lifetime of haggling and/or litigating against the Fund, to recover a portion of what was decided necessary in their lawsuit against the tortfeasor.

It would seem that depriving a person of the right to collect a judgment would create a serious constitutional question concerning the taking of a property right,[4] especially, as has proven to be the case, the Fund is not an adequate replacement for the right to the enforce the judgment that has been destroyed by statute. Having been created and promoted as a substitute to provide the

[4] There are a number of other serious constitutional issues raised by the Fund. See, Kessler and Fahrenkopf, *The New York State Medical Indemnity Fund: Rewarding Tortfeasors Who Cause Birth Injuries by Rationing Care to Their Victims*; 22 Albany Law Journal of Science and Technology 173 (2012).

care that would have been paid for by the judgment that has been taken away, it would seem that the Fund's (New York State's) obligation to pay for care should be interpreted in the light most favorable to the child's needs. It would appear that such was the Legislative intent. Indeed, the Regulatory Impact Statement of the Department of Health at the time that the initial Fund regulations were proposed stated that "subdivision 3 of section 2999-h of the PHL sets forth a broad definition of "qualifying health care costs" for services and supplies" and gives the Commissioner of Health authority to further "define" such "qualifying health care costs" by regulation. It does not give the Commissioner the right by regulation to significantly *restrict* such broad definition of "qualifying services." Unfortunately, however, not only do the current regulations fail to comply with what should be the "broad" definition of the services which the Fund will provide, but the proposed amendments create even more onerous restrictions. They further limit care and equipment, and increase the burden on the families of Fund children. As such, they are inconsistent with the purpose of the legislation that created the Fund.

The Proposed Amended Regulations

Based on my conversations with families, their experiences with the Fund has been universally frustrating and unpleasant. It must be kept in mind that taking care of a severely disabled child with cerebral palsy, as most of the Fund enrollees are, is a full time job, even if nursing or respite care is available. The Fund has made the process by which it processes and evaluates requests for services into a maze which even highly educated and sophisticated parents cannot navigate successfully. For less sophisticated caregivers, the Fund has made the process nearly impossible.

The burden of constant applications, requests, compliance, documentation, Fund denials, resubmissions, and appeals makes the already challenging lives of these families even more

difficult – and that is when the family is successful in obtaining the requested services. When they are not, these children are forced to go without. One mother told me recently that dealing with the Fund consumes upwards of twenty hours of her time a week, or more.

By its own Regulations (§69.10-4 (3)-(8)), the Fund is required to provide a "case manager" who is required to establish a "comprehensive case management plan to assist the enrollee to manage all qualifying health services needed by the enrollee…"to assist... the enrollee... to obtain the services set forth in the... plan," and to "assist... the enrollee with any forms necessary." None of the families with whom I have spoken have *ever* received such a plan, or gotten the required assistance. The "case managers" are geographically remote, usually located out of New York State, and have never even seen or otherwise evaluated the child whose care they are supposed to be coordinating. Rather than acting as a "case manager" advocating for necessary care and finding it, their role appears to be to serve as a gate keeper to restrict care and save money.[5] Indeed, at least one parent quoted their case manager as saying that she was specifically told that keeping her job was dependent on denying their application for a requested item of care. So these families are left on their own to find caregivers, equipment, and contractors. Their experience with the Fund consists of begging for services or approvals, and fighting denials. They must contend with an army of Fund and Health Department employees who seek to limit the services that these families receive.

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[5] The Case Management Society of America's Standards of Practice requires "recognition" that a case manager's "primary responsibility is to his/her clients," and also that "[t]he case manager should advocate for the client at the service-delivery, benefits-administration and policy-making levels."
http://www.cmsa.org/portals/0/pdf/memberonly/StandardsOfPractice.pdf)

Similarly the Commission for Case Management Certification requires that "[c]ase managers' first duty is to their clients – coordinating care that is safe, timely, effective, efficient, equitable, and client-centered."
http://stage.cmbodyofknowledge.com/content/case-management-knowledge-2

The "case managers" employed by the Fund do not appear to be acting in accordance with these well-established ethical requirements for professional case managers.

The current Regulations are far more restrictive in providing services and equipment than could have been envisioned when the Fund was created by the Legislature. Unfortunately, the proposed amendments make the situation worse. Here are some examples.

Assistive Technology

Although the description of the amendment to what constitutes "assistive technology" (§69-10 (b)) euphemistically asserts that it is to "clarify" which items will be covered by the Fund, the true impact is to severely limit what they will provide. Under the current regulations an assistive device will be paid for if it is "determined necessary by a physician for purposes of... *habilitation, ability to function, or safety* in his or her current or desired residence." The amended regulation, in contrast, now allows a device *only* if it "is essential for activities of daily living" and now specifically *excludes* anything that is used for recreational or therapeutic purposes. Moreover, under the amended regulations, the Fund will not approve anything that is not designed specifically for a person with a disability or which would be useful in the absence of an injury.

The scope of this proposed restriction is breathtaking. *A severely disabled child will now no longer be entitled to obtain equipment which provides therapy or recreation to her.* So, for example, under this definition, a child who cannot play with traditional toys is prevented from getting special switch operated toys designed for the handicapped, and which are necessary for both therapeutic purposes (switch activation for controlling her environment) as well as enjoyment.

One mother recently told me that her son is able to activate toys only though special sensory switches. These "toys" provide occupational therapy to improve function so that someday he may be able to use learning and recreational toys independently, and thereby improve his ability to control his environment. The proposed amended regulations will not cover these assistive

devices because they are therapeutic and recreational in nature, and not essential for activities of daily living. Similarly, this same child requires a Bluetooth switch that can used to access an iPad with special needs applications. Since the Bluetooth device is for therapeutic and/or recreational purposes, and is not specifically designed for a disabled person – and, even though the applications are designed for the disabled – the switch would not qualify under the amended Fund regulations.

Environmental Modifications

Similarly, the asserted purpose to the proposed amendment to home modifications is to "clarify" what items will be approved. In fact, the purpose is to exclude significant categories of home modifications, and also to limit the purposes for which modifications will be provided by the Fund.

The current regulations (§69-10.1(m)) define an "environmental modification" as an "interior or exterior physical adaptation to the residence where the enrollee lives that is necessary to insure [his] health welfare, and safety... [and] enables him... to *function with greater independence in the community and/or helps avoid institutionalization..."* The proposed amended regulation eliminates "function with greater independence in the community" as a legitimate purpose of home modification. Instead, they seek to limit modifications for the benefit of these children *only to those that enable "activities of daily living."*[6] Therefore, home modifications to allow access to recreation, those that are therapeutic, or which enhance quality of life, are excluded.

[6] Activities of daily living are limited to " basic self care tasks such as dressing and undressing, self feeding, bowel and bladder management, ambulation... communication... functional transfers... and personal hygiene and grooming." (§69-10.1 (a)). Thus anything that is therapeutic, improves function, or quality of life, or is recreational, therefore, is not for an activity of daily living, and therefore prohibited.

The proposed regulations prohibit any modification that adds square footage or even renovations to an existing home if its purpose is for "providing therapy." The list of items that are *not* covered under the proposed amended regulations, even if they are important, include elevators (even if that is the only means of accessing the home); intercoms (even if that is the only method of communication from a child who is not mobile); fencing and security gates; and even bathtubs necessary for aqua therapy.

One quadriplegic cerebral palsy child's family requested but was denied a large inside bathtub in order to provide aqua therapy which was ordered by a physician as essential to moving the child's otherwise immobile limbs. The only alternative source of providing the required aqua therapy was at a rehabilitation center many miles away, and was only available during school hours. This would have required pulling the child out of school frequently, driving many miles, undressing him and redressing him (no simple task with a child with this disability) and then returning him to school. The Fund would presumably pay for the aqua therapy sessions – at a much greater ongoing cost than proving a tub – but not for the tub itself, which not only would have saved money but improved the child's education and quality of life, and decreased the challenges to his caregiver.

A client of mine has a hypoxic brain injury, and though almost fifteen years old, is functioning at the level of a five year old. He cannot be left unsupervised. Yet, the proposed amended regulations will prohibit payment for fencing and a security gate so that he could be allowed to safely play outside in his yard without an adult being present at all times to prevent him from wandering into the street.

Many children with these disabilities are quite temperature sensitive, and require a constant environment within limited temperature ranges and often times air filtration. For them air

conditioning is not a luxury but a medical necessity, and having it in a home may prevent the need for institutionalization. Yet the proposed regulations prohibit this item. Similarly, many of the Fund children require constant access to electrically powered medical appliances, in some cases as a matter of life and death. Yet the proposed amended regulations prohibit upgrades to a home's electrical system unless it is *solely* to provide power to these medical devices. One family whom I know was denied a backup generator to power life critical equipment because it would have served the entire house. Apparently to the Fund, the child's equipment are not allowed to move within the house, or a separate circuit for his equipment could be added and his caregivers would be required to try care for him in the dark even if the equipment remained functional.

The proposed amended regulations also prohibit adding square footage to an existing home. One family who contacted me had a home with a small garage which would only fit a compact car. It would not fit a handicapped van, which the family required for their child's wheelchair. The Fund denied their request to increase the size of the garage to accommodate the van. This requires the family to stand outside to get the child and his wheelchair out of the van in the cold, rain or snow, and expose him to the elements.

Caring for a quadriplegic child requires an enormous amount of specialized and sometimes bulky equipment to keep them functioning. Even if the Fund may pay for the necessary equipment, many of these families have no place put it. Yet the proposed amendments – even where square footage is not increased – *prohibit "renovation of existing rooms... for the purpose of providing therapy, training, education or storage.*" Under the proposed amendments, therefore, a family cannot increase the square footage of an existing residence to provide for room for necessary therapy, training, education and storage, yet neither can they make renovations to that existing structure to provide for such necessities. I have seen many "dining rooms" that are no longer

usable by the family because they have become only the storage place available for such essential equipment.

Another family whom I know was denied a wheelchair accessible path to enable access to the backyard, resulting in the child being stuck inside when at home. A recent decision by the Fund–approved by the Commissioner of Health denied yard modifications necessary for wheelchair access, simply because they were outside. The current regulations (§ 69-10.1 (m) defines an "environmental modification" as

> an interior or *exterior* physical adaptation *to the residence in which an enrollee lives* that is necessary to ensure the health, welfare, and safety of the enrollee, *enables him or her to function with greater independence in the community....* (emphasis added)

Unbelievably, the "exterior" modifications that "enable[d]...her to function with greater independence in the community" was denied by the Fund, and the denial was approved by the Commissioner of Health. In the decision denying the wheelchair accessibility they wrote that modifications are limited

> "to the residence *in which* the enrollee lives. *The enrollee does not reside in her backyard. Her residence is her house.*" (emphasis added)

The proposed amendments to the regulations seek to codify this tortured interpretation and thereby cruelly prevent those home modifications to enable use of the exterior of a home by a disabled child.

The proposed amendments also prohibit modifications to the basement of a home – and even modifications to provide *access* to a basement unless "such access is necessary for an enrollee for an activity of daily living..." Apparently the Fund does not consider therapy or recreation, or simply being able to access the entire house to be with the rest of the family to watch TV or engage in other activities, to be very important. The enrollee will simply not have access to

the entire premises under the proposed amended Fund regulations.

Respite Care

Providing care to a quadriplegic child is a twenty four hour a day – seven day a week job. The level of burnout and stress on these families is enormous. Although the Fund does recognize respite care as appropriate, the proposed regulations place new and unreasonable restrictions on it. Respite care is limited to twenty hours per week (1,080 hours per year). However, the proposed regulations eliminate the possibility of respite care for "substitute care... because the caregiver [parent] is not at home because of work or school." This adds to the difficulty of the parent to become employed and imposes an additional significant economic hardship on these families. Implicit in the regulations is the unfounded assumption that families alone have the unpaid responsibility to provide full time care even to adult enrollees, and that a primary caregiver is precluded from becoming employed to support themselves or their family.

In addition, the proposed amendments provide that "respite care may not be provided by a relative or member of the household." Thus, family members – grandparents, aunts, uncles – the people other than parents who are most familiar with taking care of the disabled child's needs – cannot be paid for respite care. Instead, the caregiver must find a stranger, with limited knowledge of caring for the child, who is available – often on short notice – and willing to undertake this responsibility for the Medicaid rate of reimbursement. (See below). It is my understanding that even Medicaid does not impose this restriction on close relatives providing paid respite services.

Exterior Physical Adaptation

A new definition is proposed for "exterior physical adaptation" which is authorized only if it is to provide two accessible entrances to the premises. The new regulation excludes coverage, among many other things, to "modifications to an existing driveway... or improvement of a

walkway that is not necessary for entrance into or exit from the home." This language appears to seek to codify the unreasonable determination described above whereby it was found that because a child "does not reside in the backyard," she cannot get modifications to enable her access to it.

One family who contacted me had requested approval for a slight change to the grade of a driveway – which because of the length and configuration of the wheel chair van – was damaging its undercarriage and lift mechanism. This would be prohibited under the proposed amendments. As noted above the family who requested alterations to an exterior backyard walkway to make it wheelchair accessible so that the child could utilize the backyard with the rest of the family would be prohibited under the proposed amendments.

Approval of Home Modifications and Assistive Technology

In addition to the already extensive process for Fund approval of home modifications or assistive technology, the proposed amendments create an entire new level of complexity that almost no parent – much less a parent who is providing care to a severely disabled child twenty four hours a day – could navigate by themselves. The process requires hours of time and extensive consultation with professionals – architects, rehabilitation professionals, and construction contractors – in order to even apply for these services, often at great personal expense to the parents of these children. One family who contacted me submitted a detailed fifty page report from a rehabilitation professional to support their application for home modifications, only to see it largely rejected. Another family told me that they have had to retain a rehabilitation professional at their own expense to prepare their application. The process needs to be simplified, not made more challenging, and the Fund needs to provide help in getting these services – as it is required to do by its own regulations (§69-10.4) – instead of imposing more roadblocks.

Rates of Payment

This is a critical issue which has a significant impact on the health and well-being of children in the Fund. The statute creating the Fund (PHL §2999-j) specifically provides that private physicians shall be paid at one hundred percent of the "usual and customary rates." Yet the regulations and the proposed amendments provide for physician payments at the "eightieth percentile of the usual and customary rates for private physician services." I do not understand how this is consistent with the statute. I have had families tell me that their regular physicians will not accept these rates and thus their children's access to medical care is compromised.

Even more concerning is the rate of payment for other than physician services at the "Medicaid rate." Even when nursing care is approved, for example, it is almost impossible to get qualified providers to work at Medicaid rates. One family told me, for example, that they are approved for care aides by Medicaid forty-four hours per week and extra seven hours per day while their child is not in school. At the Medicaid rate of $11.99 per hour, they are fortunate to get aides for twenty hours a week. Because of the child's care needs, the aides need a nursing or special needs background and they cannot just hire a babysitter. The otherwise approved hours are left unfilled. Many other families on have shared similar experiences. By precluding a "relative" from providing paid respite services, the proposed amended regulations exacerbate this situation.

