GREATER NEW YORK HOSPITAL ASSOCIATION
555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

MEMBER LETTER

July
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ML-77

TO: Chief Executive Officers (New York State)

FROM: Kenneth E. Raske, President

RE: GNYHA Requests Veto of "Lavern's Law," Shares White Paper with Governor

Last week, via the attached letter and white paper, I respectfully asked Governor Andrew Cuomo to veto "Lavern's Law" and instead convene a taskforce on comprehensive medical malpractice reform that will 1) identify reforms that will make medical malpractice premiums more affordable, and 2) consider the need for reasonable consumer protections.

The bill, which passed on the last day of the legislative session, would extend New York's 2.5-year medical malpractice statute of limitations to up to seven years from the date of occurrence in certain cases. Although intended to apply only to cases alleging failure to diagnose cancer, the bill is so ambiguously drafted that its scope is unclear. It also contains a very damaging retroactive provision that would "revive" claims that are currently time-barred. Experts that GNYHA has consulted have estimated that the bill would increase hospitals' and doctors' medical malpractice costs by 10-15% per year prospectively, with an equal or greater percentage increase for the retroactive provision.

While Governor Cuomo indicated as far back as two years ago that he is inclined to support this concept, we will nonetheless seek a veto based on the merits.

Our white paper makes the following key points:

- New York State hospitals and providers already shoulder some of the highest medical malpractice costs in the nation, and the medical malpractice insurance market is extremely unstable
- Looming Federal funding threats could strip billions from New York hospitals and providers over the coming years
- Even if the bill's numerous drafting flaws could be fixed, which is far from certain, it is still poor policy and would make New York an outlier among states that have similar laws, as those states have a more balanced mix of malpractice laws

For questions on the bill, please contact David Rich (**rich@gnyha.org**) or Andrew Title (**atitle@gnyha.org**). For questions on medical malpractice or the white paper, please contact Laura Alfredo (**lalfredo@gnyha.org**).

Attachment

cc: Chief Operating Officers
Government Affairs Forum
Legal Affairs Committee

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July 11, 2017

Hon. Andrew M. Cuomo
Governor of New York State
NYS State Capitol Building
Albany, NY 12224

Dear Governor Cuomo:

Attached is a thoughtful piece on the problems associated with A8516/S6800, the medical malpractice statute of limitations "discovery rule" that the Legislature recently passed. Because of the severe problems documented in the attached paper, I am respectfully requesting that you veto this legislation.

Because I understand full well the need for medical malpractice reforms, I humbly recommend that the Executive Branch establish a taskforce to consider measures that would make medical malpractice insurance premiums more affordable, while at the same time providing consumers with reasonable protections.

Thank you for considering our comments.

Very Truly Yours,

Kenneth E. Raske
President

The Wrong Bill At The Wrong Time

Executive Summary

For years, the case of Lavern Wilkinson has inspired calls for an extension of New York's medical malpractice statute of limitations in the form of a "discovery rule." The Greater New York Hospital Association (GNYHA) has opposed such legislation not because Ms. Wilkinson's case is not sympathetic, but because anything that would add to New York's already exorbitant medical malpractice costs must be offset by other reforms.

On the last day of session, the Legislature took the opposite approach and passed a discovery rule as a standalone bill. The purpose of this paper is to explain how damaging this legislation would be for New York, not only because of the high malpractice costs already facing our hospitals and providers, but also in light of looming Federal funding decreases. For these reasons, we respectfully urge Governor Andrew Cuomo to veto the bill and convene a taskforce on comprehensive medical malpractice reform.

Insurance carriers have preliminarily estimated the bill's prospective financial impact as increasing coverage costs by 10-15% per year with an equal or greater percentage increase in additional costs due to the bill's extraordinary retroactive application. One hospital system has estimated its own direct costs at $8-9 million per year, with an additional $16-18 million for retroactive exposure.

These additional expenditures would only add to the astronomical malpractice costs faced by New York's hospitals and providers. New York consistently leads the states in malpractice payouts, spending a total of approximately $700 million last year, or $35 per capita, on payouts and almost $96 per capita on premiums. The insurance market is dysfunctional and increasingly out of the reach of the Department of Financial Services due to the prevalence of out-of-state entities that have cut into the market share of New York's few admitted carriers. If signed into law, this bill may be the final straw that pushes some of those admitted carriers into liquidation.
Added to these challenges are unprecedented Federal funding threats that could strip New York health care of billions of dollars over the next few years. These threats are varied and go beyond the Affordable Care Act's (ACA) "Repeal & Replace" efforts. The most affected would be the 27 hospitals on the State's "Watch List" and the New York State taxpayers whose subsidies keep those hospitals open.

In such an environment, any medical malpractice policy changes must be made with great care and deliberation. Achieving comprehensive malpractice reform would be an ambitious, contentious undertaking, but New York's citizens—and those who care for them—deserve our best efforts toward a more balanced and equitable system.

Introduction

For years, there has been a drumbeat of calls for New York to extend its medical malpractice statute of limitations by enacting a "discovery rule." These calls have been inspired by the cases of people such as Lavern Wilkinson, whose claims were time-barred. While sympathetic to the situation Ms. Wilkinson and others found themselves in, GNYHA has steadfastly opposed such legislation. Given the exorbitant medical malpractice costs affecting New York's hospitals and physicians, a discovery rule cannot be enacted in a vacuum. It must be offset by other measures to rationalize the system and control costs. And with attempts being made in Washington to strip health insurance and Medicaid coverage from millions of New Yorkers, our call for comprehensive medical malpractice reform has never been more crucial.

A.8516/S.6800 is a perfect example of how not to legislate medical malpractice policy. S6800 was introduced on the Sunday before the end of the legislative session (Father's Day) and passed three days later, on the last day of session. The Assembly followed that evening. It has numerous drafting errors that will likely generate years of litigation. Even if the drafting problems could be fixed—a big "if"—the bill is still poor policy. When compared with other states' discovery rules, it is clear that A.8516/S.6800 would make New York a true outlier among states—one that has a discovery rule that is completely unbalanced by other reforms. **When one considers the likely impact of this bill on New York State's unstable medical malpractice insurance market and looming Federal funding threats, it is clear that the most prudent course is to veto the bill and convene a gubernatorial taskforce on medical malpractice reform**.

