A Self-Inflicted "Crisis"

New York's Medical Malpractice Insurance Troubles Caused By Flawed State Rate Setting and Raid on Rainy Day Fund

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Acknowledgments

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Introduction

Last summer's decision of the New York State Insurance Department to authorize a 14-percent increase in medical malpractice insurance premiums was accompanied by a wave of warnings that rates were causing a doctor-shortage "crisis" and suggestions that the insurance industry was in dire straits that could not be cured by the rate hike alone. Gov. Eliot Spitzer appointed a "Medical Malpractice Liability Task Force" to "define the major causes of medical malpractice and of the high cost of insurance."

Critics of the civil justice system, predictably, tried to use these purported crises to justify imposing an array of restrictions on New Yorkers' legal rights. The most offensive proposal concerns newborns. It would deprive neurologically impaired infants of their legal rights, leaving their welfare to the whims of a state-run fund. Our research shows that these funds are failures in the two states that have conducted similar experiments with the rights of patients.

In reality, the data show that most of these "crisis" claims are vastly exaggerated and those that are valid have nothing to do with a proliferation in litigation. It is worth noting that the situation in New York state is, when compared with the national medical malpractice insurance marketplace, an aberration. Nationally, rates are generally stable or are even slightly decreased from previous levels.

This study examines the three plausible explanations for recent insurance rate increases and the financial struggles claimed by New York's insurance providers: 1) an increase in litigation; 2) the combustion of poor state regulation and normal volatility in the insurance market; and/or 3) marked changes in the quality of patient safety.

We unequivocally conclude, in the first instance, that increasing medical malpractice litigation is not to blame for the insurance industry's woes or its recent rate increases. The evidence irrefutably demonstrates that malpractice payments in New York fell to historic lows in recent years and that amounts paid out either went down or rose only modestly, depending on the measure used.

The combination of volatility in the insurance market and derelict state regulation is almost certainly the explanation. Insurance companies are still recovering from an eight-year period in which state regulators held rates stagnant. Meanwhile, the state in the 1990s raided nearly $700 million from the rainy-day fund of an insurance pool set up to cover risky doctors (those who are unable to obtain commercial insurance). When the pool suffered massive losses this decade, the state's insurance providers were forced to absorb more than $500 million in red ink. Although more regulated than those in most states, New York's insurance providers also suffered in recent years from some of the same problems that afflicted the industry nationwide – most notably, decreased investment income.

Even though New York has not seen an increase in medical malpractice litigation, the state should make use of the current focus on the subject to improve patient safety. While these steps may not immediately ameliorate insurance rates, they would undeniably reduce unnecessary injuries and deaths. The data indicate that New Yorkers suffer from a chronic

incidence of inexcusable errors, such as wrong-site surgeries, wrong *patient* surgeries, and abandonment of foreign materials, such as sponges, in patients' bodies. Meanwhile, an average of more than 550 New Yorkers a year have died since 1999 due to adverse incidents in the state's hospitals – and these are just the incidents that have been reported. The state's patient safety performance ranked 49th of the 50 states in a 2006 study by the independent rating organization Health Grades Inc.

The toll exacted by bad doctors is reflected in the program that covers physicians who cannot obtain commercial insurance. Only about 1 percent of the New York's doctors are in the program, but they have committed malpractice at such an alarming rate that they are chiefly responsible for the program's loss of more than $500 million this decade.

New York's comptroller issued a report this past summer lambasting the state for inept oversight of suspect physicians. The comptroller's findings were underscored by recent revelations that health officials delayed notifying more than 600 people that they had potentially been exposed to deadly diseases by a single physician improperly reusing syringes. Astonishingly, the state regards its investigation into the physician, Dr. Harvey Finkelstein, as a "non-disciplinary" matter.

Although increases to medical malpractice rates exceeded inflation for the past five years, overall rate increases have not been onerous. From 1991 to this year's 14-percent hike, the average annual increase has been merely 3.5 percent – or about half the rate of medical inflation over the time period.

Claims by some that New York's population of doctors is dwindling are the most absurd of all. By almost any standard – whether one examines the number of licensed doctors, practicing doctors, "at risk" specialists, or full-time equivalent doctors – New York's doctor supply is higher, and healthier, than it has been in any year for which data are available.

One exception, though not notable, is the much-ballyhooed purported shortage of obstetricians. While the number of obstetricians did drop slightly this decade, the state's birthrate actually declined at a faster rate, meaning that the small change in the number of obstetricians had little impact on access to care.

Among our key findings are:

1. New York is not facing a litigation crisis.

- Medical malpractice payments on behalf of doctors were only 0.61 percent of New York's total medical expenses in 2004, the most recent year for which total medical expenses are available. Premiums were only 1.02 percent of total medical costs in 2004. The average percentage of costs expended for premiums was lower in the first five years of this decade than in the entire 1990s.

- The number of malpractice payments in New York is at an historic low. Each of the last five years ranks in the bottom five out of the last 13 years in the number of payments per licensed physician.

- The amounts paid out in malpractice payments (when adjusted for inflation on a per capita basis) were slightly higher over the past five years than in the preceding eleven years while the inflation-adjusted amounts paid out per practicing physician were slightly lower over the past five years.

- The types of cases leading to medical malpractice payments in New York are serious, and compensation levels accord with the severity of the injury. Of ten categories of outcomes tracked by the federal government's medical malpractice database, the five categories resulting in the largest payments all involve permanent injuries or death.

- Deaths from adverse events are the leading cause of medical malpractice payments in New York. Although such cases yield only the 4th highest average payout (out of ten outcome categories), deaths occur at such an alarming rate that payments to grieving survivors account for the greatest amount of dollars paid.

- Costs for cases involving brain damage, blamed by some for rising insurance rates, are in fact modest in comparison with other types of cases. The category for injuries including brain damage ranks 5th of 10 in total amounts paid out. This fact exposes the lunacy of the radical proposal to deprive newborn babies of their legal rights and cede their care to a state-run fund. Any slight savings that might result from such an unjust experiment would barely reduce overall medical malpractice payments in New York.

- The number of malpractice cases in the pipeline is virtually constant. The rate of cases initiated over the most recent five-year period was less than 2 percent up or down from previous years, depending on the measure used.

2. New York's government is primarily responsible for insurance problems.

- Recent medical malpractice rate hikes and financial woes claimed by the insurance industry are due to three main factors:

    1. The need for insurance companies to catch up from an eight-year period in which state regulators held rates stagnant;

    2. The state government's expropriation of nearly $700 million from the rainy-day fund of a program that insured high-risk doctors and its subsequent imposition of a policy that forced medical malpractice insurers to absorb all of the program's losses, which have totaled more than $500 million this decade; and

    3. The insurance market's typical boom-bust cyclical nature.

3. Receiving health care in New York is unsafe.

- An independent rating organization, Health Grades Inc., gives New York abysmal grades – ranking New York's patient safety record 49th out of the 50 states, and grading the safety records of 47 percent of New York's hospitals among the nation's worst 15 percent.

- New Yorkers suffer from an unconscionable frequency of inexcusable errors, such as surgeries on the wrong body part or, even, the wrong patient. Meanwhile, adverse events in hospitals have claimed the lives of more than 550 New Yorkers a year since 1999 – and those are just the cases identified by a reporting system that notoriously undercounts incidents.

- The state's oversight of physicians is woefully inadequate. New York's comptroller found that the state's Office of Professional Medical Conduct (OPMC) failed to investigate about 175 doctors for whom investigations should have been triggered based on the agency's existing criteria. Moreover, the comptroller found that the agency's criteria for initiating investigations are too narrow and should be broadened.

- A sliver of doctors are responsible for nearly half of the dollars paid out for medical malpractice in New York. Physicians who made three or more malpractice payments between 1990 and 2006 – accounting for no more than 4 percent of New York's doctors – were responsible for nearly half (49.6 percent) of medical malpractice dollars paid out on behalf of doctors in the time period. Only 10.8 percent of these physicians experienced disciplinary action affecting their license to practice.

- About 1 percent of the state's doctors are in a program for those physicians who are unable to obtain commercial insurance. These doctors have made such staggering malpractice payments that they are chiefly responsible for the program's losses of more than $500 million this decade. These losses, which commercial insurers must absorb on a shared basis, are largely responsible for the financial troubles the state's insurers are facing.

4. New York's population of doctors is flourishing.

- New York's population of physicians is at an all-time high by numerous measures and its number of doctors in training is by far the highest in the country, with half-again as many residents and fellows as California and more than twice as many as any other state.