The same is true of other services. For example, I was contacted by the family of a child who, for a number of medical necessity reasons, required various enhancements to his eyeglasses at a cost of almost $250.00, which his mother paid out-of-pocket. She was initially reimbursed at the Medicaid rate of $16.00 before complaining and was eventually being reimbursed the cost.

Nor do the unreasonably low rates of pay to providers merely limit the services that these children can get. They have the significant potential to adversely impact their health and even longevity. Even if the plaintiff is fortunate enough to acquire providers at Medicaid rates, then the issue is whether the quality of care would be sufficient for the plaintiff's needs. A number of studies and articles confirm the fear that Medicaid rates will compromise access to the care that these vulnerable children (and adults) require. A 2011 study published in the *New England Journal of Medicine* established that Medicaid patients (the equivalent of Fund enrollees, since reimbursement for most services are at Medicaid rates) experienced significant delays in getting appointments with medical subspecialists as compared to private pay or private insurance company patients. The delay in getting appointments was about twice as long—an average of forty-two days under Medicaid—compared to twenty days with private insurance. [7]

When care is restricted and inadequate there is legitimate concern that these children may suffer unnecessarily, and likely die prematurely.[8] It is hardly surprising therefore, that investigative reporting discovered that borne out by developmentally disabled individuals. The *New York Times* article cited describes a number of unexplained deaths and other injuries to disabled individuals in state facilities, most of which apparently related to poor care, such as choking and drowning. The *Times* reported "the average age of those who died [from] unknown causes was 40, while the average age of residents dying of natural causes was 54." The State Commission on Quality of Care and Advocacy for Persons with Disabilities found that there had been "concerns about the quality of care in nearly half" of the unexplained deaths. The

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[7] Bisgaier & Rhodes, "Auditing Access to Specialty Care for Children with Public Insurance," 364 *New Eng. J. Med.* 2324, 2325, 2328 (2011); Harrington et al., "Nursing Staff Levels and Medicaid Reimbursement Rates in Nursing Facilities," 42 *Health Services Res.* 1105, 1106–07 (2007).

[8] *See e.g.* Kessler, "Critical Analysis of the Life Expectancy Research from an Attorney's Perspective," in *Pediatric Life Care Planning and Case Management,* (797–799) (Susan Riddick-Grisham ed., 2004); Hakim & Buettner, "In State Care, 1,200 Deaths and Few Answers," *New York Times*, Nov. 5, 2011, at A1, available at http://www.nytimes.com/2011/11/06/nyregion/at-state-homes-simple-tasks-and-fatal-results.html

"unexplained" death rate for individuals cared for by the State of New York was more than four times higher than the rate in Massachusetts and Connecticut.

Thus even if the Fund were to approve nursing care for a certain number of hours, as noted, it is likely that the family would be unable to find nursing staff who would be willing to work in the home at those rates or on all shifts. The same is true with necessary equipment, and certain providers, particularly those who provide more expensive or higher quality equipment, may refuse to provide their goods at Medicaid rates–all of which has the significant potential to compromise the health and well-being of these children and their caregivers.

Cost to Regulated Parties

The proposed amended regulations assert that "there are no costs to regulated parties by these regulations. Qualified plaintiffs will not incur any costs in connection with applying for enrollment in the Fund or coverage by the Fund." That statement is simply untrue. Even a cursory review of the regulations as they exist presently – and made worse by the proposed amendments reveal there are tremendous costs to families – both out- of-pocket and in the time and energy expended to try to obtain benefits. One mother estimated to me recently that, in addition to providing full time care to her child, she spent on average more than twenty hours a week dealing with Fund issues, making it impossible for her to get even a part time job. Based on my discussions with a number of families, this mother is not unique, and who knows how many families just give up because of the difficulties in getting services and payment from the Fund. If a family appeals the Fund's denial of a service or item, they incur significant cost in time and likely require legal counsel at significant expense in order to pursue the appeal. The appeals process is anything but user friendly and the Fund families consider it so stacked in favor of denials that they often just give up rather than pursuing an appeal.

Consumer Advisory Committee

The Fund enabling statute (PHL §2999-j (16) requires the Commissioner to "convene a consumer advisory committee for the purpose of providing information, as requested by the commissioner, in the development of the [Fund] regulations..." I do not know if such a consumer advisory committee exists and, if so, who serves on it, or whether the Commissioner ever requested any information from the Committee about the proposed amendments to these regulations. Certainly none of the parents to whom I have spoken are aware of any such committee, and it is difficult to believe that any reasonable consumer advisory body would be in favor of either the proposed amended regulations or the way these families have been treated even under the current regulations.

Suggestions for Improvement

Based on my discussion with many families over the last several years, it is clear the Fund is not meeting the needs of these children and their caregivers. The process to obtain services is overly and unnecessarily complex, and the rates of payment are inadequate for these families to obtain the services and equipment that these children require. It certainly does not provide an adequate substitute for the right to recover damages for future care pursuant to a judgment so that parents can make health care decisions and provide for their child's needs.

The Fund regulations (§69-10.4) require that enrollees be provided with a qualified case manager who will prepare a "comprehensive written management plan to assist the enrollee... to manage the delivery of all qualified health care services... and also to assist the enrollee to obtain those services and filling out the forms necessary to obtain payment." However, based on my discussion with a number of families, the case managers are geographically remote, they are not

qualified or even aware of the child's needs or services available to these families, and they have not fulfilled their obligation to provide the comprehensive case management plan.

The Fund needs to provide better services to these families. As a start, they should be required to comply with §69-10.4, but more importantly, since the Fund and its contractor's employees primary role seems to be denying payment for services, the Fund should be required to create an ombudsman at the Fund's expense whose sole role is to advocate on behalf of these children for necessary services within the Fund. This ombudsman should not be employed by the contractor but rather should function independently and answer only to the enrollee and his or her family—as the ethical standards for professional case managers require.

In addition, consistent with the Legislative intent that the Fund serve as an adequate substitute for the money judgment or settlement that was taken away from these children, the Regulations should be amended to assure that "qualifying health care services" is "broadly" interpreted, as was stated at the time of the initial adoption "Emergency" regulations. Specifically the regulation should provide that services, equipment or ordered by a child's physician or other professional are presumptively valid, both initially and in any administrative or judicial review proceeding, and the burden should be on the Fund to overcome that presumption to deny a service or item.

There are other remedial measures that would help to level the playing field, and assure that these children have access to the care, equipment and services which they require. These might include penalizing the Fund or its contractor for an unreasonable delay or denial of services, and enhanced and more available judicial review. Legislative action may be necessary to make these changes.

Conclusion

The Fund is not adequately meeting the needs of the children covered by it. It overly and unfairly restricts what it will pay for, and the process to get approval is much too difficult and expensive for these families to navigate–particularly when the deck is stacked against them. The proposed amendments to the regulations make a bad situation worse – much worse. It is respectfully urged that the proposed amendments be withdrawn, and that the regulations be fixed to better meet the needs of these families, as the Fund was intended to do.

Respectfully on behalf of the NYS Academy of Trial Lawyers,

MICHAEL W. KESSLER

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Cell (212)

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December 16, 2019

Honorable Chairwoman Helene E. Weinstein
Assembly Ways and Means Committee
LOB 923
Albany, NY 12248

Honorable Thomas J. Abinati
LOB 744
Albany, NY 12248

RE: **Bill A2347/A9018-A**

Establishes an office of the state medical indemnity fund ombudsman and a medical indemnity fund advisory panel to advocate for, assist and represent the interests of the qualified plaintiffs

New York State Medical Indemnity Fund (the"MIF") has enrolled over 600 of the most medically fragile children severely injured upon birth born due to medical malpractice

Dear Chairwoman Weinstein:

Please ask your committee to send Assemblyman Thomas J. Abinati's A2347 (the "Bill") to the assembly floor at the start of the 2020 Legislative Session on January 8th. **(See attached as Exhibit A)** This Bill will "establish an office of the state medical indemnity fund ombudsman and a medical indemnity fund advisory panel to advocate for assist and represent the interests of qualified plaintiffs."

My twelve-year old son, Luke, is one of these qualified plaintiffs. He has severe cerebral palsy spastic quadraparesis which caused developmental delays, severe scoliosis, severe reflux and epilepsy.

This MIF was statutorily created back in 2011 to reduce the cost of the medical malpractice insurance specifically for all New York hospitals which have maternity units. Only children who suffered brain or spinal injuries during labor and delivery at these hospitals can be enrolled. To be enrolled in the MIF, the families must give up their rights to pursue a jury trial. **(See attached as Exhibit B, Public Health Law 2999-j (6) (b)).** It is my understanding from our settlement conference that if we had decided to pursue a trial, any award would be expunged

and Luke would have been automatically be enrolled in the Fund by the presiding judge.

After the November 2018 elections, I read your interview with the Legislative Gazette. In this interview you stated that during your new tenure as Chairwoman of the Assembly Ways and Means Committee you wanted to *"find opportunities that lend a solution to the needs facing our families."* This Bill is exactly your opportunity. MIF families have to constantly fight for every single item. Currently without an advocate, we juggle 24-hour caregiving with appeals and endless phone calls to claims. One Hundred percent (100%) of the time hiring a lawyer would cost more than the item we are fighting for.

On June 14, 2017, the NYS Senate Health Committee held a Round Table for parents, attorneys and providers. I testified that fighting the MIF became a part time job. I am unusual MIF parent as I practiced law for a short time and know how to interpret government regulations. **Even with my background I struggled.** Towards the end our construction appeal I had to hire a lawyer. I acted pro se for three years. (**See attached as Exhibit C, In the Matter of Howard Zucker vs. Heidi Skau acting on behalf of L.S. (" the Order"**) How many other parents are also struggling, taking their children to the hospital, working full time, and spending any energy they have left fighting the MIF. No other group needs an advocate more than us, the MIF families.

The MIF: A History of Abuse of Power

- In the spring of 2016 during my request for environmental modification, the MIF **ordered** the independent evaluator, Accessible Options to **recommend nothing.** I got a call from the evaluator crying, as she did not know what to do. I immediately filed a complaint with the Inspector General against the MIF administrator as this action was inappropriate.

  As you can read in the Order, the administrative judge awarded us 60% of our requested construction items. However, MIF refused to act and I was advised the only way to enforce the order was to file an Article 78 proceeding. It was at this point that the cost of the litigation in the NYS Supreme Court system would cost more than the construction.

- On June 20, 2016 the Department of Finance- Health Bureau decided they want to make the NYMIF just another Medicaid program. They promulgated a new set of amendments deleting all the benefits the families were receiving that when beyond the standard Medicaid benefits. State Senator Hannon, the New York Trial Lawyers Association and the families of the MIF banded together to defeat these regulations. (**See attached Exhibit D, the proposed regulations, a scathing letter from Senator Hanon to Commissioner Zucker and the Memorandum of the NY Trial Lawyers**)

- One of the benefits the MIF was looking to get rid of in the proposed regulations was recreational and therapeutic assistive technology. Since their attempt to amend the

regulations failed, their current practice is to just outright deny items with no reasonable explanation. **This scenario is the most pressing example of why an advocate is so desperately needed. (See attached Exhibit E, the MIF's nonsensical denial, my reconsideration argument and finally their approval.**

- This past June, the NYS Court of Appeals, Third Department overturned another MIF denial, in the Matter of Anson v. Zucker, 162 A.D.3d 1179 (3d Dept. 2018) According to the New York Law Journal, " the Third Department found this determination arbitrary and capricious". The MIF family in this case was requesting a lift to get their child in and out of a therapy spa. (**See attached Exhibit F, an excerpt from the article.)**

Since Luke was enrolled in the MIF in 2014, I had to fight for glasses, a handicapped rental van, dental bills, OTC laxatives, a wheelchair ramp, environmental modifications and most recently assistive technology.

In September 2018, the MIF hired a new administer, Public Consulting Group ("PCG"). A new director of Case Management, Michelle Clickner, has done her very best to help me. Unfortunately, she cannot run the MIF all by herself. A statutory advocate and a creation of advisory panel will go far to act a backstop to the abuse of power and indifference we the families have faced over the years.

Please Chairman Weinstein, I just want to focus on my son.
We need an ombudsman.
We need an advisory panel to protect us from harmful amendments.

In the Bill's Justification section, State Senator Hannon specifically referenced me, "One parent, who is a lawyer by trade, testified to the need of a patient advocate". Please assign great weight to this letter as this Bill was created on my behest. Once the Bill is sent to the floor I will make an effort to contact each assemblyman to tell them my personal story. A story that is the same for each and every MIF family!

Doctors Hospital seeking legislative support for new obstetrics program

By: Tim Curtis Daily Record Business Writer February 20, 2020

Doctors Community Hospital in Lanham.

Believing too many Prince George's County residents go outside of the county for health care, Doctors Community Hospital plans to create an obstetrics program, allowing more babies to be delivered in the county.

Doctors and Anne Arundel Medical Center, which recently joined together to form the Luminis Health system, plan to brief the Prince George's County House Delegation in the next few days, according to lawmakers and a hospital spokesman.

Prince George's residents particularly seek care outside the county when it comes time to deliver babies. An estimated 80% of babies born to Prince George's residents are born outside of the county.

Two county hospitals — University of Maryland Prince George's Hospital Center and MedStar Southern Maryland Hospital Center – provide delivery services.

Many Prince George's families go to Anne Arundel Medical Center for baby deliveries. Other hospitals patients choose include those in Montgomery County and Washington.

One of the benefits of Doctors and Anne Arundel joining forces under the Luminis brand, the hospitals said at the time, was to allow Anne Arundel to help Doctors with its community needs assessment and with any opportunities that arose out of that assessment.

It appears as though the obstetrics unit is a place where Anne Arundel's performance can help the Lanham hospital fill a need. A significant majority of the babies delivered outside of the county come from Doctors' service area.

The Doctors' unit would also be able to provide comprehensive women's health care, including breast health and cardiac care.

Convincing patients to stay in Prince George's County over delivering their babies in other counties was also an impetus in building University of Maryland Capital Region Medical Center in Largo, replacing the Prince George's Hospital Center.

At the hospital's groundbreaking in 2017, U.S. Rep. Anthony Brown and then-County Executive Rushern Baker III, both Democrats, spoke about their difficulties having children in the county.

Brown said he was told by doctors that if he wanted them to deliver his wife's baby, he would have to find a different hospital than the one in Prince George's County. Baker said his plan was to have his first daughter at Providence Hospital, despite living down the road from the Prince George's Hospital Center in Cheverly.

"University of Maryland Capital Region Health supports greater county access for women who experience uncomplicated pregnancies," the system said in a statement. "We also, however, recognize the critical importance of keeping the care of high-risk pregnancies and newborns requiring neonatal intensive care within the county. As the only health system in Prince George's County that provides specialized obstetrics services to residents and their families, we look forward to continuing to provide this high-level of care in a new, state-of-the-art hospital in Largo, the University of Maryland Capital Region Medical Center, which is scheduled to open April 2021."

The two hospital systems have fought over programs in the past. When Anne Arundel Medical Center received a certificate of need to create a cardiac care program, University of Maryland Capital Region Health went to court to try to stop the program, saying it would take patients away from a program meant to be a crown jewel of the new hospital.

A Prince George's County Circuit Court judge ruled against Capital Region Health. The system dropped its appeal last April, allowing Anne Arundel to proceed with its program.

