ARTICLES

THE NEW YORK STATE MEDICAL INDEMNITY FUND: REWARDING TORTFEASORS WHO CAUSE BIRTH INJURIES BY RATIONING CARE TO THEIR VICTIMS

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TABLE OF CONTENTS

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I. INTRODUCTION

For many years New York's medical community has asserted that increased medical malpractice insurance premiums have contributed to driving up the cost of medical care.[1] Whether or not this is true,[2] it is unquestioned that when a child suffers a severe neurologic injury at birth, the cost of caring for that child (who will eventually become an adult and may live for fifty years or more) can be enormous. It has been argued, that because of this enormous cost, malpractice verdicts and settlements arising from birth trauma, as compared to other causes of medical malpractice, contributes disproportionally to "high" malpractice costs paid by hospitals and obstetricians.[3]

It would seem that the most obvious way to decrease the cost of obstetric malpractice (and simultaneously improving patient outcome) would be to reduce the incidence of malpractice and the

[1] *See* GREATER N.Y. HOSP. ASS'N, OVERVIEW OF THE NEW YORK STATE MEDICAL INDEMNITY FUND FOR NEUROLOGICALLY IMPAIRED NEWBORNS (March 2011), *available at* www.gnyha.org/10711/File.aspx; Amos Grunebaum et al., *Effect of a Comprehensive Obstetric Patient Safety Program on Compensation Payments and Sentinel Events*, 204 AM. J. OBSTETRICS & GYNECOLOGY 97, 102–03 (2011).

[2] It was recently reported that medical malpractice insurance is, by a wide margin, the most profitable line of property and casualty insurance. "The medical professional liability insurance (MPLI) sector continues to stand out among insurance sectors for its ability to garner profits and generate returns far in excess of the composite averages of its property/casualty peers, according to a recently released A.M. Best Co. special report." *A.M. Best Special Report: Medical Professional Liability Outperforms, But is This Sustainable?*, BUSINESS WIRE (May 2, 2012, 10:41 AM), http://www.businesswire.com/news/home/20120502006132/en/A.M.-Special-Report-Medical-Professional-Liability-Outperforms.

[3] *See* GREATER N.Y. HOSP. ASS'N., *supra* note 1. It is beyond the scope of this article to address, much less resolve, any argument as to the extent of malpractice premium cost increases, the causes of any such increases, or whether such increases are justified.

severity of the injuries that occur, as some leading hospitals have done.[4] Another possibility, as some states have tried, would be to create a type of "no fault" system similar to workers compensation—all birth injured children would have certain but reduced compensation, in exchange for eliminating the need to establish that their injury was the result of malpractice, though they may still have to prove causation.[5]

Instead of adopting these approaches, effective April 1, 2011, New York took the unprecedented step of rationing care to children who had *proven* that they were injured at birth by the negligence of a hospital, physician, or other health care professional. The Legislature and the Governor did this by preventing these children from recovering their court determined damages for future care costs from the tortfeasor who caused their injuries, and forcing them into the state administered New York State Medical Indemnity Fund. The Fund is entitled to completely ignore the findings of the court as to the future care required by the child. Rather, the Fund will exclusively determine the nature and extent of the care that the malpractice victim will get and how much it will pay for such services.[6]

Ironically, instead of controlling health care costs by reducing the incidence of obstetric malpractice (and the legal and care costs associated with it), the Fund may actually wind up increasing both the number of birth related injuries and costs. There are two reasons for this: first, since the cost of their negligence is no longer born by the wrongdoer, there will be less incentive to practice sound medicine;[7] second, because the Fund applies to settlements as well as judgments, and the tortfeasor is unconcerned with the actual cost of care, there may be an incentive to settle less meritorious cases without regard to its total cost to the Fund.[8] Nor does the Fund reduce the number of what may be asserted to be "frivolous" or unmeritorious claims. To the contrary, the Fund *only* applies to cases in which the

[4] Grunebaum, *supra* note 1, at 97, 102–104.

[5] *See* VA. CODE ANN. § 38.2-5002 (West 2011); FLA. STAT. ANN. § 766.303 (West, 2011). The success or failure of these measures is beyond the scope of this article.

[6] *See* Thomas A. Moore & Matthew Gaier, *Budget Bill's 'Tort Reform' Targets Rights of Injured Children*, N.Y. L.J., April 5, 2011, at 3.

[7] *See* Lawrence Knipel, *Diverse Consequences Arising From State Medical Indemnity Fund*, N.Y. L.J., Nov. 15, 2011, at 7.

[8] *See id.*

injured child has already established liability and causation to the satisfaction of the court, or to cases that the defendant has deemed sufficiently meritorious by agreeing to settle it.[9]

Entirely aside from the potential adverse health consequences that are likely to result from the limitations to care that are inherent in the bureaucratic determination of indispensable care services to the most catastrophically injured malpractice victims, the manner in which the Fund is set up to operate creates a host of logistical and legal issues for the enrollee. Perhaps more important, there are a number of serious questions concerning whether the Fund, and the way it is designed and operates, is constitutional.

Despite a long tradition of tort law that allows a worthy plaintiff the right to recover sufficient damages from a negligent defendant to provide for the future care necessitated by the tortfeasor's wrongdoing, the Fund makes no such provision. Instead, the Fund treats the successful plaintiff in a manner that is essentially no different than if he were receiving Medicaid—though ironically in some ways a Medicaid recipient has greater legal rights than someone forced into the Fund.[10] Although it would seem only reasonable that someone who was harmed by the negligence of another should at least be entitled to a recovery that provides for care needs beyond the often inadequate minimal care provided by Medicaid, such is not the case under the Fund.[11] This article will initially focus on the consequences that will occur to the families of children enrolled in the Fund. It will then examine the federal and New York State Constitutional issues that are raised by (1) the creation of the Fund, (2) the manner in which the Fund operates, and (3) the Fund's impact on the rights of the children who are forced into it and thus deprived of the right to enforce their judgment against the tortfeasor who caused the need for future care.

Part II of this article provides a general background to the Fund and compares it to the manner in which damages in medical malpractice cases are traditionally determined in New York. Part III explains how the Fund will function under the "emergency regulations" promulgated by the Department of

[9] *See* Moore & Gaier, *supra* note 6.
[10] *Id.*
[11] *Id.*

Health as of March, 13, 2012,[12] and how these regulations may ultimately impact the quality of care provided to Fund enrollees. Part IV discusses the practical difficulties that the Fund will present to both enrollees and the state, and how it may impact the care received by these children—who of course will eventually become adults. Finally, Part V considers the various constitutional issues that are implicated by the Fund. These include possible violations of the separation of powers, the right to a jury trial, the appropriation of public monies for private purposes, and the denial of due process and equal protection.

II. BACKGROUND

A. The Medical Indemnity Fund

Effective April 1, 2011 the Legislature created the New York Medical Indemnity Fund, with the stated goal of controlling the costs of malpractice insurance for obstetricians and hospitals providing obstetric services.[13] It is critical to note that participation in the Fund is mandatory, and is applicable only after the plaintiff receives a judgment or settlement that includes the tortfeasor's liability for future medical care arising from medical malpractice that causes a birth related neurological injury.[14] Therefore, the Fund has nothing to do with reducing "frivolous" or "unmeritorious" claims, since it only applies to

[12] The Fund's "emergency regulations" were adopted on September 15, 2011, have been readopted as "emergency regulations" several times, and remain in force as of June 1, 2012, the date of the submission of this article. As a result, there have never been any public hearings on the Fund regulations, nor have any public hearings been noticed as of this time. Thus, there has been no opportunity for the public to submit comments on the regulations, even though it is more than one year after the Fund was enacted and more than seven months after applications for enrollment have been accepted. After this article was submitted for publication, the Fund readopted "emergency regulations" effective June 15, 2012. Although there are slight changes in the "new" emergency regulations, they do not change the discussion contained in this article as submitted. However, some of the changes further demonstrate a violation of the separation of powers and also further impair an enrollee's access to care. Moreover, the authority cited for enacting "emergency regulations" indefinitely is the initial budget bill which created the Fund. 2011 N.Y. Sess. Laws ch. 59, Part H, §§ 52, 111, 111(q) (McKinney). This is a further illustration of the unconstitutional enactment of changes in substantive law in a budget bill which is prohibited by Article VII, Section 6. *See infra* Part V.F.

[13] 2011 N.Y. Sess. Laws ch. 59, Part H, §§ 52, 111, 111(q) (McKinney).

[14] N.Y. PUB. HEALTH LAW § 2999(j)(6)(7) (McKinney Supp. 2012); Knipel, *supra* note 7; Moore & Gaier, *supra* note 6.

plaintiffs who have either successfully won their cases at trial, or persuaded the defendant to settle their claims because of the defendant's concern that the plaintiff will succeed at trial. The Fund transfers the financial obligation of the defendant and/or his insurer to pay for future care costs as determined by the court, to the state and its taxpayers. This has significant ramifications to each of these parties. The restrictions on recovery for future care costs only apply to a small subclass of medical malpractice victims: those who have suffered neurologic impairment that occurred during (1) labor, (2) delivery, or (3) any period of resuscitation after birth.[15]

The Fund therefore serves as a mandatory alternative to a money judgment for future medical care that was determined by the jury.[16] The Fund does not automatically take effect simply because an infant has suffered a birth related neurological injury and asserts that it is a result of medical malpractice. In order to be covered, a child who has suffered a neurologic impairment at birth must initiate a lawsuit against the defendants and then either (1) receive a judgment of damages based upon a jury verdict, just as in any other malpractice case or (2) reach a settlement agreement with the defendants.[17] In either instance, it must be recognized that a portion of the damages relate to the future care needs of the infant.[18] The Fund has no effect with regard to any pain and suffering damages or economic damages that are not attributable to future medical care.[19] However, once the birth injured child is accepted into the Fund, the defendant is completely relieved of the obligation to pay any portion of the settlement or judgment attributable to any aspect of future care costs, whether or not the Fund actually pays for or provides the services determined to be necessary by the court.[20] The Fund, therefore, does not provide payments to anyone except those who have already successfully won or settled a malpractice case.[21]

As noted, the Fund is mandatory for any malpractice victim who has suffered a birth-related neurological injury. The plaintiff cannot choose to simply recover his damages from the defendant

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15 PUB. HEALTH § 2999-h(1).
16 *Id.* § 2999-j(6)(b); Knipel, *supra* note 7.
17 PUB. HEALTH § 2999-j(6).
18 *Id.*
19 *Id.* Moore & Gaier, *supra* note 6.
20 PUB. HEALTH § 2999-j(6).
21 *Id.*

or opt out of the Fund. Thus, regardless of any adverse consequences to the plaintiff, he is stuck with all of the restrictions and limitations that the Fund imposes.[22] The statute requires that any judgment made in favor of any plaintiff for future care damages resulting from such injury must decree "the future medical expenses of the plaintiff shall be paid out of the fund."[23] After a judgment or settlement where a finding that future care will be required for a birth related neurological injury, either the plaintiff *must*, *or the defendant* may, make an application to place the infant plaintiff into the Fund.[24] Therefore, the *defendant* has the right to be relieved from paying that portion of the judgment relating to future care costs by placing the plaintiff into the Fund, thereby imposing future care costs on the state.

The Commissioner of Taxation and Finance serves as the custodian of the Fund and it is to be administered by the Superintendent of Financial Services or her designee.[25] It appears that the Fund is to be financed by a combination of general appropriations as well as a "quality contribution" collected by the state from general hospitals.[26] The "quality contribution" is based on a tax of 1.6 percent on impatient revenue of the general hospital derived from "inpatient obstetrical patient care services."[27] The legislative appropriation for the first year of the Fund came from the Health Care Reform Act Fund and amounted to $30 million.[28] The amount that is

[22] *Id.* § 2999-j(6)–(7); Knipel, *supra* note 7.

[23] PUB. HEALTH § 2999-j(6)(b). Even though this statement is made, the Fund regulations, as described below, place significant limitations on the types and the extent of care that will provided, how much they will pay for it, and even if such care will in fact be provided.

[24] *Id.* § 2999-j(7).

[25] *Id.* § 2999-i(1)–(2).

[26] *Id.* §§ 2807-d-1, 2999-i(5); THOMAS A. MOORE & KEVIN P. MCMULLEN, MEDICAL MALPRACTICE: DISCOVERY & TRIAL § 17:2.4[B][1] (7th ed. 2012). The term "contribution" is a euphemism since the funding source is neither a "contribution" nor related in any way to the improvement of the quality medical services. In fact it is a tax on obstetrical services, and this may have significant legal consequences. *See infra* Part V.C. Moreover, by eliminating the responsibility of the tortfeasor to pay for the damages caused by his or her negligence it is hard to see how this will in any way lead to an improved "quality" of services. Knipel, *supra* note 7.

[27] PUB. HEALTH § 2807-d-1; MOORE & MCMULLEN, *supra* note 26, § 17:2.4[B][1].

[28] PUB. HEALTH § 2807-d-1; Joel Stashenko, *Lawyers Await Specific Regulations on Infant Medical Malpractice Fund*, N.Y. L.J., April 20, 2011, at 1.

supposed to be appropriated by the Legislature will be increased each year based on the increase in the consumer price index published by the U.S. Department of Labor.[29]

The tax ("quality contribution") rate is fixed, and the number of births in New York is relatively constant. The number of children covered by the Fund, however, will inevitably increase each year for several decades as more children are enrolled, but before a significant number of enrollees die and exit the plan. Therefore, there can be no assurance as to how long the tax will raise enough money for the Fund to remain solvent and either continue to accept new enrollees or pay care promised to those already accepted into the Fund. Perhaps for this reason, the Legislature specifically provided that when 80 percent of the Fund's resources are already allocated to "beneficiaries," enrollment will be suspended and the Fund will no longer accept new applicants until the Fund's liabilities are below 80 percent of its resources.[30] During the period of suspension judgments and settlements would be satisfied as if the Fund did not exist.[31] The appropriation to the Fund must, in addition to paying for care to enrollees, bear the cost of administering the Fund, thereby further reducing the amount available for care, and increasing the risk of insolvency.[32]

Instead of the plaintiff having the resources to pay for the future care from her recovery determined by the court, the plaintiff would have to apply anew to the Fund Administrator to seek payment for future care services. Because such care could be denied by the Fund, the very care to which the infant plaintiff was already found entitled by a court, after a full hearing on the merits, may forever be in jeopardy.[33] Since, as noted above, it was recognized that the appropriation by the Legislature may not be sufficient to pay all the potential claims of birth injury malpractice victims, the Administrator would have every

[29] PUB. HEALTH §§ 2807-d-1(2), 2999-i(5), (7).

[30] *Id.* § 2999-i(6)(a). This has potential constitutional ramifications because it clearly envisions a scenario in which two identically injured children, with identical judgments for future care costs, could wind up with vastly different recoveries based solely upon the timing of whether the Fund was exhausted by the time of the year that their individual judgments were obtained. *See infra* Part V.B.

[31] PUB. HEALTH § 2999-i(6)(b).

[32] *Id.* § 2999-i(3).

[33] N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.6 (2012); *see id.* §§ 69.7–69.13 (explaining the prior approval requests process for future services).

motivation to deny the care to which the child was already found entitled.[34] In addition, the Fund legislation provides that the Fund Administrator will be appointed by the Superintendent of the Department of Financial Services.[35] Thus, any political appointee who assumes this position will be beholden to the state and its finances and not to the plaintiff or the judgment rendered by the court.

The ultimate impact to those children who "qualify" for payment by the Fund is to remove both the court and the child's caregivers as the final arbiter of health care decisions, even though there was already a previous jury verdict determining future care damages. Instead, the Fund would decide what type of care is appropriate for the infant victim, the quality of that care, and how much they will pay for it, without any regard whatsoever to the jury's finding. [36] As a consequence, at least with respect to future care, the child is in no significantly better position than if he had no claim for malpractice at all, and had to rely solely upon Medicaid.[37] Moreover, without control of the assets from a recovery for future care costs, the child's family will be unable to plan for or assure essential care for their child after they are no longer able to do so.[38]

B. Malpractice Judgments in New York: Article 50-A

It is important to understand the manner in which damages for medical malpractice plaintiffs are determined in New York. Since its revision in 2003, Civil Practice Law and Rules (CPLR) Article 50-A specifies how damages are to be computed and paid

[34] *See supra* notes 25–32 and accompanying text.

[35] PUB. HEALTH §§ 2999-i(2)(a).

[36] *Id.* § 2999-j(2), (6); Moore & Gaier, *supra* note 6.

[37] Moore & Gaier, *supra* note 6.

[38] Some have argued that because of the prevalence of Supplemental Needs Trusts, the Fund avoids the potential of a double payment for future care costs to the birth injured child. GREATER N.Y. HOSP. ASS'N., *supra* note 1. This argument is without basis because to the extent that a Supplemental Needs Trust pays for items that are not covered by Medicaid, there is obviously no "double" payment. *See* LEE S. KREINDLER ET AL., 16 NEW YORK PRACTICE SERIES—NEW YORK LAW OF TORTS § 21:44 (2011). For items that would otherwise be paid by Medicaid for the child's care costs, under a Supplemental Needs Trust these payments must be repaid to Medicaid at the time of the death of the child. N.Y. SOC. SERV. LAW § 366(2)(b)(2)(iii)(A) (McKinney 1971 & Supp. 2012); KREINDLER ET AL., *supra* note 38, at § 21.44. Accordingly, there would not be a situation where there would have been a "double" payment.

in all medical negligence cases, including birth injury cases.[39] As will be seen, the interplay between the Fund and Article 50-A will create an additional subclass of birth injury plaintiffs who are treated differently, not only from other tort victims, but also from other malpractice victims with the exact same injury.[40]

Article 50-A and CPLR section 4111 form the basis for assessing damages for future care expenses.[41] In summary, the statutes require that the jury make a finding of (1) the annual cost of care; (2) whether the condition is permanent (which in these cases it almost always is); and (3) a rate of inflation applicable to future care costs.[42] Future costs are established by expert testimony, usually by a life care planner, by physicians, or some combination of both.[43] Medical inflation is usually proven by an economist, and has averaged around 5.75 percent since 1950, depending on how it is measured.[44] Assuming a life expectancy of at least seventy years, a present value cost of care at $150,000 per year at current market rates going up even only 4 percent per year would greatly exceed a present value of $10 million per case.

After the jury makes the findings required by statute, the Judge then takes the annual cost of care, applies the jury determined inflation rate, and arrives at a total, which for purposes of entering a judgment, computing attorney's fees and interest, is discounted to present value using the appropriate investment discount rate.[45]

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[39] N.Y. C.P.L.R. § 5031 (McKinney 2007).

[40] C.P.L.R. § 4111 (McKinney Supp. 2012); C.P.L.R. § 5031; *see infra* Part V.B.

[41] C.P.L.R. §§ 4111, 5031.

[42] C.P.L.R. §§ 4111(d), 5031(d).

[43] Michael W. 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); Michael W. Kessler, *Defeating the Reduced Life Expectancy Defense*, *in* 2 ASS'N TRIAL LAW AM. ANN. CONVENTION REFERENCE MATERIALS: TRAUMATIC BRAIN INJURIES 2283 (2004).

[44] Robert W. Johnson, *Presenting Damages for Earning Capacity and Future Medical Expense Damages: An Economists Perspective*, *in* 1 ASS'N TRIAL LAW AM. ANN. CONVENTION REFERENCE MATERIALS: TRAUMATIC BRAIN INJURIES 1277 (2005).

[45] C.P.L.R. § 5031(d), (f).

C. The Impact of the Fund on Article 50-A in Birth Injury Malpractice Cases

As discussed above, the substantive law of damages in *all* medical malpractice cases and how they are paid is governed by CPLR Article 50-A, and in particular section 5031 and its counterpart section 4111, detailing the findings to be made by the jury.[46] These provisions of law—which also direct the court how to compute and enter judgment in a malpractice case—were not repealed or amended by the Fund statute, and therefore remain in force.[47] Some of the provisions of section 5031 would appear to inherently conflict with the Fund legislation, and some of the Article 50-A provisions could—and section 4111 *would*—still be applied even if it was determined that the Fund statute takes precedence.[48] These conflicts would seem to be a consideration with respect to several of the constitutional arguments discussed below—separation of powers, the right to a jury trial, equal protection, and due process.

By its terms, the application of section 5031 is just as obligatory as is the Fund legislation. It commands, among other things that "the court *shall* proceed as follows" and "the court *shall* apply to the findings of past and future damages."[49] It would appear that nothing in the Fund legislation eliminates the defendant's obligations pursuant to CPLR section 5031(h). That section mandates that "judgment shall be entered on the lump sum payments and the present value of the streams of payments required to be made by the defendants under this section."[50]

Section 5031(b) provides that "all damages for future loss of services . . . of five hundred thousand dollars or less shall be paid

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[46] *Id.* §§ 4111(d), 5031. Section § 4111 enumerates the specific findings required by the jury to provide the basis for the court to enter Judgment under Article 50-A. *Id.* § 4111(d).

[47] 2011 N.Y. Sess. Laws ch. 59 (McKinney).

[48] Since by its own terms the Fund legislation only applies after the jury has fulfilled its fact finding role, the requirements of section 4111 will necessarily still apply. N.Y. PUB. HEALTH LAW § 2999-j (McKinney Supp. 2012).

[49] C.P.L.R. § 5031, (a) (emphasis added).

[50] *Id.* § 5031(h). This is required even under the Fund, because without this component of the judgment, there would be no means of computing attorney's fees or interest. N.Y. PUB. HEALTH LAW § 2999-j. Similarly, because the Fund will cease to take enrollees after it is 80 percent exhausted, it can never be known at trial whether the plaintiff will be enrolled. As a result there can be no alternative but to compute the judgment in accordance with Article 50-A and C.P.L.R. section 4111. PUB. HEALTH § 2999-i(6).

in a lump sum."[51] This is inherently contradictory to the Fund legislation, which provides that portion of the judgment related to future care is carved out of the judgment and such services are to be paid by the Fund as they are approved and incurred.[52] Although it could be argued that the more specific birth injury case legislation trumps section 5031(b), it is equally likely that by leaving this section intact and by failing to except birth injury cases from its application, the Legislature intended to require that for cases under $500,000 the Fund would not apply, and that the defendant would have to pay that sum in cash. Similarly if the Fund statutory scheme does or does not apply to these cases, a conundrum is created: either the court's independence to fashion a judgment under section 5031 is impaired, or, if section 5031 takes precedence, a discriminatory "subclass" and "taking" has been created.[53] In that instance, birth injury victims with future damages less than $500,000 are treated differently not only from other malpractice victims (because they are enrolled in the Fund), but from birth injury victims with damages greater than $500,000 (because they are entitled to a lump sum payment). These issues raise additional significant equal protection arguments.

A similar and perhaps even more vexing issue is created by CPLR section 5031(g), which mandates that "[t]he defendants and their insurance carriers shall be required to offer and to guarantee the purchase and payment of an annuity contract to make annual payments in equal monthly installments of the remaining streams of payments specified in such subdivisions (c) and (d). . . ."[54]

In the first place, with respect to the taking of a property right determined by the court and the denial of a jury trial, nothing could better demonstrate the differences between this annuity requirement and care being provided by the Fund instead. Under section 5031(g), the defendant must offer an annuity to guarantee payments of the sums for future care as determined by the jury, whereas under the Fund, there is no lifetime reserve. To the contrary, it is purely "pay as you go," as long as the Fund has

[51] C.P.L.R. § 5031(b).

[52] PUB. HEALTH § 2999-j.

[53] The Fund creates a cornucopia of different subclasses of tort victims that it discriminates against, as this article will point out below.

[54] C.P.L.R. 5031(g).

assets.[55] There is nothing to back the "promise" of future care or assure that it will be paid, even if it were to duplicate the care that the jury found to be required. Similarly, there would appear to be no reason why the annuity requirement cannot be applied even if the Fund statute was determined to be applicable. This section still requires that "defendants and their insurance carriers," offer an annuity to the plaintiff to guarantee payments.[56] One can only presume that the Legislature's failure to repeal or amend section 5031 as applied to birth injury cases meant, at a minimum, those portions of that section that can be applied consistent with the Fund must still be applied. Section 5031(f) would appear to fall into this category. To the extent that it is asserted the Fund legislation effectively superseded section 5031(f), it would appear to demonstrate the Fund's infringement of the separation of powers, a taking without compensation, a denial of equal protection, and interference with the right to a jury trial.[57]

By leaving Article 50-A intact when the Fund was created, it is certainly reasonable to argue that the Legislature fully intended at least portions of it would continue to be applied, even in birth injury malpractice cases, and there is little basis to conclude otherwise.

III. HOW THE FUND OPERATES: THE REGULATIONS

Without the opportunity for any significant public comment, effective September 15, 2011, emergency regulations to effectuate the New York State Medical Indemnity Fund were adopted by the New York State Department of Health.[58] These regulations were adopted pursuant to Public Health Law Section 2999-j(15).[59] They have been readopted, apparently as "emergency regulations"—and therefore without public hearings—again in December 2011 and March 2012. This analysis of how the Fund is designed to actually operate will follow the sequence of the Regulations themselves.

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[55] Stashenko, *supra* note 28.

[56] C.P.L.R. 5031(g).

[57] *Id.* C.P.L.R. 5031(f); *see infra* Part V.

[58] 33 N.Y. Reg. 25–26 (Sept. 28, 2011).

[59] N.Y. PUB. HEALTH LAW § 2999-j(15) (McKinney Supp. 2012); N.Y. COMP. CODES R. REGS. tit. 10, § 69-10 (2012); *id.*

A. Definitions

It is important to have an understanding of certain definitions in the regulations have a grasp of the various problems and issues that the Fund is going to have in trying to provide care to children who have suffered neurologic impairment from an injury at birth.

Assistive Technology

"Assistive technology (AT) means an item, piece of equipment or product system, whether purchased ready to use or needing modification or customization, ordered by a physician, that is used to maintain, increase or improve the functional capacities of the user."[60] Notably it must be "ordered by a physician."[61] This would seem to preclude assistive technology equipment recommended by other providers such as physician's assistants, nurse practitioners, physical, occupational, or speech therapists.[62] More importantly, the assistive technology that is approved may be entirely inconsistent with the "assistive technology" found by the jury or court to be necessary.