- The state's slight drop in obstetricians between 2000 and 2005 was less than the decline in the state's birthrate over the same time period.

5. New York doctors' incomes will likely be unaffected by rising insurance premiums.

- Researchers have found that premiums consistently make up only a small percentage of doctors' total expenses and that rising premiums have not, historically, depressed physicians' incomes.

Recommendations

We have a series of recommendations, which should not be treated as comprehensive. They are summarized here:

- In a manner consistent with other health priorities, New York should refund the nearly $700 million it siphoned from the rainy-day fund of the insurance pool for high-risk doctors;

- The state should consider steps to prevent future boom-bust cycles in the malpractice insurance industry, such as setting a minimum annual rate increase indexed to inflation;

- The state should make a top priority of improving patient-safety;

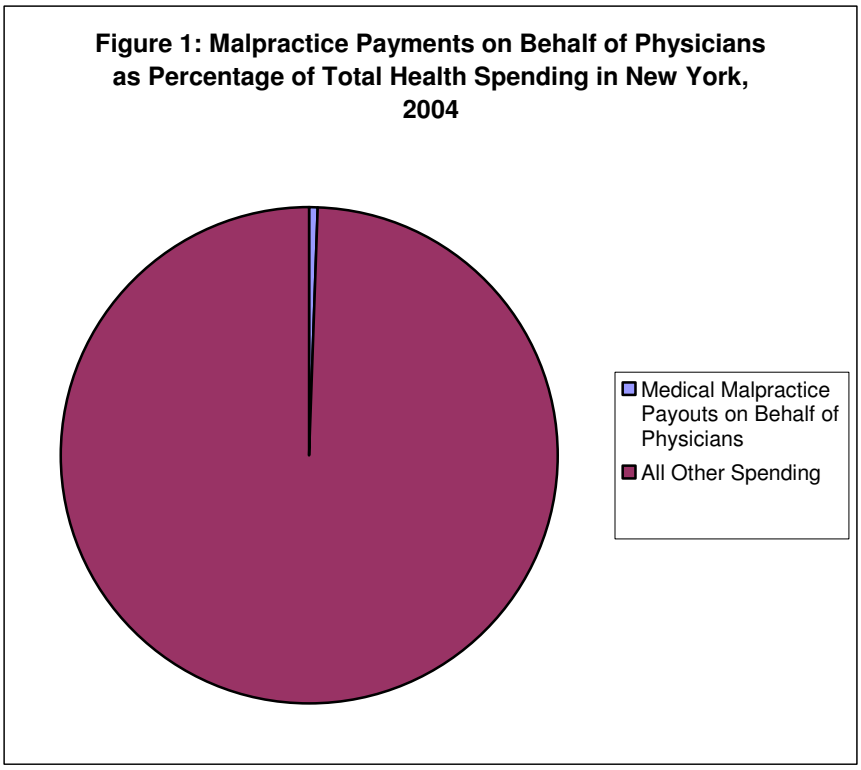
- The state should improve its woeful oversight of physicians; and

- The state should take a hard look at the records of doctors who are unable to obtain commercial insurance. Malpractice payments by these physicians (who account for fewer than 1 percent of the state's doctors) are largely responsible for the bind that New York finds itself in today.

I. New York Is Not Facing a Litigation Crisis

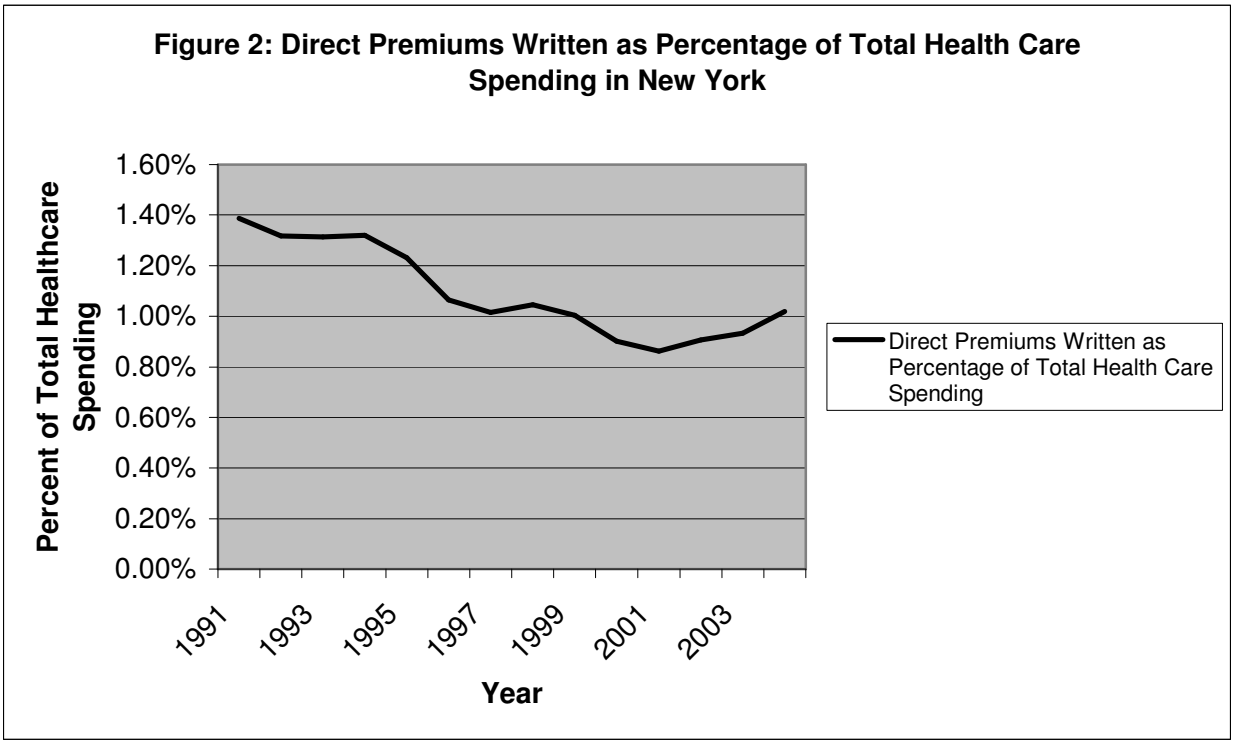
Arguments that medical malpractice litigation is largely responsible for the marked increase in health care costs do not withstand scrutiny. Since 1991, when the federal government began collecting the data, medical malpractice payments made on behalf of physicians have never accounted for even as much as 1 percent of New York's overall health care spending.

The sum of medical malpractice payments made by New York's doctors in 2004 was $765.8 million, accounting for only 0.61 percent of the $126.1 billion New Yorkers spent on health care that year (the most recent year for which such costs are available). Medical malpractice payments were no more than 0.77 percent of New York's overall health care costs in any year since 1991. The three years in which medical malpractice consumed the highest share of health care costs occurred in the early 1990s.



Sources: National Practitioner Data Bank and Center for Medicare Studies

Medical malpractice premiums also have made up no more than a sliver of total health care costs. They have ranged from 0.86 percent to 1.39 percent of costs. Their share was lower in the first five years of this decade than in the 1990s.



Source: Center for Medicare Studies and A.M. Best and Co., special data compilation for Americans for Insurance Reform.

Examination of medical malpractice data since 1991 – the earliest full year for which such information exists – reveals that the recent level of medical malpractice litigation in New York has been below normal or relatively normal, depending on the measure used.[i] The annual numbers of medical malpractice payments in New York were at historic lows in recent years and the inflation-adjusted amounts paid were only slightly higher over the past five years on a per capita basis and slightly lower on a per practicing physician basis.

In 2006, New York had the fewest medical malpractice payments (including both settlements and judgments from court verdicts) per capita of any year since 1991. It also had the second fewest total payments. Each of the last five years has ranked in the bottom five out of the last 13 years in the number of payments per licensed physician.

[i] Medical malpractice payment statistics and some data on medical errors and doctor discipline in this report were drawn from the National Practitioner Data Bank (NPDB), a federal repository of medical malpractice information created by Congress.