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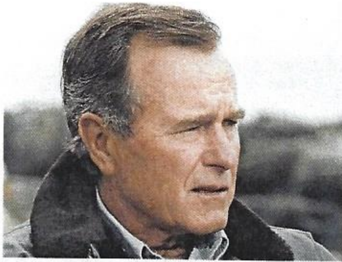

George H. W. Bush | 1924-2018

Leader of a nation, a family

He launched a dynasty, but first this proud public servant stayed true during a tumultuous era.

Washington Post

George H.W. Bush, the 41st president of the United States and the father of the 43rd, was a steadfast force on the international stage for decades, from his stint as an envoy to Beijing to his eight years as vice president and his one term as commander in chief from 1989 to 1993.

The last veteran of World War II to serve as president, he was a consummate public servant and a statesman who helped guide the nation and the world out of a four-decade Cold War that had carried the threat of nuclear annihilation.

His death, at age 94 on Friday, also marked the passing of an era.

Although Bush served as president three decades ago, his values and ethic seem centuries removed from today's acrid political culture. His currency of personal connection was the handwritten letter — not the social media blast.

» See BUSH, 7A

Tampa Bay Times

FLORIDA'S BEST NEWSPAPER | tampabay.com | ★★★★ Sunday, December 2, 2018 | $2

A TIMES INVESTIGATION

Johns Hopkins promised to elevate All Children's Heart Institute. Then patients started to die at an alarming rate.

Leslie Lugo's family visits her grave in September.

HEARTBROKEN

STORY BY KATHLEEN McGRORY AND NEIL BEDI, PHOTOS BY EVE EDELHEIT | *Times Staff*

Sandra Vázquez paced the heart unit at Johns Hopkins All Children's Hospital.

Her 5-month-old son, Sebastián Vixtha, lay unconscious in his hospital crib, breathing faintly through a tube. Two surgeries to fix his heart had failed, even the one that was supposed to be straightforward.

Vázquez saw another mom crying in the room next door. Her baby was also in bad shape.

Down the hall, 4-month-old Leslie Lugo had developed a serious infection in the surgical incision that snaked down her chest. Her parents argued with the doctors. They didn't believe the hospital room had been kept sterile.

By the end of the week, all three babies would die.

The string of deaths in mid 2017 was unprecedented. Nurses sobbed in their cars. The head of cardiovascular intensive care sent an email urging his staff to take care of themselves and each other.

The internationally renowned Johns Hopkins had taken over the St. Petersburg hospital six years earlier and vowed to transform its heart surgery unit into one of the nation's best.

Instead, the program got worse and worse until children were dying at a stunning rate, a *Tampa Bay Times* investigation has found.

Nearly one in 10 patients died last year. The mortality rate, suddenly the highest in Florida, had tripled since 2015.

Other children suffered life-changing injuries. Jean Kariel Viera Maldonado had a heart transplant at All Children's in March 2017. Soon after, the stitching connecting the 5-year-old's new heart to his body broke, and he had a massive stroke. Today, he can no longer walk, speak or feed himself. His parents care for him full time.

» See CHILDREN, 12A

EIGHT CHILDREN: All of these kids went to the Heart Institute and had problems with their care. Four died. Read their stories, beginning on **12A**.

FLORIDIAN
A chat with Barry Manilow
The singer talks Christmas songs, retiring from touring and ... holograms. **1E**

LOCAL
Teachers with guns?
The idea is back, but many Florida educators still say no thanks. **1B**

EDITORIAL
Testing for justice
Let DNA testing remove doubt in death row cases. **18A, 21A**

BUSINESS
Trimming the tree
Christmas tree sales are off to a strong start in Tampa Bay, shortage or not. **1D**

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EVE EDELHEIT | Times

Sebastián Vixtha was supposed to be 'completely normal' after surgery.

The doctors who diagnosed Sebastián Vixtha's heart defect told his mother it was serious. But they were hopeful about his long-term prognosis, as long as he underwent three surgeries. "He's going to be normal, completely normal," Sandra Vázquez recalled them saying. At 2 weeks old, Sebastián survived a risky heart surgery at All Children's and returned home. But one month later, he started vomiting and had to return to the hospital. While he was there, his heart stopped. The doctors said his aorta had narrowed. They tried to open it up two different ways. Sebastián seemed to be getting better, so the doctors scheduled another surgery in May. "They clearly told us that this surgery would be less risky than the first," his mother said in Spanish. But after that procedure, Sebastián suffered a second heart attack. He died on June 1, 2017.

EVE EDELHEIT | Times

Leslie Lugo picked up a serious infection in the hospital.

Leslie Lugo was born Jan. 2, 2017, with Down syndrome and a number of serious heart defects often associated with it. Her first procedure on Jan. 12 went well, records show. But after a second surgery that March, she developed an infection deep in her surgical wound. Peer-reviewed research shows such infections occur in fewer than 5 percent of heart surgery cases. The doctors and nurses spent eight weeks treating Leslie's infection with antibiotics and a wound vacuum system. She needed another surgery after that and came out too weak to breathe or pump blood to her body on her own. She died a few days later on May 30.

Leslie's mother, Ma Candelaria Tellez, said her doctors had told her All Children's was the best hospital. In the end, she felt deceived. "I don't recommend this hospital to anyone," she said in Spanish.

Leslie is buried at a cemetery beside the interstate near the family's home in Dover. On a windy afternoon this September, her family visited the grave with two bunches of roses, one red, the other pale peach. Her mother washed her headstone, removing the browned leaves and branches that had blown onto the plot. Her father strung up a balloon with the characters from the movie *Frozen*. The family of five huddled together, the mother's gaze fixed off in the distance. They stayed until it started to rain.

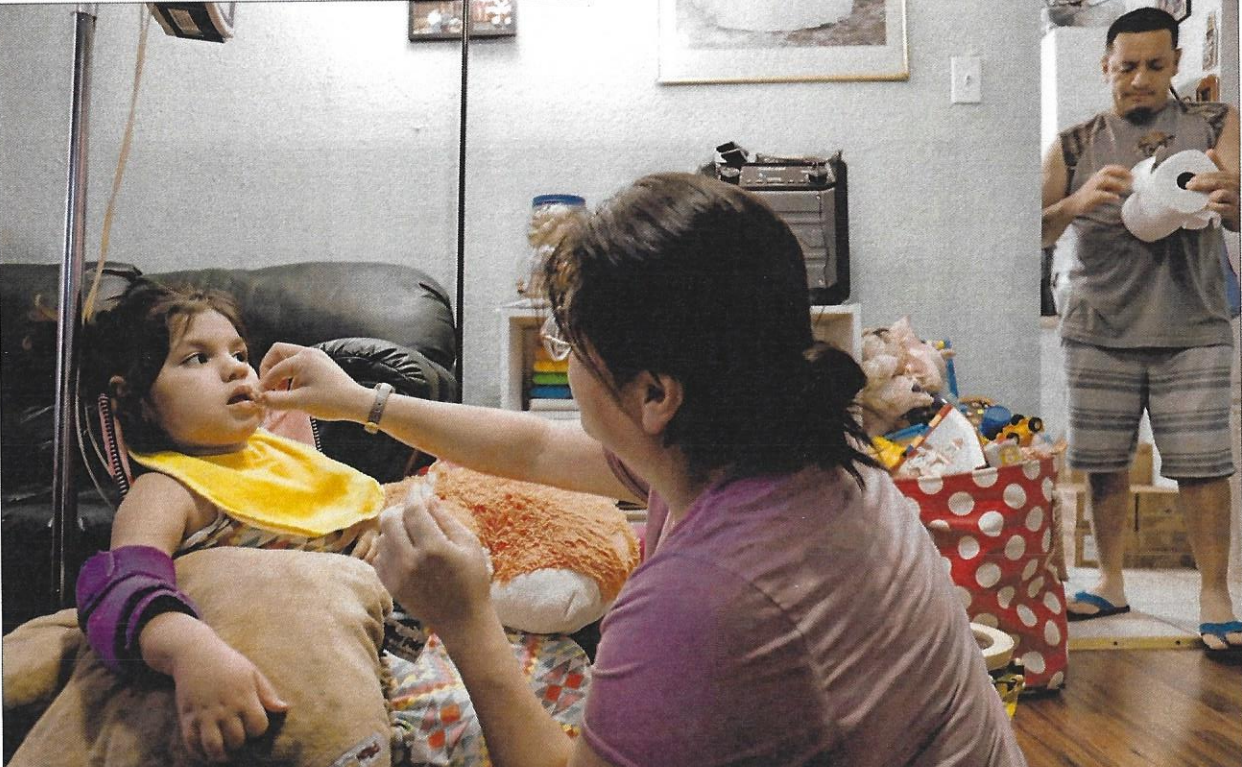
NEIL BEDI | Times

Madeline Rebori traveled 900 miles to be saved.

Not long after Madeline Hope Rebori was born in 2015, a cardiologist at the All Children's Hospital Heart Institute said nothing could save her, her parents recalled. Her family got a second opinion from a Stanford doctor, then took her to Cincinnati Children's Hospital, where surgeons performed a life-saving surgery. Madeline is now 3 years old. She takes tap and ballet. She performed to *I'm a Little Teapot* at a recent recital. Madeline still needs one more surgery for her heart to be fully repaired. Her parents, Brian and Stephanie Rebori, are optimistic. They intend to take her back to Cincinnati.

En español

Para leer en español en Centro Tampa, visite **tampabay.com/corazonroto**.



EVE EDELHEIT | Times

» CHILDREN
continued from 1A

Times reporters spent a year examining the All Children's Heart Institute — a small, but important division of the larger hospital devoted to caring for children born with heart defects.

They compared Florida's 10 pediatric heart surgery programs by analyzing a state database of 27 million hospital admissions spanning a decade. Then they reviewed thousands of pages of medical reports, interviewed current and former hospital workers, spoke with top health care safety experts and tracked down families across Central Florida coping with catastrophic outcomes.

They discovered a program beset with problems that were whispered about in heart surgery circles but hidden from the public.

Among the findings:

- All Children's surgeons made serious mistakes, and their procedures went wrong in unusual ways. They lost needles in at least two infants' chests. Sutures burst. Infections mounted. Patches designed to cover holes in tiny hearts failed.
- Johns Hopkins' handpicked administrators disregarded safety concerns the program's staff had raised as early as 2015. It wasn't until early 2017 that All Children's stopped performing the most complex procedures. And it wasn't until late that year that it pulled one of its main surgeons from the operating room.
- Even after the hospital stopped the most complex procedures, children continued to suffer. A doctor told Cash Beni-King's parents his operation would be easy. His mother and father imagined him growing up, playing football. Instead, multiple surgeries failed and he died.
- In just a year and a half, at least 11 patients died after operations by the hospital's two principal heart surgeons. The 2017 death rate was the highest any Florida pediatric heart program had seen in the last decade.
- Parents were kept in the dark about the institute's troubles, including some that affected their children's care. Leslie Lugo's family didn't know she caught pneumonia in the hospital until they read her autopsy report. The parents of another child didn't learn a surgical needle was left inside their baby until after she was sent home.

'Maybe they should have hit the pause button.'

As a newborn in 2013, Alexcia Escamilla survived one of the most difficult procedures in pediatric heart surgery. But after another surgery in 2016— a procedure that was supposed to be much less risky — Alexcia suffered a stroke that left her unable to walk or speak. Her mother, Rosana Escamilla, never allowed herself to believe the doctors were at fault. A woman of faith, she held a conviction that God had his reasons. Alexcia's father, Oscar, quietly harbored doubts.

Two years later, when Rosana learned other children's surgeries had gone badly, she spread out her daughter's medical records and began closely studying each detail. "If there was such turmoil they should have stopped and said, 'We are going through some changes,'" she said. "Maybe they should have hit the pause button."

The *Times* presented its findings to hospital leaders in a series of memos in early November. They declined interview requests and did not make the institute's doctors available to comment.

In a statement, All Children's did not dispute the *Times'* reporting. The hospital said it halted all pediatric heart surgeries in October and is conducting a review of the program.

"Johns Hopkins All Children's Hospital is defined by our commitment to patient safety and providing the highest quality care possible to the children and families we serve," the hospital wrote. "An important part of that commitment is a willingness to learn."

All Children's isn't the first hospital to struggle with pediatric heart surgeries. Several heart programs, including one at St. Mary's Medical Center in West Palm Beach, have shut down after reports of high mortality rates.

Most pediatric heart surgeries involve stopping a child's heart and operating in a space no larger than a walnut shell. But advances in science and technology have made them strikingly safe. In Florida, the survival rate for children who have surgery to correct a heart defect is now 97 percent, the *Times* found.

All Children's had earned a reputation as a community treasure that parents could trust to guide them through the terrifying experience of having a seriously ill child. Under Johns Hopkins, everyone assumed it would only get better.

"You hear Johns Hopkins, there's a sense of prestige," said Rosana Escamilla, whose daughter Alexcia suffered a stroke after heart surgery in 2016. "You think your child is in the best hands."

Instead, operations that surgeons described as low risk began failing.

"Somebody has to do something," Sandra Vázquez remembers one of the other mothers telling her in a quiet corner of the unit, "because they are killing our children."

In interviews in April and May, All Children's CEO Dr. Jonathan Ellen told the *Times* that the Heart Institute had its "challenges" under control. It had slowed surgeries to the lowest level possible without shutting down.

"We've already self-policed our way out," Ellen said, noting that the hospital had been performing only low-complexity heart operations for much of 2017.

It was a tacit acknowledgment that All Children's hadn't been able to perform the hardest heart procedures.

But the hospital couldn't handle the less complicated cases either, records and interviews show.

NEIL BEDI | Times

Ca'terriunna McGowan needed a new heart.

Twelve days after she was born, Ca'terriunna McGowan went to Johns Hopkins All Children's Hospital in hopes of getting a new heart. She was designated high priority on the transplant waiting list. Ca'terriunna had been sedated for most of her life. As she waited for her new heart, she grew sicker. In January 2018, her blood tested positive for a bacterial infection. In March, her heart rate was erratic. Her new heart came in early May. The transplant was a success, records show, but complications continued. Her kidneys and liver started to fail. "She was going downhill," recalled her father, Glen McGowan, as he stood outside his house and clutched photos of Ca'terriunna before and after her operation. At the end of May, Ca'terriunna was placed on heart and lung support. She died in June.

Bigger ambitions

All Children's Hospital opened in St. Petersburg in 1926 as the American Legion Hospital for Crippled Children. Over the decades, it had grown into a profitable children's hospital, locally run and independent.

But members of its board had bigger ambitions. They wanted a partner to raise the hospital's profile.

In 2011, they effectively gave the hospital to the Baltimore-based Johns Hopkins, which was in the midst of expanding into a $6 billion global health system. All Children's would be its sixth hospital.

Johns Hopkins is considered the birthplace of modern American medicine. At the time, its flagship hospital had held the top spot on *U.S. News & World Report's* rankings for 21 straight years.

By the end of 2012, two longtime Hopkins faculty members were appointed to key roles in St. Petersburg.

Ellen, the director of pediatrics at the Johns Hopkins Bayview Medical Center in Baltimore, replaced the hospital's CEO. And Dr. Paul Colombani, the director of pediatric surgery at the Johns Hopkins Children's Center, became chief of pediatric surgery.