Birth-related injury

> Birth-related neurological injury means an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury that occurred in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability . . . .[63]

This definition would not appear to include birth trauma that relates either to disfigurement or nerve damage, facial palsy, or other motor damage that does not result from an injury "to the brain or spinal cord."[64] The definition would also seem to be broad enough to include even neurologic injuries that have nothing to do with the birthing process or resuscitation after delivery, because it covers anything caused by a medical service "provided or not provided during the delivery admission." What if

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[60] N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.1(b).
[61] *Id.*
[62] *Id.*
[63] *Id.* § 69-10.1(c).
[64] *Id.* Knipel, *supra* note 7.

a child does not leave the hospital from the delivery admission but suffers a hypoxic brain injury as a result of an unrelated anesthesia error surgery to correct a congenital defect?[65] There may well also be an attempt by some enterprising attorneys to bring autism under the auspices of the Fund.[66]

Durable Medical Equipment

"Durable medical equipment" must also be "ordered by a physician," in contrast to other providers. It must meet the following criteria: (1) "withstand repeated use for a protracted period of time," (2) be primarily used for medical purposes, (3) cannot be useful without an injury, (4) is "not usually fitted, designed, or fashioned for a particular individual's use;" and, (5) if equipment is "intended for use only by one patient, it may be either custom-made or customized."[67] The definition seems to be self-contradictory, since it would appear that criteria (4) and (5) conflict with each other.

Environmental Modification

> Environmental modification (Emod) means 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 and enables him or her to function with greater independence in the community and/or helps avoid institutionalization and has been ordered by a physician. Emods include but are not limited to: ramps, widened doorways and handrails, roll-in showers, vertical lifts, and cabinet and shelving adaptations.[68]

Environmental modification requires an order by a physician, and not by any other type of provider.[69] This may also conflict with the jury's findings.

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[65] N.Y. PUB. HEALTH LAW § 2999-h(1) (McKinney Supp. 2012); N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.1(b). The author was recently consulted in a case where there was a failure to diagnose and treat a condition unrelated to delivery or resuscitation but which occurred before the child was discharged home after birth. Is this covered under the Fund? If so the number of potential Fund enrollees could greatly exceed the number of children the Fund can sustain.

[66] Knipel, *supra* note 7.

[67] N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.1(j).

[68] *Id.* § 69-10.1(m).

[69] It is unclear how a physician is qualified to determine the nature of environmental modification that is required.

Fund Administrator

"Fund Administrator means the Superintendent of Financial Services or any person or entity designated by the Superintendent for purposes of administering the Fund, if any."[70] Since the statute specifically authorizes the Superintendent to contract with a private entity to administer the Fund (and such contractor is paid out of the Fund) this could mean that instead of a jury, the court, the victim's family, or even an agency of government making health care decisions for these children, a private company will be deciding what health care services will be approved or denied.[71]

Habilitation Services

"Habilitation means assisting a child to achieve developmental skills involving mobility, communication, and the activities of daily living when impairments have caused the delay or have blocked initial acquisition of the skills."[72] The plaintiff may not, and at some point inevitably will not be a "child." It is unclear whether such services will be provided to an adult, though presumably they will.

Physician and Physician Assistant

"Physician" and "Physician Assistant" refers only to persons licensed to practice as such in New York State, another state, or the District of Columbia.[73] This leaves out a physician from another country, and perhaps even U.S. territories.

Qualified Plaintiff

> Qualified plaintiff means every plaintiff or claimant who (i) has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or (ii) has sustained a birth-related neurological injury as the result of alleged medical malpractice and has settled his or her lawsuit or claim therefor.[74]

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[70] N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.1(o).
[71] N.Y. PUB. HEALTH LAW § 2999-i(2)–(3) (McKinney Supp. 2012).
[72] N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.1(p).
[73] *Id.* § 69-10.1(v)–(w).
[74] *Id.* § 69-10.1(y).

Qualifying Health Care Costs

The definition of "qualifying health care costs" is very broad. It does include "custodial" care and "nursing" care, but it is unclear as to whether this definition includes services such as home health aides or licensed practical nursing services.[75] Although respite care is not specified in the definition, it is referred to elsewhere in the regulations and is limited to no more than 45 days a year (less than one day per week) without prior approval.[76] Transportation costs are limited to "health care related appointments."[77] Other unenumerated health care costs are covered if a physician, physician assistant, or nurse practitioner has justified them in writing.[78] Qualifying health care costs do not include anything "provided or available" by a school IEP or Early Intervention Program, or "through any commercial insurance under which the enrollee is covered."[79]

The Fund will, therefore, not make payments for care items that may be paid by school districts or private insurance companies.[80] Any amount of money paid by the Fund is reduced by the collateral source rule, and this would include care provided by school districts or private insurance.[81] Several groups that provide services to disabled children have raised concerns that the interplay between different government programs and health care providers, as well as payment at Medicaid rates, will ultimately inhibit access to care by either complicating the payment system, limiting providers who will accept these low rates, or by giving private insurance an incentive to drop coverage for their services.[82]

Two other critical issues are presented. First, with regard to services provided by a school district, a plaintiff could be bound by a school district's finding of what services it will provide. This is because "qualifying health care costs" excludes anything

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[75] *Id.* § 69-10.1(z).
[76] *Id.* § 69-10.6(a).
[77] *Id.* § 69-10.1(z).
[78] *Id.*
[79] *Id.*
[80] *Id. See* N.Y. PUB. HEALTH LAW § 2999-j(3) (McKinney Supp. 2012) (stating that the Fund will not pay for qualifying health care costs that are paid for by "collateral source[s]").
[81] PUB. HEALTH § 2999-j(3); N.Y. C.P.L.R. § 4545 (McKinney Supp. 2012).
[82] Michael Bergen, Matthew Hyland & Izel Obermeyer, *Important Movement of Our Association*, N.Y. PHYSICAL THERAPY ASS'N (July 11, 2011, 11:03 AM), http://nypta.blogspot.com/2011/07/important-movement-of-our-association.html.

provided by a school district.[83] For example, the school district may have found—over the plaintiff's objection—that a child does not require a one-to-one aide, even though the family and/or the court in the malpractice action may have determined otherwise. Therefore, even though these services were found to be necessary by a jury, neither the defendant nor the Fund may be required to provide such care; under these circumstances, the plaintiff would have to do without it. The Fund leaves what has the potential to be a huge gap with regard to certain types of developmental care by merely assuming that school districts will gladly provide and pay for such services. Second, the interplay between the Fund, a school district or other governmental entity such as Medicaid, and a commercial payer will likely result in disputes between the three with respect to what entity has to pay for what service. This would leave the plaintiff caught in the middle. In the meantime, she will be left waiting for care to be provided—if indeed it is ever provided at all.

B. Application and Enrollment Process

Section 69-10.2 provides for the application and the process to become enrolled in the Fund.

> An application for enrollment . . . may be submitted by [either]: (1) a qualified plaintiff; (2) a person authorized to act on . . . [the] behalf [of a qualified plaintiff]; or (3) [*by*] *a defendant* in a medical malpractice . . . action that results in a court-approved settlement or judgment issued on or after April 1, 2011, [that includes a] finding that the plaintiff sustained a 'birth related neurological injury.'[84]

Section 69-10.2(b) requires that an application to the Fund be on the form provided, as set forth on the Fund's website.[85] The Application must include a medical release form to the Fund. *Thus a Fund recipient must surrender a lifetime of medical privacy merely to try to get the services to which he was found entitled by a court.*[86] The application also requires "a certified

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[83] N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.1(z).

[84] *Id.* § 69-10.2(a) (emphasis added).

[85] *Id.* § 69-10.2(b).

[86] *Id.* § 69-10.2(b)(1). Another serious question that is raised by this requirement to provide a lifetime waiver of medical privacy is whether it violates HIPPA. Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, 110 Stat. 1936 (1996); *see* discussion *infra* notes 393, 597.

copy of the court-approved settlement or judgment."[87] This provision assumes that a settlement would require judicial approval. There may be circumstances in which a settlement may not have to be approved, such as where the injured child is legally competent and has reached majority.

This provision requires that the plaintiff provide extensive documentation of the "specific nature and degree" of the applicant's injury, including its "impact on . . . activities of daily living."[88] The Fund will accept a sufficiently detailed life care plan prepared for litigation, a summary provided by the child's physician, or other materials provided to the court to support the settlement or to enroll in other health related programs, as long as they "accurately reflect[] the applicant's condition . . . ."[89]

Subparagraph (4) also requires that the applicant provide the names, addresses and phone numbers of "all providers," of services at the time of the application.[90] There may be dozens of providers and it would be a very burdensome process to gather and continue to update this material.

Subparagraph (5) requires documentation of "all other present sources of health care coverage . . . . "[91] Private health coverage must be used before the Fund will pay.[92] Private insurance, however, may indeed provide better coverage than the Fund. More importantly, under a private health insurance policy, contractual legal rights to enforce policy benefits may be more favorable than the remedies and burden of proof necessary to reverse a Fund decision. This creates another discriminatory subclass of birth injury victims—those who have private insurance versus those who do not.

Paragraph (c) permits the use of documentation submitted for enrollment in "another health related program" to be utilized in the Fund application, provided that it is still current.[93] It is questionable whether any such information will either suffice under the requirements of the Fund application, or be sufficiently

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87 N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.2(b)(2).

88 *Id.* § 69-10.2(b)(3).

89 *Id.*

90 *Id.* § 69-10.2(b)(4).

91 *Id.* § 69-10.2(b)(5).

92 N.Y. PUB. HEALTH LAW § 2999-j(3) (McKinney Supp. 2012); N.Y. C.P.L.R. § 4545(a) (McKinney Supp. 2012); N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.1(z).

93 N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.2(c).

current for the Fund's application process.

Paragraph (d) requires the Fund Administrator to review the "court approved settlement or judgment" to ensure it states the Plaintiff has sustained an injury making her eligible for Fund benefits.[94] It further provides—in a stunning invasion of the separation of powers—that "[i]f the [required] language . . . is missing or is not clear, the Fund Administrator shall refer the settlement or judgment back to the court that approved the settlement or issued the judgment to add clarifying language, if appropriate."[95] *The Fund Administrator, therefore, can order the court what to put in a judgment.*

Paragraph (e) requires the Fund Administrator to review all of the submitted documentation within fifteen business days of submission and notify the applicant of any missing information necessary to complete the application.[96] If all the paperwork is found to be in order, the plaintiff shall be enrolled in the Fund within another fifteen business days.[97] Thus the enrollment process, assuming that everything was timely submitted and is found to be acceptable, will take thirty business days, or approximately forty days. In the meantime, the plaintiff receives no benefits, and may be deprived of care.

Paragraph (g) provides for the Fund Administrator to assign a Fund "case manager" to the enrollee within seven business days of receipt of all the necessary paperwork.[98]

C. Claims Assistance Manager

Section 69-10.3 provides for a claims assistance manager whose duties include (a) "answering questions regarding the information and documentation [necessary to complete] the application process;" (b) investigating any claimed delays in either the application process, claims, claims denials, prior approvals, or reviews; and (c) "assisting in resolving any issues [between] enrollees and case managers or the assignment of case managers."[99] It does not explain what, if any, authority that the claims assistance manager has to resolve these issues, or how

[94] *Id.* § 69-10.2(d).
[95] *Id.*
[96] *Id.* § 69-10.2(e).
[97] *Id.* § 69-10.2(f).
[98] *Id.* § 69-10.2(g).
[99] *Id.* § 69-10.3.

this person is assigned to assist an enrollee.[100]

D. Case Management

Section 69-10.4 is a critical section of the regulations referring to the plaintiff's case management. As a practical matter, this section transfers health care decisions from the plaintiff and his or her family, to the Fund. A "case manager" designated by the Fund is assigned to each plaintiff.[101] The case manager will not be beholden to the client, but rather to the Fund, in order to get paid and receive assignments.[102]

Paragraph (a) defines case management functions and makes it clear that the Fund appointed case manager will be expected to insert themselves into every intimate detail of the plaintiff's life *forever*.[103] It should be kept in mind that the state appointed case manager will play a major role in all care decisions, despite the fact that the enrollee has already been determined to be a victim of malpractice and entitled to various health care services by the jury or a court.[104] The enrollee is being *forced* to completely surrender to the Fund case manager, any medical or personal privacy, her fundamental family intimacy, and more importantly, the right to make primary decisions concerning critical medical issues.

The case manager is charged with the following:

> (1) [making] an initial assessment and periodic reassessments of the enrollee's medical needs; (2) evaluating the enrollee's strengths, informal support system and environmental factors relevant to . . . care;[105] (3) reviewing information [from] the enrollee, [his or her] informal support system, and current

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[100] *Id.*

[101] *Id.* § 69-10.2(g).

[102] *Id.* § 69-10.1(d), -10.5(a).

[103] *Id.* § 69-10.4(a).

[104] N.Y. PUB. HEALTH LAW § 2999-j(6)–(7) (McKinney Supp. 2012).

[105] This is another way of saying that the case manager can consider but not pay for the care provided by the family—presumably to avoid paying for outside care. The family is not obligated to provide free "custodial" care beyond normal parenting duties, and if they do, they are entitled to be compensated for it. *See* Schultz v. Harrison Radiator Div. General Motors Corp., 683 N.E.2d 307, 311 (1997); Auer v. New York, 733 N.Y.S.2d 784, 787 (App. Div. 3d Dep't 2001); King v. New York, 393 N.Y.S.2d 93, 94 (App. Div. 3d Dep't 1977); 1B ASS'N OF JUSTICES OF THE SUPREME COURT OF THE STATE OF N.Y., COMM. ON PATTERN JURY INSTRUCTIONS, N.Y. PATTERN JURY INSTRUCTIONS: CIVIL § 2:280 (West 2012). The case manager should not be entitled to consider the "informal support system" to limit what the Fund will pay for.

> providers (including [the school system]) regarding . . . services . . . [currently] provided . . . and any . . . gaps in the services . . . ;[106] (4) establishing a comprehensive, written case management plan to provide for coordinated delivery of all qualified health care services [necessary];[107] (5) securing services determined in the case management plan . . . through referral to agencies or persons qualified to provide those services;[108] (6) assisting the enrollee with any forms necessary [to receive services or getting those services paid for]; (7) providing crisis intervention [for] . . . emergency service needs; (8) developing alternative provider sources . . . in the event of service disruption;[109] and (9) monitoring and providing follow up services . . . (A) [to] verif[y] that [the] quality of services provided [are received at the amount and frequency specified in the plan as well as] (B) documenting . . . the [enrollee's] medical condition and progress made; and (10) . . . coordinat[ing] . . . [with any] other case manager [in another health related program].[110]

Paragraph (b) describes the qualifications for a case manager.[111] It does not require any expertise other than training or experience in "the performance of assessments and the development of case management plans."[112] Significantly, it requires absolutely no expertise or experience in dealing with the assessment or the care needs of neurologically impaired children

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106 This further highlights the invasive nature of the duties and powers by the Fund and its case managers. Even if the case manager is well-meaning and properly motivated, she is not responsible solely to the plaintiff.

107 This does not account for services that may not be covered under "qualified health care services." Moreover there is no requirement as to how frequently the plan must be reviewed, nor is it specified what services would be included as "qualified health care services," and these could change over time. *See* N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.4. For example, certain services provided by a school district might become "qualified health care services" after the enrollee reaches majority. *See id.* § 69-10.1(z).

108 This is a critical provision since it reinforces the fact that it is the Fund appointed manager, and not the family, the jury, or court, who will initially determine what services will be provided. Then, having been free to ignore the jury or the family, the Fund case manager will play a major role in determining who provides such services and how much they will be paid. This may work out fine, but then again, there is significant potential that it will not.

109 Although this is a worthy goal, it is significantly impaired by the reimbursement of services at Medicaid rates. Moore & Gaier, *supra* note 6. The case manager has no power to get emergency services at higher rates if that would be necessary in order to avoid disruption of even "critical" services. *See* PUB. HEALTH § 2999-j(4); N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.4, .20.

110 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.4(a).

111 *Id.* § 69-10.4(b).

112 *Id.*

or adults.[113]

Paragraph (c) provides that an enrollee may request a change in case managers by written request.[114] There is no assurance that there will be a reassignment.[115] Reassignments, if they do occur, will only be made "as promptly as possible based on case manager availability and existing caseloads," or in other words, solely at the convenience of the Fund.[116]

There is no description or limitation as to the number of enrollees who can be assigned to a case manager, or how available the case manager must be to the plaintiff.[117]

E. Claims Submission Process

Section 69-10.5 describes the claims submission process.[118] Paragraph (a) is critical, since it requires that "[a]ll providers providing services to an enrollee must accept assignment of payment from the Fund."[119] This not only means that all providers other than physicians will be reimbursed at Medicaid rates, but it also compels such providers to agree to the payment submission and approval process. This alone, even without the Medicaid reimbursement rate limitations, will undoubtedly limit access to care.[120] Moreover, there is no way for residents of states other than New York, or other countries, to compel their providers to accept Fund assignment, or the Medicaid level rates that will be paid by the Fund. As discussed below, this may impair the constitutional right of freedom to travel.[121]

Paragraph (d) provides that claims for services submitted within ninety days will be paid within forty-five days of receipt, thus compelling a provider to wait a significant time to be reimbursed.[122] It provides no remedy to the provider if the bill is not accepted or not paid within forty-five days.[123] The paragraph also provides that claims submitted after ninety days may not be paid at all, unless the provider can show good cause for the

113 *Id.*
114 *Id.* § 69-10.4(c).
115 *Id.*
116 *Id.*
117 *Id.* § 69-10.4.
118 *Id.* § 69-10.5.
119 *Id.* § 69-10.5(a).
120 *See* Moore & Gaier, *supra* note 6; Bergen, *supra* note 82.
121 *See infra* Part V.B, V.D.2.
122 *Id.* § 69-10.5(d).
123 *Id.*

delayed billing. The finding of good cause would presumably be made by the Fund Administrator.[124]

F. Prior Approval Request Process

Section 69-10.6 describes the items that require prior approval by the Fund before they will be provided. Essentially anything that is expensive will require "prior" Fund approval. This section prescribes the procedures that must be followed in order to obtain such approval.[125] The concept of "prior approval" itself is contradictory to the way the statute was written and promoted. The prior approval process was supposed to be the exception rather than the rule.[126]

Under paragraph (a) some of the more common and significant items that require prior approval are (1) assistive technology, such as augmentative communication devices; (2) handicapped modifications for vehicles and the home; (3) private duty nursing;[127] (4) "custom made durable medical equipment;" (5) hearing aids; (6) enteral formula (i.e. tube feeding nutrition);[128] (7) planned specialist or hospital visits requiring "travel involving overnight accommodations;"[129] (8) experimental treatment; and (9) respite care for more than 45 days in a calendar year.[130]

Paragraph (b) provides that other than for emergency requests, prior approval requests should be determined within thirty days from the time necessary documentation to support it has been received by the Fund.[131]

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[124] *Id.*

[125] *Id.* § 69-10.6.

[126] N.Y. PUB. HEALTH LAW § 2999-j(2) (McKinney Supp. 2012).

[127] Depending on what is meant by "private duty nursing," this could be an enormous concern. Nursing type care at various levels is a significant, and is usually the single largest component in each of these cases. ROBERT J. WALLING & DEREK W. FREIHAUT, COMMONWEALTH OF VIRGINIA STATE CORP. COMMISSION, 2011 ANALYSIS OF THE VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM 21–23 (2011).

[128] However the regulations state that no prior approval is required where the enrollee has documentation that he or she is fed by feeding tube, gastrostomy, or J-tube. N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.11(a). It appears that if a new mode of feeding is initiated the Fund must give "prior approval."

[129] This definition is inconsistent with the definition of "prior approval," which does not refer to overnight accommodation. *Id.* § 69-10.1(x).

[130] *Id.* § 69-10.6(a).

[131] *Id.* § 69-10.6(b).

Paragraph (c) relates to documentation for all expenses other than private duty nursing, which is treated separately and discussed below.[132] In order to obtain prior approval, the request must be accompanied by a written justification from the enrollee's treating physician stating why the service, equipment, or treatment is necessary, and "what other alternatives have been tried or explored."[133] This again gives the Fund the right to second guess both the physician's determination concerning the necessary health care for the plaintiff, as well as the right to ignore the findings that have already been determined in court.

The prior approval process creates an inherent conflict of interest for any professional charged with making these determinations on behalf of the Fund. This is inevitable, because the financial well-being of the Fund will necessarily be balanced against the best possible care that the plaintiff could receive. Instead of the plaintiff using the recovery to make her own health care determinations in her own best interest, such care will now be determined by the Fund Administrator or its contractor—essentially its own HMO. This is important because, unlike contractual and legal limitations that constrain restrictions on care by an HMO or insurer, the Fund can change the rules during the process, without limitation, and decide what services are "necessary" and which will be paid. Since the Fund Administrator has an incentive to preserve its funds, there is every motivation to deny payments for services, even those that a court has already determined are justified and appropriate.

A course of care or treatment that the child's family believes is in her best interest may be subject to prior approval by the Fund and denied. "Prior Approval" refers to the requirement that the Fund Administrator must approve many aspects of care and equipment in advance.[134] This substitutes the Fund's determination for that of the child's family and the court. It may result in delay and possible additional expense to secure care. Although the statute provides that the payment of qualifying health care costs "shall not be subject to prior authorization, except as described by the commissioner in regulation," the regulations essentially reverse this presumption, and require virtually any significant category of expenditure to have prior

[132] *Id.* § 69-10.6(c).
[133] *Id.*
[134] *Id.* § 69-10.1(x).

approval.[135] Despite the statute's purported intent to provide seamless care with a minimum of bureaucratic involvement it is apparent that a substantial amount of the most essential and costly services needed by an enrollee's care will require the Fund's prior blessing.[136]

Similarly, the plaintiff may well simultaneously have a private case manager, a case manager from a private insurance company, a Medicaid case manager, as well as one appointed by the Fund. This will inevitably lead to conflicts between them concerning what benefits will be received, who will provide them, and how much the providers will be paid. Although independent "case management" is inevitably a component of future care costs, there does not appear to be a provision under either the statute or the regulations to provide for such services, except for the state designated and paid "case manager" whose loyalties are divided, and who certainly is not chosen by the enrollee. This is no different than if the Fund decided which doctors or therapists could treat the plaintiff. In fact, to a certain extent they have done so, both by inserting their own case manager and by limiting the reimbursement to most providers at Medicaid rates.

G. Prior Approval Requests for Environmental Modifications

Section 69-10.7 specifies the requirements to obtain prior approval for environmental modifications.[137] This section, and a similar provision for vehicle modifications, clearly illustrates the differences between what the plaintiff would be entitled to under a jury's finding, and what the Fund may or may not allow.[138]

Paragraph (a) requires that home modifications can only be made to the "enrollee's primary residence."[139] This by itself creates numerous potential problems. Many of these plaintiffs do not own residences, and because they are limited to future care costs from the Fund, as compared to collecting damages from a

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[135] N.Y. PUB. HEALTH LAW § 2999-j(2) (McKinney Supp. 2012).

[136] *Compare id.* ("The provision of qualifying health care costs to qualified plaintiffs shall not be subject to prior authorization, except as described by the commissioner in regulation . . . ."), *with* N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.6–.13 (describing the various medical requests that need to be preapproved in order to receive coverage, including expensive needs such as private duty nursing and nonemergency ambulance transportation).

[137] N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.7.

[138] *Id.* § 69-10.7–.8.

[139] *Id.* § 69-10.7(a).

tortfeasor, they will not likely have sufficient funds to purchase a residence. Paragraph (a) does provide, however, that if the "family does not own [a] residence, [that] written permission of the property owner must be [obtained]."[140] It is unclear how readily agreeable a landlord would be to making handicapped accessible modifications to a rental property.

Paragraph (b) requires the enrollee to provide written documentation of the assessed value of the residence and proof of adequate homeowners or rental insurance.[141] Paragraph (c) requires that any modification "must meet applicable State and local building codes."[142]

Paragraph (d) provides that the Fund administrator will not approve any home improvement "that is not medically necessary to ensure the health, welfare and safety of the enrollee by enabling him or her to function with greater independence in the community and/or by helping him or her to avoid institutionalization."[143] Apparently no consideration is given to the family's needs if they are caring for an enrollee at home, or whether such care would be made easier, less burdensome for them, or provide a better quality of life for the injured Fund enrollee.

Paragraph (e) sets forth the documentation necessary to support an application for home modification "prior approval."[144] It requires a written statement from the treating physician "on the physician's letterhead" stating why the modification is medically necessary.[145]

Subparagraph (2) is extremely burdensome to the enrollee. It requires "a comprehensive evaluation of the proposed project by a rehabilitative evaluation agency or an independent building contractor who has significant experience working with ADA building standards."[146] The "comprehensive evaluation" must include "pictures of the specific location" as well as specifying the need for the modification, the reason why the proposed modification was selected, whether it is the most cost effective

140 *Id.*
141 *Id.* § 69-10.7(b).
142 *Id.* § 69-10.7(c).
143 *Id.* § 69-10.7(d).
144 *Id.* § 69-10.7(e).
145 *Id.* § 69-10.7(e)(1). Again, it is unclear how a physician is qualified to make these determinations.
146 *Id.* § 69-10.7(e)(2).

means of meeting the plaintiff's needs, and any safety concerns associated with the modification and how they will be met.[147] There are no standards by which the Fund will evaluate the project.[148]

Prior approval requests must also contain "a minimum of three acceptable bids from qualified contractors" who "have no outstanding judgments against [them] and/or . . . [the] business on file with the New York State Department of Law or the Better Business Bureau."[149] The requirement to obtain three bids in many geographic areas is not only time consuming to families who are attempting to provide full time care to a severely disabled child, but may be expensive as well.