Figure 3: Number of Medical Malpractice Payments in New York

Year[ii]	Total Number of Payments (rank)	Payments Per 100,000 Residents (rank)	Payments per 100,000 Licensed Physicians Practicing In New York (rank)
1991	1,706 (13)	9.4 (10)	n/a
1992	1,906 (6)	10.4 (t5)	n/a
1993	1,930 (5)	10.5 (t3)	n/a
1994	1,985 (3)	10.8 (1)	3,597 (2)
1995	1,642 (16)	8.9 (16)	3,207 (7)
1996	1,703 (14)	9.2 (t11)	3,189 (8)
1997	1,767 (11)	9.5 (9)	3,308 (6)
1998	1,888 (8)	10.1 (7)	3,437 (5)
1999	1,978 (4)	10.5 (t3)	3,549 (3)
2000	2,038 (1)	10.7 (2)	3,670 (1)
2001	1,987 (2)	10.4 (t5)	3,486 (4)
2002	1,773 (9)	9.2 (t11)	3,111 (10)
2003	1,760 (12)	9.1 (15)	2,954 (11)
2004	1,897 (7)	9.8 (8)	3,184 (9)
2005	1,768 (10)	9.2 (t11)	2,787 (12)
2006	1,702 (15)	8.8 (17)	2,748 (13)
Avg. 1991-2001	1,866	10.0	3,430
Avg. 2002-2006	1,780	9.2	2,957

Sources: National Practitioner Data Bank, U.S. Census and the Federation of State Medical Boards.

Meanwhile, the cumulative value medical malpractice payments, when adjusted for inflation and changes to the state's population, rose only modestly. The average over the past five years was 3.6 percent higher than in the preceding 11 years. Inflation-adjusted average annual payments per practicing physician over the past five years were 3.2 percent lower than in the preceding 11 years.

[ii] NPDB offers several methods to calculate year of payment, including the year of judgment or settlement and the year in which a payment is recorded by NPDB. This analysis uses the year recorded because it is the most consistently available data. By law, reports must be made to NPDB within 30 days of payment.

Figure 4: Medical Malpractice Payments in New York Since 1991

Year	Total Value, Adjusted for Inflation[iii]	Inflation-adjusted Value per 100,000 Residents (rank)	Inflation-adjusted Value Per Licensed Physician Practicing in New York (rank)
1991	$311,925,550 (16)	$1,721,205 (16)	n/a
1992	$417,453,206 (7)	$2,287,834 (6)	n/a
1993	$432,230,023 (5)	$2,352,278 (3)	n/a
1994	$467,081,010 (2)	$2,530,306 (1)	$8,463 (1)
1995	$327,481,583 (15)	$1,767,867 (15)	$6,397 (12)
1996	$342,262,030 (14)	$1,841,261 (14)	$6,408 (11)
1997	$359,558,464 (13)	$1,927,251 (13)	$6,732 (9)
1998	$386,758,321 (12)	$2,062,062 (11)	$7,041 (8)
1999	$404,211,283 (8)	$2,140,641 (8)	$7,252 (5)
2000	$435,468,909 (4)	$2,291,925 (5)	$7,841 (3)
2001	$442,419,162 (3)	$2,316,864 (4)	$7,762 (4)
2002	$402,397,153 (10)	$2,099,361 (9)	$7,060 (7)
2003	$430,277,779 (6)	$2,236,574 (7)	$7,221 (6)
2004	$474,144,586 (1)	$2,457,787 (2)	$7,957 (2)
2005	$398,161,551 (11)	$2,061,334 (12)	$6,277 (13)
2006	$403,729,819 (9)	$2,091,194 (10)	$6,519 (10)
Avg. Through 2001	$393,349,958	$2,112,681	$7,237
Avg. 2002-2006	$421,742,178	$2,189,250	$7,007

Sources: National Practitioner Data Bank, Federation of State Medical Boards, Bureau of Labor Statistics and U.S. Census. See Footnote iii for discussion of the inflation rate used.

The New York State Unified Court System keeps track of the progress of medical malpractice cases filed across the state. It offers data on "Requests for Judicial Intervention" (descriptions of cases submitted to the court after the complaint and answer are filed) and "Notes of Issue" (a notice certifying that a case is ready for trial).

The rate of both Requests for Judicial Intervention and Notes of Issue was about the same over the past five years as it was in the preceding six years (the time period for which such data are readily available).[1]

[iii] Figures adjusted to 1990 dollars. The inflation rate used in this report is a 60 percent/40 percent blend of the U.S. Medical Care Services rate and the Consumer Price Index. The Medical Care Services rate is particularly relevant because a significant portion of malpractice payments covers future medical costs. In the absence of a definitive study on future medical costs' average share of malpractice payments, we used as a guideline a Physician Insurers Association of America (PIAA) statement in January 2007, which observed that reimbursement for other costs "such as lost wages, non-medical care, household expenses, pain and suffering and the claimant's cost for attorney fees and courts costs" often are "40 percent or more of the total award."

Overall, there was only slightly more than a 1 percent change in both indices over the past five years. Requests for Judicial Intervention were 1.4 percent higher over the past five years while Notes of Issue were 1.2 percent lower.

Figure 5: Requests for Judicial Intervention in New York, 1996-2006

Year	Requests for Judicial Intervention per 100,000 Residents (rank)
1996	23.7 (2)
1997	23.8 (1)
1998	22.8 (6)
1999	19.2 (11)
2000	21.2 (10)
2001	22.5 (7)
2002	22.9 (5)
2003	23.2 (3)
2004	23.0 (4)
2005	22.0 (8)
2006	21.4 (9)
Avg. 1996-2001	22.2
Avg. 2002-2006	22.5

Source: New York State Unified Court System

Figure 6: Notes of Issue in New York, 1996-2006

Year	Notes of Issue per 100,000 Residents (rank)
1996	13.6 (10)
1997	13.4 (11)
1998	18.3 (2)
1999	15.9 (6)
2000	16.5 (5)
2001	18.8 (1)
2002	17.4 (3)
2003	16.7 (4)
2004	15.0 (8)
2005	15.0 (9)
2006	15.2 (7)
Avg. 1996-2001	16.1
Avg. 2002-2006	15.9

Source: New York State Unified Court System

Patient Outcomes in Cases Resulting in Malpractice Payments Tend To Be Severe

In 2004, NPDB began collecting data on the severity of patient outcomes of cases that resulted in medical malpractice payments. The data lead to the following conclusions about medical malpractice payments in New York state:

- Significant payments tend to be reserved, appropriately, for permanent injuries or death. The five categories that had the highest total amounts paid and the largest average payments all involved permanent injuries or death;

- Deaths are the leading cause of medical malpractice payments in New York. Cases involving death had both the largest number of malpractice payments and the largest total amounts paid; and

- The category involving a need for lifelong care ("quadriplegic, brain damage, lifelong care") resulted in the highest *average* payments, although this category was fifth in total amounts paid.

Figure 7: Patient Outcomes in Cases Involving Medical Malpractice Payments, 2004-2006

Outcome	Total Value of Payments Paid (rank)	Average Payment (rank)	Number of Payments (rank)
Death	$480,133,750 (1)	$398,121 (4)	1,206 (1)
Significant Permanent Injury	$452,170,000 (2)	$497,437 (3)	909 (2)
Major Permanent Injury	$306,791,000 (3)	$669,849 (2)	458 (6)
Minor Permanent Injury	$262,166,800 (4)	$309,890 (6)	846 (3)
Quadriplegic, Brain Damage, Lifelong Care	$256,511,250 (5)	$872,487 (1)	294 (7)
Major Temporary Injury	$170,426,750 (6)	$270,519 (7)	630 (5)
Minor Temporary Injury	$92,083,250 (7)	$139,732 (8)	659 (4)
Undetermined	$30,115,600 (8)	$386,097 (5)	78 (9)
Insignificant Injury	$6,520,550 (9)	$77,626 (9)	84 (8)
Emotional Injury Only	$2,488,250 (10)	$80,266 (10)	31 (10)

Source: National Practitioner Data Bank

Creating a New Fund for Neurologically Impaired of Infants Is Not the Answer

The recent increase in medical malpractice premiums, combined with insurance companies' claims of financial crisis, has resurrected an old and once-discarded idea: to establish a fund for neurologically impaired infants. Such a program, in theory, would pay these infants' future medical costs at the cost of eviscerating their constitutional rights to seek redress in court.

The need for such a radical policy shift is not grounded in any data. In fact, similar experiments in Florida and Virginia are marked failures. Virginia enacted its Birth-Related Neurological Injury Compensation Act in 1987. Florida followed Virginia's lead the next year, passing the Birth-Related Neurological Injury Compensation Act (NICA) in 1988. It is noteworthy that over the ensuing twenty years and countless other "medical liability crises," no other state has enacted similar legislation.