The new leaders took special interest in the All Children's heart surgery program, already one of the best in the state, but not among the ranks of the country's elite.

The goal was to build a "top-flight, excellent program that could provide unique care for children," Ellen told the *Times* in April.

The hospital's heart surgeons were already performing about 200 procedures annually.

Dr. James Quintessenza, the chief of pediatric heart surgery, took the most cases, including many of the hardest ones. He had consistently good results.

Dr. Jeffrey Jacobs performed surgeries, too, but was a leader outside the operating room. He edited academic journals, spoke at conferences around the world and sat on committees devoted to improving safety.

A third surgeon, Dr. Paul Chai, operated at All Children's only occasionally.

In 2013, Chai left for a job in New York. The hospital's new leaders replaced him with Dr. Tom Karl, then 65, who had spent the previous six years practicing at a children's hospital in Australia.

Karl had worked at some of the nation's best pediatric heart surgery programs and published more than 100 peer-reviewed papers. But in 2008, the University of California San Francisco had suspended his clinical privileges amid allegations he "disrupted patient care and educational activities," he later told the Florida Board of Medicine. He said internal politics were to blame.

After Karl arrived in St. Petersburg, the hospital's administration made a consequential change. For years, All Children's cardiologists sent their most complicated cases to Quintessenza for surgery. Now all cases were to be distributed equally among Quintessenza, Karl and Jacobs.

» See CHILDREN, 14A

The doctors

Dr. Jonathan Ellen
A longtime Johns Hopkins administrator, Dr. Jonathan Ellen came to All Children's in 2011 as physician-in-chief, and was later promoted to CEO. He set out to turn the Heart Institute into one of the nation's top programs.

Dr. Paul Colombani
Dr. Paul Colombani is the chief of surgery at All Children's. He came to the hospital after 20 years as the chief of pediatric surgery at the Johns Hopkins Hospital in Baltimore. Multiple employees voiced concerns about surgeries to him as early as 2015.

Dr. Jeffrey Jacobs
An editor of multiple medical journals and frequent speaker at conferences, Dr. Jeffrey Jacobs is known for his academic work. Employees started expressing concerns about his surgeries in 2015.

Dr. Tom Karl
All Children's hired veteran heart surgeon Dr. Tom Karl in 2014 from a children's hospital in Australia. Employees started expressing concerns about his surgeries in 2015.

Dr. James Quintessenza
Dr. James Quintessenza was an All Children's pediatric heart surgeon for almost 30 years. After disagreements with Colombani, he was demoted and pushed out in 2016.

Dr. Nhue Lap Do
Dr. Nhue Lap Do joined the All Children's Heart Institute surgical team in mid 2017, straight out of fellowships at the Johns Hopkins Hospital and the Children's Hospital of Philadelphia.

Photos from *Times* archives, the *Baltimore Sun* (2015), All Children's press release, the *San Francisco Chronicle* (2000) and UK HealthCare.

EVE EDELHEIT | Times

Cash Beni-King's parents begged doctors to fight for him.

Cash Beni-King had multiple surgeries in the five months he was alive. After the first, his tiny heart was too weak to work on its own. After the second, a stroke left him paralyzed. Cash died on July 4, 2017. His younger brother is named Zven, pronounced "seven" and spelled with four letters in memory of the day Cash died. Cash's mother, Yiniisi Beni, recently created a remembrance wall in the living room, hanging photos of Cash around words like "family" and "love." Looking at it brings her to tears. His father, Gold King, said he blamed himself for a while. He believes things would be different if he had chosen another hospital for his son. "He would still be here with us," he said.

» CHILDREN
continued from 13A

As Ellen continued to fold All Children's into Johns Hopkins, relationships with teams of private-practice cardiologists and critical care doctors who had played key roles in the unit began to fall away. Johns Hopkins preferred to use its own employees.

"Disrupting a chemistry in that program was what led to the problems that they have today," said Dr. Al Saltiel, who was the president of the critical care group. "You can't replace the entire team at the same time."

The changes troubled Quintessenza. After disagreements with Colombani, he was demoted, then pushed out of the program in June 2016. He had been at the hospital for almost three decades.

By the end of the year, Quintessenza was named chief of pediatric cardiothoracic surgery at Kentucky Children's Hospital. He declined to comment.

Colombani referred questions to an All Children's spokeswoman.

Midway through 2017, All Children's replaced Quintessenza with a young heart surgeon, Dr. Nhue Lap Do, straight out of fellowships at the Johns Hopkins Hospital and the Children's Hospital of Philadelphia.

Karl and Jacobs would handle all of the hardest cases.

'Take her home and love her'

Medical professionals noticed problems with surgeries performed by Karl and Jacobs as early as 2015.

Their patients were returning to the operating room to deal with unforeseen complications, six current and former employees told the *Times*.

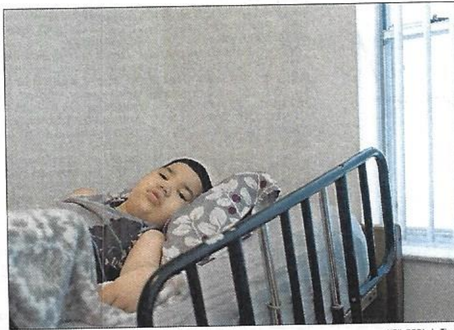
Parents who had chosen the program for its strong reputation began having confounding experiences.

Madeline Hope Rebori was born with a complex heart condition in June 2015. Karl had already met her parents, who recall him saying the condition could be repaired with surgery. But after Madeline arrived, a different All Children's doctor told them nothing could save her, they said.

His instructions to the family: "Take her home and love her."

It is not clear who made the decision. But Brian Rebori was stunned. He asked to speak with Karl. The hospital would not make the surgeon available, he said.

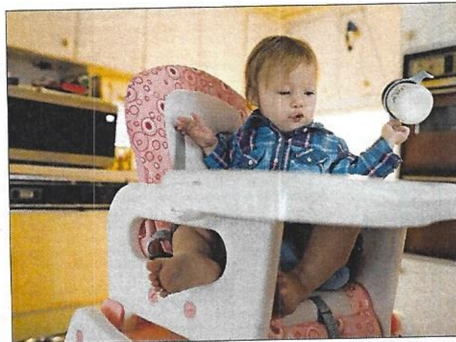
The father found a surgeon at Stanford University Medical Center who agreed to review Madeline's records. In a letter, the surgeon acknowledged that her heart condition was an unusual variant of a defect called Tetralogy of Fallot. But his team had seen dozens like it and had repaired "a great majority" surgically, he said.



NEIL BEDI | Times

Jean Kariel Viera Maldonado's stitches broke, with life-changing results.

Jean Kariel Viera Maldonado first got sick in Puerto Rico, where his family lived. One hospital sent him to another. It was a cardiologist who realized his heart was enlarged and said he might be a candidate for a transplant. For that, however, he would need to leave Puerto Rico. The cardiologist recommended three hospitals: the Children's Hospital of Philadelphia, Boston Children's and Johns Hopkins All Children's. Jean Kariel's parents chose All Children's because they had family in Florida. Before the transplant in 2017, the family visited Walt Disney World. Jean Kariel sprinted through the parks and rode the junior rollercoaster. His parents hold on to that memory. Shortly after the March transplant, the stitching connecting Jean Kariel's new heart to his body broke, and he suffered a debilitating stroke. He can no longer walk. As he keeps growing, it's getting harder to maneuver him around the house and into the car. His parents worry about what's to come.



MONICA HERNDON | Times

Katelynn Whipple left the hospital with a needle in her chest.

Katelynn Whipple needed emergency heart surgery soon after her birth in July 2016. Her aorta, the body's main artery, needed to be lengthened. Her parents thought the surgery went well. But at a followup appointment days after she was discharged, they learned an All Children's surgeon had left a needle in their daughter's chest. Katelynn's parents took her back to the hospital and asked Dr. Tom Karl to remove the needle. Karl said the needle didn't exist, Katelynn's parents told the *Times* earlier this year. The needle was removed during a later surgery at St. Joseph's Children's Hospital in Tampa. All Children's ultimately settled with Katelynn's family. The hospital will give her $5,000 annually for four years beginning on her 18th birthday, and $25,384 on her 25th birthday, records show.

All Children's later conceded that a procedure could be done, medical records show. Madeline's parents took her to a hospital in Cincinnati, where she had life-saving surgery that August. She turned 3 this year.

"I went from planning a funeral to planning a life," Brian Rebori said.

Surgical intervention is almost always recommended for babies with Madeline's condition, even if the first step is to improve the baby's chance of survival, said Dr. Michael Monaco, a pediatric cardiologist at Morgan Stanley Children's Hospital in New York.

Back at the Heart Institute, things got worse after Quintessenza left in June 2016. With Karl and Jacobs as the only surgeons, the program experienced its highest six-month mortality rate in eight years, the *Times* analysis shows. At least four children died.

Karl and Jacobs each declined to comment when reached by *Times* reporters. They referred questions to the hospital and did not respond to emails outlining the *Times*' findings. The emails did not bounce back.

In one 2016 case, which the *Times* first reported in April, Karl left a surgical needle in the aorta of newborn Katelynn Whipple. Other physicians knew it was there. Nonetheless, Katelynn was discharged with the needle in her body. It was removed three weeks later during an unrelated surgery at St. Joseph's Children's Hospital in Tampa, records show.

Leaving a surgical needle inside a patient is virtually always a serious, preventable mistake. It happened two times that year in the Heart Institute, All Children's acknowledged in April.

In June 2016, Jacobs and Karl operated on 3-year-old Alexcia Escamilla.

Alexcia had been born with a heart condition requiring three surgeries. She had already undergone one of the most challenging procedures in pediatric open-heart surgery as a newborn, performed by Quintessenza. About one in five patients die.

She survived it, and a second surgery by Quintessenza.

Alexcia grew into a happy toddler who danced around the house and chased children at parties. She played with dinosaurs and trains, never dolls. She preferred her hair in a side ponytail. She couldn't wait for the bus that took her to preschool. Some afternoons, when it took her home, she stood firmly on the top step, refusing to climb down.

The final surgery was supposed to be much less risky than the first. The chance of complications — bleeding, infection, stroke, major organ system injury, death — was in the 2 percent to 3 percent range, according to her medical records.

This time, Jacobs took the lead. Karl assisted.

After surgery, blood began pooling around Alexcia's lungs. A vein in her esophagus had burst. It isn't clear why. She had to return to the operating room.

The next day, nurses noticed Alexcia was less responsive. A brain scan showed she had suffered a stroke. Neurosurgeons removed a portion of her skull, so her brain had room to swell. She was put in a medically induced coma.

When Alexcia woke up, she could no longer control her movements or stabilize her neck. She looked "like Gumby," recalled her mother, Rosana Escamilla. Alexcia stared vacantly at her parents.

"She lost everything I loved about her," Escamilla said.

Strokes during or after pediatric heart surgery are rare. One peer-reviewed study found they happen in 5 percent of cases. Another pegged the rate as lower than 1 percent.

A variety of factors can cause a stroke, said Dr. Francisco Puga, professor emeritus of cardiovascular surgery at the Mayo Clinic. He said poor surgical technique is one of them.

Internal warnings

The errors and rising death rates weren't the first indications hospital leaders had that the program was in trouble.

Late in 2015, the four physician assistants who worked in the operating room called for a meeting with their supervisor and Colombani, the chief of surgery. They brought up specific operations that had gone badly and expressed doubt in Karl's and Jacobs' surgical abilities, according to several people with

» See CHILDREN, 15A

Times file (2009)

Eight years ago, All Children's Hospital was an independent and profitable institution. Board members wanted to elevate its reputation and turn it into an academic and research hospital. They effectively gave the hospital to Johns Hopkins in 2011. The new leaders transformed the hospital's heart surgery unit.

» CHILDREN
continued from 14A

direct knowledge of the meeting. They spoke on condition of anonymity, worrying that going public could hurt their careers.

That December, the physician assistants had a second meeting about their concerns, this time with the surgeons, the department's leadership team and the hospital's new director of human resources.

Karl and Jacobs continued operating.

Four other medical professionals working in the institute told the *Times* they were so worried about patient safety that they met with their supervisor, human resources or the hospital ombudsman in 2015 or 2016. Three said they named Karl, Jacobs or both surgeons in the conversation.

One former All Children's cardiologist, Dr. Elise Riddle, also noticed poor results. She discussed her experiences in sworn testimony in June 2018 as part of a hearing to determine whether her current employer, Arnold Palmer Hospital for Children in Orlando, should be allowed to open a pediatric heart transplant program.

Riddle testified that she could not access comprehensive data on the All Children's Heart Institute's performance, even as chairwoman of the program's quality improvement committee.

"Essentially all cardiologists were forbidden from looking at our outcomes data," she said.

Riddle added that the administration and the surgeons had "squashed transparency" by prohibiting discussion on ways to improve care.

"Multiple levels of administration had actually tried to hide some outcomes," she said.

Riddle left in 2016. The four physician assistants left, too, along with several doctors, nurses and other medical professionals in the unit. Riddle described it as "a mass exodus."

She declined to be interviewed by the *Times* but provided a statement calling for a "detailed, external review of the cardiovascular surgical outcomes, major complications, deaths, volumes, and the degree of or lack of transparency."

'Suboptimal outcomes'

In early 2017, the hospital's leaders took a step that showed they recognized the program was struggling.

They started sending heart surgery patients younger than a month old to other hospitals, Ellen told the *Times*. Those are often the most difficult cases.

But the Heart Institute kept seeing patients with less complicated conditions.

The hospital said its heart surgery program admitted 106 patients last year. The method the *Times* used to identify cases in the statewide admissions data is conservative; it accounted for 83 patients.

Over the last decade, the program's surgical results had been on par with other Florida hospitals, the *Times* analysis shows. By 2017, that had changed.

Heart surgery patients at All Children's last year were three times as likely to die as those across the state.

They were four times as likely to come out of surgery needing a machine to do the work of their hearts and lungs.

Their surgical wounds were five times as likely to split open.

They took twice as long to recover from surgery.

They were three times as likely to become septic, a potentially deadly response to infection.

Leslie Lugo, Cash Beni-King and Jean Kariel Viera Maldonado all developed infections in the hospital after surgery, their medical records show. The Centers for Disease Control and Prevention considers infections "largely preventable" in a sterile hospital environment. Experts say a spike can indicate broader problems in a surgical unit.

Jean Kariel was 5 in March 2017 when he received a heart transplant. Karl was the lead surgeon. His parents were told the procedure went smoothly, they said. But when Jean Kariel returned from the operating room, he screamed for water.

His blood pressure plummeted. Karl rushed him back into the operating room.

That's when physicians discovered the stitching connecting his new heart to a vein called the inferior vena cava had broken, leaving him bleeding internally for 20 minutes. He had a stroke that damaged much of his brain, his records show.

Jean Kariel's parents said they were told stitches had never broken like that after a heart transplant at All Children's. One critical-care doctor told his family "they were making a sincere attempt to find the cause of this unexpected complication," Jean Kariel's medical records show.

All Children's never told them anything more about it, they said.