This paper is separated into two parts. Section I contains a discussion of the financial impacts of the bill in the context of the challenges that New York is already facing. Section II sets forth a legal analysis of the bill's features and how it compares to other states' discovery rules.

I. The Impacts in Context

A.8516/S.6800 would lengthen the current statute of limitations, which generally runs two and a half years from the date of the act, omission, or failure, to up to seven years from the date on which a health care provider allegedly failed to diagnose cancer or a malignant tumor and would do so both retrospectively and prospectively.[1] GNYHA has consulted with a variety of stakeholders about the financial impacts of the legislation. Insurance programs and carriers have preliminarily estimated the bill's prospective financial impact as potentially increasing costs by 10-15% per year, with an equal or greater percentage increase (translating into hundreds of

[1] The two and a half year statute of limitations would run from the date that the plaintiff knew or should have known of the negligence and injury, instead of the date when the negligence occurred, with an outer limit of seven years from the date of occurrence. Claims that are currently time-barred would be revived and could be brought anytime up to two and a half years after the effective date of the act. To what extent the act is truly limited to cancer cases is open to interpretation, as the bill is so ambiguously drafted. The bill's ambiguities are discussed more fully in Section II.

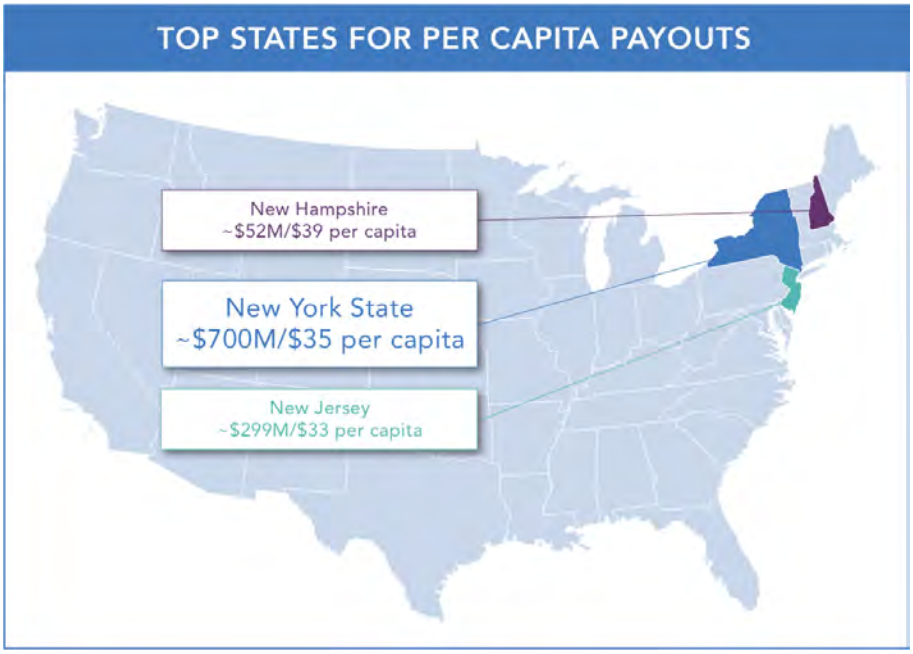
millions of dollars) in additional costs due to the bill's extraordinary retroactive application. These numbers are preliminary and reflect the challenge of basing projections on patterns that are unknowable, i.e., the number and nature of cases that were never brought, as well as the unclear drafting of the bill.

These numbers will translate into real dollars coming out of hospital operating budgets across the State. Since many hospitals self-insure for medical malpractice, either in addition to or in lieu of commercial coverage, many will experience direct, dollar-for-dollar impacts. One hospital system has preliminarily estimated its own direct costs at $8-9 million per year, with an additional $16-18 million for retroactive exposure.

New York's hospitals and providers have been facing astronomical medical malpractice payouts and premiums for years and have few commercial coverage options. They are now also fighting against severe and imminent funding cuts that will affect millions of their patients. Now is not the time to increase their malpractice costs.

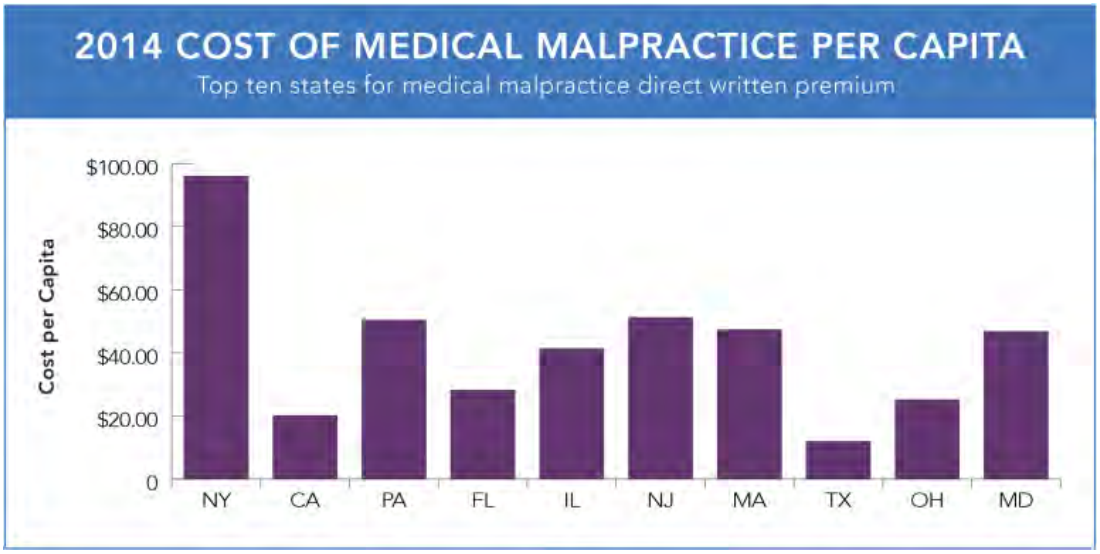
Exorbitant Payouts and Premiums

New York leads the nation in medical malpractice payouts, which totaled more than $700 million last year, and until this year, it has been number one among states on a per capita basis as well.[2]