Some key observations about these funds, and some applicable lessons are below:

- These funds were not intended to provide fair compensation for brain damaged infants and their families; they were intended to cap the financial liability of negligent doctors. The funding of these programs is based on fixed assessments paid by doctors and hospitals. As a result, program administrators, by design, give a higher priority to maintaining the funds' solvency levels than they do to publicizing the availability of compensation or paying the meager benefits provided to victims of negligence and their families.

- While participation in the fund is voluntary on the part of physicians, it is involuntary for infants and their families. If a physician elects to participate, then patients and their families are bound by that decision and must accept the benefits made available by fund administrators. The Web site for the Virginia fund notes that a large percentage of births state-wide are notionally covered by the fund:

"participating physicians and hospitals provide Program coverage to more than 65 percent of all births statewide and nearly 85 percent of births in Northern Virginia."[2]

- The single most notable attribute of these programs is their very small scale. It was predicted that Virginia would accept about 40 cases per year and Florida about 60. In fact, the Virginia program has accepted only 101 cases since 1988, an average of five per year.[3] Florida has done slightly better (Florida has more than two times the number of births annually than Virginia does). NICA, the Florida program, accepted a total of 211 claims through 2006, an average of 11 per year.[4]

- Even with this small claims load, and despite the fact that the stated purpose of these programs was intended to simplify and expedite the process, 93 percent of claimants in Florida use an attorney. The median time from injury to resolution in Florida is 899 days, or almost two-and-a-half years.[5]

- Although the Virginia fund has been badly underutilized by the injured, its existence did, sadly, allow dangerous physicians to continue practicing. "Barred from being sued, doctors and hospitals were supposed to get close scrutiny from disciplinary boards in each of the birth-injury petitions. Not a single action has been brought against a doctor or a hospital," wrote the *Richmond Times-Dispatch's* Bill McKelway, who has covered the fund's travails for years.[6] The existence of the fund, McKelway concludes, has removed any negative consequences for negligent behavior.

- The promises that these programs made – that they would be a no-fault plan to cover injured infants and render determinations of fault unnecessary – have been broken in practice. Instead, the funds impose additional work on injured families to prove they are deserving of compensation. While a family does not technically have to prove negligence, almost all injuries that will meet the program's eligibility requirements are, by definition, injuries that were actually caused by negligence at the time of delivery.[7] For example, in Virginia, families must prove all of the following elements of a claim: 1) child delivered by a participating doctor or hospital; 2) child who suffered a birth-related neurological injury, as defined by Virginia law; 3) injury must have resulted from oxygen deprivation or mechanical injury during labor, delivery, immediate post delivery; 4) child must be permanently motorically disabled and developmentally disabled or cognitively disabled; 5) child must need assistance with all daily living activities.

- There are significant damages that these funds never cover and that the child and family forfeit because they are unable to file a malpractice claim. For example, families are not compensated for the child's pain, mental anguish, disfigurement, or loss of ability to enjoy life. In many cases, these damages are significant and describe very real losses in quality of life.

- Virginia and Florida were prompted to create these funds because of a specific actual and threatened withdrawal of liability coverage for physicians delivering babies.[8] No similar danger exists today in New York.

Data on New York medical malpractice cases maintained by the NPDB indicate that neurological injuries (which fall under the "Quadriplegic, Brain Damage, Lifelong Care" outcome category) yield among the highest average medical malpractice payments in New York, which is unsurprising because such cases incur extensive economic and non-economic costs.

But payments for these injuries are in no way a major part of medical malpractice costs in New York. The "Quadriplegic, Brain Damage, Lifelong Care" category ranks halfway down the list – *fifth* – of ten outcome categories that show total amounts paid over the past three years (the years in which NPDB has tracked such data). That category of injuries ranks just below "Minor Permanent Injury" and just above "Major Temporary Injury." Notably, payments for neurological injuries are only a subset of the category that also includes compensation for "Quadriplegic" and "Lifelong Care" injuries.

The recent hike in medical liability premiums has nothing to do with patients' litigation behavior. Instead, the need for the hike, as we show in Section II of this report, was caused by the state's flawed rate setting and raid on its rainy day fund. The state should not consider proposals to provide immunity for negligent doctors and hospitals for some of the most serious injuries imaginable to New York's youngest, most vulnerable and defenseless citizens: newborn babies.

II. New York Government Primarily Responsible for Insurance Problems

Most of the blame for solvency issues claimed by the state's medical malpractice insurers lies with the New York state government.

During the 1990s, state officials left insurers in a precarious position by extracting $691 million from the surplus of a program that provides insurance for doctors who are unable to obtain commercial policies. The state further jeopardized insurers by calling for any shortfalls in the insurance program for high-risk doctors (those unable to obtain commercial insurance) to be borne solely by medical malpractice insurers. Previously, that risk was spread across all providers of property-casualty insurance.[9]

Meanwhile, state regulators kept annual insurance rate hikes stagnant for nearly a decade. As revenues from premiums lagged, insurers eventually had to dip into their reserves to cover claims for policies they issued. Additionally, insurers were required to absorb $525 million in losses between 2000 and March 2007 suffered by the program covering high-risk doctors.[10]

Recent Hikes Were Preceded by a Long Period of Stagnant Rates

Rate hikes in recent years largely made up for low rate increases throughout the latter half of the 1990s and early part of the current decade. From 1995 until 2003, medical malpractice insurance rates actually *declined* by an average of 1.4 percent per year. The average rate hike between 1991 and 2007 was only 3.5 percent, or slightly more than half of the overall U.S. medical inflation rate (6.5 percent).

Figure 8: Approved Medical Malpractice Insurance Rate Increases in New York, 1991-2008

Policy Year	% Change
1991-92	-5.0
1992-93	0.0
1993-94	14.0
1994-95	8.0
1995-96	0.0
1996-97	-10.0
1997-98	0.1
1998-99	0.0
1999-00	0.2
2000-01	-1.0
2001-02	-0.8
2002-03	0.0
2003-04	8.5
2004-05	7.0
2005-06	7.0
2006-07	9.0
2007-08	14.0
Average	3.5

Source: N.Y. Department of Insurance

When the industry began to suffer losses, its woes had as much to do with declining revenue as increasing payments. Medical malpractice insurers in New York actually collected $23.1 million *less* in premiums in 1999 in actual dollars than they had five years earlier.

Figure 9: Insurance Companies Premiums Received vs. Medical Malpractice Payments, 1991-2005

Year	N.Y. Premiums	Direct Losses Paid	Direct Losses Paid as a Pct. of Premiums Written
1991	$793,879,724	$409,388,834	51.6
1992	$811,974,970	$559,175,764	68.9
1993	$870,300,422	$615,013,468	70.7
1994	$923,163,546	$576,724,483	62.5
1995	$905,070,538	$544,403,418	60.2
1996	$822,075,016	$591,710,868	72.0
1997	$816,663,055	$598,744,431	73.3
1998	$886,935,822	$634,166,913	71.5
1999	$900,034,082	$795,112,336	88.3
2000	$849,687,717	$700,772,374	82.5
2001	$881,194,813	$698,555,720	79.3
2002	$992,924,544	$732,555,312	73.8
2003	$1,107,374,159	$781,788,782	70.6
2004	$1,284,228,574	$980,901,472	76.4
2005	$1,372,467,390	$935,093,278	68.1

Source**:** A.M. Best and Co., special data compilation for Americans for Insurance Reform.

New York's Disastrous Management of Pool for Risky Doctors Has Exacerbated Problems

A great deal of the malpractice insurance companies' financial troubles occurred because they were forced to cover losses borne by the Medical Malpractice Insurance Plan (MMIP), an insurance program for doctors who are unable to obtain conventional insurance. MMIP, which covers only about 1 percent of the state's physicians, lost about $525 million between its inception in 2000 and March 2007.

New York's irresponsible management of the insurance program in the 1990s is why these losses accrued to insurance companies' balance sheets, rather than being paid out of a reserve fund. Between 1992 and 1997, the state siphoned $691 million out of the program's surplus fund. In 2000, the state altered the program. Insurance policies from the Medical Malpractice Insurance Association (MMIA) were transferred to the Medical Malpractice Insurance Plan (MMIP).[11] And the new program required the state's medical malpractice insurance providers to cover any losses suffered by the MMIP. (In contrast, if MMIA had suffered losses they would have been covered by *all* of the state's property-casualty insurance providers.)