Before the procedure, Jean Kariel played soccer and rode horses with his father near their home in the Puerto Rican countryside, his parents said.

Now he's in a wheelchair, mute.

"I had a child who walked and talked, and they returned him to me like this," his mother, Karen Maldonado, said in Spanish.

Later in the spring of 2017, Sebastián Vixtha, Leslie Lugo and another baby died within a week.

The deaths prompted the Heart Institute's nursing director, Lisa Moore, to send an email to the institute's staff about the "suboptimal outcomes in our surgical program." She said the program's leaders recognized "the gravity" of employee concerns and were working on a "structured action plan."

Around that time, 3-month-old Cash Beni-King had a patch sewed over a hole in the center of his heart.

The operation's expected survival rate: 95 percent.

Karl performed the procedure in June 2017; Jacobs assisted. The surgeons believed the hole was closed completely, according to Karl's notes on the procedure. But tests proved otherwise. They reinforced the patch with additional stitches.

Cash came out of the operating room attached to a heart and lung support machine. Multiple attempts to wean him off the machine over the next week failed. Karl performed another surgery to reinforce the stitches around the hole. Shortly after, Cash suffered a serious stroke.

On July 3, 2017, Jacobs told Cash's parents there was no way to save him. The next day, as his parents begged doctors to keep him alive, Cash was disconnected from heart and lung support. Distraught, Cash's father broadcast his son's last moments on Facebook.

At least one other baby died before Ellen had what he described as a "hard conversation" with Karl. They decided Karl should focus on mission work and academics, instead of operating at the hospital, Ellen said in April. Karl remained on staff.

Not long after, in November 2017, a team from the top-ranked Texas Children's Hospital came to St. Petersburg to evaluate the heart surgery unit. Ellen said the hospital asked for the review. He has repeatedly declined to release the team's report.

By the end of December, at least eight children had died.

The hospital could have sent many of those cases to other heart surgery programs. There are five in Central Florida alone, including St. Joseph's in Tampa.

'New heights'

Even as turmoil engulfed the Heart Institute, Ellen announced he wanted to expand it.

In May 2017, he sent an email to hospital staff announcing moves that would support "continued growth of our program," including a promotion for Jacobs to co-director.

"Our combined efforts over the past six years have pushed the quality and safety of our cardiac care forward," Ellen wrote. "The time has come for us to leap to new heights of innovation."

Growing programs like the Heart Institute had been central to Johns Hopkins' strategy from the beginning.

In 2012, Johns Hopkins rolled out an ambitious plan to create new revenue sources that would ultimately double its profit, adding between $150 million and $200 million over the next few years. A portion of the money was expected to come from expanding "high-demand, high-revenue" specialty centers, company newsletters show.

The All Children's Heart Institute fit the bill.

Heart surgery patients represent less than 3 percent of All Children's admissions. But in recent years, they have been responsible for between 13 percent and 17 percent of the hospital's total billing, the *Times* analysis shows. Heart patient billing peaked at $142 million in 2014.

The year that eight children died, the unit's patients were billed $83 million — 10 percent of the hospital's total.

The hospital billed another $28.5 million for 31 admissions to the Heart Institute in the first quarter this year, the latest data available.

How much of that the hospital received is unclear. Private insurers and federal programs like Medicaid and Medicare negotiate or set their own reimbursement rates, typically below full value. The final payments aren't tracked in the state admissions data.

Ellen told the *Times* in May that patient safety and quality — not money — drive the hospital's decision-making.

"I don't actually know how much money the program makes," he said.

In April 2018, the hospital began flying in a surgeon twice a month from the Johns Hopkins Hospital in Baltimore to lead all heart operations, Ellen said. But the arrangement ended after six months, when the surgeon took a job in Chicago.

Although Jacobs and Do are still listed as surgeons on All Children's website, the hospital isn't performing heart surgeries, according to its statement to the *Times*. Karl was removed from the website in July. The hospital didn't answer questions about whether he is still employed.

Public face

The Heart Institute's marketing efforts bore little resemblance to what was actually happening inside the operating room.

Online, as recently as September 2017, the Heart Institute called itself "a leading pediatric cardiac surgery and cardiology program in the United States" that provided the "highest level" of care.

At one point that year, a video on the All Children's Facebook page touted: "Johns Hopkins All Children's Heart Surgery Program performs 1000+ heart surgeries per year."

Actually, the Heart Institute performed 164 procedures on 106 patient admissions last year, Jacobs told the *Times* in April.

Dr. Jorge McCormack, a private-practice cardiologist with privileges at the hospital, sent a screenshot of the video to a state oversight committee in November 2017, raising concerns about "overzealous" and potentially inaccurate marketing efforts.

The hospital removed the video.

Few of the parents the *Times* interviewed were aware of the Heart Institute's struggles at the time of their children's surgeries. None who lost children filed lawsuits, and there is no public sign of any investigations that predated the *Times'* reporting.

Some parents have since learned the hospital withheld information about their children's care.

Katelynn Whipple's parents didn't know a needle had been left in her chest until after she was discharged from the hospital, they told the *Times*. They returned and demanded the needle be taken out. Karl denied it existed, they said.

After the *Times* detailed her case, regulators cited All Children's for not telling Katelynn's parents and for not properly reporting the incident to the state, both violations of state law. Regulators also cited the hospital for not disclosing the second needle incident that year.

Ma Candelaria Tellez said she discovered her daughter Leslie Lugo had picked up pneumonia in the hospital only by reading her autopsy report.

Tellez became suspicious while her daughter was still alive. She said she noticed a milky substance leaking from Leslie's surgical wound after her second heart surgery in March 2017. The doctors denied Leslie had an infection for a week, she said.

Leslie's medical records show that she had mediastinitis, an infection that can develop after heart surgery if a caregiver or instrument is contaminated. It occurs in fewer than 5 percent of pediatric heart surgery cases and can be linked to the expertise of the surgical team, according to published research.

Doctors told Leslie's family that infections were "normal" and "happen all the time," her mother recalled.

What if

Glen McGowan remembers when the doctors at Arnold Palmer Medical Center told him in late 2017 that his newborn daughter, Ca'terriunna, would need a heart transplant.

He will never forget how one doctor reacted when he said he was transferring her to All Children's.

"The doctor grabbed me by the arm and he said, 'Please, don't take your baby there,'" McGowan recalled.

But the family's Jeep was having problems. All Children's was an hour closer than the second nearest option. McGowan felt he had no choice.

Ca'terriunna got a transplant, performed by Do and assisted by the veteran Johns Hopkins surgeon who was flying in from Baltimore. She died at All Children's in June. Medical records show sepsis contributed to her death.

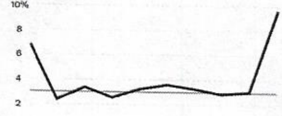
Months later, McGowan stood outside his Avon Park home, clutching two framed photos of Ca'terriunna. His voice got quiet.

"I should have listened to that doctor," he said.

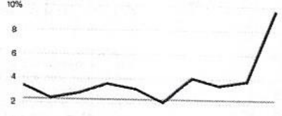
Problems increase

Each of the following charts represents a metric that can indicate problems in a pediatric heart surgery unit. At the All Children's Heart Institute (—) every one spiked in 2017 to be much higher than the 10-year average (—) for programs across the state.

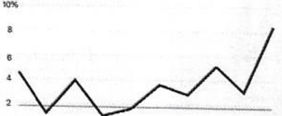
Mortality



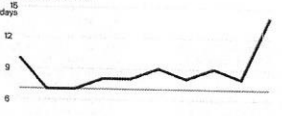
Heart support



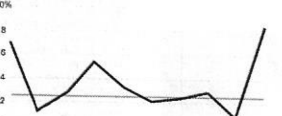
Wound rupture



Length of stay



Sepsis



No one forces children's hospitals to report these outcomes publicly. All Children's publishes four-year mortality averages, but including four years of data can mask recent problems. The *Times* produced single-year figures by analyzing millions of rows of billing data that track individual admissions to hospitals across Florida. For details on how the analysis was performed — including the full results, actual computer code and how it was vetted — visit **tampabay.com/heartdata**.

'She lost everything I loved about her'

Her surgery was supposed to be low risk. But an unusual complication changed Alexcia Escamilla's life.
Watch the full video at **tampabay.com/heartvideo**.

About the reporters

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Johns Hopkins to pay nearly $40 million to two families hurt by All Children's heart surgeries

The hospital has been negotiating with 11 families; some were struggling to afford the immense cost of care.

Rosana Escamilla gives her daughter Alexcia tiny pieces of food to taste in their home in August 2018. Alexcia was left paralyzed after a heart surgery at John Hopkins All Children's Hospital. The details of her case match the public filing of a $12.75 million settlement the hospital recently signed with a family. [EVE EDELHEIT | Tampa Bay Times]

By **Kathleen McGrory** and **Neil Bedi**
Published Aug. 23, 2019
Updated Aug. 28, 2019

The families of two children who were paralyzed after heart surgeries at Johns Hopkins All Children's Hospital will receive $26 million and $12.75 million in settlements with the hospital, state records show.

Although the identities of the children are not public, the records describing their cases match two of the patients featured in a *Tampa Bay Times* investigation into the hospital's troubled heart unit. Both families were struggling with the costs of caring for a permanently disabled child with no relief in sight.

A third family that lost a child after heart surgery will receive $750,000.

Last year, the *Times* reported that the death and complication rates in the All Children's heart surgery unit had spiked in recent years, even after frontline workers warned supervisors about problems. The CEO, three other executives and two surgeons and stepped down after the *Times* investigation published and regulators demanded sweeping changes. The hospital has halted heart surgeries while it restructures the department.

RELATED COVERAGE: Johns Hopkins promised to elevate All Children's Heart Institute. Then patients started to die at an alarming rate.

All Children's spokeswoman Danielle Caci said she could not comment on the settlements "due to privacy concerns."

In June, Johns Hopkins Health System CEO Kevin Sowers told the *Times* that he and hospital leaders had reached out to the families of children who died or were injured in the hospital's heart surgery unit.

https://www.tampabay.com/investigations/2019/08/23/johns-hopkins-agrees-to-pay-nearly-40-million-to-two-families-hurt-by-all-childrens-heart-surgeries/

"We made a mistake, and we need to make sure we help support these families and make it right," he said.

The three newly disclosed settlements raise the amount the hospital has paid to families who sought treatment in the Heart Institute to more than $40 million. A fourth family whose daughter died after a heart transplant settled a legal claim for $2.35 million in May.

Additional settlements are expected. The health system disclosed to investors in February that it was negotiating with 11 families, admitting liability in most cases.

RELATED COVERAGE: These eight children went to the All Children's Heart Institute. Here's what happened to them.

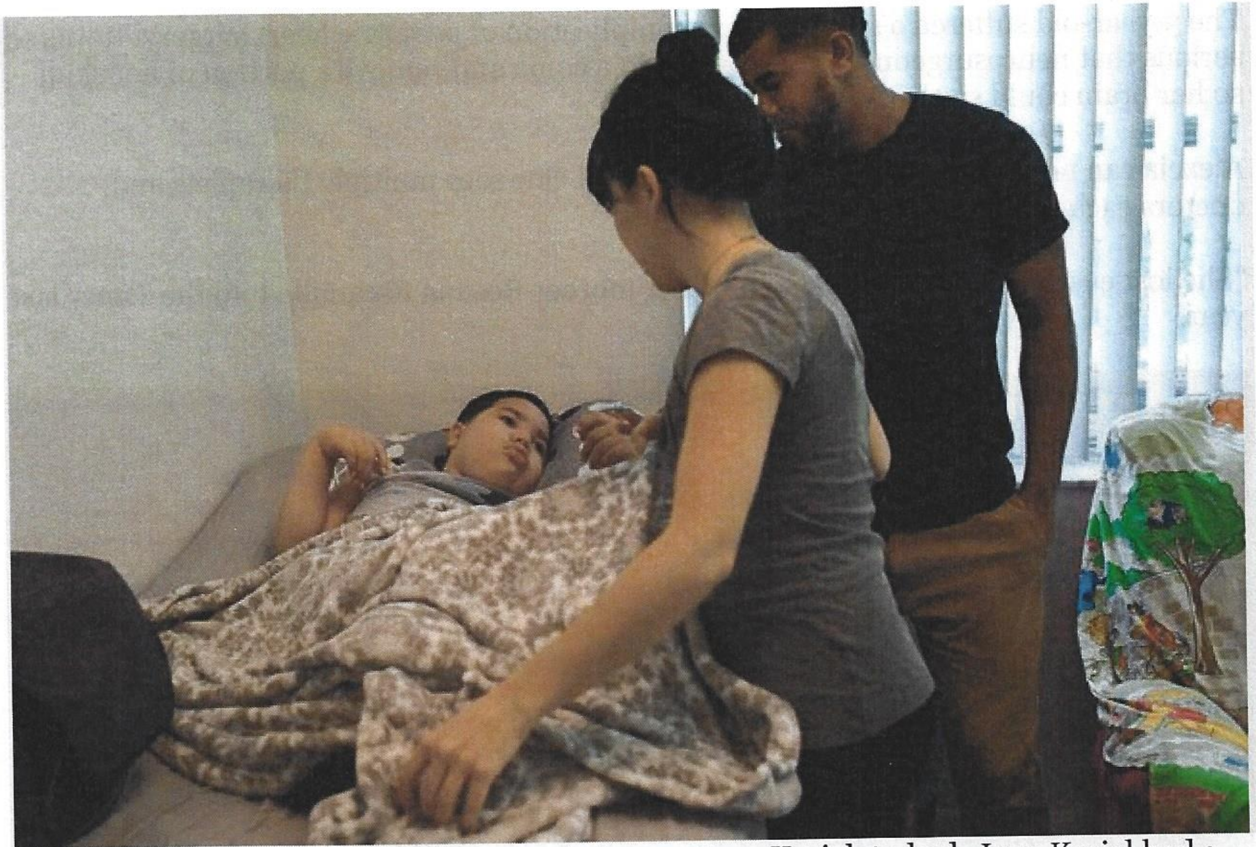
Most of the families featured in the *Times* story didn't know the unit had systemic safety issues before reporters approached them last year. The parents who believed problems had occurred with their children's care said that before the investigation published, they struggled to find lawyers willing to take their cases.

Malpractice settlements often include nondisclosure clauses that prohibit patients and their representatives from discussing the arrangements publicly.

But the settlements were recorded in an online database maintained by Florida's insurance regulator, along with some basic details on each case. Although the database does not typically list patient names, other details match two patients featured in the *Times*' reporting last year.

The $26 million settlement was for a male patient who suffered brain damage and lost the use of his limbs following a March 2017 heart transplant. His principal injury is described as a broken suture, the medical term for a stitch that holds tissues together after an injury or surgery.

Those details match the case of Jean Kariel Viera Maldonado, who suffered a massive stroke after a heart transplant in March 2017. His medical records, which his parents shared with reporters, show that the stitching connecting his new heart to a vein called the inferior vena cava had broken, causing him to bleed internally for 20 minutes.



Karen Maldonado and John Viera put their son, Jean Kariel, to bed. Jean Kariel had a stroke after a heart transplant at All Children's last year. His parents care for him full time. [NEIL BEDI | Tampa Bay Times] [NEIL BEDI | Tampa Bay Times]

Before the surgery, Jean Kariel was a vibrant 5-year-old who played soccer and rode horses. Since the transplant, he has been unable to walk, speak or feed himself.