Paragraph (g) provides that where less than three bids are submitted, a written explanation must be provided detailing (1) why additional bids were not submitted and (2) how it was determined that the considered bids are reasonably priced.[150]

Paragraph (f) requires the bid to describe the scope of the work and its specifications, proof of adequate insurance, and "a statement signed by the contractor . . . that the work will be done in a workmanlike manner . . . and will comply with all applicable building and zoning laws."[151]

Paragraph (h) describes how the Fund will evaluate the bids.[152] It goes into an involved description that "[i]f the two lowest comparable bids are within 10 percent of each other, the enrollee . . . may choose the contractor."[153] However, "[i]f there is more than a 10 percent difference between the two lowest comparable bids," the Fund will choose the lowest bid, unless "the higher bid reflects higher quality, longer durability or a higher degree of safety."[154] In that case—and this is quite revealing—"the Fund shall choose the bid that represents the best value for the *Fund* and the enrollee."[155] Thus, the Fund will not solely consider the enrollee's interests. After a winning bidder is chosen, the Fund will pay one-third of the total bid

147 *Id.*

148 *See id.* § 69-10.7 (disclosing the procedure but setting no standards as to review).

149 *Id.* § 69-10.7(e)(3).

150 *Id.* § 69-10.7(g).

151 *Id.* § 69-10.7(f).

152 *Id.* § 69-10.7(h).

153 *Id.*

154 *Id.*

155 *Id.* (emphasis added).

amount to the contractor at that time.[156]

Subparagraph (i) requires that any change in specifications that increases the price of the modification requires Fund approval.[157] Subparagraph (j) provides that no further payment (i.e., the remaining two-thirds of the cost) will be paid until the Fund receives an undefined "evaluation," confirming that the project meets the plaintiff's "functional needs" and "is in compliance with the initial evaluation."[158] It is possible, therefore, that although an approved modification could be done properly, it may not meet the enrollee's functional needs once it is completed, in which case payment may not be forthcoming. In that case, there may be a mechanic's lien on the premises that would be the obligation of the enrollee to satisfy.[159]

Subparagraph (k) does provide that the Fund will pay for the cost of evaluating the pre- and post-project modification, as well as the cost of the project.[160] However, it does not say when such payment will be made, thus possibly requiring the family to advance it and hope that they will be paid back.

Subparagraph (l) provides for repairs to modification projects, but requires prior approval for modifications that have worn out.[161] As noted, there does not appear to be any thought concerning payment for modifications if the enrollee moves, or how many times in a lifetime modifications will be paid for.[162] This may be even more relevant in premises that are rented by the enrollee.

The potential effect of the rigorous nature of these provisions is twofold. First, the neurologically impaired child and his family may be deprived of home modifications essential to making care less onerous and improving life quality. Second, ironically, the more challenging it becomes to obtain an appropriate home environment, the more likely it will be that an increased number of these individuals may be forced to be institutionalized, leading to even higher possible costs to the Fund.

Moreover, the Fund fails to adequately take into consideration some of the most common situations that will likely be

156 *Id.*
157 *Id.* § 69-10.7(i).
158 *Id.* § 69-10.7(j).
159 *See id.*
160 *Id.* § 69-10.7(k).
161 *Id.* § 69-10.7(l).
162 *Id.* § 69-10.7.

encountered. For example, if a landlord denies permission to an enrollee for an environmental modification it will be unlikely that the family will be able to secure housing appropriate to enable the plaintiff to be cared for at home.[163] When the family is in control of making home modifications, the process may become more feasible, quicker, less expensive, and better meet the family's needs. It also must be noted that the Fund permits payment only for environmental modifications, and not for new housing, which may be more cost effective and which the enrollee may need in many instances.[164]

In addition to these problems, the overbearing bureaucratic procedures required for environmental modifications necessarily discourage potential providers of care and services from undertaking this work.[165] The most disturbing aspect of the complicated application process is that the Fund is not making its determination based on what may best fit the enrollee's situation, would make the plaintiff the most comfortable, or would maximize the quality of her life. Rather, the Fund's decision is required to be based on whether the modification allows for an *appropriate balance between the injured enrollee's minimum needs and the best value provided to the Fund*.[166] These regulations, therefore, do not exist to assure quality of life care, but rather to limit what the Fund is obligated to pay. The enrollee does not care about the best value to the Fund, only the service that best meets his needs.

The Fund only allows for repairs to the modifications if they are "cost effective."[167] The regulations do not state how cost effectiveness is to be measured or provide any procedure with regard to necessary repairs.[168] If a repair is not deemed to be cost effective, apparently the recourse for the plaintiff is to seek prior approval for an entirely new modification. When modifications are worn out through normal use, the Fund requires the enrollee to reapply for approval for a new modification.[169] The regulations are silent however, to what happens if the modification is

163 *Id.* § 69-10.7(a).
164 *Id.* § 69-10.7.
165 *See id.*
166 *Id.* § 69-10.7(h).
167 *Id.* § 69-10.7(l).
168 *Id.* § 69-10.7.
169 *Id.* § 69-10.7(l).

damaged or destroyed by something other than normal use.[170] This implies that the Fund might not be obliged to accept an application for a modification that was damaged or destroyed in a fire or simply failed to function to meet the family's needs.

H. Prior Approval Requests for Vehicle Modifications

Section 69-10.8 provides prior approval requirements for vehicle modifications, such as handicapped accessible vans.[171] These requirements are similar, but perhaps even more burdensome, than are the regulations applicable to home modifications.[172] In the first place, the Fund will only pay for modifications to "a vehicle owned by the enrollee or a member of the enrollee's household who has consistent and ongoing contact with the enrollee and provides *unpaid* primary, long term support to the enrollee."[173] This will present a major obstacle to many enrollees. The Fund will not pay for the vehicle itself, but rather only for the modification.[174]

Paragraph (b) specifies the requirements to support an application for vehicle modification including an evaluation of the modification by "a Driver Rehabilitation Specialist who has been certified by the Association of Driver Rehabilitation Specialists and approved by New York State Adult Career and Continuing Education Services-Vocational Rehabilitation (Acces-VR)."[175] The evaluation must specify the most cost effective means of meeting the enrollee's needs, and a detailed specification of the work required.[176]

Paragraph (c) limits vehicle "[m]odifications . . . to vehicles that are registered, insured and meet New York State inspection

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[170] *See id.* § 69-10.7 (failing to specifically identify how modifications damaged by other than normal use should be handled). Even if someone else causes damage, should the innocent child/enrollee be penalized?

[171] *Id.* § 69-10.8.

[172] *Compare id.* § 69-10.7 (allowing modifications are only if to the enrollee's primary residence or written permission if not owned by enrollee), *with id.* § 69-10.8 (allowing modifications to a vehicle if owned by enrollee *or a person that provides unpaid, primary long term support to the enrollee*, and if the vehicle is providing access to services or supports in the community, which increase their independence).

[173] *Id.* § 69-10.8(a).

[174] *Id.* §§ 69-10.8(a), (d), (l).

[175] *Id.* § 69-10.8(b), (k). One can imagine how difficult it might be to find one of these specialists in a rural county.

[176] *Id.*

standards."[177] This would preclude vehicles that are registered, insured or meet the standards of other states or countries where the enrollee might reside. This would seem to interfere with the constitutional right of freedom to travel or live in other states or countries.[178]

Paragraphs (d) and (e) and (f) impose even greater restrictions on the ability of many, if not most enrollees to get vehicle modifications, and certainly more than if the plaintiff could recover damages for vehicle modifications from the defendant, as other tort victims can. Paragraph (d) limits "[m]odifications . . . to (1) a new vehicle . . . purchased by the enrollee or a member of the enrollee's household or (2) [a] structurally sound [vehicle], not in need of . . . repair [that is] less than 5 years old or [with] less than 50.000 miles" on it.[179] Without significant cash funds from the judgment, it is unlikely that the plaintiff or his family will be able to access sufficient funds to buy a new or low mileage van for modification. If this were not bad enough, pursuant to Paragraph (f) the cost of modifications cannot exceed the Blue Book value of the vehicle.[180] These provisions essentially eliminate poor or lower socioeconomic group plaintiffs from having a handicapped accessible van. Many enrollees will not be able to afford a used van with less than fifty thousand miles. The Fund would thereby deprive these families from any accessible transportation at all.

Paragraph (e) limits modifications for wheelchair accessible vans to those necessary to assure "safe transportation and safe access into and out of the vehicle."[181] The comfort of the enrollee or ease of use of the modification is apparently not a consideration.[182]

Paragraph (h) requires three bids for modifications,[183] and paragraph (g) limits bids only to those "that meet Acces-VR's qualifications for performing vehicle modifications."[184] If fewer

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177 *Id.* § 69-10.8(c).

178 *See infra* Part V.

179 *Id.* § 69-10.8(d). Many people in New York do not own and cannot afford a new or low mileage used vehicle. No alternative means of generally available handicapped transportation service is provided for by the Fund Regulations.

180 *Id.* § 69-10.8(f).

181 *Id.* § 69-10.8(e).

182 *See id.*

183 *Id.* § 69-10.8(h).

184 *Id.* § 69-10.8(g). Again, in most counties it will be difficult to find three bidders and, even if they can be found, this is a major and unnecessary

than three bids are submitted a written explanation must be submitted as to why.[185]

Subparagraph (j) requires that any change in specifications that increases the price of the modification requires Fund approval.[186] Similar to home modifications, subparagraph (k) provides that complete payment will not be made until the Fund receives an evaluation confirming that the project meets the enrollee's "functional needs" and is in compliance with the initial evaluation.[187] Again, it is possible that an approved modification could be done properly, but after it is completed not meet the enrollee's functional needs, in which case payment may not be forthcoming.

Subparagraph (l) does provide that the Fund will pay for the cost of the pre- and post-project evaluation, as well as the cost of the modification and, in limited circumstances, travel costs.[188]

The problems that these Fund regulations present with respect to vehicle modifications are similar to those that have been discussed with regard to home modifications. A jury may well have found that a handicapped accessible van would have been included in the plaintiff's future care costs as part of a reasonably considered life care plan. Under the Fund, however, an injured enrollee is not entitled to the cost of a new or even low mileage used van equipped for her disabilities.[189] The Fund will only provide for vehicle modifications, not the purchase of a vehicle.[190] Therefore, if the enrollee does not already have a vehicle—most usually a van that is suitable for modification to fit the plaintiff's needs—the enrollee will simply not get accessible transportation from the Fund at all.

Although the regulations allow for modifications for vehicles that the plaintiff's family currently owns, this too is subject to limitations. The owner of the van must be the person who provides the "*unpaid* primary, long-term support to the enrollee" and "has consistent and ongoing contact with the enrollee."[191] This indicates that a handicap accessible van modification is not

imposition on families.

185 *Id.* § 69-10.8(h).

186 *Id.* § 69-10.8(j).

187 *Id.* § 69-10.8(k).

188 *Id.* § 69-10.8(l).

189 *Id.* § 69-10.8.

190 *Id.*

191 *Id.* § 69-10.8(a).

available under the Fund in any circumstance where the injured enrollee is institutionalized or where the family member would get paid for the care of the child even if they had to give up another paying job to do so. Moreover, the Fund will only pay for a modification if the vehicle is the enrollee's "primary source of transportation."[192] Without the full recovery of a judgment many, if not most, urban dwellers will not be able to afford a van. Most enrollees in New York City, for example, will essentially be deprived of a handicapped accessible van, even for outings to other parts of the state.

The regulations further restrict the availability of modifications by requiring that (1) modifications can only be made on new vehicles, vehicles less than five years old, or vehicles with less than 50,000 miles on them; and (2) "[t]he cost of the modification[ ] may not exceed the Blue Book . . . value [for] the vehicle.[193] This significantly limits the opportunity for those who cannot afford a new van to be able to modify an older one, which they might be able to afford. In order for the Fund to pay for modifications a potential van, therefore, must fall within the small window of being new enough to qualify as being less than five years old or having 50,000 miles, and simultaneously be old enough to be affordable for the family to purchase, and still be sufficiently expensive to possess a Blue Book value that exceeds the cost of the modifications that must be made to it.[194]

These problems are in addition to similar constraints that vehicle modifications share with the prior approval for environmental modifications described above. The process is long and protracted, requires evaluations by independent parties, and requires at least three bids.[195] Again, if the difference between the two lowest bids be greater than 10 percent, the Fund is to pick the bid that it feels provides the best value to the Fund, and not what best meets the plaintiff's needs.[196] Finally, the regulations make absolutely no provision for maintaining the modified van and how that will be paid for.[197] Presumably that burden would fall onto the enrollee, even though she likely lacks the ability to pay for it because she has been prevented from

192 *Id.*
193 *Id.* § 69-10.8(d), (f).
194 *Id.*
195 *Id.* §§ 69-10.7(e), (g), (j), 69-10.8(b), (h), (k).
196 *Id.* § 69-10.8(i).
197 *Id.* § 69-10.8.

recovering this sum from the defendant-tortfeasor.

I. Prior Approval Requests for Assistive Technology

Section 69-10.9 provides for prior approval requests for Assistive Technology.[198] Essentially the bidding process for this service restates the bidding requirements for home and vehicular modifications.[199] The differences will be highlighted below.

Paragraph (a) provides that a request for an assistive technology device shall also "be considered to include a request for AT services."[200] This is assistance from the Fund "to the enrollee in the selection, acquisition, and use of the appropriate AT device and necessary training."[201] Although this paragraph may sound benign, what it really does is supplant the decision of the family's physician and other providers, who answer solely to the family in choosing assistive devices. The decision on equipment may be based on *the Fund's assessment and motivations in keeping cost low*, rather than the enrollee's needs, preferences, or choices.[202] For example, insurance companies and government programs may refuse to pay for electric wheelchairs because they claim that the patient was not an appropriate candidate, even though her doctors, teachers, or family felt otherwise. It is a further example of the Fund inserting itself where a court, a jury, the family, or a health care professional disagrees with the Fund's assessment.

Paragraph (b) describes the requirements to be a provider of Assistive Technology Equipment.[203] A provider must either (1) be approved under 18 N.Y.C.R.R. Part 504, (2) be a provider under the New York State Office for Persons with Developmental Disabilities Community Based Waiver Program, (3) be a licensed pharmacist, or (4) be a Durable Medical Equipment provider.[204] For Personal Emergency Response Systems, the provider must be approved under an existing contract with a local Social Services District or a similar agency in another state.[205] No provision is

198 *Id.* § 69-10.9.
199 *Compare id.* § 69-10.9, *with id.* § 69-10.7, *and id.* § 69-10.8.
200 *Id.* § 69-10.9(a).
201 *Id.*
202 *Id.* § 69-10.9(a), (e), (g)–(i).
203 *Id.* § 69-10.9(b).
204 *Id.*
205 *Id.*

made for providers outside the United States.[206]

Similarly, under paragraph (c) anyone making an assistive technology assessment must be either (1) "a New York State Acces-VR approved provider" (or equivalent in another state—but not outside the United States), (2) an "Independent Living Skills trainer" (past or present under the New York State Community Waiver program, but apparently not another state or country), or (3) a "professional who is knowledgeable about the full range of devices and/or technology available to assist individuals with disabilities."[207] This latter catchall would seem to include almost anyone, or perhaps no one.

Paragraph (d) requires that AT devices requested from the Fund must meet Underwriters Laboratory standards or comply with any applicable Federal Communications Commission requirements.[208]

The process for requesting AT is quite detailed and extensive. It "must include . . . justification for . . . how the [requested] equipment . . . will meet the needs and goals of the enrollee in . . . improving . . . functional capacities in an efficient and cost effective manner."[209] It also "must include . . . all assessments made to determine the necessary AT, including [(1)] . . . information [regarding] the [enrollee's unique] needs and preferences, . . . limitations and prognosis; [(2)] . . . the environment [for where the equipment] will be used; [(3)] the basis for selecting the particular AT [and its] advantages over other options. . . ; and" (4) *any information regarding at least three alternatives considered.*[210] If there are less than three options considered, that fact must be justified to the Fund.[211]

Under paragraph (f) if any AT equipment requires home modification, information and permission of the landlord must be provided if the home is not owned.[212]

Paragraph (g) requires written explanation justifying the

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206 *Id.*

207 *Id.* § 69-10.9(c).

208 *Id.* § 69-10.9(d).

209 *Id.* § 69-10.9(e)(1). This again places cost efficiency at the top of the list, above the needs of the plaintiff, or whether the court found that certain equipment was warranted.

210 *Id.* § 69-10.9(e)(2).

211 *Id.* § 69-10.9 (e)(2)(D). All of this creates a major burden on families, when in fact the court, the family, or a health professional has likely already made a direct or indirect finding that such equipment was justified.

212 *Id.* § 69-10.9(f).

choice of AT equipment and, as noted above, if less than three alternatives were considered, an explanation as to why there were less than three.[213] As with vehicular and home modifications, under Paragraph (h) if the two lowest bids are within ten percent of each other the enrollee may choose between the providers, but if there is more than a ten percent difference, the Fund will pick the lowest bidder, unless one provides "higher quality, longer durability or a higher degree of safety," in which case the Fund will choose the "best overall value."[214] The choice of the enrollee's family or health professional is apparently irrelevant.

Paragraph (i) permits "cost effective repairs" with written justification "and two or more estimates for the repair," as well as "a plan to minimize future loss or damage."[215] There is no discussion as to how often AT equipment can be replaced as needs change or technology improves.[216] Paragraph (j) may severely limit access to AT equipment. It arbitrarily provides that the Fund will not pay "more than the wholesale cost of the equipment plus 50 percent."[217] It is unknown whether this will impair the availability of certain types of equipment to Fund enrollees.

J. Prior Approval Requests for Private Duty Nursing

Section 69-10.10 provides for prior approval for "private duty nursing."[218] Depending on how private duty nursing is defined (and there is no definition of "private duty nursing" in the regulations or statute) this could be the single most critical item covered, or perhaps not covered, by the Fund. For example, it is unclear as to whether private duty nursing refers to only registered nursing care, or if it refers to someone less credentialed, such as a licensed practical nurse, a licensed care aide, or another person providing skilled or "custodial type" care to a neurologically impaired patient. Many of these children will require caregivers with extensive training and specialized skills. These individuals cannot be safely left with someone whom has

213 *Id.* § 69-10.9(g).
214 *Id.* §§ 69-10.7(h), 10.8(i), 10.9(h).
215 *Id.* § 69-10.9(i).
216 *Id.*
217 *Id.* § 69-10.9(j).
218 *Id.* § 69-10.10.

no experience in dealing with a person who is neurologically impaired, much less providing the specialized care such as suctioning or G-tube feedings that is required.

Paragraph (a) provides that a request for private duty nursing care, either at home or in a hospital, "must be accompanied by a physician's written order and treatment plan."[219] If "private duty nursing" is to be provided in a "hospital setting," paragraph (b) provides that the physician's order must also state that the enrollee requires "individual and continuous care beyond that available by the staff of the hospital."[220]

Paragraph (c) refers to "nursing services" and requires a "physician's order . . . stat[ing] either that there is no approved home health [care] agency available to provide the intermittent or part-time nursing services [required] . . . or that the enrollee is in need of individual and continuous care beyond that available from an approved home health agency."[221] This would seem to imply that nursing services less than registered nurses may be covered by the Fund without prior approval, but there is no provision that actually states this, and the answer to that question remains unclear.[222] It is further provided, however, that "[t]he Fund Administrator may request [updated] periodic treatment plans and other medical information as he or she determines the particular circumstances warrant prior to approving additional periods of private duty nursing."[223]

Paragraph (d) provides that under an urgent situation, a physician may order private duty nursing services for up to two nursing days if a prior approval request is submitted.[224] The section further provides that a claim for these services can be submitted to the Fund for payment, but there is no provision stating that they will actually make payment under these circumstances.[225]

Payment for nursing care services at Medicaid rates has the

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[219] *Id.* § 69-10.10(a). It is unclear whether a hospital setting includes a nursing home, another custodial care type facility, or a group home.

[220] *Id.* § 69-10.10(b)

[221] *Id.* § 69-10.10(c). It should be noted that this paragraph refers to "nursing services" as opposed to "private duty nursing." *Id.* This might imply that "nursing services," and the requirement of prior approval, therefore, is broader than "private duty nursing" services.

[222] *See id.*

[223] *Id.*

[224] *Id.* § 69-10.10(d).

[225] *Id.*

potential to severely compromise the care of enrollees because families will have greater difficulty finding nurses to work at these rates. This will directly impact on the quality of care, quality of life, and even longevity of neurologically impaired children, as well as their families who are providing care. It may also have the effect of requiring families to indefinitely provide the necessary around the clock care simply because there will be a shortage of nurses at below market reimbursement levels. Despite the fact that a court may have found that the plaintiff was entitled to full time nursing care the Fund could nonetheless reject such a request when the plaintiff is enrolled in the Fund. Even if such care is approved, the low payment rates may make it difficult to find willing providers.[226] There have already been concerns raised that payment by the Fund at Medicaid rates will have a negative impact on the accessibility to services of critical providers.[227]

The fact that nursing care is paid at Medicaid rates is apparently based on the presumption that family members are going to be able to provide the majority of care for the injured enrollee. This presumption is neither valid nor appropriate. A parent is not obligated to, in effect, serve a "life sentence" caring for a neurologically impaired individual. Under the law of damages in New York, such parents are entitled to have appropriate assistance either in the home or by facility care. If they do elect to provide care themselves, they are entitled to be compensated for it.[228] Depending on the individual's needs, the level of care may require full time private duty nursing, a full-time registered nurse, or other skilled caregivers. Each enrollee's need is going to be different. Certain enrollees in the Fund are going to require suctioning, specialized feeding, or other care intensive needs. Family members are not obligated to bear these burdens alone, and the regulations are completely devoid of clarification as to what is, and is not, covered in this regard.[229] The low reimbursement rate provided by Medicaid creates an

[226] *See id.* § 69-10.10(c).

[227] Bergen, *supra* note 82.

[228] *See* Schultz v. Harrison Radiator Div. General Motors Corp., 683 N.E.2d 307, 311 (1997); Auer v. New York, 733 N.Y.S.2d 784, 787 (App. Div. 3d Dep't 2001); King v. New York, 393 N.Y.S.2d 93, 94 (App. Div. 3d Dep't 1977); 1B N.Y. PATTERN JURY INSTRUCTIONS, *supra* note 105, at § 2:280.

[229] *See* N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.10–.11.

additional problem.[230] Even if the Fund were to approve nursing care for a certain number of hours, there is no guarantee that the family would be able 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.

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. It is not unlikely that the care provided under the Fund would be inferior to that which would be available at market rates if the plaintiff were not forced into the Fund. Recent studies and articles confirm the fear that Medicaid rates will compromise access to the care that these vulnerable children (and adults) require.[231] When care is restricted and inadequate there is legitimate concern that these children may suffer unnecessarily, and perhaps die prematurely.[232]

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.[233] 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.[234]

It is hardly surprising therefore, that recent investigative reporting discovered that developmentally disabled individuals

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[230] Charlene Harrington et al., *Nursing Staff Levels and Medicaid Reimbursement Rates in Nursing Facilities*, 42 HEALTH SERVICES RES. 1105, 1106–07 (2007).

[231] *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).

[232] *See* Kessler, *Critical Analysis*, *supra* note 43; 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-state-homes-simple-tasks-and-fatal-results.html (describing a recent case of an individual drowning, because of an allegedly low staffing level due to inadequate funding).

[233] Bisgaier & Rhodes, *supra* note 231, at 2328.

[234] *Id.*

whose care was either provided or managed by the State of New York were dying prematurely at an alarming rate.[235] A November, 2011 *New York Times* article 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, drowning.[236] 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."[237] 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.[238]

A 2011 editorial in the Albany Times Union noted that the state of New York was spending on average $144,000 per year per developmentally disabled person under their care.[239] Despite this, *the "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.*[240] These findings, therefore, may well be a preview of will happen when the Fund, rather than families, is making health care decisions for neurologically impaired patients.

K. Prior Approval Requests for Enteral Nutritional Formula

Section 69-10.11 requires prior approval for supplemental nutritional formula.[241]

Paragraph (a) specifies that no prior approval is necessary if the Fund has documentation that the child is fed by NG tube, G-tube or J-tube.[242]

Paragraph (b) specifies that requests for additional nutritional formula to be provided orally as a supplement must be ordered by a physician, physician's assistant, or nurse practitioner, and the order must specify "a diagnosed medical condition or pathological process causing malnutrition" *and* "clinical findings

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235 Hakim & Buettner, *supra* note 232.

236 *Id.*

237 *Id.*

238 *Id.*

239 TU Editorial Board, *A Deadly System for the Disabled*, TIMES UNION (Nov. 9, 2011, 6:01 AM), http://blog.timesunion.com/opinion/a-deadly-system-for-the-disabled/15958/.

240 *Id.*

241 N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.11(2012).

242 *Id.* § 69-10.11(a).

supporting malnutrition," a physiologic disorder resulting from surgery, or laboratory confirmation of low protein.[243] Such clinical findings would include involuntary weight loss, a failure to gain weight or height in six months, or the loss of lean body mass.[244]

The regulations do not appear to consider the possibility that a patient may be fed by tube, but still be able, and indeed medically required, to take supplemental enteral formula or other nutrition by mouth.[245]

L. Prior Approval Requests for Transportation for Medical Care and Services

Section 69-10.12 requires prior approval for transportation to receive medical care and other services.[246] *It does not provide for the Fund to pay for specialized transportation services that would be required by a disabled enrollee for recreational or other nonmedical treatment.*[247] Therefore, a disabled individual who cannot afford a vehicle or cannot meet the requirements to obtain vehicle modifications as set forth in Section 69-10.8, but nevertheless needs specialized transportation for activities of daily living, is not entitled to such transportation under the Fund.[248] They will have no means to access the community.