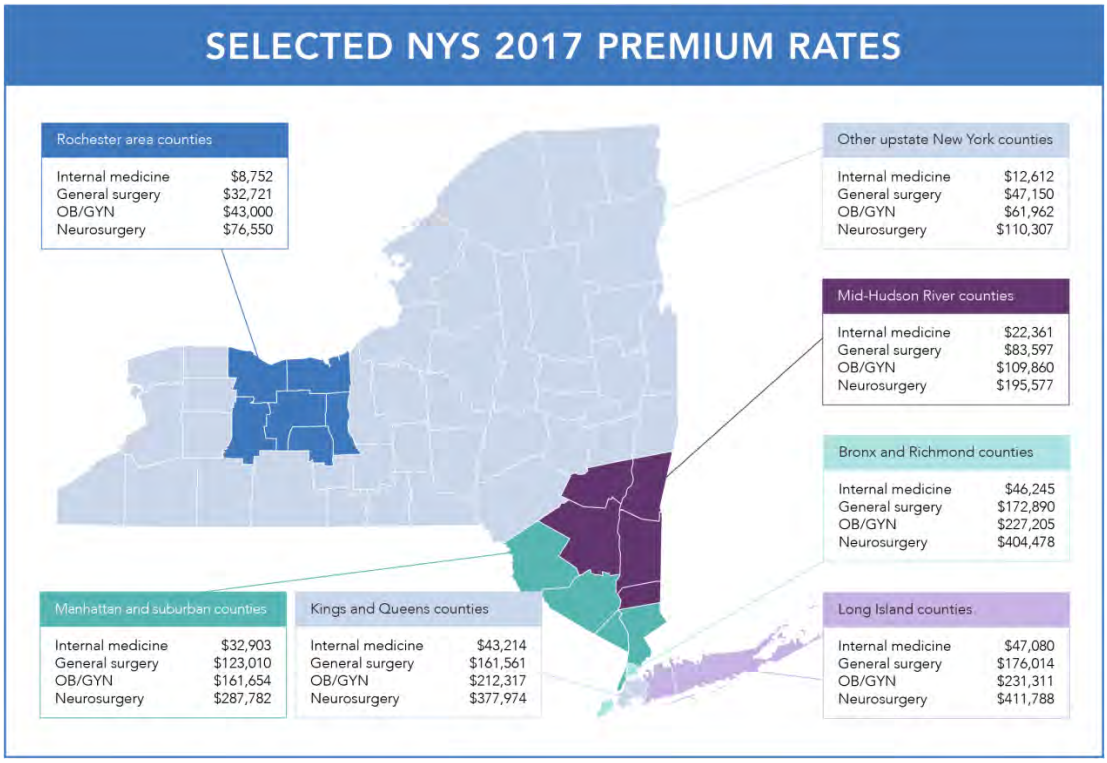


[2] Diederich Healthcare, 2017 Medical Malpractice Payout Analysis, February 2017. New York was number one among states for both total and per capita payouts in Diederich's 2015 and 2016 analyses. The Diederich analysis also reflects that claim frequency and, to a lesser extent, severity have trended favorably over the last several years nationwide. It is impossible to say why, though there is a well-known cyclical component to insurance claims. Regardless, relative to other states, New York continues to be an outlier.

New York similarly outpaces all other states for direct written premium.[3]



New York also consistently has the highest or among the highest physician premium rates in the country, with obstetricians paying more than $200,000 and neurosurgeons paying more than $400,000 per year in standard rates in some downstate regions.[4]



[3] Florida Office of Insurance Regulation. 2014 Cost of Medical Malpractice per capita–Top Ten States for Medical Malpractice Direct Written Premium.
[4] Approved 2017 rates for an admitted New York State carrier.

The large disparity in premiums between the upstate and downstate regions, as well as relative to other states, undercuts the argument that New York's medical malpractice experience is somehow a function of low quality of care. Not only is that argument counterintuitive—New York City is a magnet across the country and around the world for individuals in need of cutting-edge care—it is also demonstrably false. **As the numbers prove, in New York State malpractice experience is more a function of the litigation environment in which one has the misfortune to practice, rather than the quality of care**. And this is despite the fact that our hospitals have made strides in reducing adverse outcomes through programs that GNYHA is proud to lead. [5]

A Fragile Insurance Market

The New York medical malpractice insurance market is in a state of disarray, with an increasing number of physicians abandoning New York's troubled admitted insurers and seeking cheaper policies from risk retention groups (RRGs) that are not even regulated by the Department of Financial Services (DFS). The few remaining admitted companies providing medical malpractice insurance for physicians are financially fragile, to put it generously.[6] One can easily foresee that the shock of new liabilities created by A.8516/S.6800 may be the final straw that pushes certain carriers into liquidation. And should the recently arrived RRGs flee the market, New York's physicians—and their hospital employers—will have even fewer options.

This state of affairs negatively affects downstate hospitals, particularly those that are financially distressed, in two ways: (1) they are often unable to purchase commercial coverage for themselves, even at catastrophic levels, and (2) they face enormous challenges securing coverage for their employed doctors, particularly those that practice in high-risk specialties. These hospitals are in a fight for survival; those that have any resiliency at all try to keep their self-insured trusts funded to adequate levels based on actuarial projections, but it is a constant challenge to maintain that funding in light of pressing operational needs. Even well-resourced hospitals struggle to conserve every dollar for patient-care purposes. This problem will only grow if the insurance market continues to deteriorate, as hospitals are employing physicians at unprecedented rates due to health care reform. [7]

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[5] Working in collaboration with the New York State Department of Health, Healthcare Association of New York State (HANYS), and GNYHA members have dramatically reduced their rates of early elective newborn deliveries resulting in reduced morbidity and healthier newborns and mothers. As part of a national contract with the Centers for Medicare & Medicaid Services, GNYHA, and HANYS have engaged over 170 hospitals in a comprehensive quality improvement program resulting in significant reductions in patient harm due to infection rates related to surgery, urinary catheters, and central line use; avoided over 10,000 adverse medication related events; and reduced over 40,000 readmissions to hospitals within 30 days of discharge.