His mother became his full-time caregiver in their small Central Florida apartment. But 18 months after the surgery, she was already having trouble maneuvering him into the car. She was worried about the day she could no longer lift him.

Reached by phone Wednesday, Jean Kariel's father, John Viera, declined to comment.

The $12.75 million settlement went to a female patient who had had a heart surgery known as a Fontan procedure in June 2016. The settlement record says the patient had internal bleeding and a stroke. She suffered severe brain damage and lost the use of her limbs.

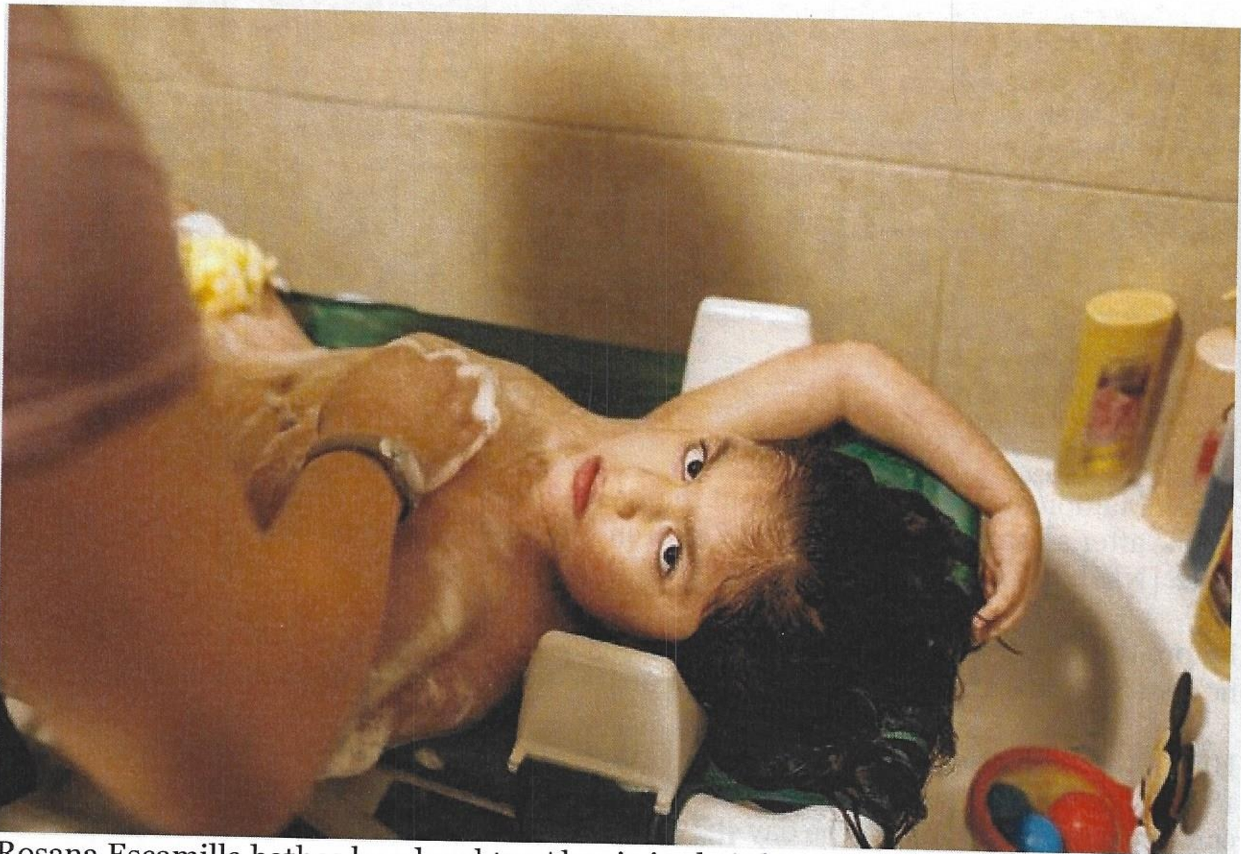
Alexcia Escamilla had a Fontan procedure in June 2016.

Her medical records, which her family shared with the *Times*, show that the chance of complications was in the 2 percent to 3 percent range. But after the operation, a vein burst and blood began pooling around her lungs.

The 3-year-old suffered a stroke, a rare complication of pediatric heart surgery. It was so serious that neurosurgeons had to put her in a coma and remove a portion of her skull so her brain could swell.

Alexcia can no longer speak or control her body. She sees multiple therapists and doctors each week.

"She lost everything I loved about her," her mother Rosana Escamilla told the *Times* last year.



Rosana Escamilla bathes her daughter Alexcia in their home in August 2018. During heart surgery at All Children's, Alexcia suffered from a stroke that left her unable to communicate. Alexcia has a special bed she uses while taking baths because she can't sit up by herself. [EVE EDELHEIT | Tampa Bay Times] [EVE EDELHEIT | Tampa Bay Times]

Escamilla declined to comment this week.

The family that will receive $750,000 lost a child who was injured in the hospital in the spring of 2017. Reporters were unable to identify the child based on the description of the case.

All three settlements, as well as the one from May, were reached outside of court, records show.

https://www.tampabay.com/investigations/2019/08/23/johns-hopkins-agrees-to-pay-nearly-40-million-to-two-families-hurt-by-all-childrens-heart-surgeries/

RELATED COVERAGE: Read all the *Times*' stories on the All Children's Heart Institute.

Experts say settlement amounts are typically based on the injured patient's medical expenses, the cost of future care and lost earning capacity, as well as pain and suffering. They also take into account what a jury might decide if the case went to trial.

Jorge E. Silva, a Miami-based medical malpractice attorney and adjunct professor at Florida International University College of Law, said it isn't unusual for claims involving children who suffered brain damage to result in multi-million dollar awards.

"If you get a life-care planner to say that taking care of this kid who is profoundly disabled is going to cost millions for the rest of their life, and you add to that the pain or suffering of this child, you can easily arrive at $10, $20, $30, $40 million," he said.

Families that lose children tend to receive smaller settlements because they do not have to shoulder the same long-term medical expenses. But each case is different. In 2018, St. Mary's Medical Center in West Palm Beach paid $8.9 million to the family of a child who died in its now-closed children's heart surgery department, records show.

In some high-profile cases, the hospital or doctor has an incentive to settle out of court, said Scott McMillen, an Orlando-based medical malpractice attorney who was not involved in the Heart Institute cases. That's because a jury may also choose to award punitive damages.

"It's what amount of money will it take to get the attention of the defendant," he said.

The problems in the All Children's heart surgery program began after Johns Hopkins took over the hospital in 2011 and made a series of personnel changes. Nurses and other frontline workers began noticing unusual complications as early as 2015 and warned their supervisors that children were being injured or dying after straightforward procedures. But the surgeries continued.

By 2017, All Children's had the highest death rate of any pediatric heart surgery program in the state in the last decade, a *Times* analysis of state data found. The rates of complications such as sepsis and wound ruptures had also spiked.

After the *Times* investigation, the hospital had to enter into a 12-month contract with the government promising additional oversight to avoid losing federal funding. State lawmakers also passed a law increasing oversight for pediatric heart surgery programs.

Johns Hopkins has vowed to make sweeping changes to its policies and structure, including new checks and balances on the hospital's president, more thorough vetting of doctors and improved monitoring of patient safety and quality metrics.

KATHLEEN MCGRORY

Deputy Investigations Editor

NEIL BEDI

Investigative Reporter

https://www.tampabay.com/investigations/2019/08/23/johns-hopkins-agrees-to-pay-nearly-40-million-to-two-families-hurt-by-all-childrens-heart-surgeries/

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MARYLAND LAW ALREADY PROTECTS HOSPITALS AND HEALTH SYSTEMS WITH CHARITABLE IMUNITY ABOVE THE LIMITS OF THEIR AVAILABLE INSURANCE

Maryland hospitals and health systems claim that the global market for excess and reinsurance coverage is "hardening," thereby making such insurance coverage more expensive. They claim that large medical negligence judgments would "wipe out" a hospital or health system that didn't have enough medical professional liability insurance to cover the size of the judgment.

In fact, the Maryland Insurance Administration reports that health care professional liability insurance in Maryland is both available and affordable, because of increased competition among insurers who have entered the market to offer such coverage to Maryland physicians:

> The ***stable rate environment and the continuing availability of coverage in the Maryland market*** are positive indicators for health care providers. Likewise, the closed claim and filed lawsuit numbers remain substantially below peak levels of 2012 – 2013. ***This should encourage potential risk bearers that have previously declined to enter or expand their presence in the Maryland market*** during the previous times of less stability to take advantage of growth opportunities within the State.

Md. Ins. Admin., "2019 Report on the Availability and Affordability of Health Care Professional Liability Insurance," at 4 (Sept. 1, 2019) (emphasis added).

Even if a Maryland hospital was faced with extraordinary potential liability, Maryland law affords hospitals with charitable immunity above their available insurance coverage. Section 5-632(c) of the Courts and Judicial Proceedings Article provides:

> A hospital or related institution that is a charitable institution and is insured against this liability in an amount of not less than $100,000 is not liable for damages in excess of the limits of that insurance.

Md. Cts. & Jud. Procs. Code Ann. §5-632(c). Because all hospitals in Maryland are charitable institutions, they enjoy charitable immunity in excess of the limits of their available insurance. If a Maryland hospital or health system could not afford to purchase excess or reinsurance coverage on the global market, charitable immunity would protect against being "wiped out" by extraordinary potential liability.

Within the last decade, for example, The Johns Hopkins Hospital faced an extraordinary class action lawsuit arising from the wrongful conduct of its agent and employee, Nikita Levy, M.D. In court filings in that case, Jane Doe No. 1 *et al.* v. The Johns Hopkins Hospital, *et al.*, Case No. 24-C-13-001041 (Cir. Ct. Baltimore City), the Johns Hopkins Defendants asserted that charitable immunity protected them from liability in excess of their available insurance.

In the Order certifying the class action, the Hon. Sylvester Cox agreed that charitable immunity protected the Johns Hopkins Defendants from liability above $190 million:

(OVER)

10. In connection with the final certification of the Settlement Class, the Court makes the following findings with respect to Maryland Rule 2-231(b)(1)(B):

   a. The Johns Hopkins Defendants are charitable organizations, and therefore ***entitled to immunity*** for third-party tort claims under the Maryland doctrine of charitable immunity, ***except to the extent of available insurance***.

   b. The only assets potentially available to satisfy the Settlement Class members' claims are Johns Hopkins insurance policies, which are wasting policies.

   c. The $190,000,000 Class Action Settlement Amount represents the total assets available to satisfy the Settlement Class Members' claims, considering that:

      i. The limits of Johns Hopkins professional liability insurance would be substantially eroded (and indeed have already been substantially eroded) were Johns Hopkins to continue to defend this class action or, if decertified, lawsuits brought by individual Settlement Class Members; and

      ii. Johns Hopkins' insurers have raised certain defenses to coverage.

   d. In making the findings set forth in paragraphs 10.b and 10.c, the Court has considered the sworn testimony of James R. Murray, Esq., an attorney in the Washington DC office of Dickstein Shapiro, LLP, and a nationally regarded expert in insurance coverage issues. The Court finds that Mr. Murray's testimony is credible.

Order Granting Final Approval of Mandatory Class Settlement Agreement, dated September 19, 2014 (emphasis added). Because Maryland's law of charitable immunity protects hospitals and hospital systems beyond the limits of their available insurance, the liability of Johns Hopkins was limited to its insurance in the Levy Class Action.

In summary, radical and offensive "tort reform" like SB 879, the so-called Maryland Infant Lifetime Care Act, is completely unnecessary, because Maryland's hospitals and health systems are protected by charitable immunity from liability above the levels of their available insurance.

Charitable immunity protected Johns Hopkins from liability above its insurance coverage, and it would do the same for any other hospital threatened with extraordinary liability.

Accordingly, even if excess or reinsurance coverage is temporarily unavailable or unaffordable because of a hardening of the global market for such coverage, ***that would not be a crisis***, and ***hospitals and health systems would have nothing to fear from the tort system***, because Maryland law already provides hospitals and health systems with charitable immunity above their available insurance.

MSAR # 2976

2019 Report on the Availability & Affordability of Health Care Professional Liability Insurance

Submitted to the
Legislative Policy Committee
by the
Maryland Insurance Administration

Al Redmer, Jr.
Commissioner

September 1, 2019

EXECUTIVE SUMMARY

Healthcare professional liability insurance (hereinafter "medical malpractice insurance") covers doctors and other healthcare professionals for liability claims arising from the treatment and care of patients. This annual report is based on data supplied by insurer groups to the Maryland Insurance Administration ("MIA"). The continuous availability and affordability of medical malpractice insurance to practitioners in Maryland is a vital and necessary component of Maryland's health care system.

In 2002 and 2003, rapid and substantial increase in medical malpractice insurance premiums threatened to weaken access to high-quality health care in Maryland. The General Assembly acted in 2004 and 2005 to stabilize the medical malpractice insurance market and to require the MIA to collect relevant data and report annually to the General Assembly on the state of Maryland's medical malpractice market. This data is summarized in Exhibits A through L.

In Maryland, medical malpractice insurance is available to be purchased from admitted insurers, non-admitted (surplus lines) insurers and risk retention groups. All writers of medical malpractice insurance are licensed or authorized by the MIA to conduct business in the state. In 2018, 67 insurer groups wrote medical malpractice insurance policies in Maryland for all types of health care providers. Total medical malpractice premium collected by these insurer groups was $286,320,300, representing a decrease of 1.7 % from the prior year. Admitted insurers accounted for 50% of the total written premium, while surplus lines insurers and risk retention groups accounted for 16% and 34% respectively.

While the number of insurer groups engaged in the medical malpractice market in Maryland is substantial and has not fluctuated significantly over the past ten (10) years, the marketplace remains highly concentrated with respect to premium volume. The leading admitted insurer and the leading risk retention group account for 59% of the total premium volume collectively. That said, the market's premiums remained stable over the past year as evidenced by the fact that only five (5) insurers made a rate increase filing during fiscal year 2019 (July 1, 2018 through June 30, 2019). These filings resulted in average increases of between 2.4% and 10.9 % to a total of 3,147 policyholders. These increases were offset in the market by premium decreases averaging 4.4% impacting over 5,800 policyholders insured by our largest market share insurer group. Our second largest insurer group did not make a rate impact filing in fiscal year 2019. Thus, medical malpractice insurance premiums have again remained affordable and stable in Maryland's market over the past year.

INTRODUCTION

Health care providers are not required by law to purchase and maintain medical malpractice insurance. Providers who elect to not purchase this coverage cannot participate in health care networks supporting preferred provider organizations, health maintenance organizations or managed care organizations.

Medical malpractice insurance premiums began to escalate in 2002 and increased substantially in 2003 and 2004. The General Assembly intervened in 2004 and 2005, including directing the MIA to collect data and report back to the General Assembly on this critical insurance market segment annually. In response, the MIA provides this report each year, including among other metrics, information about the number of active insurers in the medical malpractice insurance market in Maryland, premium rates for selected medical specialties and data for closed medical malpractice claims.