Even transportation for "non-emergency ambulance . . . or . . . ambulette" is subject to prior approval by the Fund Administrator and must be supported by an order from a physician, nurse practitioner, physician's assistant, or a facility servicing the enrollee.[249] Paragraph (b) specifies that only authorized commercial providers will be paid.[250]

Paragraph (c) lists six criteria used in determining whether approval will be granted: "(1) whether . . . the enrollee's condition necessitates a mode of transportation other than that ordinarily used"[251] and if such mode of transportation is the only one that can be safely used; (2) whether multiple treatments are required

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243 *Id.* § 69-10.11(b).
244 *Id.* § 69-10.11(b)(2).
245 *See id.* § 69-10.11.
246 *Id.* § 69-10.12.
247 *See id.*
248 *Id.* § 69-10.12(c); *see id.* § 69-10.8.
249 *Id.* § 69-10.12(a).
250 *Id.* § 69-10.12(b).
251 As noted, because of the restrictions on vans and/or other transportation the enrollee may well not have access to appropriate transportation for regular use to access the community at all.

"over a short period of time that would cause an undue financial hardship;"[252] (3) if "the geographic location of the enrollee and the provider of medical care and/or services are such that the usual mode of transportation would be inappropriate;" (4) "whether the distance to be traveled for medical care and/or services would require a large transportation expense that would result in an undue financial hardship for the enrollee;" (5) whether there is a need to continue medical care or obtain services with a specific provider outside the enrollee's usual geographic location; and (6) the enrollee's unique circumstances.[253]

If the plaintiff cannot acquire a modified van either on their own or through the Fund, his options for transportation are very limited. The only transportation provided by the Fund is that which is required to transport the plaintiff to receive medical care.[254] Therefore, the Fund will not provide for transportation to recreational or other activities that would improve the quality of life of the plaintiff and integrate her into the community. The Fund simply would not provide for trips to the library, a ball game, the mall, or to give an urban enrollee an occasional trip to the country to get some fresh air.

Even if a physician deems such treatment requiring transportation to be necessary, prior approval for such transportation might still be denied pursuant to the criteria that the Fund must consider in determining whether an application should be approved.[255] These criteria effectively eliminate the ability for the enrollee to choose when certain medical care is necessary, who is going to provide that care, and where that care is going to be provided. This is because the Fund simply may not provide for transportation to a certain location or geographic area for care if it is felt that such care could be provided more proximately to the enrollee.[256] Apparently no consideration is given to the quality of care that may be provided elsewhere. Under the Fund's criteria one neurologist, for example, is as good as the next. The Fund has the power to prevent an enrollee from obtaining even necessary medical services outside of their home

[252] As discussed below, apparently ordinary financial hardship, or even simply not being able to afford transportation, is not enough to warrant payment.

[253] *Id.* § 69-10.12(c).

[254] *Id.* § 69-10.12.

[255] *Id.* § 69-10.12(c).

[256] *Id.* § 69-10.12(c)(5).

area because it is likely that the enrollee will not be able to secure a van on her own and has to rely on the Fund for all transportation. For example, someone who lives in rural upstate New York may be precluded from obtaining transportation to obtain medical services in New York City, Boston, or California. It would appear that fundamental decisions about where care is to be provided should not be within the control of the Fund. No other malpractice victim has such restrictions imposed on him. It would appear only fair that the injured plaintiff should be entitled to the care that a jury determined is necessary to make her whole, and not merely the care that the Fund decides they can spare.

Additionally, the regulations are not concerned whether transportation to and from medical care will be a "financial hardship" on the enrollee's caretakers, but will only approve transportation if the Fund decrees that it amounts to an "*undue* financial hardship."[257] It is unclear how the Fund would consider what constitutes an "undue financial hardship" as opposed to just a regular "financial hardship," or if the Fund will consider any other financial means that the plaintiff might have at her disposal, potentially creating an inequity between enrollees with different levels of income.

M. Prior Approval Requests for Other Qualified Health Expense Payments

Section 69-10.13 provides for prior approval requests for qualified health care expenses that are not otherwise specified.[258]

This section specifies "that requests [for] payment or reimbursement for any out of the ordinary qualifying health care cost shall provide the documentation required in section 69-10.6(c) . . . and any other relevant information the Fund Administrator deems necessary."[259] This gives the Fund Administrator the right to insist on prior approval for essentially all "qualified" health care expenses. It is therefore completely contrary to the spirit and intent of the statute, which provides that no qualified health care costs shall require such prior authorization except as provided by the Commissioner by

[257] *Id.* § 69-10.12(c)(2),(4).
[258] *Id.* § 69-10.13.
[259] *Id.*

regulation.[260] The net effect of these prior approval sections, and in particular this section, is that it completely reverses the process, and essentially makes everything subject to prior approval by the Fund.

N. Expedited Prior Approval Process

Section 69-10.14(a) provides for an "expedited prior approval process" within forty-eight hours where a physician certifies and documents that there is an "urgent need" for such services and approval.[261] Paragraph (b) permits such services to be provided on an "emergency basis" pending the expedited prior approval process if the application for approval is submitted without delay.[262]

The problem here is that there is no assurance, even if services are provided on an emergency basis or for expedited prior approval, that such request will ultimately be approved by the Fund.[263] This will tend to discourage providers from providing even "emergency" services that are within the category of prior approval because of the possibility of eventual rejection. Moreover, there is no provision for payment even to a provider who is acting in a good faith belief that there was an urgent or emergency need for services, if the Fund Administrator ultimately disagrees that the service was required.[264]

O. Claim and Prior Authorization Review Process

Section 69-10.15 describes the process for obtaining administrative review of a denial of services applied for under the Fund, whether or not prior approval was required.[265] Pursuant to Paragraph (a), the enrollee must complete a claim denial review form within thirty days of the denial of the requested service. It may be submitted electronically, by mail, or hand delivered.[266]

Paragraph (b) requires the form to specify the basis for an

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260 N.Y. PUB. HEALTH LAW § 2999-j(2) (McKinney Supp. 2012); N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.13.

261 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.14(a).

262 *Id.* § 69-10.14(b).

263 *Id.* § 69-10.14.

264 *Id.*

265 *Id.* § 69-10.15.

266 *Id.* § 69-10.15(a).

assertion that the request for services was improperly denied, and permits the enrollee to request a review by phone or in person.[267]

Paragraph (c) requires that "[a]ll written evidence, including the names of witnesses a party intends to present at the hearing, must be provided to the other party at least 5 business days prior to the hearing."[268]

Paragraph (d) allows a person who has been denied prior approval to request "an informal conference in addition to a formal review."[269] In this instance, the Fund Administrator will designate someone from the Fund to informally discuss the reasons for the denial, at least one week before the formal hearing.[270] The regulation does not specifically give the "informal" Fund designee the authority to reverse the denial.[271] By scheduling the "informal conference" as little as a week before the formal hearing, it essentially precludes the plaintiff from avoiding the expense to prepare for the formal hearing. Given the apparent lack of authority to alter the denial, it appears that this process exists solely to try to convince the plaintiff that the denial was justified, and therefore discourage pursuit of the formal hearing.

Paragraph (e) provides for the assignment of a hearing officer designated by the Commissioner and providing notice of the hearing to the requesting party.[272]

Paragraph (f) describes the requirements of the hearing notice which must include (1) "the date, time and place of the hearing . . . within a reasonable distance from the requestor;" (2) a statement of the issues at the hearing; (3) " the manner in which the hearing will be conducted;" and (4) a statement informing the enrollee of her right to be represented by counsel.[273] If the plaintiff resides in another state or country, this paragraph would suggest that the hearing would have to be out of the state or country, or any place in the world—though it is difficult to believe that the Fund Administrator would actually

[267] *Id.* § 69-10.15(b).
[268] *Id.* § 69-10.15(c).
[269] *Id.* § 69-10.15(d).
[270] *Id.*
[271] *Id.*
[272] *Id.* § 69-10.15(e).
[273] *Id.* § 69-10.15(f).

comply with this requirement at a distant location.[274]

Paragraph (g) permits all papers and notices to be served by regular mail, which is deemed complete three days after mailing.[275] Actual receipt is not required.[276] No thought is given to the possibility that a party may live across the country or even outside the United States, where delivery within three days may be problematic.

Paragraph (h) requires the Commissioner of Health to assign a Hearing Officer.[277] Presumably this is an employee of the Health Department, though the regulations are silent on this issue.[278] The Hearing Officer must not have a "personal bias," though this term is undefined.[279] Any party (presumably the Fund, the enrollee, and perhaps a provider denied payment) may request that the Hearing Officer be disqualified "for personal bias or for other good cause" established by affidavit stating the basis for disqualification.[280] Apparently it is the Hearing Officer who will decide whether he or she should self-disqualify.[281] The Hearing Officer may also, on her own motion, disqualify herself "for bias."[282]

Paragraph (i) provides that the hearing is to be conducted "in a fair and impartial manner."[283] It also enumerates the powers of the Hearing Officer, granting her the authority to (1) "rule upon requests by all parties to the hearing, including requests for adjournments"[284] (2) administer oaths and issue subpoenas to require the attendance of witnesses and the production of documents;[285] (3) "admit or exclude evidence," though no

274 This is not just hypothetical. The author was actually recently consulted by an attorney in Australia who represents an Australian citizen injured at birth in New York City, but who currently resides in Australia. Does anyone seriously think that the Fund would schedule a hearing in Australia?

275 *Id.* § 69-10.15(g).

276 *Id.*

277 *Id.* § 69-10.15(h).

278 *See id.* § 69-10.15(h).

279 *See id.*

280 *Id.* § 69-10.15(h)(1).

281 *Id.* § 69-10.15(h)(4).

282 *Id.* § 69-10.15(h)(2).

283 *Id.* § 69-10.15(i).

284 *Id.* § 69-10.15(i)(1).

285 *Id.* § 69-10.15(i)(2). It is unclear where this subpoena power comes from, or how one enforces a subpoena for an out of state or foreign witnesses or records. *See* N.Y. PUB. HEALTH LAW § 2999-j (McKinney Supp. 2012) (making no mention of any subpoena power).

standards are provided;[286] (4) "limit repetitious examination or cross examination . . . or . . . testimony;"[287] (5) "hear arguments on facts and law," though again no standards as to how this is applied are presented;[288] (6) "order . . . opening statements summarizing why the . . . Fund Administrator's [decision] was [correct] or was not correct;"[289] (7) "order the parties to appear at a pre-hearing conference . . . to simplify the issues[and] expedite the hearing;"[290] (8) "ensure that a written or electronic verbatim record of the proceedings is made and made available to the parties;"[291] (9) "perform [any] other acts . . . necessary for the maintenance of order and efficien[cy]" throughout the hearing "unless otherwise prohibited by law or regulation;"[292] and (10) adjourn the hearing at the request of a party for good cause, or at the hearing officer's own motion if he or she determines that proceeding "would be prejudicial to a party's due process rights."[293]

Paragraph (j) describes the manner in which the hearing shall be conducted which "shall provide . . . a fair and prompt resolution of [the] dispute."[294] The parties have the right to be "represented by legal counsel or other individuals with specialized training relevant to the hearing and may be accompanied by a person of his or her choice."[295] "The hearing shall be closed to the public unless the enrollee [or her representative] requests an open hearing."[296] "The parties . . . shall have an opportunity to present evidence and to question all witnesses at the hearing" and every witness shall be under

286 N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.15(i)(3). A later paragraph does state that "[t]he formal rules of evidence shall not apply," *id.* § 69-10.15(j)(5), There is no provision for out of state witnesses or "trial" depositions from experts who cannot attend a hearing, *see id.* §69-10.15 (noting that the regulations do not provide for out of state witnesses or depositions from experts who may be absent from a hearing).

287 *Id.* § 69-10.15(i)(4).

288 *Id.* § 69-10.15(i)(5).

289 *Id.* § 69-10.15(i)(6).

290 *Id.* § 69-10.15(i)(7). This also could increase legal fees to the enrollee.

291 *Id.* § 69-10.15(i)(8). There is no specific requirement that the plaintiff is entitled to this without cost, thereby further increasing the cost to the plaintiff to challenge a denial of services. *Id.* § 69-10.15.

292 *Id.* § 69-10.15(i)(9).

293 *Id.* § 69-10.15(i)(10).

294 *Id.* § 69-10.15(j).

295 *Id.* § 69-10.15(j)(1).

296 *Id.* § 69-10.15(j)(2).

oath.[297]

Subparagraph (5) requires the Hearing Officer to "consider all relevant evidence" including "records, documents, and memoranda submitted into evidence," though "[t]he formal rules of evidence shall not apply."[298] There is no guidance as to what is or is not admissible evidence.[299] In the event that the parties stipulate to settle the dispute prior to the decision, "a hearing officer will issue a consent order" that will "have the same force and effect as an order issued by the Commissioner."[300]

Paragraph (k) requires the hearing officer to "render a written *recommendation* to the Commissioner within 30 days of the hearing."[301] The hearing officer's recommendation includes "the relevant facts, the applicable law[s], regulations, and official policies . . . upon which the recommendation is based."[302]

Under Paragraph (l), "[t]he Commissioner or his or her designee shall review the hearing record and the hearing officer's recommendation and issue a decision that contains findings of fact, conclusions of law and the reason(s) for the determination and, when appropriate, directs the Fund Administrator to take specific action."[303] The Commissioner's decision shall be issued no more than thirty days from the Hearing Officer's recommendation.[304] *Thus, the Commissioner is not bound by the Hearing Officer's "recommendation" even if it is favorable to the enrollee.*

Paragraph (m) requires mailing of a decision to all parties to the hearing and the Fund Administrator, and provides that the Commissioner's decision shall be final subject to the enrollee's right to seek judicial review.[305]

This appeals process is burdensome because the enrollee will need to pay for attorneys, experts, and possibly the enrollee's care while the appeal is pending. The regulations create even more impediments to an enrollee successfully reversing a denial of services.

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297 *Id.* § 69-10.15(j)(3)–(4).
298 *Id.* § 69-10.15(j)(5).
299 *Id.* § 69-10.15(j).
300 *Id.* § 69-10.15(j)(6).
301 *Id.* § 69-10.15(k) (emphasis added).
302 *Id.* It is unclear what might constitute an "official policy." *Id.*
303 *Id.* § 69-10.15(l).
304 *Id.*
305 *Id.* § 69-10.15(m).

First, there does not appear to be any requirement that the Fund initially specify the basis for the denial. As a result the enrollee must guess the reason and blindly attempt to respond to it.[306] Moreover, although the enrollee is required to disclose to the Fund all of her written evidence and the names of her witnesses, there is no reciprocal provision requiring the Fund to specify any witnesses or written evidence so as to enable the enrollee to prepare her argument.[307]

Second, the family will likely have to incur significant legal expense, including expenses for expert witnesses to present an appeal, despite the fact that such witnesses likely had already either testified or submitted reports justifying the requested services at trial, and may have had their position accepted in a court of law. Experts at trial, who may have been secured at great expense and from a great distance may have to retestify, possibly on short notice, especially if the services denied are time sensitive. The enrollee may not be able to afford either the legal expense or appropriate expert testimony. This will not only limit chances of a successful appeal, but may deter the enrollee from even initiating a review.

Third, there is no provision for the reimbursement of attorney's fees or expert expenses, even if the appellant is successful in overturning the Fund denial.[308] Nor is there a provision for continued services pending the review decision, which can take up to sixty days (thirty days for the hearing officer's recommendation to the Fund Administrator and another thirty days for the Fund Administrator's decision).[309] In the meantime, even if ultimately successful, the enrollee must do without the necessary services and incur the expense of the review process, merely to get that care that she has already won in court.

Finally, the Fund will presumably be having multiple hearings involving what may be a limited number of Hearing Officers. This will enable the Fund, in contrast to the enrollee, to establish

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306 *Id.* § 69-10.6 (providing process for approval of requests); *See id.* § 69-10.15 (providing process for denial review but not requiring the Fund to provide the basis for the denial).

307 *See id.* § 69-10.15(c) (allowing for witnesses but not requiring Fund to specify witnesses).

308 *See id.* § 69-10.15 (allowing for representation by attorney during denial proceedings but not providing for reimbursement of fees incurred).

309 *See id.* § 69-10.15(k)–(l) (providing for a review period of up to sixty days but no continued services in the interim).

a "track record" of favorable Hearing Officers who are inclined to control costs. The Fund can keep track of these Examiners and potentially misuse their knowledge of a hearing officer's proclivities to seek disqualification. Since the regulations make no reference to payment of the hearing officer, it can be presumed that they will be state employees, and thus possibly not entirely impartial.

The net effect of these provisions, when combined with the fact that services may not be provided while the review process is pending, may well mean that the enrollee could go without services—even if they are successful in overturning the denial—for an extended period of time.[310] If the denial is maintained and the plaintiff is required to go back to court, the delay will be even longer, even if they are eventually successful. The significant costs and potentially devastating consequences to the plaintiff in the meantime are apparently not considered by the regulations.

Should the enrollee have to go back to court in an attempt at an appeal, she would be limited to an Article 78 proceeding.[311] In this setting the plaintiff will have a higher burden of proving the need for services than she did in establishing her need "'for the care at trial in the first instance. At the malpractice trial all that was required was establishing the need for care by a preponderance of the evidence.[312] By contrast, in order to reverse a determination by the Fund denying care, she will have to show that the determination made by the Fund Administrator (1) "was made in violation of lawful procedure;" (2) "was affected by an error of law;" (3) "was arbitrary or capricious;" or (4) lacked "substantial evidence."[313]

It also remains to be seen what, if any, standards there will be for reapplying for the same, or similar, benefits after a denial. Would *res judicata* apply to the Commissioner's denial if the enrollee simply reapplied for a denied benefit at a later date? What if any change in circumstances need to be shown to reapply?[314] The regulations do not specify if any time limits are

310 *See id.* (describing time period for review without reference to continued services during that time regardless of success of claim).

311 *See* N.Y. C.P.L.R. § 7801 (McKinney 2008) (describing scope of Article 78 proceeding).

312 1A N.Y. PATTERN JURY INSTRUCTIONS, *supra* note 105, at §1:23.

313 C.P.L.R. § 7803.

314 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.15 (providing procedure for a hearing for the denial of a claim but failing to provide standards for reapplying

applicable to prohibit reapplication for the same benefits following a denial.[315]

P. Right to Expedited Review of Denials of Request for Prior Approval

Section 69 10.16 provides for expedited review of prior approval denials under certain circumstances.[316] If a physician provides a written statement that the enrollee has an urgent need for medical services or other items, and the reason why such service or item is needed on an expedited basis, a review of the request must be conducted within ten business days of the request for expedited review and supporting documentation.[317] The Hearing Officer must make a recommendation to the Commissioner within five business days of the hearing.[318] The Commissioner is then obligated to make his or her decision within five business days of the Hearing Officer's written recommendation.[319]

Subparagraph (d) provides that pending an expedited review determination, a service or item may—but is not required—to be provided.[320] Therefore, even under the "expedited review process," the enrollee might have to go twenty days without urgently needed services even if successful.[321]

Q. Actuarial Calculations for the Fund

Section 69 10.18 relates to actuarial calculations for the Fund.[322] Paragraph (a) requires "the Superintendent [to] conduct an actuarial calculation of the estimated liabilities of the Fund for the year following [the] annual deposit [to fund it]."[323] Significantly, as noted below, there is no calculation as to

benefits after a denial, a standard of review for denial, or any requirement to disclose change in circumstances).

315 *See id.* § 69-10.5, .15.

316 N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.16 (2012).

317 *Id.* § 69-10.16(a).

318 *Id.* § 69-10.16(b).

319 *Id.* § 69-10.16(c).

320 *Id.* § 69-10.16(d).

321 *Id.* § 69-10.16 (adding together the ten business days allowed for the review of the request, the five business days the Hearing Officer has to make a recommendation, and five business days to get the Commissioner's decision, the child could potentially have to wait 20 business days for critical services).

322 *Id.* § 69-10.18.

323 *Id.* § 69-10.18(a).

whether the Fund is actuarially sound over the lifetimes of the enrollees.[324]

Actuarial calculations of estimated liability must be conducted quarterly thereafter, assessing the estimated liabilities, but again only for the ensuing year.[325] The actuarial analysis must include (1) "the number of qualifying plaintiffs admitted in the Fund, and estimates of the number of qualified plaintiffs not yet admitted;"[326] (2) mortality experiences of the plaintiffs in the Fund;[327] (3) "the amounts of benefits paid by the Fund;"[328] (4) "patterns of utilization;"[329] (5) inflationary patterns;[330] (6) expenses of the Fund administration;[331] (7) "the impact available health insurance has on the benefits paid by the Fund;"[332] and (8) "investment earnings on the assets held by the Fund."[333]

There is no discussion as to who will conduct the actuarial analysis; whether it will be done internally by the Department of Insurance or whether it can be contracted out, and if so, whether it is paid for as a cost of administration of the Fund. There is no description as to whether this analysis will be made public and whether it can be challenged.[334] The latter is important because the actuarial calculations will determine when the Fund is closed to new enrollees. If the estimates are unrealistic, it could adversely affect the settlement value of a plaintiff's case depending on whether it is likely to be within or outside the Fund.[335]

R. Suspension of the Fund

Section 69 10.19, as provided by statute, reiterates that when the Fund's current liabilities equal or exceed 80 percent of the

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[324] *Id.* § 69-10.18.

[325] *Id.* § 69-10.18(a).

[326] *Id.* § 69-10.18(b)(1).

[327] *See id.* § 69-10.18(b)(2). The mortality experience will be somewhat, if not largely, dependent on the estimate of services provided to the admitted plaintiffs. The less services that are provided, the higher the mortality rate will be.

[328] *Id.* § 69-10.18(b)(3).

[329] *Id.* § 69-10.18(b)(4).

[330] *Id.* § 69-10.18(b)(5).

[331] *Id.* § 69-10.18(b)(6).

[332] *Id.* § 69-10.18(b)(7).

[333] *Id.* 10 § 69-10.18(b)(8).

[334] *See id.* § 69-10.18 (failing to mention whether the analysis will be made public or if it may be challenged).

[335] N.Y. PUB. HEALTH LAW § 2999(i)(6) (McKinney Supp. 2012).

Fund's assets as determined by the actuarial analysis described above, the Fund shall suspend enrollment and no new enrollees will be accepted.[336] This issue is critical since it would appear to create a denial of equal protection. Some plaintiffs will be limited to the Fund, and others with the exact same injury and damage—even theoretically one of two injured twins—will be able to collect their full damages from the defendant.[337] This will be determined solely by the financial status of the Fund at a given time.[338]

Paragraph (b) provides that if the Fund's current liabilities are no longer equal to or in excess of 80 percent of the Fund's assets, enrollments will again be accepted.[339] Paragraph (c) provides that the Fund Administrator is required to provide proper notice of suspension or reinstatement of enrollment on the Fund's website.[340] Paragraph (d) provides that "[o]nce enrolled, a qualified plaintiff will remain in the Fund for his or her lifetime, and will not be impacted by a suspension in enrollment."[341] This language also raises an interesting question of whether an applicant can be placed into the Fund while a defendant appeals liability. There is no provision to deny enrollment based on an appeal, and this language states that "[o]nce enrolled, a qualified plaintiff will remain in the Fund for his . . . lifetime."[342] Since there is no lifetime reserve for any enrollee, and since neither the actuarial soundness of the Fund over a lifetime, nor the degree of funding by the state for ensuing years, much less decades, can be predicted or assured, it is difficult to see how this promise can be made or backed up.

Although the language in this section is apparently directed to the possibility of Fund suspension, it may be broad enough to cover a reversal of the defendant's liability on appeal.[343] It is possible therefore, that without a stay on appeal, a child could be

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[336] *Id.* § 2999(i)(6); N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.19(a).

[337] *See* discussion *infra* Part V.B.

[338] PUB. HEALTH § 2999(i)(6); N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.19(a); *see* discussion *infra* Part V.B.

[339] N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.19(b).

[340] *Id.* § 69-10.19(c).

[341] *Id.* § 69-10.19(d).

[342] *Id. See also id.* § 69-10.2(b) (requiring applicants to submit only a "certified copy of the court-approved settlement or judgment" and not requiring applicants to provide appellate documentation if they are appealing).

[343] *See id.* § 69-10.19(d) (maintaining that qualified plaintiffs will remain in the Fund for their lifetimes regardless of any suspensions in enrollment).

enrolled in the Fund pending appeal and, under this provision, cannot be removed even if liability is reversed.[344]

This provision, therefore, arbitrarily creates four subclasses of malpractice victims with the exact same injury, damages, and cost of care. The first class constitutes infants who suffer from a neurologic impairment as a result of malpractice after or not involving birth. They will receive their full measure of damages and can collect them from the defendant. The second category consists of birth injured children whose judgments come before 80 percent of the Fund is exhausted. The care for these victims, as long as there is continued state funding, will require Fund approval and will be paid exclusively by the Fund at Medicaid rates, instead of by the defendant or its malpractice carrier at market costs.[345] The third category will be those birth injured children whose judgment comes after 80 percent of the Fund is exhausted. They will be paid their full damages by the defendant (and/or insurance carrier) as determined by the court, just as if the Fund did not exist.[346] The fourth, hybrid category of the second and third classes, consists of those who start out in the Fund, but may be forced to remain in the Fund even if the Fund appropriation is exhausted and there is no money left to pay for their care. These children will begin by having part of their damages paid at Medicaid rates and requiring Administrative approval, but were the Fund to run out of money, the rest would presumably be paid at full rates by the defendant, but perhaps not. The question of what happens if the Fund runs out of money for individuals already in it, remains unanswered, the promise by the Fund regulations to continue paying notwithstanding.[347]

S. Rates of Payment

Section 69 10.20 provides for the rates of payment to providers

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[344] *See id.* (allowing qualified plaintiffs to remain in the Fund for their lifetimes).

[345] N.Y. PUB. HEALTH LAW § 2999-j(4) (McKinney Supp. 2012); N.Y. COMP. CODES R. & REGS. tit. 10, § 10.20(b).

[346] PUB. HEALTH § 2999-i(6).