New York's insurance superintendent and its insurance companies acknowledge that MMIP's shortfall is largely responsible for the financial distress that the New York's medical malpractice insurers are facing. "Had MMIA's reserves been preserved and allowed to grow by collecting interest over the years instead of being so severely depleted, New York's medical malpractice insurers would be in much stronger financial position today, and the problem facing New York would be far less serious," New York State Insurance Superintendent Eric R. Dinallo said in a statement announcing the 14-percent rate hike for 2007.[12]

Insurance companies have provided similar assessments to the Medical Malpractice Liability Task Force.

- Donald J. Fager and Associates Inc., which manages both Medical Liability Mutual Insurance Company, or MLMIC (New York's largest provider of medical malpractice insurance) and the MMIP, reported to the task force that the assumed deficits from the MMIP had "caused a significant drag on the surplus and financial condition" of the state's malpractice insurance providers.[13]

- "PRI has lost a significant amount of its surplus due to the mandated MMIP pool losses and requests for rate increases which were not fully granted," another carrier, Physicians Reciprocal Insurers (PRI), wrote in a submission to the task force.[14]

- "The principal driver that has detracted from Academic's financial status is the MMIP," provider Academic Health Providers Insurance Association wrote in a different submission.[15]

John DeLosh, who manages MMIP on behalf of Medical Liability Mutual Insurance Company, told Public Citizen, "we'd be sitting pretty" if the money removed from the fund in the 1990s were replaced.[16]

DeLosh explained that MMIP also has suffered from several other handicaps:

- MMIP inherited insurance policies from MMIA that did not properly reflect the specialties or levels of risk of the doctors covered. For example, DeLosh said, some full-time obstetricians were classified in less-expensive categories. Other doctors were not being charged rates that accurately reflected the extent of risks they posed. These mistakes went unnoticed in the 1990s, when the insurance industry was doing well. But they became significant problems in the early part of this decade, when investment income dropped and claims increased.[17]

  DeLosh said that MMIP has since corrected this problem by changing doctors' classifications and applying surcharges it may impose on doctors with high claims' histories. This has resulted in some doctors shifting from high-risk specialties for which they were ill-suited to less risky specialties, he said. MMIP also benefited from steady annual rate increase approvals from the state that increased baseline premiums paid by participating doctors from 125 percent of commercial rates to 292 percent of commercial rates.[18]

"We think our present book of business is in a lot better shape," DeLosh told Public Citizen.[19]

In fact, a KPMG audit released in September showed that the MMIP turned a $6.1 million profit for the year ending June 30, 2006.[20]

- New York, which picks up the tab for what is known as "first layer excess insurance" for doctors who carry $1.3 million in primary insurance, set rates for this type of coverage too low to cover costs. ("First-layer excess insurance" provides $1 million in additional coverage for claims that exceed a New York physician's primary insurance policy.) The low rates set by the state prompted commercial insurers to abandon the "first-layer excess" market, resulting in a flood of physicians statewide turning to MMIP for their first-layer coverage. The number of first-layer excess policies provided by MMIP jumped from 292 in 2002 to 13,743 in 2004.[21] (The figure receded to 677 by mid-2007). Between 2000 and mid-2007, MMIP collected $101 million in first-layer excess premiums, for which it anticipates paying out $209 million in total claims.[22]

  MMIP's problems in the first-layer excess market were exacerbated, according to DeLosh, because the state has postponed paying its share of the premiums for as long as four years. "So we lost all that investment income," DeLosh said.[23]

MMIP's ratio of losses paid to premiums collected between 2000 and mid-2007 was 191 percent.[24] In contrast, the worst ratio for commercial insurers in any year since 1991 was 88 percent, in 1999. The commercial insurers' ratio was 61 percent in 2005.[25] (These figures do not include overhead or other expenses.)

Figure 10: MMIP's Premiums Received vs. Medical Malpractice Payments, 2000 Through Mid-2007

Type of Coverage Offered	# of Practitioners Covered (in 2007)	Premiums Collected (in millions)	Losses (in millions)*
Physicians (Primary)	510	$210	$332
First-layer Excess	677	$101	$209
Facilities	n/a	$79	$184
Second-layer Excess	n/a	$8	$14
Podiatrists	70	$7	$17
Dentists	216	$6	$33
Nurse Midwives	22	$1	$3

Source: MMIP

* Includes both payments already made and predicted losses.

Insurance Markets Are Generally Cyclical

New York's medical malpractice insurance market differs from those in other states because the state regulates annual rate increases. Nonetheless, the state has experienced many of the hallmarks of cyclical volatility in its insurance market. As Tom Baker noted in *The Medical Malpractice Myth*, "the insurance industry goes through a boom-and-bust cycle that creates medical malpractice insurance crises like the past one. Lawyers, judges, and juries have little or nothing to do with it."[26]

The property-casualty insurance industry readily acknowledges that its premiums result from market-driven cyclical shifts that are somewhat unrelated to claims. The Insurance Information Institute provides the following explanation of the cyclical nature of the property-casualty market (which includes medical malpractice insurance) on its Web site:

> A dominant factor in the [property-casualty] insurance cycle is intense competition within the industry. Premium rates drop as insurance companies compete vigorously to increase market share. As the market softens to the point that profits diminish or vanish completely, the capital needed to underwrite new business is depleted. In the up phase of the cycle, competition is less intense, underwriting standards become more stringent, the supply of insurance is limited due to the depletion of capital and, as a result, premiums rise. The prospect of higher profits draws more capital into the marketplace leading to more competition and the inevitable down phase of the cycle.[27]

In addition to these predictable but erratic market fluctuations, some of the increases in medical malpractice premiums, nationally, in 2001 through 2003 were likely caused, at least in part, by insurance companies' declining investment income. In submissions to the Medical Malpractice Liability Task Force, New York's companies point to declining investment income as contributing to their problems. One company noted, "investment returns for most insurance companies have decreased over time as a reflection of a long, historic low interest rate environment in the U.S."[28]

Medical malpractice premiums, nationally, appear likely to remain relatively stable in coming years because of the recent run-up in rates. "The financial results of medical malpractice insurers show the crisis in medical malpractice insurance in most states is lessening as premiums reach acceptable levels relative to costs," the Insurance Information Institute wrote in September 2007.[29]

New York's recent rate insurance shifts likely are out of sync with national trends because their rates are regulated by the state. New York's rates lagged behind national rate increases, which peaked in 2005 and have leveled off since then.[30]

III. Receiving Health Care in New York Is Unsafe

Although the state's need to play catch-up for nearly a decade of below-inflation rate increases is a primary reason for the recent run-up in rates, reducing the number of malpractice incidents would likely help lessen the effects of future cyclical jumps in premiums. And regardless of its favorable effect on premiums, improving patient safety for the residents of New York should be a top priority for the state's health care system for moral and ethical reasons. The data indicate that there truly is a patient safety emergency in the state of New York.

The available information on patient safety leads to two fundamental conclusions:

1. Improvements in patient safety will reduce malpractice claims in the long view (even if no immediate insurance rate reductions result); and

2. New York must take definitive steps now to improve its patient safety record. Far too many medical errors occur in New York.

The risk-management and reinsurance company, Aon, recently released a national study concluding that, nationally, medical malpractice hospital claims and the rate of increase in claim severity are at their lowest levels in eight years. Significantly, Aon concluded that "the nation's best hospitals, those recognized for their patient safety environments, exhibit significantly lower liability costs compared to national averages." Aon also found that "patient safety initiatives aimed at obstetrics and emergency departments are linked to reductions in the number of claims in those areas."[31]

The topic of medical error has been the focus of at least some attention over the past decade. In 1999, the Institute of Medicine of the U.S. National Academy of Sciences released a landmark report, *To Err is Human*. The report concluded that medical errors kill as many as 98,000 people in the United States every year, and called on medical providers and institutions to cut such mistakes in half in the ensuing five years.[32]

In January 2000, New York State Health Commissioner Antonia Novello pledged to meet the Institute of Medicine's goal of a 50 percent reduction in hospitals' medical errors within five years.[33] Seven years later, there is no evidence that such progress has been made.

We analyzed the incidence of easily preventable errors recorded in both the NPDB and in New York's Patient Occurrence Reporting and Tracking System (NYPORTS), a state system that tracks "unintended adverse or undesirable developments in an individual patient's condition occurring in a hospital."[34] We also cross-referenced the NYPORTS data with a recently issued set of adverse incidents – categorized by the federal government as "never events" because they should never happen – for which Medicare recently announced it will no longer provide reimbursement.