MARYLAND'S MEDICAL MALPRACTICE INSURANCE MARKET

Admitted insurers, surplus lines insurers and risk retention groups all provide medical malpractice insurance policies to a wide variety of health care professionals in Maryland.[1] Exhibits A1 through A5 provide detailed information about these insurer groups. As in the previous year, in 2018, the top two (2) insurer groups operating in Maryland were an admitted insurer created by the General Assembly[2], Medical Mutual Liability Insurance Society of Maryland (MMLIS); and, MCIC Vermont (MCIC), a risk retention group organized under Vermont law operating in Maryland as a non-admitted insurer. These two insurers captured 59% of the market by premium volume, which was a decrease of 3.25% from the prior fiscal year. Exhibit A1 illustrates the 2018 premium and market share data for each insurer group. Exhibit A2 lists the change in written premium for each insurer group by type of license from 2017 to 2018. The small drop in written premium of these top two market share groups contributes to a slightly less concentrated market and confirms that competition exists in the market.

Exhibit A3 is a pie chart showing the 2018 market share of the top nine (9) admitted insurers and a pie chart of the top nine (9) insurers including surplus lines insurers and risk retention groups. Exhibit A4 shows the change in market share of the current top five (5) insurers over the period from 2005 – 2018. MMLIS' share of the market was 30%, a decrease of 4% from last year while MCIC's share of the market increased to 29%. This activity is a continuation of a trend over the past 6 years where it appears that MCIC continues to make inroads into the market share of MMLIS. The total market share of the top two (2) insurer groups remains high at 59% of the market, and continues to be stable.

MEDICAL MALPRACTICE INSURANCE PREMIUMS IN MARYLAND

In response to an increase in medical malpractice insurance premium rates between 2001 and 2005, the General Assembly created the Maryland Health Care Provider Rate Stabilization Fund ("Fund"). Insurance Article, Section 19-802 of the Annotated Code of Maryland established the Fund, effective April 1, 2005.[3] The Fund subsidized medical malpractice insurance premiums paid by eligible health care providers to admitted insurers that elected to participate in the program through calendar year 2008.

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[1] Refer to MIA's *Comparison Guide to Medical Professional Liability Insurance Rates* ("*Comparison Guide*") for a detailed listing of insurers and premiums across the State.

[2] See Chapter 544, Section 1, Laws of Maryland, 1975.

[3] The Fund consists primarily of revenues generated by annual premium tax imposed on health maintenance organizations and managed care organizations pursuant to § 6-102 of the Insurance Article.

Exhibit A5 shows the history of MMLIS' rate changes from 2003 through 2019. Of note is that the sole rate increase since 2009 was 4% in 2012. MMLIS' rates effective January 1, 2018 dropped 2% and its most recent rate filing, effective January 1, 2019, reflects a decrease of 4.4%. The rates of MMLIS, the State's largest writer of medical malpractice insurance by premium volume, have remained stable since 2006.

Medical malpractice insurance premiums vary by specialty, policy limits and practice location. Exhibits B through G provide premium comparisons for twenty (20) different specialties utilizing a base premium for policy limits of $1MM per incident / $3MM annual aggregate for the years 2016 – 2019. Although the premium rates may differ among companies within a specialty, these Exhibits indicate stability in medical malpractice insurance premiums during this time period.

Exhibits B through G also highlight the differences in premiums among insurers. To assist providers in comparing medical malpractice insurance premiums, the MIA publishes the *Comparison Guide to Maryland Medical Professional Liability Insurance Rates* ("*Comparison Guide*") on an annual basis. The *Comparison Guide* is available on the MIA's website (www.insurance.maryland.gov) using the following link:

http://www.insurance.maryland.gov/Consumer/Documents/publications/medicalliabilityrateguide.pdf

The *Comparison Guide* compares general pricing among the major admitted insurers, surplus lines insurers and risk retention groups offering medical malpractice insurance in Maryland.

By law, medical malpractice insurers are required to offer policies with high deductible options of $25,000, $50,000 and $100,000.[4] Exhibits H and I illustrate that high deductible options are not popular among providers. Although policies having a deductible of less than $25,000 are sold, liability insurance policies, including medical malpractice insurance policies, are routinely issued with no deductible.

CLOSED CLAIMS

One factor affecting medical malpractice insurance premium rates is the number of claims filed, also known as claim frequency. Admitted insurers are required to submit certain closed claim information on a quarterly basis to the MIA. A claim is a demand for compensation arising from the alleged malpractice of a health care provider or facility. Exhibit J summarizes the closed claim data provided to the MIA by insurer and Exhibit K summarizes the data by specialty.

[4] Insurance Article, § 19-114 of the Annotated Code of Maryland. This statute was amended in the 2019 legislative session to limit this requirement to policies with annual premiums of $5,000 or more effective October 1, 2019.

Between 2009[5] and 2013 closed claims generally increased among all insurer types (admitted, non-admitted and risk retention groups). The number of closed claims hit a peak for admitted insurers 2013 at 957. The number of closed claims hit a peak for non-admitted insurers in 2012 at 425. The closed claim totals for 2018 were -47%and -20% off these peak totals for admitted insurers and non-admitted insurers respectively.

Exhibit L summarizes the number of lawsuits filed by jurisdiction and venue. The number of lawsuits peaked in 2013 and decreased by 41% in 2014 and again by 7% in 2015. In 2016, the number of lawsuits rose by 2% (22 lawsuits). For 2017, the number of lawsuits increased by 8 %, but was 30% below the peak year of 2014. For 2018, the number of lawsuits was 869, which was a reduction of 6% from the previous year.

CONCLUSION

The MIA continues to monitor concentration, availability and affordability trends for the key medical malpractice insurance market in Maryland. The market continues to be relatively stable but remains concentrated with 59% of the written premium acquired by two (2) insurers. Premium rates were stable or decreasing again this year across the market as a whole and within the two (2) largest market share insurers. The five (5) insurers that entered the market in 2016 – 2017 acquired a collective market share of 1.45% and there are (2) insurers that entered the market in 2017 - 2018.

The stable rate environment and the continuing availability of coverage in the Maryland market are positive indicators for health care providers. Likewise, the closed claim and filed lawsuit numbers remain substantially below peak levels of 2012 – 2013. This should encourage potential risk bearers that have previously declined to enter or expand their presence in the Maryland market during the previous times of less stability to take advantage of growth opportunities within the State.

[5] In 2005, the MIA used one form of on-line reporting, but that tool became unworkable. Since 2009, the data has been collected using a different tool that enables the MIA to access and query the data more easily. This change in systems may have resulted in a change in data collection.

JANE DOE NO. 1, JANE ROE NO. 1, JANE ROE NO. 2, and JANE ROE NO. 3 Plaintiffs,	:	IN THE CIRCUIT COURT
v.	:	FOR
THE JOHNS HOPKINS HOSPITAL, JOHNS HOPKINS COMMUNITY PHYSICIANS, and JOHNS HOPKINS HEALTH SYSTEM CORPORATION	:	BALTIMORE CITY Case No.: 24-C-13-001041
Defendants.	:	

: : : : : : : : : : : : :

PROPOSED ORDER GRANTING FINAL APPROVAL OF MANDATORY CLASS SETTLEMENT AGREEMENT

The Plaintiffs, Jane Doe No. 1, Jane Roe No. 1, Jane Roe No. 2, and Jane Roe No. 3, by and on behalf of others similarly situated ("Plaintiffs"), and Defendants, The Johns Hopkins Hospital, Johns Hopkins Community Physicians Inc., and The Johns Hopkins Health System Corporation (together, "Johns Hopkins"), having entered into a proposed Settlement Agreement in this Action, and the Court having duly considered and preliminarily approved the proposed Settlement Agreement, ordered the Parties to provide notice of the Settlement Agreement to the Settlement Class Members, duly considered all objections to Settlement Agreement, and considered the Parties' arguments and submissions in support of final approval,

IT IS ORDERED AS FOLLOWS:

1. For purposes of this Order, the Court adopts the definitions set forth in the Settlement Agreement.

Class Notice

2. The Court previously ordered the Plaintiffs, through the Claims Administrator, to directly mail an approved form of notice of the Preliminary Approval Order to all individuals

who previously received written notice of the October 30, 2013 Conditional Certification Order and all individuals who previously registered as members of the Settlement Class. The Court further ordered the Parties to provide notice to any Settlement Class Members who were minors as of the date of the Preliminary Approval Order but who have not previously registered as Settlement Class Members (a) by mailing written notice to their parents or (b) through alternative means.

3. The Court previously ordered the Plaintiffs, through the Claims Administrator, to provide publication notice of the Preliminary Approval Order pursuant to the approved Class Publication Notice Plan.

4. Through the Claims Administrator, the Plaintiffs subsequently provided notice of the Preliminary Approval Order to the Settlement Class in the manner ordered by the Court, as required by Md. Rule 2-231(h).

5. The Court finds that the notice of Preliminary Approval Order, as well as the manner in which it was provided to Settlement Class Members, fairly and adequately described the proposed class settlement and the manner in which class members could object to the settlement.

6. The Court further finds the Plaintiffs provided valid, due, and sufficient notice to the Settlement Class Members; and complied fully with the Maryland Rules of Civil Procedure, due process, and all other applicable laws. A full and fair opportunity was afforded to Settlement Class Members to object to or to comment on the Settlement and to participate in the hearing convened to determine whether the Settlement Agreement should be given final approval.

7. In making the findings in Paragraphs 4-6, the Court has considered the sworn testimony of Jeanne C. Finegan, the President of HF Media, Inc., which is a division of the

Heffler Group and which has served as the Claims Administrator in this Action. The Court finds Ms. Finegan's testimony to be credible.

Class Certification

8. Pursuant to the Settlement Agreement and for purposes of this settlement only, the Court certifies the following final Settlement Class pursuant to Maryland Rule 2-231(b)(1)(B):

> All former patients of Nikita A. Levy M.D. ("Dr. Levy") or all such persons' personal representatives, heirs or assigns, wherever located, who have or may in the future have any claim against (1) Nikita A. Levy, M.D. ("Dr. Levy") or the Estate of Nikita A. Levy, or (2) The Johns Hopkins Health System Corporation, The Johns Hopkins Hospital or Johns Hopkins Community Physicians (or any other person or entity affiliated with Johns Hopkins), arising out of, based upon, related to, or involving injuries and damages claimed as a result of the Dr. Levy's photographing or videotaping activities or boundary violations while he was an actual or apparent agent, servant, or employee of Johns Hopkins.

9. In connection with the final certification of this Settlement Class, the Court makes the following findings concerning the requirements of Maryland Rule 2-231(a):

a. The Settlement Class consists of over 12,000 former patients of Dr. Levy, and therefore is (i) sufficiently numerous such that joinder of all members is impracticable and (ii) sufficiently ascertainable, in that former patients of Dr. Levy may be identified through Johns Hopkins' medical records.

b. There are questions of law or fact common to the Settlement Class for purposes of determining whether this Settlement should be approved, including but not limited to:

i. Whether Dr. Levy was an actual or apparent agent, servant or employee of the Johns Hopkins Defendants at all times;

ii. Whether the Johns Hopkins Defendants are vicariously liable for Dr. Levy's actions;

iii. Whether the Johns Hopkins Defendants' actions and/or alleged failures to act, including their alleged negligent failure to properly investigate, credential, qualify, select, monitor, and supervise Dr. Levy, directly and proximately resulted in foreseeable injuries or damages to the Settlement Class Members; and

iv. What was the extent and nature of Dr. Levy's alleged misconduct, including his surreptitious photography and videotaping of Settlement Class Members and/or engaging in boundary violations.

c. The claims of the Representative Plaintiffs, Jane Doe No. 1 and Jane Roe Nos. 1, 2 & 3, are typical of the claims of Settlement Class Members, considering that each Representative Plaintiff is a former patient of Dr. Levy, and each seeks to recover damages from the Johns Hopkins Defendants arising from his alleged misconduct under vicarious liability and negligence theories.

d. The class representatives will adequately represent the Settlement Class in that:

i. The interests of the Representative Plaintiffs are sufficiently identical to the other members of the Settlement Class based on their status as former patients of Dr. Levy and the misconduct alleged in the Amended Complaint;

ii. The Representative Plaintiffs have been cognizant of their duties and responsibilities to the Settlement Class Members; and

iii. As previously determined in the Court's October 30, 2013 Order approving Plaintiff's Motion for the Appointment of a Steering Committee, Class Counsel are experienced in class actions and other complex litigation, and have been involved in protracted litigation involving medical malpractice for many years.

10. In connection with the final certification of the Settlement Class, the Court makes the following findings with respect to Maryland Rule 2-231(b)(1)(B):

a. The Johns Hopkins Defendants are charitable organizations, and therefore entitled to immunity for third-party tort claims under the Maryland doctrine of charitable immunity, except to the extent of available insurance.

b. The only assets potentially available to satisfy the Settlement Class members' claims are Johns Hopkins insurance policies, which are wasting policies.

c. The $190,000,000 Class Action Settlement Amount represents the total assets available to satisfy the Settlement Class Members' claims, considering that:

i. The limits of Johns Hopkins professional liability insurance would be substantially eroded (and indeed have already been eroded) were Johns Hopkins to continue defend this class action or, if

decertified, lawsuits brought by individual Settlement Class Members; and

ii. Johns Hopkins' insurers have raised certain defenses to coverage.

d. In making the findings set forth in paragraphs 10.b and 10.c, the Court has considered the sworn testimony of James R. Murray, Esq., an attorney in the Washington D.C. office of Dickstein Shapiro LLP and a nationally regarded expert in insurance coverage issues. The Court finds that Mr. Murray's testimony is credible.

e. The Class Action Settlement Amount, which represents the limited fund set at its maximum, is insufficient in to pay all the claims of the 12,000 Settlement Class Members, considering both the sheer number of the claims and the nature the misconduct alleged in the Amended Complaint.

f. Pursuant to the Settlement Agreement, the entirety of the Class Action Settlement Amount, less any costs, expenses or attorneys' fees awarded by the Court, will be devoted to the satisfaction of the Settlement Class Members' claims.

g. Pursuant to the Settlement Agreement's Allocation Plan, the Class Action Settlement Amount will be distributed to similarly situated Settlement Class Members in an equitable manner. Plaintiffs' counsel will submit the expenses reasonably incurred in the course of the allocation procedure and administration of this matter for payment from the Qualified Settlement Fund, subject to the approval of this Court.

Fairness, Adequacy and Reasonableness

11. The Court finds that the Settlement Agreement, including all exhibits thereto is fair, adequate and reasonable under applicable Maryland law.

12. In connection with the final approval of the Settlement Agreement, the Court makes the following findings with respect to the Settlement Agreement's fairness:

a. The Settlement Agreement is the result of over twenty months of vigorously contested mediation and negotiations between Plaintiffs and the Johns Hopkins Defendants.

b. The mediation was conducted by John W. Perry, Jr., a highly regarded mediator in significant class actions across the country, and Brian Nash, a highly regarded attorney with 40 years of experience litigating and mediating cases in an around Baltimore City. The mediators engaged the Parties in repeated in-person and telephonic sessions in their attempt to reach a settlement.

c. During the mediation, the Parties zealously advanced their arguments, and each side demonstrated a willingness to continue to litigate rather than accept a settlement that was not in their client's interests.

d. Throughout this litigation, the Parties have been represented by highly experienced and competent counsel.

e. In making the findings in paragraphs 12.a-d, the Court has considered the sworn testimony of the mediator, John W. Perry, Jr. and Brian Nash, whose testimony the Court finds is credible.