[347] *Id.* § 2999-i(6). This creates yet more administrative headaches. It is not clear whether a defendant can ever be released or a judgment satisfied even if a child starts out in the Fund. Since there can never be any assurance that there will be a sufficient appropriation to pay future care costs, either the defendant remains responsible to pay the judgment or the plaintiff has to go without essential care services.

of services.[348] This is a critical section because, as discussed previously, the rate of payment for services will have a direct impact on the availability and access to care by enrollees.[349] This will necessarily adversely impact the quality of life and even the longevity of the plaintiff.

Paragraph (a) provides that physician's services are paid at the "usual and customary charges for [such] services" as specified by "FAIR Health, Inc."[350] Even if it is assumed that such payments are "reasonable" and generally accepted by physicians, there is certainly no assurance that any particular physician or specialist will accept this amount. This has the significant potential, therefore, to reduce access to care and health care choices by the plaintiff.

More importantly, Paragraph (b) provides that for "services, supplies, equipment and medications"—a category that encompasses almost everything else—payment for such items will be at the Medicaid rate.[351] Paragraph (c) provides that services for which there is not a Medicaid rate will be paid in the manner described by the prior approval process, that is, the three competitive bids.[352]

T. Payment for Services Between April 1, 2011 and October 1, 2011

Section 69 10.21 provides for payment for expenses incurred between (a) the six month period of time between when the Fund took effect on April 1, 2011 and when the Fund started accepting enrollees on October 1, 2011, and (b) the time between the judgment or settlement and actual enrollment in the Fund.[353]

Paragraph (a) states that plaintiffs who were eligible to enroll after April 1, 2011 "must rely upon private health insurance or Medicaid to cover medical expenses" for the period prior to October 1, 2011. [354] Paragraph (b) provides that after October 1, 2011 (when the Fund actually started taking applications) the

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348 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.20.

349 Moore & Gaier, *supra* note 6.

350 N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.20(a).

351 *Id.* § 69-10.20(b).

352 *Id.* § 69-10.20(c).

353 *Id.* § 69-10.21.

354 *Id.* § 69-10.21(a). This means that they have been deprived of payment for services from the defendant *and also deprived of payment for these services by the Fund as well.*

Fund will reimburse health care costs incurred between the time of approval of a settlement or judgment and the date the plaintiff is enrolled in the Fund.[355]

U. Residence of Qualified Plaintiffs

Section 69 10.22 deals with the residence of qualified plaintiffs.[356] Under Paragraph (a), enrollees are "required" to advise the Fund administrator of any address change.[357] It is unclear where the authority to require this information is found. Nor is any concern expressed about the loss of privacy associated with this obligation.[358]

Paragraph (b) specifies that eligibility or continued enrollment "is not dependent on the current or past residency of a qualified plaintiff."[359] Although this statement may be technically true, as a practical matter, the regulations present numerous problems related to the freedom to travel.[360]

The Fund does not address many issues that would arise with respect to where the plaintiff can live. It is unclear how the Fund would handle situations where the plaintiff has more than one residence, such as where his parents are divorced. In that instance, the plaintiff might not be eligible for any modification assistance from the Fund, for example, because it is possible that between the two households the plaintiff might not have a "primary" residence.[361] The Fund also creates the potential to disturb whether the plaintiff can even stay at the home of certain family members if it refuses to allow for the modification of more than one residence. These limitations would not arise if the plaintiff received his damages from the tortfeasor and was

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[355] *Id.* § 69-10.21(b). This of course assumes that the child's family had access to such care during that period.

[356] *Id.* § 69-10.22.

[357] *Id.* § 69-10.22(a).

[358] The basis for this requirement, as well as the obligation to continue to provide medical authorizations would presumably be justified on the grounds that they are necessary to maintain eligibility for a government benefit, such as would be the case with Medicaid. The critical distinction is that the child is *forced* into the Fund, and is there only because the State took away his right to obtain payment for judicially determined damages from the defendant, and thereby the concurrent right to avoid these invasions of privacy.

[359] N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.22(b).

[360] *See* discussion *infra* Parts V.B., V.D.2.

[361] N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.7(a).

thereby able to tailor her care to her own unique situation.[362]

Additional issues arise when a plaintiff's family wishes to relocate. There are currently no regulations regarding payments for expenses that result from relocation. The Fund then may very well refuse to pay for environmental modifications for a new home, especially if the home they are leaving is equipped with the necessary modifications.

Residence issues are also created with respect to payment of services. If the child is not a resident of New York, or moves out of New York State, it is unclear what the reimbursement rate would be, especially if the other state's Medicaid reimbursement rates are higher than those in New York.[363] It would appear that an enrollee would not be allowed to use a higher Medicaid reimbursement rate from another state.[364] As a result, a child receiving New York rates in another state risks not having access to services. In fact, if a child who is a resident of another state is born in New York, and personal jurisdiction cannot be asserted in her home state, the child's only recourse might be to accept payment from the Fund, at New York Medicaid rates, even though her only connection to New York was her birth. The child's residence should not affect the damages recoverable. Finally, it is also conceivable that the child might live outside the U.S., and outside the reach of Medicaid providers. Forced enrollment in the Fund might preclude them from receiving care overseas.

IV. PRACTICAL DIFFICULTIES OF THE FUND

The Fund creates several practical difficulties for both the state and the enrollees who will be covered by the Fund. The most critical issue is the manner by which the Fund receives its

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[362] *Id.* § 69-10.21(b).

[363] *See* Moore & McMullen, *supra* note 26 § 17:2.4 (noting that it is unclear whether New York rates can be used while residing in Florida).

[364] Consider two twins, both injured by New York obstetric malpractice, at the same time, with identical injuries. One twin lives in a different state. This might result in the twins receiving different amounts from the Fund. *See* Moore & McMullen, *supra* note 26 §17:2.4 (questioning whether under § 69-10.22 a person who lives out of state can use New York rates). Depending on the timing of their actions, the order of their births, and the approval process for acceptance in the Fund it is theoretically possible that even if they lived in the same household, one of the twins may be covered under the Fund, and one not. *See* N.Y. PUB. HEALTH LAW § 2999-i(6) (McKinney Supp. 2012); *see also* N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.19(a).

assets, and whether it will be able to survive at over the long term. As noted previously, there are also significant issues with regard to patient's rights, such as medical privacy and access to care.

A. Funding Insufficiency

How the Fund will manage its assets, and more important whether there will be sufficient funding to fulfill its obligations, presents a major potential problem. The Fund is limited to a first year appropriation of $30 million dollars.[365] The level of future funding is based on a 1.6 percent tax on obstetrical services in New York. The amount raised in the future is unlikely to keep pace with the number of enrollees added to the Fund each year. The number of births in New York will remain relatively constant.[366] Therefore, the number of new enrollees will continue to grow, essentially doubling (or more) in the second year and increasing by a similar number each year for decades until the enrollees start to decease. As the Fund continues to get more and more enrollees, there is no way to assure sufficient funding to keep the promise that their services will be paid, and once the Fund fills up there will be no way to accept new enrollees without significantly more money. At some point the financial burden on the state may become unsustainable. In addition, new enrollees and the expenses for each enrollee are not going to remain consistent from year to year, and how the Fund is going to deal with this dilemma is unclear. Finally, the Fund is dependent not only on appropriations at the state level, but it will also likely be very sensitive to any changes in the Medicaid system.[367]

The cost of future care will be paid from the Fund.[368] It appears that the sum of $30 million that was appropriated to the Fund in the first year includes the cost of administering the Fund, and

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[365] PUB. HEALTH § 2807-d-1; Stashenko, *supra* note 28.

[366] *Table 5: Live Birth Summary by Mother's Age 2009*, N.Y. DEP'T HEALTH, http://www.health.ny.gov/statistics/vital_statistics/2009/table05.htm (last visited Feb. 29, 2012); *Table 5: Live Birth Summary by Mother's Age 2008*, N.Y. DEP'T HEALTH, http://www.health.ny.gov/statistics/vital_statistics/2008/table05.htm (last visited Feb. 29, 2012); *Table 5a: Live Birth Summary by Mother's Age 2007*, N.Y. DEP'T HEALTH, http://www.health.ny.gov/statistics/vital_statistics/2007/table05a.htm (last visited Feb. 29, 2012).

[367] *See* PUB. HEALTH § 2999-j(4); N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.20(b).

[368] PUB. HEALTH § 2999-j(6)–(7).

this cost can be contracted out privately.[369] Even the initial appropriation may be inadequate, because as described above (1) every year the number of enrollees in the Fund will increase until they start to expire in significant numbers over ensuing decades; (2) the cost to provide care for these enrollees will increase every year due to inflation;[370] (3) it cannot be known how many plaintiffs will be eligible for the Fund in any given year;[371] (4) the cost to provide care for each applicant will vary —perhaps significantly; (5) the annual cost of the Fund will be difficult to predict due to necessary up-front expenditures related to patient care such as home or vehicle modifications; and (6) the cost to administer the Fund must be covered by the Fund itself.[372]

In fact, the fiscal stability of the Fund depends on the hope that the Fund will never reach its 80 percent limit. For example, consider the scenario where the Fund starts out the year with the initial $30 million appropriation.[373] Assuming that there is a 15 percent cost of administering the Fund ($4.5 million) no new applicants can be taken into the Fund after $20,400,000 (80 percent of the balance) is spent.[374] Even if it were assumed that approximate net cost of care is only $100,000 per case per year, this is only a maximum of 204 potential plaintiffs covered.[375] Interestingly, it is estimated that the Fund could be responsible for up to 200 new applicants per year.[376] However, whatever magic number of enrollees exhausts the Fund in any given year, if the 80 percent limit is reached the Legislature would have to increase funding beyond the first year's $30 million appropriation in subsequent years merely to provide for the enrollees already in the program.[377] This is because each year the number of plaintiffs whom the Fund will be capable of covering will decrease because

369 *See id.* §§ 2807-d-1, 2999-i(2)(c); Stashenko, *supra* note 28.

370 Johnson, *supra* note 44.

371 *See* Stashenko, *supra* note 28 (noting that the care provided to an enrollee will be decided on a case by case basis and that the size of the Fund in later years will vary according to its needs).

372 PUB. HEALTH § 2999-i(3).

373 *Id.* § 2807-d-1(2).

374 *Id.* § 2999-i(6).

375 VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM, COMPREHENSIVE ANNUAL FINANCIAL REPORT 26 (2010) (showing that the average expense per claimant is roughly 100,000 dollars). Many of these children can require care that can cost several times $100,000 per year, even excluding high front end first year costs.

376 Knipel, *supra* note 7; Stashenko, *supra* note 28.

377 PUB. HEALTH § 2999-i(6).

of inflation.[378] Depending on how many of the enrollees die in any given year, only a very small number of additional plaintiffs will ever again be covered by the Fund without an additional influx of cash. Assuming that the first year $30 million appropriation is sufficient to pay for all of the eligible enrollees in that year, in order to take in any new plaintiffs, the Legislature would likely have to appropriate more than $60 million in the following year (because of inflation), and likely more than $90 million in the year after that, increasing every year until the Fund becomes unsustainable. If such multiplying appropriations do not occur, despite even the best of intentions, there can be no assurance that future Legislatures will increase Fund appropriations sufficiently. The Fund will have to cease taking new plaintiffs forever, thus creating even more different subcategories of infants that have suffered a birth related neurological injury as a result of malpractice. Any birth injury plaintiff who is unlucky enough to be in the first cases tried or settled will be in a wholly different class of recovery from everyone else with the exact same injury and damages, and for whom the Fund will lack the assets to cover them.

The way the Fund is structured and financed, it is by no means certain that payments of future care costs will be available over an enrollee's entire lifetime. Indeed it is highly likely that they will not.[379] There was no requirement that an actuarial computation determine that the Fund would be actuarially sound in the first place (beyond the ensuing year).[380] Were there no concern about the ongoing solvency of the Fund, it would not have been necessary to include the "failsafe" of stopping enrollment when the Fund is 80 percent exhausted. Nor is there a requirement of an actuarially sound lifetime reserve for each enrollee. Rather, the Fund makes payments on a "pay as you go" basis in the same manner as does Social Security.[381] If the Fund runs out of money, or the Legislature decides to eliminate or

[378] *See* Johnson, *supra* note 44 (discussing the effects of inflation on medical costs).

[379] *See* PUB. HEALTH § 2999-i(5), (6)(a) (detailing how additional funds will need to be deposited into the Fund, and the contingency of Fund liabilities becoming larger than the amount of monies within the Fund).

[380] *See id.* § 2999-i; N.Y. COMP. CODES R. REGS. tit. 10 § 69-10.18(a) (2012) (setting out how to determine the amount paid into the fund, without mandating the process would be actuarially sound).

[381] Stashenko, *supra* note 28.

reduce funding in the future, the plaintiff may be without a remedy. It is unclear whether an enrollee will be able to go back to the original defendant or their insurer in order to get the resources necessary to obtain care. If the defendant has since gone bankrupt, or the insurance aggregate that would have been available to an initially covered plaintiff has been used, then the plaintiff may well be totally out of luck when it comes to funding future care.

B. Potential Backlogs of Enrollees and Up-Front Costs

It is also possible that the Fund will become bombarded with applicants in future years, particularly over the next several years. It was initially estimated that there are approximately 200 cases per year of obstetrical malpractice involving hypoxic injury to which the Fund would be applicable.[382] If this is accurate, then because (1) the Fund purports to apply to pending cases as well as new cases, and (2) it may take 3–4 years or more for these pending cases to be resolved, there may be as many as 800 or more pending cases with approximately 200 more coming on line each year.[383] This backlog alone, therefore, will mean that without a quadrupling of the budget allocation over the next three years–and continuing significant increases in future years–less than one out of four eligible qualified plaintiffs may be "covered" by the Fund.[384]

This computation assumes that the Fund can only expect 200 applicants per year. There is reason to believe that the Fund may be subject to many more potential enrollees. Since the Fund is now willing to accept future care costs—which in most instances is the largest component of damages—the defendant has a decreased incentive to take the risk of an adverse outcome, and may be more inclined to settle with the plaintiff and stick him in the Fund.[385] As a result, plaintiffs who have more questionable claims of liability or causation may be more likely to get a settlement from the defendant for a nominal amount of pain and suffering because the defendant knows that it will not be

[382] Knipel, *supra* note 7; Stashenko, *supra* note 28.

[383] N.Y. COMP. CODES R. REGS. tit. 10 § 69-10.2(a)(3).

[384] *See* Stashenko, *supra* note 28.

[385] *See* Knipel, *supra* note 7 ("For a severely impaired infant, lifetime benefits could easily be worth millions of dollars . . . [while the] settling defendant does not have to pay the cost for plaintiff's inclusion in the Fund, and its annual premium to finance the Fund, if any, remains unaffected.").

responsible for future care costs.[386] There is also an issue with respect to the possibility that autism, or unrelated post delivery/resuscitation malpractice occurring prior to discharge but after delivery, may be covered by the Fund.[387]

Regardless of how small the recovery for future care costs or the amount allocated to future care in a settlement, full lifetime benefits are required to be paid by the Fund.[388] Instead of diminishing the number of lawsuits, the Fund may actually increase them, and thereby contribute to its own demise as unsustainable.

It is unclear how the Fund would address actuarial reserves and pay for front end loaded upfront costs like future home renovations, or a handicapped accessible van that may be required to keep a child (and eventually an adult) at home. If these upfront costs are included, the number of enrollees who can be covered in the first year will drop significantly. Usually these big ticket items, such as handicapped accessible vehicles, or home renovations are accounted for in a life care plan on an annualized basis.[389] But if they are all required–as will likely be the case–in the first year of the Fund, the first year cost to the Fund will be much higher than the average annual cost for typical care–thus further reducing the number of new plaintiffs that the Fund can accept, both in the first year and in each subsequent year, without a significant increase in funding.

C. Dependence on Medicaid

Nor is there any assurance that Medicaid will continue to provide necessary services or funding, much less at rates that will provide the care that the court has determined are appropriate. There are currently serious proposals before Congress to transform Medicaid payments to make "block" grants to states, and the states may or may not use these grants to pay

386 *See id.* (demonstrating for questionable claims it is better to settle because plaintiff will receive millions of dollars in care over their lifetime and the defendant is less likely to resist because they do not pay any of the costs).

387 *Id. See supra* note 65; *infra* note 468.

388 *See* Knipel, *supra* note 7. Ironically, the amount of future care costs that the Fund is obligated to pay is entirely unrelated to the amount of the verdict for future care costs or settlement. Theoretically the defendant can agree to settle a birth injury claim for one dollar and bind the Fund to millions of dollars in future care costs.

389 Joel N. Morse & Jeffrey M. Siedenberg, *Transportation Expenses in Life Care Plans: An Incremental Approach*, 10 J. LEGAL ECON. 61 (2000).

Medicaid benefits as presently constituted.[390] The fact that the Fund relies on the Medicaid payment rates set at the federal level means that the Fund, and all of its enrollees, are directly affected by any changes to these rates.[391] Any changes to Medicaid rates could have a dramatic and unpredictable impact on the availability of essential care services.

D. Medical Records and Documentation

As discussed earlier, a defendant may enroll the plaintiff in the Fund and thereby escape liability to pay the cost of future care necessitated by their negligence.[392] This forced enrollment in the Fund infringes on the plaintiff's medical privacy interest, and imposes a continuing significant burden to provide extensive medical information to the Fund over her entire lifetime.[393]

The regulations require that an application include (1) "a [signed] medical release form, which shall be in compliance with applicable laws and regulations pertaining to patient confidentiality;" (2) "documentation regarding the specific nature and degree of the applicant's birth-related neurological injury or injuries, including diagnoses and impact on the applicant's activities of daily living and instrumental activities of daily living;" and (3) a life care plan.[394]

The Fund's impact on the privacy interests of the plaintiff, including any HIPPA implications, could be the topic of another paper. The most obvious question presented by the regulations is what happens when a defendant files an application to enroll the plaintiff but the plaintiff refuses to sign a medical release form. It would appear that, because acceptance into the Fund is required by the statute in order to receive any payment at all for future medical expenses, the plaintiff is required to waive his medical confidentiality to the Fund Administrator, forever.[395] In

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[390] Mary Agnes Carey & Marilyn Werber Serafini, *How Medicaid Block Grants Would Work*, KAISER HEALTH NEWS (Mar. 6, 2011), http://www.kaiserhealthnews.org/Stories/2011/March/07/block-grants-medicaid-faq.aspx (last visited Feb. 25, 2012).

[391] N.Y. PUB. HEALTH LAW § 2999-j(4) (McKinney Supp. 2012); N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.20 (2012).

[392] PUB. HEALTH § 2999-j(7); N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.2(a).

[393] *See* discussion *infra* Part V.D.4. As noted previously this may also violate HIPPA. Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, 110 Stat. 1936 (1996).

[394] N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.2(b).

[395] PUB. HEALTH § 2999-j(7).

addition, the Fund claims that it is authorized to share this information with third parties for a variety of reasons. For example, the Fund can use the medical release to determine eligibility of the plaintiff for other governmental benefit programs (presumably to see if the Fund can reduce its own liabilities); to review the quality of care provided; to coordinate with health insurance companies; to "gather statistics and data for use in shaping public policy;" and to "determine the financial status" of the Fund.[396] Once a neurologically impaired child injured at birth is enrolled in the Fund, she will be required to "consent" to the lifetime release of her medical records, and such records will end up in any number of places beyond her control.

In addition, the documentation that an enrollee is required to submit in order to qualify under the Fund is extremely burdensome for the plaintiff to produce.[397] There is significant time, effort and cost associated with creating and updating these materials.[398] Although it is true that under most circumstances such documentation would have been created for the litigation, that is not necessarily so. Once it is recognized that a child may end up in the Fund there is less reason for plaintiff's counsel to incur the expense and effort necessary to produce these materials.[399] In a settlement situation, a higher percentage of damages allocated to future care costs would actually work against the plaintiff because it would reduce any proportion of cash that is collectable.[400] Therefore, the Fund required "life care plan" type documents will not necessarily be available to the plaintiff, who must bear the burden and cost of providing them to the Fund.

E. Plaintiff's Actual Recovery: Medicaid Liens and Attorney's Fees

Since costs awarded for future care will not be recoverable under the Fund, the plaintiff's actual cash recovery for any injury

396 NEW YORK STATE MEDICAL INDEMNITY FUND, NOTICE OF PRIVACY PRACTICES 1–2 (2012), *available at* http://www.dfs.ny.gov/insurance/mif/mif_privacy.pdf.

397 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.2.

398 *See* JOY PRITTS, HEALTH POLICY INST. GEORGETOWN UNIV., YOUR MEDICAL RECORD RIGHTS IN NEW YORK: A GUIDE TO CONSUMER RIGHTS UNDER HIPAA, 10–12 (2005) (stating that a request for a copy of medical records could take up to 30 days and can require a fee for every copy).

399 PUB. HEALTH § 2999-j(6).

400 *Id.* § 2999-j(6)(a).

caused by medical malpractice will be limited and reduced. In fact, plaintiff's cash recovery will be reduced even further by any Medicaid liens for reimbursement of past medical expenses paid.[401] Finally, even though the plaintiff is in the Fund, her attorney still needs to get paid, and the flawed methodology for determining the attorney's fee actually creates a potential conflict of interest between the attorney and the plaintiff client.[402] Between the Fund, Medicaid liens, and attorney's fees, it is unclear whether there will be sufficient cash left for the plaintiff to make a significant impact on quality of life.

1. Medicaid Liens

In many, if not most, instances the neurologically impaired child will have been receiving Medicaid assistance up until the judgment or settlement. Medicaid is entitled to place a lien on any recovery collected by the plaintiff for the past medical expenses it paid.[403] The state, however, may not encumber any recovery beyond that expended for medical care.[404] Therefore, if there is a settlement reached between a plaintiff and a defendant for less than the amount that the entire case is worth as determined by the court or agreed to by stipulation, the state is only entitled to recover the portion of the settlement that represents compensation for past medical expenses.[405] In the case where a settlement does not provide an allocation for past medical expenses, the state can recover no more than the proportion between the amount of the claim was worth and the amount of the entire settlement.[406] This principle has come to be known as "equitable allocation."[407]

Before *Arkansas Dept. of Health and Human Services v. Ahlborn*,[408] New York law had been that Medicaid had a lien on the plaintiff's entire recovery regardless of how the recovery was apportioned.[409] Although it appears *Ahlborn* has overruled this

401 N.Y. SOC. SERV. LAW § 104-b(1) (McKinney 2003).
402 PUB. HEALTH § 2999-j(14).
403 SOC. SERV. § 104-b(1).
404 *Id.*
405 Ark. Dep't of Health and Human Servs. v. Ahlborn, 547 U.S. 268, 284–85 (2006).
406 *Id.* at 274–75, 292.
407 Morales v. N.Y.C. Health & Hosp. Assoc., 935 N.Y.S.2d 850, 851–52 (Sup. Ct. N.Y. Cnty. 2011).
408 547 U.S. 268 (2006).
409 Calvanese v. Calvanese, 710 N.E.2d 1079, 1080 (N.Y. 1999).

principle, it is unclear to what extent New York will accept or attempt to limit its holding. Some cases have embraced *Ahlborn* and have required allocation hearings to determine how much of their lien Medicaid can collect.[410] At least one case however, *Morales v. New York City Health and Hospital Assoc.*,[411] appears to limit the holding of *Ahlborn*, asserting that equitable allocation only applies when there is a "legal . . . impediment" to the plaintiff's full recovery.[412]

Although *Morales* has speculated that the Medical Indemnity Fund would qualify as such a legal impediment where equitable allocation would be appropriate, New York law, at least according to *Morales*, may not be as settled as previously thought, even before adding the additional ingredient of the Fund.[413] Regardless of whether equitable allocation is embraced, the injured plaintiff still has to satisfy a Medicaid lien with a cash recovery now further reduced by the application of the Fund and the restriction on recovery for future care costs. If equitable allocation is used in a settlement involving a qualified plaintiff, it becomes very important to determine the portion of the settlement allocated to "future care costs," which is picked up by the Fund and is not recoverable by the plaintiff, that should be counted toward the total value of the claim.[414] If equitable allocation is applied and excludes future care costs in calculating the full value of the case, then Medicaid may be able to collect a large portion of the cash available to the plaintiff.[415] This is because the cost of any past medical care received by the qualified plaintiff would represent a much greater proportion of the total value of the case, as compared to if future care costs were included into the calculation. For example, in a $50,000 settlement on what is agreed to be a $100,000 claim that excludes future care costs in the calculation would allow Medicaid to take half of their lien.[416] If the full value of the claim

410 *See, e.g.*, Homan v. Cnty. of Cattaraugus Dept. of Soc. Serv., No. 76064, 2009 WL 2751070, at 1–2 (Sup. Ct. Cattaraugus Cnty. Aug. 27 2009); Lugo v. Beth Israel Med. Ctr., 819 N.Y.S.2d 892, 895–97 (Sup. Ct. N.Y. Cnty. 2006).

411 935 N.Y.S.2d 850 (Sup. Ct. N.Y. Cnty. 2011).

412 *Id.* at 852.

413 *See id.*

414 *See* N.Y. PUB. HEALTH LAW § 2999-j(6)(a) (McKinney 2012) (stating that future medical payments shall be made in accordance with the fund/title).

415 *See Morales*, 935 N.Y.S.2d at 851 (noting that the state can only recover a Medicaid lien representing past medical expenses).

416 *See Ahlborn*, 547 U.S. at 269–70 (explaining that the state can only take a

includes future care costs, raising the value to $1 million, then a $50,000 settlement would only allow for Medicaid to collect one-twentieth of the settlement under *Ahlborn*. Either way, Medicaid will be able to take a significant portion of the limited cash available to the plaintiff.