[6] D. Goldberg, "Growing Concern Over Shifts in N.Y. Medical Malpractice Market," *Politico*, (April 9, 2016), http://www.politico.com/states/new-york/albany/story/2016/04/growing-concern-over-shifts-in-ny-medical-malpractice-market-033298 (accessed 06/26/2017).

[7] A 2012 SullivanCotter survey found that three-quarters of health care organizations said they increased physician staffing levels in 2011, adding an average of 12 specialists and nine primary care physicians. Three-quarters of organizations said they planned to hire more physicians and Advanced Practice Clinicians (APCs) in 2012. This was even before the payment reforms

Some suggest that the acquisition of Medical Liability Mutual Insurance Company (MLMIC) by a Berkshire Hathaway company is an indicator of market health. This overly simplistic view fails to account for all the market forces driving the proposed acquisition. MLMIC's current financial posture is a relatively recent development; it has wisely managed its liabilities and investments well enough to amass a surplus and enjoys stability—for now. But MLMIC's annual earned premium has diminished steadily over the past few years as its market share has been reduced by RRGs increasingly entering the State to capitalize on a bad situation. Indeed, since Berkshire Hathaway itself operates an RRG, it is an open question how much of the New York State physician market will be out of reach of DFS, assuming the transaction is completed.

The prevalence of RRGs is a symptom of the market's dysfunction—physicians are understandably enticed by RRGs' much lower rates. But whether these companies will be able to cover their liabilities as the policies mature is anyone's guess because they are not subject to New York State regulation. The State does not mandate their form of coverage, premium levels (which could very well be inadequate), or capitalization requirements. Also, since they are not required to contribute to the New York State guaranty fund, they are not eligible for the fund's protection in the event of bankruptcy. This troubles both the plaintiff bar and the defense community immensely.

Federal Funding Threats

This medical malpractice environment is difficult to navigate in the best of times. But now, New York's hospitals and providers are facing unprecedented challenges in the coming months and years from a series of Federal Medicare and Medicaid policy changes (both legislative and regulatory). These include direct cuts to Medicaid and Medicare disproportionate share hospital (DSH) funding for safety net hospitals, as well as significant funding cuts from the Republicans' efforts to "Repeal & Replace" the ACA, which will disproportionately impact New York because the State fully embraced the ACA's opportunities to expand coverage to low-income populations. **Given the Federal threats, there simply could not be a worse time to increase medical malpractice costs for New York hospitals**.

enacted under the Affordable Care Act had gained traction. https://www.sullivancotter.com/attracting-and-retaining-physicians-through-benefits/, accessed June 28, 2017.

The range of threats is varied and unprecedented:

Description	Source	Amount	Impacted Entity
Medicaid DSH Cuts	Current law (ACA)	Average annual cut of $787 million (2018-2025)	Public and voluntary safety net hospitals
Medicare DSH Cuts	Proposed regulation	$730 million annually	Public and voluntary safety net hospitals
ACA Repeal & Replace	Proposed legislation	$7 billion cut over 2017-2020, and billions annually thereafter	NYS Budget/Medicaid program and Essential Plan
ACA Cost-Sharing Subsidies	Threatened administrative action	$870 million annually	NYS Budget/Essential Plan

Combined, these cuts are expected to strip billions of dollars from New York's hospitals over the next few years, and our hospitals simply do not have the resiliency to absorb such an assault. New York State hospitals on average experience a 2% operating margin, but this figure—among the lowest nationally—greatly masks the far more precarious financial position of many hospitals. There are 27 voluntary hospitals on a New York State "Watch List" because they have less than 15 days of cash on hand. The State is providing over $480 million annually in direct subsidies to these hospitals, without which they would be at imminent risk of closure. Public hospital systems such as NYC Health + Hospitals are also facing severe deficits. Hospitals simply cannot sustain the increases in operating costs that A.8516/S.6800 would cause without further imperiling their ability to take care of their communities.

For all of these reasons, GNYHA respectfully urges the Governor to veto the bill and convene a taskforce on comprehensive medical malpractice reform.

The Case for a Gubernatorial Taskforce on Medical Malpractice Reform

A taskforce on medical malpractice reform should have two relatively narrow goals: (1) identify reforms to make medical malpractice insurance premiums more affordable and (2) consider the need for consumer protections such as a more balanced discovery rule. Bills addressing both goals should be prepared and enacted as one package, not piecemeal. This will be a contentious process, no doubt. However, if it is clear that nothing will be enacted unless there is consensus among the key stakeholders, there will be an incentive to succeed.

Virginia, a state that enacted an extension to its medical malpractice statute of limitations specifically for cancer cases[8], has adopted just this approach. Years ago, the Virginia Legislature took the position that it would not pass any medical malpractice legislation without the agreement of both plaintiff- and defense-side stakeholders. The trial bar and hospital/provider

[8] In 2016, cases alleging failure to diagnose a non-malignant type of tumor, the schwannoma, were added.

communities regularly confer on proposed legislation, meeting formally prior to the legislative session and talking informally throughout the year.[9] As a result, the Virginia statutory exception for cancer cases contains compromises and balancers that A.8516/S.6800 entirely lacks, as detailed in Section II of this paper.

[9] Information based on GNYHA's 2015 and 2017 discussions with defense-side stakeholders in Virginia.