EXHIBIT 4

JANE DOE NO. 1, JANE ROE NO. 1, JANE ROE NO. 2, and JANE ROE NO. 3 Plaintiffs, v. THE JOHNS HOPKINS HOSPITAL, JOHNS HOPKINS COMMUNITY PHYSICIANS, and JOHNS HOPKINS HEALTH SYSTEM CORPORATION Defendants.	:	IN THE CIRCUIT COURT FOR BALTIMORE CITY Case No.: 24-C-13-001041

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AFFIDAVIT OF JAMES R. MURRAY

I, JAMES R. MURRAY, aver that I am over the age of eighteen (18) and that I am competent to be a witness in these proceedings. I declare the following to a reasonable degree of professional certainty, and I would testify as follows:

1. I am a senior partner and the Professional Development Leader of the Insurance Coverage Practice at the law firm of Dickstein Shapiro LLP ("Dickstein Shapiro") in Washington, D.C. Our firm was retained in March of 2013 by Jonathan Schochor of Schochor, Federico & Staton, P.A., counsel for the Plaintiffs, to act as insurance coverage counsel with respect to the Defendants Johns Hopkins Hospital, Johns Hopkins Community Physicians, Inc., and Johns Hopkins Health System Corporation's (the "Johns Hopkins Defendants") claims for insurance for the underlying liabilities of these Defendants arising out of the conduct of Nikita A. Levy, M.D. and allegations of their own direct negligence (the "Levy Claims").

2. The Plaintiffs and the Defendants have reached a settlement agreement providing for a payment of $190,000,000 in cash to the Class Plaintiffs (the "Settlement").

3. I submit this affidavit regarding the fairness and reasonableness of the settlement between the Plaintiffs and the Johns Hopkins Defendants. I also submit this affidavit in support of the Joint Motion for Approval of the Class Settlement. I have been personally and directly involved in the negotiations that led to the Class Settlement. I have personal knowledge of the matters set forth herein.

A. Experience

4. I am the Professional Development Leader of Dickstein Shapiro's Insurance Coverage Practice, which is one of the nation's largest insurance groups representing exclusively policyholders. In 2014, we were named a "Leading Insurance Policyholder Firm" by Chambers USA and by Legal 500: The Clients' Guide to the U.S. Legal Profession and a "Tier-1 National Insurance Law Firm" by U.S. News and Best Lawyers. In 2012, U.S. News named us "Law Firm of the Year (Insurance)." We have frequently been included among the top five insurance practices in the United States by Law360 and our firm has twice been named to the National Law Journal's "Plaintiffs' Hot List" (in 2013 and 2011) due in large part to the success of our insurance coverage attorneys. Our group has helped clients recover more than $5 billion from insurance companies in the last five years alone.

5. A complete copy of my biography is attached as Exhibit A. I have represented policyholders on matters involving nearly every line of insurance over the last 28 years. Law360 designated me as one of only three national "MVPs" for insurance coverage in 2011 and one of only five in 2013 (the only insurance lawyer to have received this recognition twice).

6. Since 2003, I have devoted a significant part of my insurance coverage practice to representing policyholders in pursuit of insurance coverage for claims involving underlying allegations of sexual conduct. I served as insurance coverage counsel to the Roman Catholic Archdiocese of Seattle since 2003. In 2004, the United States Bankruptcy Court for the Eastern

District of Washington appointed me special insurance coverage counsel to the Debtor Roman Catholic Diocese of Spokane. That assignment lasted through 2007 and resulted in court approval of almost $20 million of insurance settlements from the Diocese's historical liability carriers. In 2009, the United States Bankruptcy Court for the District of Oregon appointed me special insurance coverage counsel to the Debtor Oregon Province of Jesuits. That assignment lasted through 2011 and resulted in court approval of almost $120 million in settlements between the Oregon Province of Jesuits and its historical insurance companies. In 2014, the United States Bankruptcy Court for the District of Montana appointed me special insurance coverage counsel to the Debtor the Roman Catholic Diocese of Helena, which resulted in almost $15 million in insurance settlements, subject to court approval and plan confirmation later this year. I most recently served as insurance coverage counsel to the defendant Beebe Medical Center, Inc., and subsequently, with the consent of Beebe Medical Center, to the plaintiffs in litigation involving the conduct of Earl B. Bradley, M.D. a Delaware Pediatrician, which resulted in a $123.1 million settlement. I testified before Hon. Joseph R. Slights III (Delaware Superior Court) at the fairness hearing in that case. I have been qualified as an expert in insurance coverage by the United States Bankruptcy Court for the District of Montana and I testified at trial in *Richardson, Chapter 7 Trustee for Yellowstone Club World LLC et al. v. Cincinnati Insurance Company* (2011).

B. Summary of Opinions

7. These are the salient aspects of my professional opinions regarding the Class Settlement and the insurance settlements in this case. I am prepared to testify to the same.

- The limits of applicable insurance coverage for claims arising out of the acts of Nikita Levy, M.D. and the allegations of direct negligence by the Johns Hopkins Defendants are $224 million dollars;

- The insurance policies applicable in this matter are wasting policies, meaning that any expenses incurred in the defense of this matter by the Johns Hopkins Defendants or on their behalf by their insurance carrier, MCIC Vermont, Inc., would be deducted from the insurance otherwise available to pay judgments or settlements;
- The assets of the Johns Hopkins Defendants are unavailable to the Class Plaintiffs under the Doctrine of Charitable Immunity;
- The Settlement between the Johns Hopkins Defendants and the Plaintiffs is fair and reasonable. Indeed, in view of the limits of available insurance, the Johns Hopkins Defendants' Charitable Immunity, and the "wasting" nature of the available insurance policies, the result in this case is extraordinarily favorable to the Class Plaintiffs.

C. Retention by the Plaintiffs and MCIC Coverage

8. In March of 2013, Schochor, Federico & Staton, P.A. retained me to serve as insurance counsel with respect to the underlying Levy Claims against the Johns Hopkins Defendants and the Johns Hopkins Defendants' claims for insurance for those claims. Following my retention, my team received and reviewed voluminous binders of documents, including the Johns Hopkins Defendants' applicable or potentially applicable insurance policies discussed below, the underlying Class Action complaint setting forth the Levy Claims, expert reports and other additional information regarding the substance of the Levy Claims, and the mediation statements submitted in connection with the settlement process.

9. Our first step in determining the amount of available insurance was to determine what "lines" (or types) of insurance coverage were implicated by the Levy Claims. The Johns Hopkins Defendants maintain a liability insurance program comprised of a primary policy and three excess policies offering potential total coverage "limits of liability" of either: (a) $224 million in Professional Liability insurance, or (b) $205 million in General Liability insurance, depending on the applicable coverage.

10. MCIC Vermont, Inc. ("MCIC") provided all of the Johns Hopkins Defendants' Professional Liability and General Liability insurance on a claims-made basis since 1988, when Dr. Levy began working for the Johns Hopkins Defendants. Because these claims-made insurance policies respond to claims made against the insureds in the policy year in which a claim of wrongdoing is asserted (here, by service of the Class Action Complaint against the Johns Hopkins Defendants) and no historical "occurrence"-based Professional Liability and General Liability insurance policies cover any period of Dr. Levy's employment, only a single year's insurance policies are in play in this case.

11. The Professional Liability and General Liability insurance provide alternative coverage that forecloses the possibility of concurrent recovery under both coverage parts. The policies specify that if a claim implicates both the Professional Liability and the General Liability insurance, only the Professional Liability insurance will apply and provide coverage. As such, the General Liability insurance would be applicable only if the Professional Liability insurance did not afford coverage for the underlying Levy Claims. As a result, in this case, only the Professional Liability insurance applies and provides the Johns Hopkins Defendants coverage.

12. The Johns Hopkins Defendants' liability insurance program includes a primary policy bearing policy number PR 1113, which provides Professional Liability coverage for claims made during the January 1, 2013 to December 31, 2013 period (the "Primary Policy"). The program also includes three excess policies that follow form to the Primary Policy in all relevant respects (the "Excess Policies"). In total, the Primary Policy and the Excess Policies provide combined coverage "limits of liability" of $224 million for any and all Professional Liability claims. Unlike many insurance programs that are comprised of different commercial

insurers participating at each layer, a single insurer, MCIC, issued both the Primary Policy and the Excess Policies. The Johns Hopkins Defendants' Primary Policy and Excess Policies provide Professional Liability coverage for the Levy Claims.

13. In assessing the availability of coverage, the proper analysis focused on the alleged misconduct of the Johns Hopkins Defendants – i.e., whether the "Claims" against the Johns Hopkins Defendants "arise out of . . . any act, error or omission . . . in the furnishing of or the failure to furnish Professional Services." Here, the allegations in the underlying complaint support the argument that the claims against the Johns Hopkins Defendants fall within the terms of coverage. For example, the underlying complaint clearly alleges, and the facts wholly support, that the Johns Hopkins Defendants made errors and omissions in the furnishing of "medical . . . or other professional healthcare treatment or services" that satisfy the first prong of the "Professional Services" definition.

14. Although the "Professional Services" definition was satisfied as to the Levy Claims in my professional opinion, MCIC raised and, absent settlement, could have pursued arguments that the "Professional Services" definition was not satisfied based on the nature of the conduct alleged against Dr. Levy and the Johns Hopkins Defendants. In that case, the General Liability coverage might have applied, but then only if the alleged conduct caused "bodily injury" to Plaintiffs and was not excluded by a "Sexual Misconduct" exclusion applicable only to the General Liability coverage part. These potential arguments, and the likely cost of overcoming them, have informed my professional opinion as to the reasonableness of the Settlement.

D. Other Policies

15. In addition to the Professional Liability and General Liability insurance programs discussed above, the Johns Hopkins Defendants also maintained a directors and officers

("D&O") insurance program comprised of a primary policy and three follow-form excess policies offering total "limits of liability" for Entity Coverage of $25 million (subject to a $500,000 retention). The Johns Hopkins Defendants also maintained a Cyber Liability insurance policy offering total "limits of liability" for Information Security & Privacy Liability of $20 million (subject to a $500,000 retention). Neither of these additional insurance programs is applicable to the Levy Claims, as both contain a clear and specific exclusion for all claims related to or arising from bodily injury, mental anguish, emotional distress, and humiliation -- the specific harms alleged by the Plaintiffs in the underlying complaint for the Levy Claims.

E. "Wasting" Policies

16. Pursuant to the language of the MCIC Primary Policy and Excess Policies, all amounts paid in defense of an underlying lawsuit or separate lawsuits count toward the erosion of the applicable coverage limits. Thus, the sooner that an underlying suit is resolved, the more insurance will remain to pay the underlying victims. In sum, the Primary Policy and Excess Policies at issue would pay a maximum of $224 million, less all defense costs, for a covered claim. Accordingly, all costs for the Johns Hopkins Defendants' defense counsel (local and national, billable by the hour) in addition to all costs for defense medical and other experts as well as all associated costs would be deducted from any available insurance coverage prior to any payments made to the Plaintiffs.

17. On the basis of my experience working on behalf of insureds in matters concerning allegations similar to those at issue in this case, it is my opinion that if these claims were litigated individually, as opposed to through a Class Action, the wasting nature of these insurance policies would result in the vast majority of the available insurance being spent in the defense of these claims, rather than being paid to the Class Plaintiffs. It is my opinion that in any event, significantly less than $190 million would be available for recovery by the Class

Plaintiffs, were these claims litigated individually. That is because a Class Action provides economies of scale, requiring a single defense of the allegations rather than separate defenses of each individual claim, potentially by separate defense attorneys in multiple jurisdictions and with additional costs to coordinate those defenses. For example, if the Johns Hopkins Defendants spent only $25,000 in defending each case individually (which would include all lawyers' fees, experts' fees for liability issues as well as evaluating each Plaintiff for damages, and associated expenses), all insurance proceeds would be paid to the defense attorneys and experts and not the Plaintiffs. Certainly if these cases were litigated individually, a few Plaintiffs might benefit to the detriment of thousands of others.

18. It is also my opinion that even if these claims were litigated to verdict as a class action, and the Plaintiffs prevailed, there would be significantly less than $190 million available for recovery by the Plaintiffs.

F. Charitable Immunity

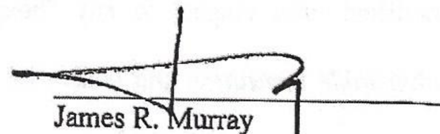
19. Recovery on behalf of the Class Plaintiffs in this matter is limited to the available insurance coverage. The assets of the Johns Hopkins Defendants are immune from suit pursuant to the doctrine of charitable immunity. Maryland traditionally holds entities that maintain their funds "in trust for charitable purposes" immune from liability in tort, *Perry v. House of Refuge*, 63 Md. 20 (1885). This common law "charitable immunity" doctrine has long since been codified with respect to any "hospital or related institution." Any such entity "that *is a charitable institution and is insured* against this liability in an amount of not less than $100,000 *is not liable* for damages in excess of the limits of that insurance." Md. Code Ann., Cts. & Jud. Proc. § 5-632(c) (West) (emphasis added). Thus, pursuant to Maryland statute, the Johns Hopkins Defendants, as charitable institutions are not liable in excess of their $224 million dollar policy limits.

G. Negotiation

20. I was present for each of the mediation sessions between defense counsel for the Johns Hopkins Defendants, the Johns Hopkins Defendants' insurance carriers, those insurers' reinsurance carriers, Class Counsel, General Counsel, and Risk Managers for the Johns Hopkins Defendants. These negotiations were arms-length, adversarial, and at times, very hotly contested.

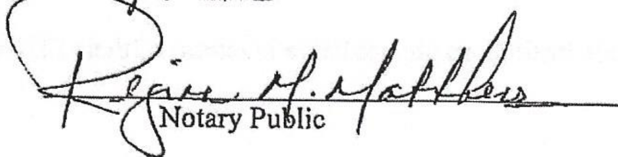
H. Conclusion

21. For all the reasons stated in this Affidavit, I believe, based on 28 years of experience, that this settlement is fair, adequate and reasonable. Indeed, it is my opinion that the result is extraordinary, based on all of the factors involved in this litigation. It is my belief that this Settlement constitutes the largest settlement of a Class Action founded upon allegations of sexual abuse, and the third largest sexual abuse settlement of any kind. Insurance coverage litigation would not have resulted in greater recovery in this matter, and the global settlement of this matter has successfully preserved insurance assets for the Class Plaintiffs that would otherwise be spent for the defense of this action. Indeed, if a global settlement had not been reached in this matter, the only future certainty would be many, many years of prolonged litigation with an uncertain outcome. Certainly, significantly less than $190 million would be available to Plaintiffs if this litigation had not been resolved in a Class Action.



James R. Murray

Sworn to before me on this 11th day of September 2014



Notary Public