2. Attorney's Fees

The manner in which the plaintiff's attorney gets paid in a Fund eligible case has the potential to place the attorney's interests at odds with that of his client.[417] In the case of a settlement, the Fund legislation requires that the settlement designate the percentage of the settlement that is to be attributed to future medical care.[418] Since the qualified plaintiff will not be able to actually recover any cash amount for future care, it is in the qualified plaintiff's interest to get the highest percentage of the settlement allocated to pain and suffering, rather than to future care costs.[419] When the Fund would apply to a particular settlement however, the attorney's fee for the qualified plaintiff's counsel is calculated by the full amount of the settlement, including the allocation to unrecoverable future care costs, and regardless of how the settlement is allocated.[420] The defendant pays the plaintiff's attorney for the portion of the fee attributable to future care costs while the proportion of the fee attributable to pain and suffering would come out of the plaintiff's recovery.[421] In the end however, the attorney's fee is still computed as if the Fund did not exist, even though his client can only actually recover the cash amount that is not apportioned to future care.[422] Thus, under these circumstances, the attorney's fee being computed is based on the total, even though the plaintiff will not get cash but instead a promise of future care benefits from the Fund. For fee purposes it does not matter how the allocation for future care costs is made, since it will

proportion of the settlement that represents medical expenses, where in this case the settlement was for one-sixth of damages so the state could only collect on one-sixth).

417 Robert Vilensky, *Settlement and Compromise Orders Under New Medical Indemnity Fund*, N.Y L.J., Oct. 26, 2011.

418 PUB. HEALTH § 2999-j(6)(a).

419 Vilensky, *supra* note 417.

420 PUB. HEALTH § 2999-j(14).

421 *Id.*

422 *Id.*

theoretically result in the same fee. This could result in the anomalous situation where the plaintiff's attorney receives more cash than does the plaintiff.

Another potential source of conflict results from the plaintiff's attorney's reduced incentive to dispute (and decrease) the proportion of the settlement designated for future medical care.[423] In fact, the plaintiff's attorney might tempted to demand a higher total settlement amount from defendant, but simultaneously agree that a higher percentage of that number be designated for future care costs.[424] This would tend to increase the plaintiff's attorneys fee, but does nothing to enhance the cash recovery of his client, and could actually decrease it.[425]

V. QUESTIONS OF CONSTITUTIONALITY

The foregoing discussion highlights the many difficult issues that are raised by the Fund, how it will be administered under the regulations, and how it will likely adversely impact the covered neurologically impaired children and their families. There is a much more fundamental threshold question, however, that is presented by this unprecedented drastic change in what has been hundreds of years of jurisprudence concerning damages in tort cases. Is the Fund legislation and its scheme even constitutional? The Fund, how it is to be operated, funded, and administered, and its disparate treatment of identically situated individuals raises a number of serious federal and state constitutional issues that will be considered in this section.[426] In

[423] *See* Vilensky, *supra* note 417 (explaining how negotiations with defendants could lead to a situation in which ultimately "the defendant pays less, the lawyer gets paid more and the client receives less up front money").

[424] *Id.* Of course since the defendant would have to pay the plaintiff's attorney's fee based on the amount allocated to future care cost, the defendant would have an incentive not to accommodate this request.

[425] *Id.*

[426] Many of the constitutional issues discussed in this article were raised in *Swanson v. N. Westchester Hosp. Ctr.* Plaintiffs' Affirmation in Sur-Reply at 2 Swanson v. N. Westchester Hosp. Ctr., No. 16743/2007 (N.Y. Sup. Ct. Westchester Cnty. Sept. 2, 2011). The authors are indebted to Christopher Meagher, Esq., for providing access to the motion papers in *Swanson*, as well as to Robert Peck, Esq., of the Center for Constitutional Litigation, and Anthony Maragno Esq., for their work on these constitutional issues. Some their efforts have been incorporated in this article, which, together with previous extensive constitutional analysis by the authors, forms the basis for much of the constitutional discussion presented here. *Swanson* was settled before the constitutional issues raised were decided.

summary, the Fund raises constitutional concerns regarding (1) separation of powers; (2) equal protection; (3) Article VII, Section 8 of the New York State Constitution; (4) due process; (5) the right to a jury trial; (6) the right of privacy; and (7) Article VII, Section 6 of the New York State Constitution.

A. Separation of Powers

A strong argument can be made that the Fund legislation is unconstitutional because it significantly infringes on judicial authority and function, and therefore violates the doctrine of separation of powers. It is important to observe precisely what the Fund statutory scheme does and what it does not do. This is not a situation where the legislature has limited the damages that can be determined by a jury or the court after liability is established in favor of the plaintiff. Rather, once there is a judicial finding of fact,[427] the legislative and executive branches of government are purporting to prevent the court from entering and enforcing a judgment based on the law and the facts of the case.[428] This is all without any assurance that the injured child will be accepted for coverage under the Fund, or that his full care needs as determined by the court will ever be paid by it.[429]

Article VI of the New York Constitution vests judicial authority exclusively in the courts of New York, and "mandates that the legislative and executive branches refrain from hindering the independence and proper functioning of the judicial branch."[430] As such, "[t]here are some matters which are not subject to legislative control because they deal with the inherent nature of the judicial function."[431] The court "has all powers reasonably required to enable a court to perform efficiently its judicial functions, to protect its dignity,

[427] As discussed below, the Fund may also violate the plaintiff's right to a jury trial. *See infra* Part V.E.

[428] N.Y. PUB. HEALTH LAW § 2999-j(6)(b), (13) (McKinney Supp. 2012).

[429] *Id.* N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.2 (2012). As discussed above, this can happen for one of three reasons: first, between the time that the judgment is entered and the plaintiff is considered for enrollment into the Fund —a period that could be several years with appeals and post-verdict proceedings—the Fund may have become 80 percent exhausted and not be accepting new enrollees; second, the Fund could accept the plaintiff and then run out of money; and third, the Fund may subsequently be dissolved.

[430] Maron v. Silver, 871 N.Y.S.2d 404, 414 (App. Div. 3d Dep't 2008), *aff'd*, 925 N.E.2d 899 (2010).

[431] A.G. Ship Maint. Corp. v. Lezak, 503 N.E.2d 681, 683 (N.Y. 1986).

independence and integrity, and to make its lawful actions effective."[432] Since the cases to which the Fund is applicable necessarily concerns infants and persons under disability, the statutory framework also significantly interferes with the courts' authority to act "in the best interests of the infant."[433]

The separation of powers doctrine is strictly construed, when, as here, there is an attempt to transfer judicial functions to the Executive—in this case the Fund Administrator.[434]

Critically, one of these "inherent" powers "is the power of a court to grant relief from its own judgments and processes."[435] As specifically related to the Fund legislation, the legislature is not permitted to affect the final judgment of a court, as it has "passed beyond the legislative power."[436] Yet, that is precisely what the Fund legislation purports to do by its very terms. It directs a court, contrary to the interests of an infant or impaired plaintiff, to enter a judgment that simultaneously is at variance with judicially determined facts and impairs the infant's ability to recover what he is due.

The legislature cannot

> assume the functions of the judiciary to determine controversies among citizens, or even to expound its own laws so as to control the decisions of the courts in respect to past transactions. . . . To declare what the law shall be, is a legislative power; to declare what it is or has been, is [a] judicial [power].[437]

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[432] People v. Little, 392 N.Y.S.2d 831, 834–835 (Yates Cnty. Ct. 1977), *aff'd*, 400 N.Y.S.2d 615 (App. Div. 4th Dep't 1977).

[433] *See* N.Y. C.P.L.R. § 1207 (McKinney 1972 & Supp. 2012); Sutherland v. City of N.Y., 483 N.Y.S.2d 307, 308 (App. Div. 1st Dep't 1985), *aff'd*, 488 N.E.2d 837 (N.Y. 1985);.

[434] *See* Ward Baking Co. v. W. Union Tel. Co., 200 N.Y.S. 865, 866, 873–74 (App. Div. 3d Dep't 1923) (holding that a statute granting the Attorney General the judicial power to subpoena should be construed narrowly so that only a judicial officer may impose punishment on "a witness for failure to obey an order or answer a question"); People *ex rel.* Sanford v. Thayer, 199 N.Y.S. 899, 900 (Sup. Ct. Ulster Cnty. 1923) (doubting the validity of a statute that empowers a state commission to make a determination of mental defect, which is a judicial question).

[435] Jones v. Allen, 712 N.Y.S.2d 306, 309–10 (App. Term. 2d Dep't 2000).

[436] *See* Gilman v. Tucker, 28 N.E. 1040, 1044 (N.Y. 1891) ("After adjudication the fruits of the judgment become rights of property. These rights became vested by the action of the court, and were thereby placed beyond the reach of the legislative power to affect."); People v. Keenan, 97 N.Y.S. 77, 79–81 (App. Div. 1st Dep't 1905), *aff'd*, 78 N.E. 1108 (N.Y. 1906) (holding that the legislature exceeds its power if it attempts to modify or vacate a judgment).

[437] McDonald v. Keeler, 2 N.E. 615, 623 (N.Y. 1885) (citation omitted). The Fund legislation purports to apply retroactively. *See* N.Y. PUB. HEALTH LAW

Certainly, at least with respect to the purported retroactive application of the Fund to causes of action and cases pending on April 1, 2011, and even to cases where a verdict was rendered but no judgment yet entered, it would seem that the judicial power is being invaded, contrary to the doctrine of the separation of powers.[438] Nor would there seem to be much distinction between those situations, and future cases in which the jury and the court has made a finding of liability and determined damages owed by a defendant as required by the CPLR In each instance the Legislature and the Executive can be considered to be improperly undercutting the judicial function.

Although the legislature is allowed to create procedural rules for the court, it is not allowed to interfere with the court's duties that "deal with the inherent nature of the judicial function."[439] Although the legislature may create "judicial procedures designed to relieve the court of specific categories of cases," it may not "regulate the details of the manner of performance of the court's constitutionally mandated duties."[440] Therefore, "[t]he Legislature is not vested with the power to arbitrarily provide that any procedure it may choose to declare such shall be regarded as due process of law."[441] In other words, the legislature cannot substitute the judgment of the court in a particular case by "compelling the court to perform a ministerial act."[442]

The Fund may therefore be violating the inherent authority of the judiciary by preventing a court from entering a judgment based on the findings made by the trier of fact. Actually, by prohibiting a judgment from being entered on future medical care costs, the statute purports to require that a court *not* enter a judgment specific to the facts found.[443] In what may be an even

§ 2999-j(6) (McKinney Supp. 2012); N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.2(a)(3) (2012); *infra* part V.D.5.

[438] In *Swanson*, the verdict was before April 1, 2011, but judgment had not been entered by that date. Plaintiffs' Affirmation in Sur-Reply, *supra* note 426, at 26–28; *infra* part V.D.5.

[439] A.G. Ship Maint. Corp. v. Lezak, 503 N.E.2d 681, 683 (N.Y. 1986).

[440] Comm'r of Soc. Servs. v. Roberto G., 423 N.Y.S.2d 155, 162 (App. Div. 1st Dep't 1979).

[441] Colon v. Lisk, 47 N.E. 302, 304 (N.Y. 1897).

[442] Riglander v. Star Co., 90 N.Y.S. 772, 775 (App. Div. 1st Dep't 1904).

[443] *Id.* The Fund legislation specifically directs that

Except as provided for by this title, with respect to a qualified plaintiff, no payment shall be required to be made by any defendant or such defendant's insurer for qualifying health care costs and no judgment shall be made or entered requiring that any such payment be made by any defendant or such

greater affront to judicial function and independence, the Fund legislation requires that once a "*prima facie*" showing is made that the infant plaintiff will be eligible for acceptance into the Fund, the court must modify *its* judgment to "reflect that, in lieu of that portion of the award that provides for payment of [future medical] expenses, and upon a determination by the fund administrator[,] that the plaintiff is a qualified plaintiff, the future medical expenses of the plaintiff shall be paid out of the fund."[444] It should be observed that there is no assurance that plaintiff will actually receive his judicially determined future care costs or even the care that the jury determined was necessary.

Moreover, once that judgment language is so modified, the court loses authority to enforce its own judgment and to assure that payment for services is ever made by the Fund.[445] This now becomes an executive function of the Fund Administrator, notwithstanding a judicial finding and the plaintiff's right to a judgment.[446] In fact, if the language is missing from such a judgment where the plaintiff has applied for inclusion into the Fund, the Fund Administrator is *required* to send the judgment or settlement back to the judge to add the necessary language to the judgment.[447] By requiring judges to include specific language in the judgment that the payment of future care costs be made by the Fund, at the direction of the executive branch (the Fund Administrator), and contrary to the jury and the court's finding, the Fund legislation may be viewed as breaching the doctrine of separation of powers.[448]

The Fund statute does not appear to be merely one of procedure. Rather, it directly impairs the substantive rights of the plaintiff. Without the "Fund language" in the judgment, the

defendant's insurer for such health care costs.
N.Y. PUB. HEALTH LAW § 2999-j(13) (McKinney Supp. 2012).

444 PUB. HEALTH § 2999-j(6)(b).

445 *See id.* § 2999-j(15) (stating that the superintendent of financial service and the commissioner will enforce the payment of claims and thereby vesting the power to enforce judgments requiring the Fund to pay in the hands of the executive branch).

446 *See id.* §§ 2999-i(2), 2999-j(5)–(6) (directing the court to modify its verdict in accordance with the Fund legislation and vesting the power to enforce payments out of the Fund in the hands of the commissioner and of the superintendent of financial services).

447 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.2(d) (2012).

448 *See id.*

plaintiff is entitled to a judgment that would be enforceable against the defendant. With the language, she is beholden to the Fund to provide for the care to which she would otherwise have been entitled from the defendant under the verdict and judgment. Nor can the Fund be compared to the no fault or workers compensation statutes with respect to its interplay with judicial functioning. Those schemes substitute a remedy and eliminate a particular cause of action from the judicial process entirely, removing the obligation that the plaintiff had to prove liability.[449] Those statutes properly "relieve the court of specific categories of cases" without interfering with judicial authority.[450] In contrast, the Fund specifically invokes the courts and relies on their resources and discretion in determining liability and damages, including future care costs that results from the negligence of a defendant, and then proceeds to ignore the judgment with regard to this critical component of damages.[451]

In another possible breach of the separation of powers doctrine, the judgment that results from a verdict determining future care costs will not have the effect of *res judicata*.[452] Instead of binding the Fund Administrator to enforce the jury's finding of the nature and types of care required, the level of care, and how much will be paid for it, these questions will ultimately be decided anew by an administrative agency in the Executive Branch.[453] The Fund Administrator does not take into consideration the findings made by the court regarding future care costs.[454] In the event that the Administrator denies payment for an item that the court had previously determined was appropriately an item of damage or essential care, the plaintiff would be required to go through an administrative appeal, and if unsuccessful, back to court with an Article 78 proceeding.[455] This

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449 N.Y. WORKERS' COMP. LAW § 10 (McKinney Supp. 2012); N.Y. INS. LAW § 5104 (McKinney 2011).

450 Comm'r of Soc. Serv. v. Roberto G., 423 N.Y.S.2d 155, 162 (App. Div. 1st Dep't 1979).

451 PUB. HEALTH § 2999-j(6); N.Y. C.P.L.R. § 5031(d) (McKinney 2007).

452 *Id.* § 2999-j(6).

453 *See id.*

454 *See id.* § 2999-j; N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.5–.6 (2012) (explaining the pre-approval process for payment for services rendered, and the possible denial of payment for certain services by the Fund).

455 *See* C.P.L.R. § 7801. Under an Article 78 Proceeding, the burden shifts to the plaintiff to show that the denial of services was without rational basis instead of the Fund Administrator bearing the burden to show that he was complying with the court's previous finding. *See id.* § 7803 (showing that the

would be despite the fact that such denial of services may have involved an item of damage that the plaintiff had already successfully litigated.

Finally, the right to "judicial review" of a Fund denial of services underscores the separation of powers issue, as well as the denial of the right to a jury trial, the lack of fundamental fairness, and the lack of finality of a judicial determination. Consider this scenario: the plaintiff gets a judgment that enumerates or effectively incorporates various components and costs of future care. The Fund Administrator is then free to ignore this finding and make his or her own determination of the services to be provided and can deny approval of services even if they were inherent or specifically found necessary by the court.[456] The plaintiff then must go through an internal administrative appeal and the hearing officer can only recommend—not determine, but only recommend—reversal of the denied services.[457] The Fund Administrator then gets another opportunity to adopt or ignore the hearing officer's finding and maintain the denial of the services that the plaintiff already succeeded in persuading the court was necessary in the first instance.[458] The plaintiff must then seek judicial review, and in order to succeed, now instead of a preponderance of evidence standard, she must show that there was no rational basis for the Commissioner's decision—merely to get back what she already won in court at the trial.[459] The burden of proof has completely shifted to the plaintiff and the standard to succeed has been raised much higher than it was before. The Fund gets four bites at the apple. First by ignoring the jury's finding and starting afresh to deny services. Second, by the hearing officer's recommendation that that the denial of services be maintained.[460] Third, the Commissioner is entitled to ignore a recommendation of a hearing examiner that the requested services be approved, and thus the Commissioner can maintain

plaintiff must raise the question that the Fund was in abuse of discretion or made a completely arbitrary finding).

[456] *See* N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.6.

[457] *Id.* § 69-10.15(k).

[458] *Id.* § 69-10.15(l).

[459] C.P.L.R. § 7803(3)–(4); 1A N.Y. PATTERN JURY INSTRUCTIONS, *supra* note 105, at § 1:23.

[460] N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.15(k).

the denial.[461] Finally, in order to reverse the Commissioner's denial the plaintiff must go to court and demonstrate that the Commissioner's decision denying benefits was "arbitrary and capricious" or without rational basis. This puts the plaintiff to an enormous burden of proof, and even if the Article 78 proceeding is successful, she has undergone significant delay and expense.[462]

Finally, the Fund eliminates a court's power to modify a verdict "if it deviates materially from what would be reasonable compensation" as to future medical costs. In doing so it upsets the power of the Appellate Division to review such verdicts where "it is contended that the award is excessive or inadequate and that a new trial should have been granted."[463]

By requiring a court, therefore, to enter a judgment at variance with the facts of a case–and the law of damages—as the jury found and applied them, a strong argument could be made that the Fund unconstitutionally interferes with judicial sovereign authority and thus violates the doctrine of separation of powers.

B. Equal Protection

The Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution, and the Equal Protection Clause of the New York State Constitution (Article I, section 11) similarly provide that no one is to be denied "the equal protection of the laws."[464] Although the state may make reasonable classifications between people, the classifications must bear some rational basis to the disparate treatment.[465] It cannot treat identically situated people differently without violating the state and federal equal protection clauses.[466]

Children who have suffered a neurologic impairment as a result of negligent care at the time of birth are treated vastly differently than others who have been injured by another mechanism or were injured only a few days after birth. Thus—even after getting a verdict and establishing their legal entitlement to a recovery—birth injured children must not only

[461] *Id.* § 69-10.15(l).
[462] C.P.L.R. § 7803(3)–(4).
[463] C.P.L.R. § 5501(c); Seidner v. Unger, 667 N.Y.S.2d 384 (App. Div. 2d Dep't 1997).
[464] U.S. CONST. amend. XIV, § 1; N.Y. CONST. art. I, § 11.
[465] Neale v. Hayduk, 316 N.E.2d 861, 862 (N.Y. 1974).
[466] U.S. CONST. amend. XIV, § 1; N.Y. CONST. art. I, § 11.

suffer a reduced recovery but surrender a panoply of rights.[467] Their rights are irrationally reduced, and in some cases eliminated as compared to (a) persons injured by nonmalpractice tortfeasors; (b) children injured by nonbirth injury malpractice tortfeasors; and (c) *even as between obstetric malpractice victims* with identical injuries and damages, an arbitrarily determined group of those who by poor timing are enrolled while the Fund is not suspended because it has not run out of funds.[468] Those excluded from the Fund because enrollment has been suspended when 80 percent of the Fund has been exhausted will get their full measure of damages and get to make their own health care decisions, while those forced into the Fund before it runs out of money, will not.[469] Likewise, the Fund discriminates amongst defendants and their insurers who—after the Fund is exhausted—will have to pay directly.[470] When a judgment is rendered or a settlement reached, it is a lottery as to whether the plaintiff will be limited to the Fund or if the defendant must pay the full amount of damages for future care.[471]

When addressing a claim that there is a violation of the Equal Protection Clause under both the federal and state constitutions,

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[467] *See infra* Part V.D.2–4 (discussing for example, children forced into the Fund suffer a loss of medical privacy, restriction to travel, and the right to make fundamental health care decisions).

[468] N.Y. PUB. HEALTH LAW §§ 2999-g–2999-j (McKinney Supp. 2012). Consider these possibilities. Each of two twins is diagnosed with a medical condition unrelated to delivery and resuscitation. One is deemed well enough to be discharged from the hospital and the other remains. Within a few days, both require identical treatment to remedy the situation. The one remaining in the hospital would arguably be covered under the Fund whereas the one that is discharged and returns from care would not, even with the identical malpractice and the same outcome and injury. What if one twin is transferred to another hospital for specialized care, creating a new admission? Is she covered by the Fund? What if the malpractice is in negligently discharging the child from delivery admission? Would this child be covered by the Fund? These scenarios may expand the Fund's obligations well beyond that which was anticipated.

[469] *Id.* § 2999-i(6)(b).

[470] *Id.*

[471] The same is true even after a child is accepted into the Fund. It is unclear what would happen if the Fund is exhausted or terminates. Although the regulations speak in terms of continuing benefits, there is no assurance that such will take place. Under those circumstances the plaintiff may be entitled to full compensation, and the defendant may be obligated to pay it. These represent yet another arbitrary and unpredictable class of identical plaintiffs and defendants against whom the Fund statute irrationally discriminates.

the applicable standard of review must first be determined.[472] As discussed below, the plaintiff's fundamental freedom to travel and her right to a trial by jury may be compromised by the way the Fund operates.[473] The right to travel is implicated because the Fund's reimbursement scheme limits payment for most services at New York Medicaid rates, and requires providers to accept Fund payments. These restrictions severely limit the rights of these children to seek care, or reside outside of New York State. The right to a jury trial is implicated because it is explicitly granted by the New York State Constitution.[474]

The strict standard of review applies to any fundamental right explicitly or implicitly protected by the Constitution.[475] Under an equal protection analysis the "freedom to travel" is a fundamental right and subjects the Fund's statutory mechanism to "strict scrutiny."[476] "In order to withstand strict scrutiny, the law must advance a compelling state interest by the least restrictive means available."[477] "[L]egislation which deprive[s], infringe[s], or interfere[s]" with a fundamental right, requires "strict scrutiny" even if such right is not completely abridged.[478]

Since New York State cannot require out of state providers to accept payments from the Fund or at New York Medicaid rates, the care available to children who live outside New York but remain in the Fund, will likely be limited. Even though both the statute and regulations assert that the residence of the plaintiff will not impact his "right" to receive benefits, in fact, the operation of the Fund severely impairs this right to any enrollee seeking care outside the state for the simple reason that their providers cannot be required by New York to accept Fund payments, much less at New York Medicaid rates.[479]

Even if the state has a compelling interest "to reduce premium

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[472] Alevy v. Downstate Med. Ctr., 348 N.E.2d 537, 542 (N.Y. 1976).

[473] *See* discussion *infra* Part V.D.2.

[474] *See* N.Y. CONST. art. I, § 2.

[475] San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 17 (1973); People v. Fox, 669 N.Y.S.2d 470, 474 (Nassau Cnty. Ct. 1997).

[476] United States v. Guest, 383 U.S. 745, 757 (1966); *Alevy*, 348 N.E.2d at 543.

[477] Bernal v. Fainter, 467 U.S. 216, 219 (1984); Aliessa v. Novello, 754 N.E.2d 1085, 1094 (N.Y. 2001); *Alevy*, 348 N.E.2d at 543.

[478] *San Antonio Indep. Sch. Dist.*, 411 U.S. at 37–38 (internal quotations omitted).

[479] N.Y. PUB. HEALTH LAW § 2999-j(11) (McKinney Supp. 2012); N.Y. COMP. CODES R. REGS. tit. 10 § 69-10.22 (2012).

costs for medical malpractice insurance coverage," it may not do so by arbitrarily discriminating between identically situated groups of individuals harmed by malpractice.[480] Pervasive social issues such as protecting children from harm and ensuring the public health are considered compelling interests.[481] Reducing malpractice insurance premiums or Medicaid costs, however desirable, would not appear to constitute a "compelling" interest sufficient to justify a denial of equal protection.

If the right to travel and the right to a jury trial are not considered, then a rational basis analysis will need to be applied because it is possible that handicapped children may not constitute a "suspect class."[482] However even if a court were to utilize a "rational basis" analysis it would appear that the Fund violates the Equal Protection Clauses of the New York and federal constitutions. The Fund treats obstetric malpractice victims differently from persons injured by every other type of medical provider, and does so without any rational relationship to a legitimate governmental purpose.[483] A statute fails rational basis when it "is so unrelated to the achievement of any combination of legitimate purposes that we can only conclude that the [statute] was irrational."[484] As discussed in more detail below, the use of public coffers to lower the cost of medical malpractice premiums is not likely to be a legitimate governmental purpose in the first place. The avowed goal of reducing malpractice insurance premiums certainly cannot be applicable to cases already litigated, or claims for which premiums have already been paid, as is the case with the purported retroactive application of the Fund statute. Retroactive application can only constitute a windfall to

480 PUB. HEALTH § 2999-g.

481 *See* New York *ex rel.* Wayburn v. Schupf, 350 N.E.2d 906, 908 (N.Y. 1976); *In re.* Lauren L., 912 N.Y.S.2d 732, 735 (App. Div. 3d Dep't 2010); Schulman v. N.Y.C. Health & Hosp. Corp., 355 N.Y.S.2d 781, 784–85 (App. Div. 3d Dep't 1974); City of New York v. New St. Mark's Baths, 497 N.Y.S.2d 979, 982 (Sup. Ct. N.Y. Cnty. 1986).

482 Matter of Levy, 345 N.E.2d 556, 558 (N.Y. 1976); *In re* Bd. of Educ. of Northport-East Northport Union Free Sch. Dist. v. Ambach, 458 N.Y.S.2d 680, 688 (App. Div. 3d Dep't 1982).

483 As noted elsewhere, even some birth trauma malpractice plaintiffs will be fully compensated once 80 percent of the Fund is exhausted, and some will be perpetually stuck in the Fund–purely by virtue of the time within the fiscal year that their case is finally resolved. PUB. HEALTH § 2999-i(6)(b).