II. The Bill in the Context of Other States' Laws

In 1975, New York reduced its medical malpractice statute of limitations from three years to two and a half years (from the date of the act, omission, or failure) due to a "critical threat to the health and welfare of the State by way of diminished delivery of health care services as a result of the lack of adequate medical malpractice insurance coverage at reasonable rates." Helgans v. Plurad, 680 N.Y.S.2d 648, 650 (1998) (*quoting* Governors Mem, L 1975, ch 109, 1975 NY Legis Ann, at 1739-1740). This reform, part of a package of initiatives, had the objective of controlling medical malpractice costs while at the same time giving aggrieved patients a reasonable period to sue. The statute has been challenged on constitutional due process and equal protection grounds, including by patients whose claims were time-barred due to no fault of their own. But courts have held that the Legislature's decision "to continue to measure accrual of a cause of action for medical malpractice from the date of the occurrence, as opposed to the date of discovery of the injury, was rationally related to the accomplishment of [the] objective." *Id.* at 650 (*citing* Sisario v. Amsterdam Mem. Hosp., 552 N.Y.S.2d 989 (1990)). Those courts recognized that in any civil justice system, there must be a balancing of objectives, as "the detriment of the harsh effect of CPLR 214-a in certain cases would be outweighed by 'the effect of potentially open-ended claims upon … defendants and society,' if the period of limitation were to run from discovery of the injury." *Id.*, at 651 (*quoting* Goldsmith v. Howmedica, Inc., 67 N.Y.2d 120, 124 (1988)).

This "balancing of objectives" is also seen in the variety of exceptions that are available to toll New York's medical malpractice statute of limitations. [10] One such exception is the continuous treatment doctrine, which is contained in statute. It extends the statute of limitations " 'when the course of treatment which includes the wrongful acts or omissions has run continuously and is related to the same original condition or complaint.' " McDermott v. Torre, 56 N.Y.2d at 405 (*quoting* Borgia v. City of New York, 12 N.Y.2d at 155 (1962)). The doctrine allows a plaintiff to maintain a cause of action based on facts that occurred more than two and a half years prior to the lawsuit's commencement where the last date of treatment was within the limitations period. It is an important exception relied upon by litigants fairly regularly.

On June 21, 2017, the New York State Legislature sought to undo this balance and passed A.8516/S.6800. The bill effectively lengthens the statute of limitations by up to seven years from the date of occurrence in cancer cases and does so both retrospectively and prospectively. It also applies an extension of the statute of limitations in cases falling under the continuous treatment doctrine.

In this section, we will focus on the bill's policy flaws and how it compares to other states' discovery rules. However, we start with an analysis of how the bill is drafted, because its many ambiguities underscore the need for a veto.

[10] In addition to the continuous treatment doctrine, New York law contains a one year discovery rule for retained foreign bodies and tolling provisions for infancy and incapacity. See N.Y.C.P.L.R. 214-a, 208. The courts have also held that the statute of limitations may be extended if the defendant engaged in fraudulent concealment. Simcuski v. Saeli, 44 N.Y.2d 442 (1978).

The Drafting Flaws

Is the bill really limited to cancer cases, and what is the statute of limitations for non-cancer cases?

GNYHA has consulted with several attorneys on Sections 2 and 3 of the bill[11], and they have suggested a variety of potential interpretations of the bill's ambiguous wording, some of which go beyond even the bill sponsors' stated intentions. In fact, there is more confusion than clarity among the legal and claims professionals we have consulted. We offer the following analysis mainly for illustrative purposes.

Section 2 of the bill, amending CPLR §214-a states

> An action for medical, dental or podiatric malpractice must be commenced within two years and six months of the accrual of any such action. The accrual of an action occurs at the later of either (a) when one knows or reasonably should have known of the alleged negligent failure to diagnose a malignant tumor or cancer, whether by act or omission and knows or reasonably should have known that such negligent act or omission has caused the injury; or (b) the date of the last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the accrual of an action. However, such action shall commence no later than seven years from the act, omission or failure complained of or last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the said act, omission or failure complained of or last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the same act, omission or failure …

One interpretation[12] holds that subsection (a) might be read to create a discovery rule for cancer cases, but subsection (b) extends the statute of limitations applicable to all cases falling under the continuous treatment doctrine, not just cancer cases. This interpretation is suggested by the use of the words "such action," which seem to be a reference to the cases described in subsections (a) and (b). Thus, the provisions taken together might arguably extend the statute of limitations from two and a half years to seven years from the last date of treatment in any case falling under the continuous treatment doctrine, whether or not cancer-related. The result would be to stack an extension on top of an exception to the statute of limitations, which goes way beyond the stated purpose and intent of the act.

[11] Although we are focusing on the amendments to CPLR §214-a, similar ambiguities can be found in Section 1 of the act, which pertains to public hospitals and providers.

[12] Others interpret both subsections (a) and (b) as being applicable solely to cancer, given the definition of the word, "accrual." Under either interpretation, however, one could conclude that a statute of limitations has been omitted for some or all non-cancer cases, which is obviously not the stated intention of the bill sponsors.

Additionally, this wording leaves open the question of what the statute of limitations would be for non-cancer cases that do not fall under the continuous treatment doctrine. If this omission is not fixed, the courts will be asked to fashion a statute of limitations to fill in the drafting gaps. A possible outcome is that the courts would fall back on the three year general negligence standard[13] because it is the closest analogue. That would effectively repeal the 1975 reform, though this was not the Legislature's stated intent.

What is the scope of the bill's revival provisions?

The revival provisions of the bill, in Section 3, are also ambiguous. Section 3 states:

> With regard to any person, who within two years and six months (or in actions to which section 50-e or 50-i of the general municipal law or section 10 of the court of claims act apply, the period applicable under such sections) prior to the effective date of this act, (a) knew or reasonably should have known of a negligent act or omission constituting failure to diagnose a malignant tumor or cancer, and knew or reasonably should have known that such negligent act or omission has caused the injury, or (b) within two years and six months (or in actions to which section 50-e or 50-i of the general municipal law or section 10 of the court of claims act apply, the period applicable under such sections) of his or her last treatment where there was continuous treatment for the same illness, injury or condition giving rise to the accrual of an action for failure to diagnose a malignant tumor or cancer; notwithstanding any other provision of law to the contrary, such person's action shall be deemed to accrue on the effective date of this act and shall be commenced within two years and six months (or in actions to which section 50-e or 50-i of the general municipal law or section 10 of the court of claims act apply, the period applicable under such sections) of such effective date, provided that if an action would be timely pursuant to subdivision (a) of this section, such action must be commenced within seven years of the act or omission referred to in subdivision (a) of this section. Where a specific provision of law exists in any other provision of law which is inconsistent with the provisions of this act, such provision shall apply unless a provision of this act specifies that such provision of this act shall apply notwithstanding any other provision of law.