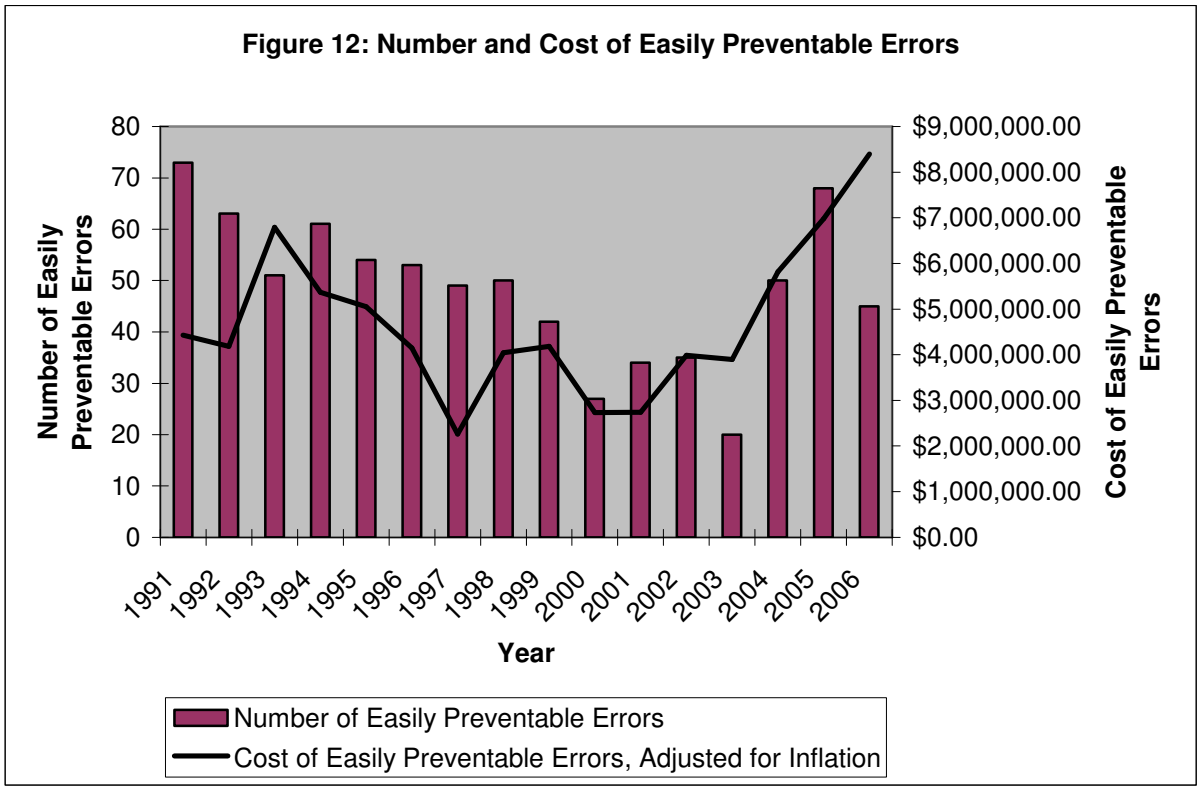
The data suggest that New York is failing to make significant headway in reducing avoidable errors, and may in fact be experiencing an increase in such errors.

The NBDB data indicate that while certain easily avoidable errors became less common in recent years, other grave errors increased, such as procedures on the "wrong patient." In 2006, New York saw a spate of payments for "wrong medication administered" and "wrong medication ordered." Other error categories – such as the number of payments for "surgical or other foreign body retained" and procedures on the "wrong body part" – remained unacceptably high in recent years, although their incidence today is somewhat below the unconscionably high levels that occurred between 1991 and 1999.

Figure 11: Easily Preventable Errors Resulting in Medical Malpractice Payments by NY Doctors

Allegation	Average, 1991-1999	Average, 2000-2006	2006
Surgical or Other Foreign Body Retained	29.8	18.4	19
Wrong Medication Administered	1.6	2.1	8
Wrong Medication Ordered	4.2	2.7	7
Wrong Body Part	8.9	4.9	6
Wrong Procedure or Treatment	9.8	3.7	3
Wrong Patient	0.0	0.9	2
Failure to Use Aseptic Technique	0.7	7.0	0
Wrong Blood Type	0.2	0.1	0

Source: National Practitioner Data Bank



Source: National Practitioner Data Bank

The NPDB does not attempt to track all adverse event in hospitals. Rather, the database merely logs the small share of incidents that result in medical malpractice payments. The more comprehensive NYPORTS statistics are intended to include all adverse incidents.

Adverse incidents are not synonymous with errors but many leave little room for any other conclusion. For instance, many NYPORTS codes are similar, though not identical, to Medicare's newly identified "Never Events" – events for which Medicare will soon refuse to pay, and for which hospitals will not be allowed to charge Medicare patients.[35]

New York's comptroller has characterized the NYPORTS data as incomplete. Still, the NYPORTS statistics present a far more disconcerting picture than the NPDB numbers. NYPORTS data show that inexcusable errors are shockingly common. The categories include serious errors such as "incorrect procedure or treatment – invasive" (which occurred 92.3 times per year since 1999, including 96 in 2005); "unintentionally retained foreign body" (92.3 per year; 90 in 2005); and "wrong patient, wrong site – surgical procedure" (22.6 per year; 19 in 2005).[36]

The data also indicate a shocking number of deaths occurring due to adverse incidents in hospitals. Between 1999 and 2005, an *average* of 555.3 deaths per year were reported in New York. That figure rose to 676 in 2005. Although these adverse incidents did not necessarily constitute errors, some undoubtedly did, and they warrant study.

Figure 13: Adverse Incidents Reported to NYPORTS, 1999-2005

NYPORTS Code Definition	Medicare "Never Events"	Average 1999-2005	2005
Death (e.g. brain death)		555.3	676
Serious occurrence warranting DOH notification (not covered by [certain other codes]		350.0	452
Malfunction Of Equipment during treatment or diagnosis, or a defective product Resulting In Death Or Serious Injury		330.3	413
Specific AMBULANCE Transfers to the hospital from an Article 28 diagnostic and treatment center, in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards		156.3	246
Termination Of Any Services Vital To The Continued Safe Operation Of The Hospital Or To The Health And Safety Of Its Patients And Personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food or contract services.		268.4	215
Impairment Of Limb, Organ or Body Functions. (limb, organ body function unable to function at same level prior to occurrence). In circumstances other than those related to the natural course of illness, disease or proper treatment (e.g., delay in treatment, diagnoses or an omission of care) in accordance with generally accepted medical standards.		96.4	212
Cardiac And/Or Respiratory Arrest Requiring ACLS Intervention.		101.6	103
Incorrect Procedure or Treatment - Invasive	Wrong surgical procedure on a patient	92.3	96
Unintentionally Retained Foreign Body (e.g., sponges, lap pads, instruments, guidewires from central line insertion, cut intravascular cannulas, needles)	Retention of a foreign object in a patient after surgery or other procedure	92.3	90
Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in loss or impairment of bodily functions.		106.9	56
Misadministration Of Radiation or Radioactive Material		32.6	55
Loss Of limb Or Organ. In circumstances other than those related to the natural course of illness, disease or proper treatment (e.g., delay in treatment, diagnoses or an omission of care) in accordance with generally accepted medical standards		30.4	38
Errors of omission resulting in death or serious injury related to the patient's underlying condition.		71.4	35
Hospital/Center Fire or other internal disaster disrupting patient care or causing harm to patients or staff.		32.0	29
Wrong Patient, Wrong Site Surgical Procedure	Surgery performed on the wrong body part Surgery performed on the wrong patient	22.6	19
Suicides And Attempted Suicides Related To An Inpatient Hospitalization, With Serious Injury.	Patient suicide, or attempted suicide resulting in serious disability, while being cared	32.1	12

NYPORTS Code Definition	Medicare "Never Events"	Average 1999-2005	2005
	for in a health care facility		
Elopement from hospital leading to death/serious injury	Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	6.3	8
Poisoning Occurring Within The Hospital (water, air, and food).		3.6	2
Rape Of A Patient. (Includes alleged rape with clinical confirmation).	Sexual assault on a patient within or on the grounds of a health care facility	4.0	2
Crime Resulting In Death Or Serious Injury.	Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care facility Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider Abduction of a patient of any age	2.9	1
Infant Abduction.	Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility	1.3	1
Infant Discharged To Wrong Family.	Infant discharged to the wrong person	0.1	0

Sources: State of New York Department of Health – New York Patient Occurrence Reporting and Tracking System Report 2002-2004 (Available at http://www.health.state.ny.us/nysdoh/hospital/nyports/annual_report/2002-2004/docs/2002-2004_nyports_annual_report.pdf), State of New York Department of Health, and Center for Medicare and Medicaid Services.