484 Kimel v. Fla. Bd. of Regents, 528 U.S. 62, 83–84 (2000); Affronti v. Crosson, 746 N.E.2d 1049, 1052 (N.Y 2001).

malpractice insurance carriers, who having been paid the premium commensurate with the risk assumed, are no longer obligated to pay the damages for which the premiums were charged. Even if the Fund does indeed lower malpractice costs for future care, it does so by rationing the care that the court determined was required. Thus the burden of reducing malpractice premiums is borne solely by the injured children who have proven that they were harmed by malpractice at birth. There is good reason, therefore, to believe that the Fund will fail the rational basis test as well.

C. Article VII, Section 8

In order to understand how the Fund legislation runs afoul of Article VII, Section 8 of the New York State Constitution, it is critical to recall exactly what the Medical Indemnity Fund legislation does. After the plaintiff succeeds in getting a final judicial determination that a health care provider negligently caused a neurologic impairment that requires future care costs, the defendant is entirely relieved from what would otherwise be his obligation to pay for these costs.[485] *Such obligation is transferred to the state, which pays off what would be the obligation of the defendant judgment debtor*. The state is therefore assuming the private debt obligation of the defendant and paying for the plaintiff's future care costs with state funds appropriated by the Legislature.[486] Although it may be hoped that the obstetric services tax will raise enough money to support Fund obligations there is no way to predict, much less assure, that such tax will match the Fund payments required.[487] Nor does it change the fact that this is a tax, and that state funds will always be required to relieve the private defendant of what otherwise would be a judgment debt. Even though the "quality contribution" will be placed in the Health Care Reform Act Resources Fund (HCRA), any money received by the HCRA Fund is still subject to control by the legislature through appropriation.[488] If the tax does not raise enough money to

485 PUB. HEALTH § 2999-j(6).

486 *Id.* §§ 2807-d-1, 2999-i(5); Moore & McMullen, *supra* note 26, at § 17:2.4.

487 Moore & McMullen, *supra* note 26, at § 17:2.4.

488 N.Y. STATE FIN. LAW § 92-dd (McKinney); PUB. HEALTH § 2807-d-1(3); OFFICE OF THE N.Y.S. COMPTROLLER, FUND CLASSIFICATION MANUAL 16, 47 (2011); Stashenko, *supra* note 28.

support the Fund there are one of two consequences: either the Legislature will have to appropriate sufficient additional general revenues to support the Fund, or the Fund will cease to take in new enrollees and/or default on making payments to current enrollees. On the other hand, in the unlikely event that the tax on obstetric services raises more money than the Fund currently needs, the state gets to keep the money to use for general state purposes.[489] It is indisputable, therefore, that state tax dollars are being used to pay off a portion of a private judgment in favor of a private individual against another private individual or corporation.

This has significant state constitutional ramifications. Article VII, Section 8 of the New York State Constitution provides that "[t]he money of the state shall not be given or loaned to or in aid of any private corporation or association, or private undertaking."[490] It would seem however, that this is precisely what the Fund legislation does. The Fund does not provide for the general payment to obstetric malpractice victims, or subsidize obstetric or hospital malpractice premiums, but rather pays off a portion of a specific judgment (at a reduced rate) to a private plaintiff, on behalf of a private defendant, thereby relieving him of a payment obligation.[491] No matter how laudable the asserted purpose to lower malpractice premiums or reduce Medicaid payments, it would appear that the Fund legislation is a clear violation of Article VII, Section 8.[492]

Article VII, Section 8 of the New York Constitution was enacted to "curb raids on the public purse for the benefit of

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[489] *See* PUB. HEALTH § 2807-d-1(2); COMPTROLLER, *supra* note 488, at 16, 47 (outlining how moneys are placed within New York's general fund and what the sources of income are under the Health Care Reform Act). It is not as though this has never happened before. In fact, the state has a history of taking monies from programs designed to help control medical malpractice premiums. *See Med. Malpractice Ins. Ass'n*, N.Y. LIQUIDATION BUREAU, http://www.nylb.org/mmia.htm (last modified Aug. 4, 2009); CONSUMER FED'N OF AM.,TESTIMONY OF J. ROBERT HUNTER, DIRECTOR OF INSURANCE BEFORE THE N.Y. DEP'T OF HEALTH MEDICAID REDESIGN TEAM: MEDICAL MALPRACTICE REFORM WORKING GROUP 3 (Oct. 27, 2011) [hereinafter HUNTER TESTIMONY], *available at* http://www.consumerfed.org/pdfs/Testimony%20NY%20MM.pdf.

[490] N.Y. CONST. art. VII, § 8 (McKinney).

[491] PUB. HEALTH § 2999-j(6), (13).

[492] To the extent that the Fund applies to pending cases, it cannot lower premiums, since they have already have been paid. This windfall to malpractice insurance companies—who have collected premiums for claims that they will never have to pay— may also be considered a "gift" of state funds to a private corporation in violation of Article VII, Section 8.

favored individuals or enterprises."[493] In *Wein v. State*,[494] the Court of Appeals considered the constitutionality of the state legislature's appropriation of funds to a municipality, and chronicled the history of this provision and its importance.[495] In *Wein*, the court noted that prior to the enactment of the predecessor to what is now Article VII, Section 8, the state had subsidized private railroad and canal companies and had not been repaid.[496] As a result, what is now Article VII, Section 8 was adopted.[497]

Wein was a "taxpayer's action" in which the plaintiff challenged the appropriation of state funds to the City of New York, which was at the time in a financial crisis.[498] The Court of Appeals held that the use of state funds for this purpose was proper, *but only because the City of New York is a public corporation*.[499] That is clearly not the case here where—no matter how "laudable" the claimed "public purpose" of this legislation—state funds are being used to make payments to a private individual, by paying a portion of a judgment of a private defendant for the benefit of a private defendant and/or private malpractice insurer.

The plain language of Article VII, Section 8, which was adopted in 1938, provides that none of the state's "money" shall be given to "any private corporation or association, or private undertaking."[500] The Court of Appeals has described the clear and unmistakable mandate of this provision:

> Subsidization by gifts of public funds to private undertakings, or by pledging public credit on their behalf, [is] banned, irrespective of how beneficent or desirable to the public the subsidized activity might seem to be. And this remains so even when the subsidized private organization performs functions beneficial to the public.[501]

In short, appropriating funds for the benefit of "a non-governmental entity"—exactly what is being done here by using

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493 Teachers Assoc., Cent. High Sch. Dist. No. 3 v. Board of Ed., Cent. High Sch. Dist. No. 3, 312 N.Y.S.2d 252, 254 (App. Div. 2d Dep't 1970).

494 347 N.E.2d 586 (N.Y. 1976).

495 *Id.* at 588.

496 *Id.* at 588–89.

497 *Id.*

498 *Id.* at 586.

499 *Id.* at 586–87.

500 N.Y. CONST. art. VII, § 8(1).

501 Schultz v. New York, 654 N.E.2d 1226, 1230 (N.Y. 1995) (citations omitted).

state funds to "pay" a portion of a private judgment—is forbidden, regardless of the intent or purpose of the appropriation.

In *Schultz v. New York*,[502] a "citizen taxpayer" commenced an action against Governor Mario Cuomo and the Governor's campaign committee, known as The Friends of Mario M. Cuomo Committee, Inc., for using state funds to publish a newsletter entitled "The Voice of the New, New York."[503] The plaintiff claimed that this document, which portrayed a one-sided viewpoint of welfare reform—a hot political issue at the time—was published only "to serve the individual and private purposes of Governor Cuomo."[504] The court held "that the document transgresses the constitutional boundary."[505] The court explained that under the constitution it is "unassailable that the use of public funds out of a state agency's appropriation" could not be used for what was clearly Governor Cuomo's private political purpose.[506] The court also distinguished the facts of this case from a situation where public funds were appropriated for a proper purpose, such as by "conveying information" or to "educate the public."[507] Significantly, however, the court also stated that Article VII, Section 8(1) applies "even when the subsidized private organization performs functions beneficial to the public."[508]

In *People v. Grasso*,[509] the Attorney General sought to prosecute a cause of action under the not-for-profit corporation law against Richard Grasso, the former Chairman of the New York Stock Exchange, for allegedly receiving "excessive compensation" during his tenure.[510] The First Department held that the cause of action must be dismissed because the New York Stock Exchange was at the time of the lawsuit a private corporation.[511] Thus, "the sole relief sought is the recovery of money that belongs to the for-profit entity and would inure to its

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502 654 N.E.2d 1226 (N.Y. 1995).
503 *Id.* at 1228.
504 *Id.* at 1230 (citing Complaint at 55 Schultz v. New York, 654 N.E.2d 1226 (N.Y. 1995) No. 6843-92).
505 *Id.* at 1231.
506 *Id.* at 1230.
507 *Id.* at 1230–31.
508 *Id.* at 1230.
509 861 N.Y.S.2d 627 (App. Div. 1st Dep't 2008).
510 *Id.* at 631, 656.
511 *See id.* at 639–41.

benefit and the private parties."[512] This use of public funds violated Article VII, Section 8 of the state constitution.[513] More specifically, in its decision the First Department stated:

> Here, the Attorney General is using public funds out of appropriations to his office to prosecute causes of action on behalf of an entity that is no longer a not-for-profit corporation and seeks only a money judgment that would benefit the owners of the for-profit entity into which the not-for-profit has been converted (even if the judgment nominally would be paid to the not-for-profit corporation). The Attorney General's continued prosecution of these causes of action . . . vindicates no public purpose.[514]

That is precisely what is happening under the Fund. A judgment by a private individual against a private physician is being "paid" at a discount with state tax funds.

Recently in *Bordeleau v. New York*,[515] the Court of Appeals revisited the restrictions set forth in Article VII, Section 8. *Bordeleau* was a taxpayer action in which the court examined whether state appropriations granted to the State Department of Agriculture and Markets (DAM) to advertise and promote New York agricultural products violated Article VII, Section 8.[516] This funding was procured for the benefit of non-profit apple and winery associations.[517]

After explaining the long history behind Article VII, Section 8, the Court of Appeals in a five to two vote upheld the state's appropriations to these public benefit associations as constitutionally valid.[518] The court determined that the plaintiff taxpayer had failed to meet its burden to establish that the appropriations were unconstitutional.[519] It held that the state may under limited circumstances directly give funding to private parties, *but only if there is "a predominant public purpose and any private benefit is merely incidental."*[520] Judge Pigott and Judge Smith both vigorously dissented from the majority,

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[512] *Id.* at 631.

[513] *Id.* at 639–41.

[514] *Id.* at 641.

[515] 960 N.E.2d 917 (2011).

[516] *Id.* at 918–19. In *Bordeleau*, the court also examined how Article VII Section 8 applied to public benefit corporations. The court determined that public benefit corporations, as independent entitles separate from the state, are not subject to Article VII § 8. *Id.* at 921–23.

[517] *Id.* at 918–19.

[518] *Id.* at 919–24.

[519] *Id.* at 919–20, 922–24.

[520] *Id.* at 923 (emphasis added).

proclaiming that the "predominant public purpose" test made it "hard to see what is left of the constitutional prohibition."[521]

It would appear that the decision and reasoning in *Bordeleau* can be readily distinguished from an Article VII, Section 8 challenge to the Fund. Although the Fund legislation asserts that the "purpose of the fund is to provide a funding source for future health care costs associated with birth related neurological injuries, in order to reduce premium costs for medical malpractice insurance coverage," as we have seen, that is not how the Fund operates.[522] Perhaps a state subsidy to physicians or hospitals to reduce their malpractice premium payments might withstand scrutiny, but clearly that is not what is occurring here. A judgment against a particular tortfeasor is being paid in part by the state. The public is not receiving the primary benefit—a private tortfeasor and/or a private insurer is getting the entire benefit by having its judgment debt paid by the state. Unlike in *Bordeleau*, neither of these purely private parties to a particular lawsuit represents an entire industry—only private entities within that industry that the state has singled out in a particular individual case. In addition, such judgments will be paid only until the Fund is 80 percent exhausted.[523] Thus some defendants' judgments will be paid, and some will not. This is hardly a manifestation of a public use of funds for a public purpose. Instead, the Fund exclusively benefits a small group of private defendants under very isolated and limited circumstances. *Bordeleau*, *Schultz*, and *Grasso* all support this notion.

In *Bordeleau*, the free advertising provided by the DAM was for the benefit of an entire industry, as opposed to any individual producer.[524] The court explained that the legislature could fairly consider the well-being of the apple and winery industries as in

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[521] *Id.* at 924–27 (Pigott, J., dissenting).

[522] N.Y. PUB. HEALTH LAW § 2999-g (McKinney Supp. 2012). The Fund does not even advance its stated purpose. First, the Fund does not apply to lower "malpractice premiums" in general, but rather applies only to malpractice premiums for a small subclass of plaintiffs and defendants—obstetricians and hospitals where babies are delivered. *Id.* § 2999-j(6). Second, application of the law to current cases cannot reduce malpractice premiums because premiums for pending cases have already been paid. N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.2(a)(3) (2012). This creates a windfall for private insurers in existing cases, but not to the defendants who paid the premiums.

[523] PUB. HEALTH § 2999-i(6).

[524] *Bordeleau*, 18 N.E.2d at 923.

the public interest, and that funding for advertising in promoting the industry furthered this public purpose.[525] *Bordeleau* did not really have the element of a definite, tangible, nonincidental benefit to a specific private party that is clearly present in this setting.[526] The funding provided was directed at interest groups that represented the industry as a whole.[527] The analogue under *Bordeleau*, as may be applied to the Fund, would be if the state decided to use its Funds to reimburse a private apple grower for advertising the unique aspects of the apples on his or her farm. It is difficult to believe that such a program would have prevailed in *Bordeleau*. Yet that is what the state is doing here: using its funds to pay off a portion of a unique judgment in favor of a birth injured child with unique care needs for the specific and sole benefit of an individual tortfeasor who caused that harm.

Both *Schultz* and *Grasso* contained an element of an individualized benefit, and it is clear from those cases that the appropriation in *Bordeleau* surely would not have survived had it been provided to one individual apple farmer rather than to the entire industry. *Schultz* involved a governor who used public monies for a newsletter that, in the opinion of the court, was primarily of value as partisan propaganda.[528] The governor and his party were seen to have benefitted from the public allocation, in that they received favorable press from public monies not available to political competitors.[529] *Grasso* involved an attorney general who, in seeking a money judgment that would only be recoverable by a for-profit entity, violated Article VII, Section 8 because the tangible benefit from any positive result would have been realized by the private entity.[530] The prosecution undertaken by the Attorney General essentially picked out one particular, individual private entity, and provided them the benefit of public labors with regard to one specific individual occurrence.[531] This is exactly what is occurring under the Fund.

The Fund picks out specific private entities who would benefit from the public coffers to the exclusion of others in the industry, and requires that a private entity actually owe a specific

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525 *Id.* at 919, 922–23.
526 *Id.* at 923.
527 *Id.* at 919, 922–23.
528 Schultz v. New York, 654 N.E.2d 1226, 1231 (N.Y. 1995).
529 *Id.* at 1230–32.
530 People v. Grasso, 861 N.Y.S.2d 627, 641 (App. Div. 1st Dep't 2008).
531 *Id.*

obligation resulting from an individual occurrence in order to realize any tangible benefit.[532] The way the Fund is set up to operate, the only tangible benefit accrues to individual private entities who have actually been found to have committed medical malpractice that resulted in a birth related neurological injury, and have been subjected to a judgment for future care damages.[533] This places the Fund far closer to the facts in *Schultz* and *Grasso* rather than it does *Bordeleau*, and even in *Bordeleau* there were two dissenters.

Unlike *Bordeleau*, which subsidized advertising for an entire industry, the Fund does not subsidize physicians or hospitals in general.[534] Only those providing obstetrical services, and even then, ironically, only the ones who have been found to have negligently caused a birth related neurologic injury in a specific case.[535] It is difficult to imagine anyone that would have less of a "public" purpose to be served—a specifically identified private health care provider who has been judicially determined to be negligent and caused significant permanent harm to a particular infant. Another Fund analogue to *Bordeleau* would be that if instead of using taxpayer funds to promote apple crop marketing, state money was used to pay a specific judgment in favor of a plaintiff injured by E-coli from the negligence of a single grower. It would seem that under this scenario, *Bordeleau* would not have been decided the same way

Finally, the fact that the Fund receives a portion of its allocated monies from a tax on hospital revenues from in-patient obstetrical services does not alter the foregoing discussion.[536] Even though there will be a tax in place that will, in theory, provide assets for the Fund, the money the Fund will actually receive is still subject to an appropriation by the legislature.[537] Monies collected from hospital obstetrical income will be deposited into the Health Care Reform Act Resources Fund (HCRA Fund), and the legislature will appropriate money from the HCRA Fund into the Fund.[538] In the past, the legislature has

[532] N.Y. PUB. HEALTH LAW § 2999-j(6)-(7) (McKinney Supp. 2012).
[533] *Id.*
[534] *See id.* § 2999-j(6)-(7).
[535] *Id.*
[536] *Id.* § 2807-d-1(1).
[537] *Id.* § 2807-d-1(3); COMPTROLLER, *supra* note 488, at 16, 47.
[538] N.Y. STATE FIN. LAW § 92-dd(b), (c), (e) (McKinney Supp. 2012); PUB. HEALTH § 2807-d-1(3); COMPTROLLER, *supra* note 488, at 16, 47; Stashenko,

collected money in the name of reducing medical malpractice premiums, only to raid the fund and use it for general state purposes. In 1975, the legislature created the Medical Malpractice Insurance Association (MMIA) to increase the availability of malpractice insurance.[539] The MMIA had to shut down in 2000, partially because the legislature kept raiding the MMIA to use its funds for general state purposes.[540] Between 1992 and 1997, the state took $691 million from the MMIA, and none of this sum was repaid.[541] There is no reason to think that the monies received from hospitals for the Fund would not be subject to the same risks.

Using state funds to pay portion of a private judgment, therefore, would appear to violate Article VII, Section 8 of the New York State Constitution.

D. Due Process

The Fifth and Fourteenth Amendments to the U.S. Constitution prohibit the taking of liberty and property without "due process" and just compensation.[542] Similarly, Article I, Section 6 of New York State Constitution provides that "no person shall be deprived of life, liberty or property without due process of law."[543] Article I, Section 7 of the New York State Constitution prohibits the taking of property for a public purpose without just compensation.[544] The Fund legislation, and the manner in which the Fund is set up to operate, presents a number of potential due process issues.[545]

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supra note 28.

539 N.Y. LIQUIDATION BUREAU, *supra* note 489.

540 *See id.* ("MMIA ceased writing policies effective June 30, 2000."); HUNTER TESTIMONY, *supra* note 489, at 3 (explaining that the state did not refund large sums taken from MMIA reserves in the 1990's).

541 HUNTER TESTIMONY, *supra* note 489, at 3.

542 U.S. CONST. amends. XIV, § 1, V.

543 N.Y. CONST. art. I, § 6.

544 *Id.* art. I, § 7(a). Ironically, if, in order to avoid the application of Article VII, Section 8 of the New York Constitution, the state were to claim that the restrictions on the recoveries of obstetric malpractice victims were for a "public" instead of a "private" purpose, they would run afoul of the just compensation requirements by impairing the plaintiff's right to recovery.

545 It is important to consider both the federal and state constitutions. Even though the language of each is virtually identical, New York's constitutional protections cannot be less than those provided by the U.S. Constitution—but state provisions may be interpreted by the state courts as providing greater protection. *See* State v. Cline, 617 N.W.2d 277, 285 (Iowa 2000), *abrogated on*

First, the Fund legislation may be depriving the plaintiff of a vested property interest in a fully litigated verdict, judgment, or settlement without just compensation. Second, by requiring her providers to accept payment from the Fund at New York Medicaid rates, the state may be impairing the plaintiff's fundamental right to freely travel and reside in venues where payment by the Fund would not be accepted, and cannot be compelled. Third, since the Fund claims the right to make health care services determinations that could limit the care chosen by the plaintiff, she might be deprived of her fundamental right to make health care decisions in order to obtain the best possible care that is specialized to her needs, and which a jury may have already determined is required. Fourth, given that the plaintiff has been involuntarily forced into the Fund, the Fund might violate the plaintiff's fundamental right to medical and personal privacy by requiring her—as a condition to receiving the care determined by a court—to give *lifetime* access to her medical, educational, insurance, and other personal information.[546] Finally, by purporting to retroactively apply the Fund to causes of action that have accrued, to actions already pending at the time that the Fund legislation was enacted, and even to cases in which a verdict has been rendered in favor of the plaintiff but not yet converted into a judgment, the Fund might violate the federal and/or state Due Process Clauses.

The purpose of the Due Process Clause is not "only to ensure abstract fair play to the individual," but also "to protect his use and possession of property from arbitrary encroachment—to minimize substantively unfair or mistaken deprivations of property, a danger that is especially great when the state seizes goods simply upon the application of and for the benefit of a private party." [547] "[T]he guaranty of due process . . . demands

other grounds by State v. Turner, 630 N.W.2d 601 (Iowa 2001) (explaining that while a state court may not interpret its "Constitution to provide *less* protection than that provided by the U.S. Constitution, the state court is free to interpret [its] constitution as providing *greater* protection for [its] citizens' constitutional rights").

[546] Griswold v. Conn., 381 U.S. 479, 485 (1965) (acknowledging "zone[s] of privacy created by several fundamental constitutional guarantees"). Does this requirement also violate HIPPA? Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, 110 Stat. 1936 (1996).

[547] Fuentes v. Shevin, 407 U.S. 67, 80–81 (1972); Mark N. v. Runaway Homeless Youth Shelter, 733 N.Y.S.2d 566, 569 (N.Y. Fam. Ct. Chautauqua Cnty. 2001).

only that the law shall not be unreasonable, arbitrary, or capricious, and that the means selected shall have a real and substantial relation to the object sought to be attained."[548] A law that discriminates arbitrarily, without a "reasonable and just relation" to a "real and substantial distinction," violates due process.[549] The discrimination against some—but not necessarily all—infants who have proven that they have been harmed by malpractice at birth as compared to other tort victims, may therefore violate the Due Process Clauses as well as deny equal protection. This is particularly so when the manner in which the Fund is applied and the rights taken from these children are considered.

In addition, "[t]he fundamental requirement of due process is the opportunity to be heard 'at a meaningful time and in a meaningful manner.'"[550] The "very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury. One of the first duties of government is to afford that protection."[551] Specifically, the legislature cannot, "without violence to the constitutional guaranty of 'due process of law,' suddenly set aside all common law rules respecting liability . . . without providing a reasonably just substitute."[552] An infant who is forced into the Fund has been deprived of these rights because she is obligated to pursue an administrative remedy after she has already proven her entitlement to a remedy at common law.[553] The Fund is not a reasonably just substitute for her remedy because, in addition to the reasons discussed above, by taking away her money judgment she may be deprived from receiving the care that she feels is most appropriate for her unique needs.[554] Instead, the Fund replaces this money judgment for future medical care,

[548] Nebbia v. N.Y., 291 U.S. 502, 510–11 (1934); Spielvogel v. Ford, 136 N.E.2d 856, 857–858 (N.Y. 1956); Defiance Milk Prod. Co. v. Du Mond, 132 N.E.2d 829, 830 (N.Y. 1956).

[549] Hotel Ass'n. of N.Y. v. Weaver, 144 N.E.2d 14, 19 (N.Y. 1957) (quoting S. Ry. Co. v. Greene, 216 U.S. 400, 417 (1910)); Cluett, Peabody & Co., Inc. v. J.W. Mays, Inc., 170 N.Y.S.2d 255, 261 (App. Div. 2d Dep't 1958) (citing *Nebbia*, 291 U.S. at 510–11), *aff'd*, 161 N.E.2d 223 (N.Y. 1959).

[550] Mathews v. Eldridge, 424 U.S. 319, 333 (1976) (quoting Armstrong v. Manzo, 380 U.S. 545, 552 (1965)).

[551] Marbury v. Madison, 5 U.S. 137, 163 (1803).

[552] New York Central R.R. Co. v. White, 243 U.S. 188, 201 (1917).

[553] N.Y. PUB. HEALTH LAW § 2999-j(7) (McKinney Supp. 2012).

[554] *See id.*

which she has already proven to a jury, with care that the Fund deems necessary for her, and which may be inadequate or underfunded.[555]

1. Vested Right to Money Judgment

The Due Process Clauses prohibit a "taking" or deprivation of property without just compensation.[556] In this setting, after the plaintiff receives a verdict, the cause of action has been proven and damages determined: "The plaintiff's right to be made whole becomes fixed when the verdict holding the defendant liable is rendered."[557] All that is necessary to convert that verdict into a judgment for money damages is the essentially ministerial act of converting that verdict into a judgment. Indeed, the Legislature and the courts specifically recognize that the plaintiff's property rights to the amount of the verdict are established at that time by providing for interest on that amount between the time of the verdict, and the entry of judgment.[558]

It is clear that a money judgment creates a vested property interest that is constitutionally protected by the Due Process Clause. By forcing an infant plaintiff to take part in the Fund upon an application by the defendant, and thereby eliminating her ability to recover a significant part of the amount of damages determined by the court, the state may be depriving an infant plaintiff of her vested property interest in any judgment or settlement to which she had been entitled.[559] This is in contrast to "tort reform" in other states, which limits the plaintiff's recovery of damages, or schemes such as Workers' Compensation, where the plaintiff trades off his tort recovery for a certainty of payment.[560] Here, the property right has already been determined by a court—and then taken away without any compensation for the loss, that is, the difference between the judgment (and the rights and flexibility that inure with it) and the promise of payment solely for those services that the Fund determines are appropriate.