It seems[14] that this section could be interpreted to allow time-barred cancer claims to be brought within two and a half years after the effective date of the act, provided that the plaintiff met the knowledge standard under the discovery rule within the two and a half years before the effective date of the act, and provided further that no more than seven years had passed since the date of the occurrence.

How revival would work with respect to cases falling under the continuous treatment doctrine is open to debate. Some wording may have been misplaced, but it appears that the effective date of

[13] N.Y.C.P.L.R. 214(5).
[14] Like Section 2, there are a variety of interpretations of Section 3 among those whom GNYHA has consulted.

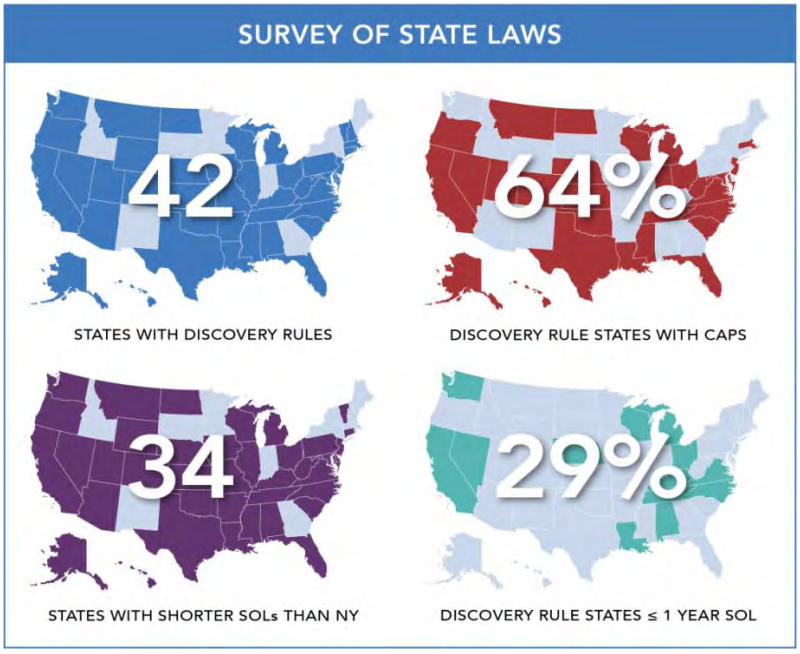
the act would become the new accrual date for any continuous treatment cases alleging failure to diagnose a malignant tumor or cancer. The language, "provided that if an action would be timely pursuant to subdivision (a) of this section, such action must be commenced within seven years of the act or omission referred to in subdivision (a) of this section ..." seems to be an effort to apply the seven year statute of repose to the revival provision, but it is unclear whether and how the seven year limitations period would work with respect to continuous treatment cases.

Fixing the many ambiguities in the bill would be a significant undertaking that is unlikely to achieve clarity, compounding its adverse effects. GNYHA respectfully urges a veto so that the stakeholders with the most knowledge and expertise can consider better options within the framework of comprehensive reform.

The Policy Flaws

For years, the proponents of Lavern's Law have argued that the majority of other states have discovery rules and that New York, with its occurrence-based approach, is an outlier. This is only half of the story, and the proponents know it.

GNYHA has consistently pointed out that while the majority of states have discovery rules, most of them have other tort reforms, most notably caps on damages. They also employ shorter limitations periods than A.8516/S.6800. The following graphics illustrate the discovery rule states' various approaches.[15]



[15] Information based on a 2015 GNYHA state survey of statute of limitations and caps.

Based on this comparison, it is clear that A.8516/S.6800 would not put New York in the mainstream but would make New York a true outlier among states—one that has a discovery rule that is completely unopposed by other reforms. To appreciate just how extreme A.8516/S.6800 is from a policy standpoint, we will review some of its key elements: (1) its retroactivity, (2) the timeframes, and (3) the definition of accrual, or the knowledge standard. We will also compare and contrast A.8516/S.6800 with Virginia's cancer-focused statute of limitations extension that uses a more balanced approach to achieve the same policy objective that the New York State Legislature aimed for.

Retroactivity

As discussed above, A.8516/S.6800 would revive cancer claims that are currently time-barred. Of all of the flawed policy decisions in the bill, this is the most extreme. **The revival provision is an overreach that will only amplify the bill's negative effects, especially in the early years of implementation.**

There can be no doubt that plaintiff attorneys will advertise heavily for time-barred claims. They will be seeking anyone who has been told that their claim is stale or who decided not to pursue a case because of its age. Indeed, we can easily envision that the plaintiff bar will begin advertising for anyone recently diagnosed with any form of cancer (as they currently do for patients diagnosed with Mesothelioma) and encourage them to consider suing every single provider that they had seen in the preceding seven years on the theory that something may have been missed. While no one can say exactly how many such cases will be brought, the obvious goal is to resurrect as many seven-year-old cancer claims as possible. This wholesale reopening will not only negatively impact New York's already precarious medical malpractice environment; it may also be unconstitutional.