New York Hospitals Score Abysmally in National Rankings

An October 2007 report by Health Grades Inc., a company that measures health care safety, found that only 2.1 percent of New York's hospitals ranked among the top 15 percent nationally while a stunning 47 percent ranked among the bottom 15 percent nationally.[37] The same group in April 2006 ranked New York's patient-safety performance 49th out of 50 states.[38]

New York's Record of Disciplining Bad Doctors Is Shameful

Medical malpractice incidents tend to be concentrated among a small percentage of doctors. Typically, only a small percentage of those doctors receive any sort of disciplinary action, and New York is no exception to this sad general state of affairs.

Between September 1990 and December 2006, 6,186 New York doctors made two or more malpractice payments. For comparison purposes, that figure represents only 7.7 percent of the 80,681 licensed physicians in New York in the first half of 2007, and probably far less than 7.7 percent of doctors practicing in the time period. (New York almost certainly had significantly more than 80,681 licensed physicians since 1990 because the 2007 data represent only a snapshot in time.) But that small share of doctors was responsible for a whopping 71 percent of dollars paid out for medical malpractice in the time period. Barely one-in-twelve (8.5 percent) of physicians with two or more payments has experienced any license-related disciplinary actions by the state.

Just 3,052 physicians made three or more malpractice payments in the time-frame studied. Yet these physicians, who represent no more than 4 percent of the state's doctors in the time period and likely significantly less than that, have been responsible for nearly half (49.6 percent) of dollars paid for malpractice incidents since 1991. Of these doctors, only 10.8 percent have received licensure actions.

Even more troubling is the fact that less than a third (31.5 percent) of the doctors who made *ten or more* payments have had a reportable licensure disciplinary action.[iv]

Figure 14: Rate of Discipline Among Doctors Who Have Made Medical Malpractice Payments

Number of Payment Reports	Number of Doctors Who Made Payments	Sum of These Payments	Subset of Number of Doctors who had One or More Reportable Licensure Actions	Pct. of Doctors Who Made Payments Who had One or More Reportable Licensure Actions	Pct. of Total Dollars Paid Out Statewide
Total	15,624	$8,801,597,900	920	5.9	100.0
1	9,435	$2,547,679,350	393	4.2	28.9
2 or more	6,189	$6,253,918,550	527	8.5	71.1
3 or more	3,057	$4,369,937,700	332	10.9	49.6
4 or more	1,631	$3,032,795,700	213	13.1	34.5
5 or more	960	$2,173,580,200	141	14.7	24.7
10 or more	127	$482,470,250	40	31.5	5.5

Source: National Practitioner Data Bank

Below we provide brief profiles of several doctors who made at least five medical malpractice payments and yet had no licensure actions taken against them:

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

[iv] A June 2007 Public Citizen report ranked New York 17th among the 50 states and the District of Columbia in its rate of taking disciplinary action against its doctors. The state should not take solace in its relatively high ranking, however, as it mostly results from the sad state of medical oversight nationally.

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

- Physician number 226332 made 72 payments in 2005 alone, totaling $8.9 million. Each one of these was for "improper technique" during anesthesia.

- Physician number 24831 made eight payments totaling $8.7 million from 1993 to 2006. Six of the eight were for surgery-related incidents, including one payment for over $3.9 million.

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

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

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

- Physician number 164130 made eight payments in 2003 and 2005, totaling $7.7 million, all for "improper performance" during surgery.

- Physician number 25009 made 15 payments between 1992 and 2005, totaling $7.3 million, including 6 for surgery and six for diagnosis-related incidents.

New York Comptroller Calls for Improved Physician Oversight

In August of this year, the New York State Comptroller released a scathing report identifying several shortcomings in the physician-oversight responsibilities of the Department of Health's Office of Professional Medical Conduct (OPMC). Among his findings were the following:

1. OPMC has not adhered to its very minimal criteria for investigating physicians. OPMC's policy is to investigate physicians involved in medical malpractices cases whenever:

   - The settlement amount is greater than $500,000;
   - There is a judgment against the licensee; or
   - There is a death of a mother or child during childbirth.[39]

   But auditors found hundreds of instances in which OPMC either failed to satisfy these criteria or is in jeopardy of failing to do so. Auditors found 177 medical malpractice

cases – mostly reported in the National Practitioner Data Bank (NPDB) – that should have triggered an OPMC investigation but which the agency failed to investigate.[40] Auditors found an additional 154 cases in New York's Office of Court Administration system that the OPMC should have been tracking, but was not.[41]

2. OPMC should expand the medical malpractice criteria it uses to initiate investigations. Several other states with physician populations comparable to New York's investigate all of the doctors who are named in a particular number of lawsuits within a certain time span – most commonly, three cases within five years. Auditors found twelve physicians with three or more medical malpractice cases filed against them in the past three years. Three of the twelve were not investigated by OPMC.[42]

3. OPMC has failed to adequately collect information from other agencies that it is supposed to use to monitor physicians.[43] Auditors found that OPMC's information-sharing with other agencies is generally poor and, in some cases, non-existent. Auditors "identified instances where OPMC does not receive complaints from outside reporting entities, including instances involving potential fraud on the part of the licensee."[44] For instance, Medicare and Medicaid maintain lists of physicians whose actions have resulted in their suspension from the programs. Yet OPMC does not use these lists, and there are physicians on them whom OPMC has not investigated.

4. OPMC should begin to proactively identify potential incidents of medical misconduct. Currently, OPMC begins investigations of doctors only in response to passively collected information, including consumer complaints, information from the legal system, insurance reports, news reports, and information from other state and professional organizations. Auditors recommended that OPMC seize the initiative and seek out incidents of medical misconduct that are not publicized through other means.

5. OPMC must complete its investigations in a more timely manner. The auditors recommended instituting a formalized time standard to differentiate between cases that are moving too slowly and cases that take a long time as a result of their complexity. Often, OPMC investigations last longer than twelve months. For example, OPMC's New Rochelle office took more than a year to conduct each of 113 investigations during the time of the audit, representing 39 percent of its caseload.[45] When investigations move this slowly, "the public is at risk of receiving substandard medical care," auditors said.[46] Much of the problem stems from OPMC's insufficient and uneven funding; the Rochester field office closes its average case in 194 days, and the average full-time investigator manages 36 cases. In contrast, the New Rochelle field office closes its average case in 327 days, and its investigators carry an average of 60 cases each.

The state's negligent oversight was illustrated recently when it was discovered that health officials delayed notifying more than 600 people that they had potentially been exposed to deadly diseases by a single physician improperly reusing syringes. The state regards its investigation into the physician, Dr. Harvey Finkelstein, as "non-disciplinary."[47]

V. New York's Supply of Physicians Is Flourishing

The announcement in July 2007 of a 14-percent increase in medical malpractice premiums prompted a new wave of declarations that New York was facing a doctor-shortage crisis:

- "The impact of these rate hikes is tremendous .... We're seeing many Obs who aren't willing to stay in practice because they just can't afford it," members of the American College of Obstetricians and Gynecologists said.[48]

- "The 14-percent increase in physician medical liability insurance premiums announced today will severely worsen the health care access crisis that has already resulted in shortages in several specialties all across New York state," wrote a representative from the Medical Society of the State of New York.[49]

- "I am concerned that the increasing cost of medical liability insurance will drive some physicians out of the field and will discourage young people from entering the medical profession in the first place," state Health Commissioner Richard Daines said.[50]

But numerous facts belie the claim that New York is facing a doctor shortage. In fact, New York's supply of doctors is growing and is the healthiest it has been in at least a decade. Such a reality is particularly meaningful in New York because it already has one of the largest populations of physicians of any state. In 2005, New York had 339 patient care physicians per 100,000 people, almost 50 percent more than national rate of 239 per 100,000 people. Just two other states – Massachusetts and Maryland – as well as the District of Columbia, boast higher physician/population ratios.[51]

The health of New York's physician population extends to its population of specialists. The numbers of doctors in specializations often regarded as "at risk" by medical malpractice crisis proponents have, in most cases, risen even faster than the state's overall population of physicians. Even the specialty of obstetrics, which is routinely said to be suffering from shortages, boasts more physicians per birth in New York today than in 2000, before the alleged "crisis" began.

We used several data sources to evaluate the population of New York physicians. Although the data sources employ different methodologies and, therefore, yield some disparate results, they invariably point to upward trends in the availability of doctors, including specialists. Sources consulted were:

- The New York State Education Department (NYSED), which issues licenses to physicians and publishes aggregated statistics.