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555 *Id.*

556 U.S. CONST. amends. V, XIV, § 1; N.Y. CONST. art. I, § 7.

557 Love v. State, 583 N.E.2d 1296, 1298 (N.Y. 1991).

558 N.Y. C.P.L.R. § 5002 (McKinney 2007).

559 PUB. HEALTH § 2999-j(6)–(7); Andree *ex rel.* Andree v. Nassau Cnty., 311 F.Supp. 2d 325, 335 (E.D.N.Y. 2004).

560 *See* FLA. STAT. ANN. § 766.118 (West 2012) (legislation limiting damages available to patient); N.Y. WORKERS' COMP. LAW § 10 (McKinney 2012).

Not only has a taking occurred, but such taking is being utilized for a private purpose—relieving a private defendant from paying a judgment obligation. A taking cannot occur against a private individual for an "incidental or colorable benefit to the public."[561] It is simply a transfer of funds from plaintiffs who have established their right to them, to private judgment debtors—doctors, nurses, hospitals and malpractice insurers—who are relieved from paying such damages.

It would appear, therefore, that the Fund may violate the Due Process Clause prohibition against taking property without either just compensation or a public purpose.[562]

2. Freedom to Travel

As discussed in the analysis of the denial of equal protection, the freedom to travel is a fundamental constitutional right.[563] "The right to travel is a part of the 'liberty' of which the citizen cannot be deprived without the due process of law under the Fifth Amendment."[564] The Fund legislation may violate both the due process and equal protection clauses, because an enrollee may be deprived of her right to travel independently from any discrimination on the part of the state. It would appear that the manner in which the Fund operates would impair the ability of a child and her family either to reside outside of New York State or obtain care outside of the state.[565]

The Fund requires that "[a]ll health care providers shall accept

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561 N.Y.C. Hous. Auth. v. Muller, 1 N.E.2d 153, 156 (N.Y. 1936).

562 Nor do the projected numbers even add up. Although some project that the Fund will reduce malpractice costs by $320 million, assuming 200 infant enrollees per year, the Fund would have to save about $1.6 million per infant, *every year*, in order to make that number. Since the annual cost of care for each child is far less that amount, it is hard to imagine how this computation was made. The more tangible benefit of the Fund actually goes to private hospitals and insurance companies, where the burden of providing future care for infant victims of malpractice falls to the state. More specifically, the system as set up actually benefits hospitals that are more prone to malpractice. With the state picking up the tab, there is no incentive for these hospitals with high rates of malpractice to improve the quality of their care. Even if a public benefit is assumed, it is hard to imagine such a benefit to the public being more than incidental to the benefit enjoyed by obstetricians, hospitals and insurance companies. Knipel, *supra* note 7, at 2–3.

563 U.S. v. Guest, 383 U.S. 745, 757 (1966); Alevy v. Downstate Med. Cntr., 348 N.E.2d 537, 543 (N.Y. 1976); *see* discussion *supra* Part V.B.

564 Kent v. Dulles, 357 U.S. 116, 125 (1958).

565 PUB. HEALTH § 2999-j(11).

from qualified plaintiff's [sic] or persons authorized to act on behalf of such plaintiff's assignments of the right to receive payments from the fund for qualifying health care costs."[566] This completely ignores the very real possibility that a health care provider outside of New York may not agree to treat an enrollee because the provider does not want to deal with the bureaucracy of the Fund, or does not want to accept New York Medicaid rates.[567] It would appear that a New York State law cannot require health care providers outside of the state to accept payment from the Fund. This will inherently impair the right of a Fund enrollee to either reside outside of New York or seek care in another jurisdiction.[568] As discussed above, an enrollee can physically travel or reside outside of New York, but not without severe restrictions to their access to medical care, because out-of-state health care providers will not necessarily accept the New York reimbursement rate, or the Fund's bureaucracy.[569] In *Swanson* referred to in this article, for example, the infant plaintiff's treating physicians were in Connecticut.[570]

By taking health care decisions away from the plaintiff and by potentially limiting her treatment and care to New York, not only does this provision limit the ability of in state residents to leave New York, but the Fund could also fail to provide an out of state resident with the necessary care to which they would be entitled. For example, if an out of state resident gave birth while passing through New York, she could be subject to the Fund if she cannot obtain jurisdiction over the defendant in her home state.[571] The freedom to travel "require[s] that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or

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[566] *Id.* § 2999-j(11).

[567] *Id.*

[568] *Id.* (requiring out of state health care providers to accept payment from the Fund, which, practically speaking, may prevent a plaintiff from leaving the state of New York since out of state providers have no legal obligation to accept payment from the Fund).

[569] *Id. See* N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.22 (2012); Given the Fund regulation's restrictions on access to transportation and the limitations on providing a handicapped accessible vehicle, even the physical or financial ability to travel to get care is open to question. *See* N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.8, .12.

[570] Plaintiffs' Affirmation in Sur-Reply, *supra* note 426, at 14.

[571] The Medical Indemnity Fund does not deny coverage to out of state residents so long as their injuries are sustained while in New York. *See* N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.22.

restrict this movement."[572] As discussed above, the right to travel is a fundamental right, and any interference with such a right is subject to strict scrutiny, requiring a compelling government interest that is narrowly tailored.[573] States cannot infringe upon the freedom to travel by denying a traveler's "basic necessities of life."[574] Medical care, including nonemergency medical care, is in fact quite properly considered to be a basic necessity of life.[575] Under this standard of review, the Fund would appear to have difficulty passing constitutional muster.

When a plaintiff receives a judgment for future care damages, she is entitled to take those damages and use them to obtain care anywhere she may choose.[576] This portability is important because it allows her to travel wherever is necessary to receive the best care available. Under prior law, if the child were to have to move out of New York for any reason, or if they were actually a resident of another state, she would be able to use the recovery to receive the care that a jury found to be appropriate.[577] Under the Fund, however, the infant plaintiff is not entitled to recover such damages or to spend them as she chooses. In order for the infant plaintiff to receive care, the Fund requires that the health care provider accept the assignment of payment from the Fund, and all of the Fund's bureaucratic requirements that go along with it.[578] This provision is to ensure that all providers accept payment from the Fund, most of which is at Medicaid rates.[579] As discussed previously, an out-of-state provider cannot be forced to accept payment from New York, and if an out-of-state provider does not want to have to deal with the Fund, the infant plaintiff who seeks treatment from such provider is just out of luck.

Therefore, the result is that the infant plaintiff is forced to accept care that is effectively limited to New York—even if the Fund approves all of the requested services. Instead of getting paid in cash, the state essentially forces the plaintiff to accept what is the equivalent of a gift certificate that would force her to

572 Shapiro v. Thompson, 394 U.S. 618, 629 (1969).

573 Memorial Hosp. v. Maricopa Cnty., 415 U.S. 250, 262, 269 (1974); *Shapiro*, 394 U.S at 634.

574 *Memorial Hosp.*, 415 U.S. at 269.

575 *Id.*

576 *See* N.Y. C.P.L.R. §§ 5031, 5041 (McKinney Supp. 2012).

577 *See id.*

578 N.Y. PUB. HEALTH LAW § 2999-j(11) (McKinney Supp. 2012).

579 *See id.*

keep coming back again and again to the same store, whether or not the service was adequate, and even if she moves thousands of miles away from it. For a neurologically impaired child who lives or decides to move out of state or seek care there, the Fund cannot guarantee that out of state providers would accept payment from the Fund and such care may therefore become unavailable. If a neurologically impaired child or his family should choose to live outside New York, or seek care outside the state, the Fund may provide little, if any care benefit to him, thus effectively forfeiting the future care component of his recovery. This is the inevitable result of eliminating the plaintiff's right to recover damages for future care and replacing it with the Fund's managed care system, in which care can only be "guaranteed" in New York—and even then only by providers who will agree to accept Medicaid reimbursement rates and the Fund's other restrictions. Instead of being able to collect and manage funds for future care, she is obligated to receive a lifetime of whatever care the Fund chooses to give her. Since the Fund cannot promise her that it will provide her own unique "basic necessities of life," or even medical care that she may require to survive, if she were to leave the state—the Fund would appear to violate or at least significantly infringe the constitutional right to freedom of travel.[580]

3. Right to Make Health Care Decisions

In addition to impairing the right to live outside the state of New York, the Fund may also create due process issues by restricting the ability of infant plaintiff and her parents to make private health care decisions. Such decisions are fundamental constitutional rights that go to the very core of liberty and even life itself. A judgment granted to an infant plaintiff in a malpractice case for future care costs is valuable to the plaintiff as a means for her to obtain the specialized care that she needs, and to maximize her quality and length of life in a manner that is best suited for her. As described above, in order to invoke strict scrutiny, it is only necessary that the state creates "legislation which deprive[s], infringe[s], or interfere[s]" with such a right.[581] The U.S. Supreme Court has recognized that "it cannot now be

[580] *Memorial Hosp.*, 415 U.S. at 269.

[581] Washington v. Glucksberg, 521 U.S. 702, 720 (1997); San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 37–38 (1973).

doubted that the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children."[582] By taking away the right to be paid the damages required for future care, and the inherent freedom to make health care choices that comes with it, the Fund legislation is effectively denying the family the right to choose their care, and even more disturbingly, the care that was deemed appropriate by a jury. This raises serious due process concerns.

The Fund is distinguished from a benefit program where a person voluntarily applies for and accepts benefits, and thereby subjects themselves to the conditions and limitations of that program. Rather, the Fund is a mandatory, involuntary substitution where the Fund makes future care decisions instead of the family using the funds owed to it as a result of a jury finding that such care was required.[583] The "care" and "benefits" provided by the Fund should not be seen in the same light as Medicaid, which sets the floor for the most basic care needs. The Fund is replacing a plaintiff's right to the care that a court has determined she was entitled.[584] The Fund and its limitations and restrictions on care is the complete antithesis of the fundamental right to make health care decisions and thereby, would appear to violate the plaintiff's due process rights in this regard as well.

The Fund has an inherent conflict of interest arising from its need to keep care costs down in order to remain solvent. As a result, the most expensive and essential components of an infant plaintiff's care all require prior approval by the Fund.[585] The application process for approval is tedious, requiring multiple bids and evaluations regarding efficiency.[586] If the Fund denies the request, and the infant plaintiff fails to meet the increased standard in order to reverse the denial in court, she will be denied even those services that the jury determined were appropriate.[587]

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582 Troxel v. Granville, 530 U.S. 57, 66 (2000).

583 PUB. HEALTH § 2999-j(6).

584 *Id.* at § 2999-j (2), (3), (6).

585 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.6(a) (2012).

586 *Id.* §§ 69-10.2, .7(g)–(h).

587 N.Y. C.P.L.R. § 7803 (McKinney 2008); PUB. HEALTH § 2999-j(6)–(7); Knipel, *supra* note 7. Whatever is "saved" by rationing care under the Fund is coming directly out of the care being provided to innocent children who were the victims of malpractice. If in fact it were true that the child would be getting the same care as without the Fund, there would be no savings at all. There

Where the Fund does not exclude care altogether, it limits the availability of care by only allowing payment at Medicaid rates for goods and services.[588] For example, even if the Fund accepts a prior approval request for private duty nursing, it is debatable whether the enrollee will be able to find caretakers willing to work at Medicaid rates. In addition, several provider organizations have already come out against the Fund, claiming that payment at Medicaid rates not only limits their ability to make care accessible, but also prevents them from providing an adequate quality of care.[589] There is already evidence that care provided at Medicaid rates has a negative impact on patient care, and can even reduce the life expectancy.[590] In the absence of the Fund the plaintiff had the right to choose her care and, if necessary, to pay higher rates to acquire needed care. Instead, the Fund denies her this right and even requires her to ask permission to acquire the kinds of care that are necessary for the patient, simply because they are expensive.[591] This raises serious due process issues as well.

4. Right to Privacy

Another fundamental constitutional liberty right that is protected by the Due Process Clauses is the right to personal privacy.[592] Unfortunately, the manner in which the Fund operates vitiates these rights, as well. As a condition of receiving benefits under the Fund, the plaintiff is required to provide a medical authorization waiving medical confidentially to the Fund Administrator *for the rest of her life*.[593] Since the Fund is entitled to require payment from School Districts and or private health insurance carriers before the Fund pays, it would also appear that they will assert the right for authorizations waiving the child's confidentiality from these sources as well.[594]

certainly can be no claim that the Fund will be more efficient in managing care, which requires permanent administrative costs. *See* PUB. HEALTH § 2999-i(3) ("The expense of administering the fund . . . shall be paid from the fund.").

588 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.20.

589 Bergen et al., *supra* note 82.

590 Bisgaier & Rhodes, *supra* note 231, at 2324; Harrington et al., *supra* note 230, at 1105; Hakim & Buettner, *supra* note 232.

591 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.6.

592 Griswold v Conn., 381 U.S. 479, 484–86 (1965).

593 N.Y. COMP. CODES R. REGS. tit. 10 § 69-10.2(b); NOTICE OF PRIVACY PRACTICES, *supra* note 396; *see* discussion *supra* Part IV.B.

594 NEW YORK STATE MEDICAL INDEMNITY FUND, NEW YORK STATE MEDICAL

This would seem to be a fundamental infringement on individual privacy, extending over a lifetime. As discussed above, the Fund is critically different than someone applying for governmental benefits, and who is obligated to agree to various conditions in order to receive such benefits. Nor is this equivalent to requiring a personal injury plaintiff to waive medical confidentiality. In the latter instance, the plaintiff initiated the action, and the defendant is entitled to the plaintiff's medical information to confirm the validity of his injury.[595] Even then, such medical authorization expires after the lawsuit is determined.[596] In contrast, under the Fund the authorization and loss of medical confidentiality does not even start until after the validity of the medical condition and entitlement to future care damages has been established to the satisfaction of a court. In order to get care under the Fund, the loss of medical privacy extends *forever*.[597]

Thus, in addition to involuntarily depriving the plaintiff of the judgment amount that would enable her to make her own health care decisions, the state is also compelling her to waive all medical confidentiality for the rest of her life.[598] The Fund has apparently recognized that it cannot effectively ration care without this information.[599] The innocent neurologically impaired malpractice victim, therefore, is not only subjected to losing her right and ability to make health care decisions, but will be subjected to rationed care, and as a condition to getting even that, will be obligated to waive medical confidentiality as long as she lives. This infringement on privacy should be sufficient by

INDEMNITY FUND APPLICATION 1–2, *available at* http://www.dfs.ny.gov/insurance/mif/mif_application.pdf.

595 Koump v. Smith, 250 N.E.2d 857, 861 (1969).

596 *See id.*

597 *See* N.Y. COMP. CODES R. & REGS. tit. 10 § 69-10.2(b)(1), (2) (noting that the release of confidential health information to the Fund is provided when patients are eligible to apply for enrollment, which usually is not until the court-approved judgment can be submitted with the application). As noted previously this requirement may also violate HIPPA. Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, 110 Stat. 1936 (1996).

598 N.Y. PUB. HEALTH LAW § 2999-j(1), -j(4), -j(8)(a), -j(12) (McKinney Supp. 2012) (showing that the plaintiff is deprived of the judgment amount because an administrator of the Fund is the one who determines what qualifying health care costs will be paid by the Fund, and which costs require payment from other sources, like private health insurance); *see* discussion *supra* Part IV.B.

599 *See* NOTICE OF PRIVACY PRACTICES, *supra* note 396.

itself to raise serious due process concerns.

5. Retroactive Application

As discussed above, the Fund legislation unprecedentedly purports to apply to all cases in which a judgment was not entered prior to April 1, 2011.[600] This would purport to deprive a plaintiff of the right to obtain full recovery of damages for future care costs in cases (a) where the cause of action has accrued but the plaintiff has not yet sued; (b) where the case has been commenced but not reached a trial verdict, and (c) even where there was a verdict prior to April 1, 2011 but no judgment had been entered.[601] The claim could also be made that the Fund applies to settlements agreed to by the parties prior to April 1, 2011, but which had not been approved by the court by that date.[602] To the extent that this legislation may be applied to pending cases that have not yet ripened into judgments, there is a concern that retroactive application may be an unconstitutional taking–and at least violate New York laws of statutory construction.

Section 53 of NY Statutes (McKinney's Vol. 1) provides: "A statute generally will not be applied retroactively where it would deprive one of a substantial right, or affect antecedent rights."[603] The Comment to this section notes:

> As a general rule, a statute will not be applied retroactively where it would, in effect, deprive one of a substantial right, or affect, or interfere with, antecedent rights, or impose an unexpected liability, at least in the absence of an unequivocal expression in the statute that the Legislature intended that the statute should have such effect. So, a preexisting right or liability, whether or not it is

600 2011 N.Y. Sess. Laws ch. 59 § 52 (McKinney); N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.2(a)(3). When there had been prior legislation to limit the recoveries of plaintiffs in malpractice cases they were applied prospectively to actions that had not yet been commenced. *See*, *e.g.*, 2003 N.Y. Sess. Laws ch. 86 §§ 1–2 (McKinney).

601 PUB. HEALTH § 2999-j(7); N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10.2(a) (noting the requirement that a person may only apply for enrollment in the Fund if he or she has a judgment for a claim or action issued on or after April 1, 2011).

602 *See* N.Y. PUB. HEALTH LAW § 2999-j(7); N.Y. COMP. CODES R. & REGS. tit. 10 § 69-10.2(a)(3). Indeed in the *Swanson* case referred to, the verdict was reached many months before April 1, 2011, but post trial motions delayed entry of a judgment until the effective date of the Fund legislation. Plaintiffs' Affirmation in Sur-Reply, *supra* note 426, at 26–28.

603 N.Y. STATUTES § 53 (McKinney 1971).

> constitutionally protected from change, will not be affected by legislation, unless legislative intent to the contrary is obvious. The doubts, if any, will be resolved in favor of holding the subsequent statute to be prospective only. Nonprocedural statutes will not be interpreted as retroactive unless the Legislature clearly intends such interpretation, and where the effect of a statute is to create a right of action which did not previously exist, it is presumed that the statute was intended to have only prospective application.[604]

In *Knapp v. Consolidated Rail Corp.*,[605] a case addressing the possible retroactive application of changes to the Workers' Compensation Law in New York, the court ruled on the issue of whether a cause of action for contribution was a vested right, and the principle of applying statutory changes to causes of action prospectively only.[606] The court stated: "[W]hile the *quantum* of [a cause of action for] contribution may be inchoate, the right to seek contribution itself is vested."[607] Any attempt to eliminate this vested right retroactively "would constitute an unconstitutional taking."[608]

Under the reasoning of *Knapp*, the Fund may not retroactively apply to cases that had been initiated before April 1, 2011, and perhaps even causes of action that had accrued but had not yet been granted a judgment. Just as *Dole v. Dow Chemical Co.*[609] granted a vested right to seek contribution, the right to seek recovery of future care costs is established by statute.[610] The Fund disrupts this vested right by eliminating the ability to recover future care damages. Juries are still required to make determinations regarding future care costs, but the Fund removes the right of the plaintiff to recover that determined sum.[611] When the plaintiff is required to prove his future care damages and obtains a verdict establishing his entitlement to them, and then is deprived of the right to such recovery, it is hard to imagine a more compelling example of the unlawful impairment of a vested right. The right to seek prove future

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604 *Id.* § 53 cmt.

605 Knapp v. Consol. Rail Corp., 655 N.Y.S.2d 732, 733 (Sup. Ct. Albany Cnty. 1997).

606 *Id.* at 735, 736.

607 *Id.* at 734.

608 *Id.* at 735.

609 282 N.E.2d 288 (N.Y. 1972).

610 N.Y. C.P.L.R. §§ 4111(d), 5031(d) (McKinney 2007).

611 N.Y. PUB. HEALTH LAW § 2999-i(6)(a) (McKinney Supp. 2012); C.P.L.R. § 4111(d).

damages is rendered worthless without the right to recover them from the defendant. [612] Thus, it may well be that the purported retroactive application violates the Due Process Clause by creating an unconstitutional taking.

E. Denial of Jury Trial

Both the New York State Constitution and the CPLR guarantee the right of a trial by jury.[613] Clearly that provision of the New York constitution is applicable to a claim for medical negligence and therefore, the plaintiff in such an action is constitutionally entitled to a determination of liability and damages by *a jury*–and not by the Fund Administrator.[614]

By its terms, the Fund cannot even apply unless a suit has been filed, and all of the litigation steps through and including appeal are followed.[615] "The assessment of damages in a personal injury action is primarily a factual determination to be made by the jury, and is accorded great deference . . . ."[616] The Fund statute only applies after a verdict determining future care cost damages is decided and judgment is rendered, and still requires that the plaintiff prove to the jury the basic elements of liability, as well as future damages, including care costs.[617]

It would appear that the plaintiff's right to a jury trial may be violated by the Fund legislation because after liability, causation, and damages for future care costs are determined by the jury, such future care cost determinations are not considered, and in fact they are completely ignored by the Fund. As discussed previously, the plaintiff is then required to apply for—and may be denied—the very care that the jury determined was required.[618] Thus, the Fund replaces the jury's determination of

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[612] In addition, it is difficult to discern how retroactive application can reduce malpractice premiums that had already been paid for the claims in existence. Retroactive application simply constitutes a windfall to liability insurers who collected premiums for risks that they will never have to pay if retroactivity is upheld.

[613] N.Y. CONST. art. I, § 2; C.P.L.R. §§ 4101, 4104, 4113.

[614] *See* Treyball v. Clark, 483 N.E.2d 1136, 1137 (N.Y. 1985) (stating that for a medical malpractice claim, a plaintiff has a constitutional right to a meaningful jury trial).

[615] *See* PUB. HEALTH § 2999-j(6).

[616] Lolik v. Big V Supermarkets, Inc., 698 N.Y.S.2d 762, 763 (Sup. Ct. N.Y. Cnty. 1999).

[617] PUB. HEALTH §§ 2999-i(6), 2999-j(6).

[618] N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.6–13 (2012).

damages, and instead promises future care that may or may not require prior approval from the Fund and that the Fund may lack the resources to provide. If the Fund denies the care requested by the enrolled plaintiff, there is no reason to think that the enrolled plaintiff will ever receive the actual future care services as determined by the jury. To that extent, the Fund Administrator acts as a "super jury." Instead of the negligent defendant paying for the plaintiff's future medical care as assessed by a jury, the plaintiff's health insurance will pay for many aspects of her care.[619] As for the expensive needs of the plaintiff that are not likely to be covered by her insurance, she will require prior approval from the Fund to get payment.[620] All of this potentially violates the plaintiff's right to a jury trial and the right to enforce the right to collect damages as determined by the jury—whose verdict with respect to future care has become entirely irrelevant by the Fund.

F. Article VII, Section 6

The Fund legislation was inserted as part of the bill approving the New York State budget. Article VII, Section 6 of the New York State Constitution prohibits substantive legislation to be part of the budget: "No provision shall be embraced in any appropriation bill submitted by the governor or in such supplemental appropriation bill unless it relates specifically to some particular appropriation in the bill, and any such provision shall be limited in its operation to such appropriation."[621] When proposing Article VII legislation, "a Governor should not put into such a bill essentially nonfiscal or nonbudgetary legislation."[622] The Legislation creating the Fund—and more importantly it as relates to this constitutional restriction—which takes away the substantive rights to a birth trauma malpractice victim to obtain his full measure of damages, the ability to make health care choices, the freedom to travel, etcetera—was passed as part of the 2011 New York State Budget.[623] It is clear that the Fund legislation does not deal solely with fiscal matters, but rather, for the most part, with substantive and procedural rights of the

619 PUB. HEALTH § 2999-j(3).
620 N.Y. COMP. CODES R. REGS. tit. 10, § 69-10.6–13.
621 N.Y. CONST. art. VII, § 6.
622 Pataki v. Silver, 824 N.E.2d 898, 909 (N.Y. 2004).
623 2011 N.Y. Sess. Laws ch. 59 (McKinney); *see supra* Part V.D.2–4.

plaintiff in a civil action, which are clearly not necessary for the appropriations to the Fund.[624] It would appear, therefore, that this legislation violates the restriction set forth in Article VII, Section 6 of the New York State Constitution prohibiting substantive law matters from being enacted through a budget bill.

VI. CONCLUSION

As detailed in this article, the Fund legislation raises a number of serious questions with respect to its constitutionality. In addition there are a number of practical difficulties in the administration of the Fund that have either not been considered by the Fund regulations, or were considered and ignored. By infringing on the ability of judges to enforce their judgments after a full trial, and allowing an executive agency to override the findings of a jury and the court, the Fund may violate the doctrine of separation of powers. Also, by using public funds to pay a portion of a judgment against a private defendant, the Fund legislation may run afoul of Article VII, Section 8. The operation of the Fund also raises multiple due process and equal protection issues where the rights of some—but not all—children who suffered a birth related neurological injury are being singled out and required to take part in a managed care system in which no other malpractice plaintiff is required to participate. Finally, the funding mechanism as well as the obligations that have been promised, raises serious questions about the long term financial viability of the Fund, and whether the Fund can actually care for its enrollees over the long term.

It is also likely that the care that these children receive will be rationed and reduced—creating long-term health and quality of life issues. Although the Fund was theoretically created to control medical malpractice costs, to the extent that it can accomplish this goal it can only do so by limiting the care available to these children, with potential adverse consequences to their quality of life and longevity. The Fund ultimately places its enrollees in a situation that is not much better than Medicaid, paying for services at Medicaid rates, and requiring prior approval for most critical services. Even though the statute seems to imply that prior approval requests are supposed to be

[624] Moore & Gaier, *supra* note 6, at 2–3.

the exception rather than the rule, the reality is that the most expensive and necessary care that would be required, such as environmental modifications, a van for transportation, private duty nursing, and enteral nutrition, would each require an extensive approval process and could end up being limited or denied. It would seem at a minimum, that an innocent child who has been harmed by the wrongful acts of another—even if the tortfeasor is a health care professional—should be at least be entitled to get the care that was necessitated by such negligence and not have her care rationed by the state. Yet the Fund has taken away that right, and it would appear inevitable that there will be a constitutional challenge to the Fund legislation that could well lead to it being invalidated.

Therefore, either because of a successful constitutional challenge, or the likely need for significantly increased funding, it is difficult to see how this Fund will remain in place over the next decade. In the meantime, unfortunately a significant number of innocent children and their families will be adversely impacted by this experiment.