The Effect of Changing the Rules on the Medical Malpractice Market

Every hospital self-insured program and insurance carrier endeavors to set their reserves based on what they think their liabilities will be. They base such estimates on prior claims experience within the program and available industry data. On top of that, they try to assess the value of claims that may have been incurred but have not yet been reported (IBNR). They attempt to put aside reserves for these claims in an effort to responsibly prepare for unanticipated eventualities. A.8516/S.6800 will require upward adjustments of every medical malpractice IBNR in the State. Unanticipated reserve changes will be challenging for all insurance companies, as they have not collected premium for the exposure, but distressed companies will be the most severely impacted due to their lack of a surplus. A similar effect will apply to distressed hospitals running self-insurance programs. As noted above, the retroactive provision's impact will be in the hundreds of millions. **The bill's retroactivity may well push some insurers and distressed hospitals over the edge.**

The Questionable Constitutionality of the Retroactive Provision

In addition to the inherent risk of resurrecting claims for which insurers never collected premium, and hospitals and providers never planned, the revival provision may also be unconstitutional. The New York State Constitution states that "[n]o person shall be deprived of life, liberty or property without due process of law." N.Y. Const. art. I, § 6. The Legislature's revival of time-barred claims could amount to a deprivation of property without due process of law. While the New York State Court of Appeals has upheld revival statutes in certain cases, it has aptly described them as an "extreme exercise of legislative power," Hopkins v. Lincoln Trust Co., 233 N.Y. 213 (1922), and has upheld such statutes where "exceptional circumstances" necessitating revival to avoid a "serious injustice" have been found. *See*, Gallewski v. Hentz & Co., 301 N.Y. 164, 174 (1950)(upholding a revival statute in the case of a man who had been interred, and presumably died, in a concentration camp during the Nazi occupation of Czechoslovakia, whose administrator filed a time-barred suit against a brokerage firm for liquidating his securities without authorization); *see also*, Hymowitz v. Eli Lilly & Co., 73 N.Y.2d 487 (1989) (upholding legislation that revived claims for injuries due to ingestion of diethylstilbestrol (DES), noting the serious injustice standard was met in part due to the long latency period of DES injuries).

In 2014, the US District Court for the Southern District of New York dismissed the claims of several individuals who were injured during clean-up of the World Trade Center site following the 9/11 terrorist attacks, finding that the revival statute, "Jimmy Nolan's Law," did not meet the serious injustice standard. *See*, In re World Trade Center Lower Manhattan Disaster Litig., 66 F.Supp.3d 466 (SDNY 2014). On appeal, the Second Circuit certified a question to the New York State Court of Appeals, seeking clarification of the applicable standard to determine a due process challenge to a revival statute. *See*, In re World Trade Center Lower Manhattan Disaster Litig., 846 F.3d 58, 70 (2d Cir. 2017). The Court accepted the certification in February, and the appeal is in the process of being briefed. Although it will never be a good time to enact legislation that revives old medical malpractice claims, given New York's situation, at the absolute minimum, it would be prudent to wait for resolution of this appeal before considering such an extreme action.

The Legislature failed to articulate any basis for the revival provision, nor did they make any effort to tailor it to exceptional circumstances or demonstrate it is necessary to avoid serious injustice. The revival provision is thus vulnerable to constitutional challenge.

The Timeframes

Most states' discovery rules employ a two-pronged limitations period: the discovery statute of limitations itself, triggered by what the plaintiff knew and when, and a statute of repose meant to

set an outer limit on such claims, usually triggered by the date of occurrence. A8516/S6800's formulation is two and a half years and seven years.

As set forth above, most states use much shorter timeframes; in many cases, one year. Through the use of shorter timeframes and other features, other states' discovery rules are internally balanced.

A.8516/S.6800 makes no attempt at such a balance. Not only are the timeframes not designed to incentivize prompt action once a plaintiff obtains knowledge of the malpractice, the extremely long statute of repose (as well as the revival provision) may incentivize marginal and outright frivolous claims. Consider the number of cancers that initially present with non-specific, relatively innocuous symptoms or no symptoms at all, such as pancreatic cancer and ovarian cancer. It is not an overstatement to say that A.8516/S.6800 would provide an incentive for plaintiff attorneys to look back over seven years of care in an effort to uncover whether something was missed in patients newly diagnosed with cancer. And New York law provides only minimal controls on the commencement of scientifically marginal cases.

Those who might argue that the requirement of a certificate of merit or expert testimony at trial will be enough to combat an influx of marginal-to-frivolous cases are simply turning a blind eye to the reality of medical malpractice litigation in New York. Certificates of merit have become *pro forma* exercises for many, if not most, plaintiff lawyers. The anonymous experts behind the certificates do not have to be in the same specialty as the defendant(s) whose care they are critiquing, are not required to make any specific findings, and never have to sign their name to their opinion; they are thus completely unaccountable. This unaccountability carries over with respect to trial experts. They are not required to issue reports or be deposed; since so few cases are tried, most are never subject to cross examination on their theories. Especially in cancer cases, where there is still so much that is unknown to science, it is not challenging to find an expert who will support just about any theory.

When one considers how A.8516/S.6800 would likely be used in the real world, it becomes clear that, contrary to the beliefs of some of its proponents, the act's effects would not be limited to radiologists. It would potentially affect all providers in New York, including primary care doctors who care for patients over a course of years for routine issues. It is thus naïve to think that the act would not increase the practice of defensive medicine, which is already a factor in health care costs.[16] Rather than relying on experience and judgment in assessing the non-specific symptoms that accompany so many cancers, doctors will likely feel compelled to order tests in

[16] Estimates vary on the cost of defensive medicine. An often-cited study estimated $46 billion in defensive medicine costs out of $2.3 trillion in overall health spending in 2008. M. M. Mello, Chandra, A., Gawande, A. A., Studdert, D.M., "National Costs of the Medical Liability System," *Health Affairs* vol.29 (2010) 1569-1577.

an attempt to definitively rule out cancer, an elusive quest in many cases that is not without its own risks.[17]

In addition to these considerations, it must be recognized that litigating old facts is extremely difficult. Facts that are seven years old at the outset of a suit can become 12 years old by the time depositions are taken and much older when the case reaches trial. The timeframes would be even longer for cases brought under the continuous treatment doctrine, since plaintiffs would have seven years from the last date of treatment following what could have been a long course of care. Parties and witnesses—if they are even available—will not have reliable recollections, and records may be unavailable.[18] A.8516/S.6800 thus upends one of the essential purposes of any statute of limitations, which is to engender "fairness to defendant and society's interest in adjudication of viable claims not subject to the vagaries of time and memory." Ackerman v. Price, 84 N.Y.2d 535, 542 (1994).

The Definition of Accrual—What Did the Plaintiff Know and When

New York currently has a bright-line standard for when the statute of limitations in a malpractice case starts to run: the date when the malpractice occurred. For the most part, this formulation has the advantage of avoiding a lot of unnecessary litigation, allowing the parties to focus on the merits.

A.8516/S.6800 seeks to replace this workable standard with one that relies in large part on the subjective knowledge of the plaintiff. This knowledge standard is two-pronged; the plaintiff would have to know not just that malpractice occurred, but also that it caused an injury.[19]

This complex standard is obviously designed to set the trigger date for the running of the statute of limitations to the latest possible time. In many cases, the two prongs may be known contemporaneously. In others, there will be a gap. In cancer cases, particularly indolent cancers that do not cause distinctive symptoms early on, such a gap may be more prevalent than other types of cases. Fixing the exact time when a plaintiff came into possession of both pieces of information—liability and causation—will be exceedingly difficult in such cases.

[17] The American Board of Internal Medicine Foundation has an initiative called, "Choosing Wisely," designed to reduce the overuse of tests and procedures. Richard J. Baron, M.D., the president and CEO of the ABIM Foundation stated the problem quite simply when he said that, "overtesting itself can do harm." J. Packer-Tursman, The Defensive Medicine Balancing Act, *Medical Economics* (January 2015). http://medicaleconomics.modernmedicine.com/medical-economics/news/defensive-medicine-balancing-act?page=full.

[18] The New York State record retention regulation for adult hospital medical records is six years, one year less than the statute of repose in A.8516/S.6800. N.Y. COMP. CODES R. & REGS. tit. 10, § 405.10(a)(4) (2016).

[19] Section 2 of the bill states that an action would accrue when "(a) when one knows or reasonably should have known of the alleged negligent failure to diagnose a malignant tumor or cancer, whether by act or omission **and** knows or reasonably should have known that such negligent act or omission has caused the injury [emphasis added] …"

A.8516/S.6800 thus would not only prolong the timeframe in which to sue, but would likely increase the number and complexity of disputes. It is possible that defendants may prevail in many of these disputes, ultimately. But litigation costs, separate and apart from settlements and judgments, are a huge cost driver. Between 2009 and 2013, nationwide, cases that received no monetary award cost an average of approximately $40,000 per case to defend.[20]

Although many states with discovery rules employ the sort of two-pronged knowledge standard proposed in A.8516/S.6800, a brighter-line approach is not unprecedented and would work better in New York's already high-cost environment. The best comparator for these purposes is the state with a similar cancer-only exception to its medical malpractice statute of limitations, Virginia.

Comparing and Contrasting with the Virginia Approach

In 2008, Virginia enacted an extension to its occurrence-based medical malpractice statute of limitations for cases alleging failure to diagnose a malignant tumor or cancer (in 2016, it was amended to include cases alleging failure to diagnose a rare non-malignant tumor, the schwannoma). Although not traditionally formulated, the Virginia discovery rule achieves the goal of extending the statute of limitations for certain cases that might otherwise be time-barred through no fault of the plaintiff. It states, in relevant part:

> The two-year limitations period … shall be extended in actions for malpractice against a health care provider as follows … In a claim for the negligent failure to diagnose a malignant tumor, cancer, or an intracranial, intraspinal, or spinal schwannoma, for a period of one year from the date the diagnosis of a malignant tumor, cancer, or an intracranial, intraspinal, or spinal schwannoma is communicated to the patient by a health care provider, provided that the health care provider's underlying act or omission was on or after July 1, 2008, in the case of a malignant tumor or cancer or on or after July 1, 2016, in the case of an intracranial, intraspinal, or spinal schwannoma. Claims under this section for the negligent failure to diagnose a malignant tumor or cancer, where the health care provider's underlying act or omission occurred prior to July 1, 2008, shall be governed by the statute of limitations that existed prior to July 1, 2008. Claims under this section for the negligent failure to diagnose an intracranial, intraspinal, or spinal schwannoma, where the health care provider's underlying act or omission occurred prior to July 1, 2016, shall be governed by the statute of limitations that existed prior to July 1, 2016. VA Code Ann. 8.01-243 (C)(3).

[20] PIAA Data Sharing Project, 2009-2013 MPL Facts (2013 Dollars), INSIDE MED. LIABILITY, Second Quarter 2015 [https://www.piaa.us/docs/IML/2Q2015IML.pdf].

Several points of contrast between the Virginia statute and A.8516/S.6800 stand out because they illustrate how the Virginia statute is balanced:

Statutory Provision	Virginia	New York
Time to sue from accrual of cancer cases	One year	Two and a half years
Time to sue for other cases	Two years	Two and a half years
Triggering event	Date of diagnosis	when one knows or reasonably should have known of the alleged negligent failure to diagnose a malignant tumor or cancer, whether by act or omission and knows or reasonably should have known that such negligent act or omission has caused the injury …
Retroactivity	No	Yes

Virginia has made several choices in enacting this law. It employs a relatively short statute of limitations, on the theory that plaintiffs should be incentivized to act promptly once they suspect they have a claim, and it is shorter than the statute of limitations applicable to non-cancer cases. The accrual itself is a bright-line standard; there will be no doubt when someone has been diagnosed with cancer. Finally, there is no retroactivity, as the line must be drawn somewhere.
Virginia does provide for a lengthy statute of repose of 10 years. However, Virginia also has statutory caps on damages. The current limit is $2.25 million, and it applies to all categories of damages, not just pain and suffering.

Conclusion

Virginia's approach illustrates how one State has chosen to balance its medical malpractice laws. It is not a set of piecemeal laws rushed through after hours, but a comprehensive system that is designed to be fair to all sides—patients and providers. It is the result of consensus among the stakeholders, as directed by the legislature. This process is extremely instructive and should be emulated by New York. **The only way to achieve this sort of balance is to veto A.8516/S.6800 and convene a gubernatorial taskforce on comprehensive medical malpractice reform.**