- The Federation of State Medical Boards (FSMB), which publishes statistics on the number of physicians practicing in-state as part of its yearly report.

- The Center for Health Workforce Studies (CHWS) at the University of Albany School of Public Health, which has used survey responses to calculate the number of active physicians by specialty area for each year from 2001 to 2005. (2006 data is not yet available).

- The American Board of Medical Specialties, which annually reports the number of physicians who are board certified, by specialty and state, providing insight into shifts in populations of specialists.

The Number of Licensed Physicians in New York Has Been on the Rise

From 1995 to 2007, the number of physicians licensed by the New York State Education Department rose from 66,817 to 80,681. This represented a 20.7 percent increase in the actual number of physicians and a 15.8 percent increase in the number of physicians per 100,000 New Yorkers. Between 2000 (before New York's alleged medical malpractice insurance crisis began) and 2007, the total number of physicians in the state increased 11.6 percent, or 9.8 percent when adjusted for the state's population.

Figure 15: Number of Licensed Physicians in New York, 1995-2006

Year	Number of Licensed Physicians	Change in Number Physicians over Previous Year	Physicians per 100,000 Residents	Change in number of Physicians per 100,000 Residents over Previous Year
1995	66,817	-	360.7	-
1996	68,273	+1,456	367.3	+6.6
1997	68,827	+554	368.9	+1.6
1998	70,180	+1,353	374.2	+5.3
1999	71,259	+1,079	377.4	+3.2
2000	72,290	+1,031	380.5	+3.1
2001	72,816	+526	381.3	+0.8
2002	74,063	+1,247	386.4	+5.1
2003	75,117	+1,054	390.5	+4.1
2004	76,843	+1,726	398.3	+7.8
2005	78,306	+1,463	405.4	+7.1
2007	80,681	+2,375	417.9	+12.5

Source: New York State Education Department and U.S. Census.

* 2007 figures are for first half of the year. All other figures reported (except for 1996) are for second half of the year. Public Citizen was unable to obtain 2006 data from the New York State Education Department.

The Number of Practicing Physicians in New York Has Risen Markedly

Some doctor-shortage claims hinge on alleged shortages of *practicing* physicians (rather than *licensed* physicians). But, New York saw a 16-percent increase in practicing physicians between 1996 and 2006, or an 11.7 percent increase when analyzed on a per capita basis.

Figure 16: Number of Practicing Physicians in New York, 1996-2006

Year	Total Number of Licensed Physicians Practicing In-State	Change in Physicians over Previous Year	Physicians per 100,000 Residents	Change in Number of Physicians per 100,000 Residents over Previous Year
1994	55,189	--	299.0	--
1995	51,193	-3,996	276.4	-22.6
1996	53,409	2,216	287.3	11.0
1997	53,409	0	286.3	-1.0
1998	54,926	+1,517	292.8	6.6
1999	55,732	+806	295.1	2.3
2000	55,531	-201	292.3	-2.9
2001	56,995	+1,464	298.5	6.2
2002	56,995	0	297.4	-1.1
2003	59,581	+2,586	309.7	12.3
2004	59,581	0	308.8	-0.9
2005	63,427	+3,846	328.4	19.5
2006	61,931	-1,496	320.8	-7.6

Source: Federation of State Medical Boards and U.S. Census

The Number of Full-Time Equivalent Physicians in New York Has Risen Markedly

Some doctor-shortage claims have focused on alleged reductions in the hours worked by doctors, leading to a conclusion that doctor availability is lessened even if the total number of doctors is the same or higher. But the best available evidence contradicts this claim.

The Center for Health Workforce Studies found that the number of active patient care physicians increased by 3,752 and the number of full-time equivalents (FTE's) increased 3,044.[52]

Both the per capita number of physicians in active care and the per capita number of full-time-equivalent physicians in active care increased 5 percent between 2001 and 2005.

Figure 16: Full-Time Equivalent Physicians in Active Care 2001-2005

Specialty Group*	Total FTEs	Change in Number of FTEs	FTEs Per 100k People	Percentage Change in FTEs Per capita
Primary Care	16,379	1,013	85	+6%
Specialists (Total)	38,062	2,468	197	+6%
IM	7,349	780	38	+11%
GS	1,427	-224	7	-14%
Surgery Specialists	6,612	175	34	+2%
Facility Based	7,777	983	40	+13%
Psychiatry	4,948	1	26	-1%
Total Physicians in Active Care	55,390	3,044	287	+5%

Source: Center for Health Workforce Studies

* Other physician specialties are not displayed but are included in the specialists total.

* Table excludes Ob-Gyns, which are discussed in more detail below.

The Number of Obstetricians in New York Is Keeping Pace with the Population

The Center for Health Workforce Studies reports that New York experienced a modest (2.8 percent) decline in the number of Ob-Gyns between 2000 and 2005. CHWS's research on the subject is particularly relevant because the Center distinguishes between Ob-Gyns who practice only gynecology and those who also practice obstetrics.

In April 2006, the Center issued a report on trends regarding the numbers of practicing Ob-Gyns. While groups that seek to portray the state's availability of doctors as a crisis seized on the Center's report of a modest decline in Ob-Gyns as evidence to buttress their argument, they ignored a major caveat. The Center concluded that "demographic changes appear to be contributing to a reduction in demand for some obstetrical services in New York."

According to the Center's data, which is obtained by surveys and is subject to some margin of error, the number of obstetricians in relation to women of childbearing age (CBA) in the state fell by only 0.7 percent between 2000 and 2005, and the number of obstetricians in relation to the state's birthrate grew by 2.4 percent.

Figure 17: Practicing Obstetricians, 2000-2005

Year	Practicing Obs.	Obs. Per 100,000 Women of CBA	Obs. Per 100,000 Births
2000	2,368	56.2	916.2
2004	2,275	54.8	913.7
2005	2,302	55.8	938.1
Pct. Change: 2000-2005	-2.8%	-0.7%	2.4%

Source: Center for Health Workforce Studies, U.S. Census, New York State Department of Health

The Number of Specialists in New York Is Increasing

Medical malpractice crisis mongers often claim shortages of desirable medical specialists. But this argument does not bear fruit either. The number of practicing physicians in New York in four specializations often deemed "at risk" because of insurance rate increases – anesthesiology, emergency medicine, internal medicine and neurosurgery – all increased by more than 50 percent since 1996. (Emergency medicine specialists have more than doubled.) Meanwhile, the number of surgeons went up by 19.6 percent.

The population of practitioners of each specialty per capita also increased substantially. Per capita increases ranged from 15.2 percent for surgeons to 102.4 percent for emergency medicine specialists.

Figure 18: Actual Number of Physicians in 'At-Risk' Specialties, 1996-2006*

Year	Anesthesiologists per 100,000 Residents	Emergency Medicine Specialists per 100,000 Residents	Internal Medicine Specialists per 100,000 Residents	Neurosurgeons per 100,000 Residents	Surgeons per 100,000 Residents
1996	9.7	3.6	64.1	1.1	13.8
1997	10.5	4.0	68.2	1.1	14.0
1998	11.0	4.4	74.1	1.2	14.1
1999	11.6	4.7	78.4	1.9**	14.3
2000	12.1	5.0	82.2	1.2	14.5
2001	12.5	5.3	86.4	1.3	14.6
2002	12.7	5.7	90.7	1.3	14.8
2003	13.5	5.9	94.8	1.5	15.1
2004	13.3	6.3	92.3	1.5	14.8
2005	13.7	6.7	93.5	1.5	14.9
2006	14.1	7.3	93.5	1.6	15.9
Pct. Change: 1996-2006	+45.1%	+102.4%	+45.9%	+46.3%	+15.2%

Source: American Board of Medical Specialties, U.S.Census
* Excludes Ob-Gyns, which are discussed above.
** Number is highly aberrational and may be incorrect.

New York Is Training More Doctors than any Other State

A recent article in the *Journal of the American Medical Association* raved over New York's success in training doctors. "With over 15,000 residents and fellows training in more than 1,100 programs in the state, New York is, by far, the nation's leader in graduate medical education. Its nearest competitor, California, has fewer than 60 percent as many residents and fellows in training."[53]

Figure 19: Residents and Fellows on Duty December 1, 2006

State	Residents/Fellows
New York	15,548
California	9,088
Pennsylvania	7,110
Texas	6,633
Illinois	5,781

Source: *Journal of the American Medical Association*, Vol. 298 No. 4, July 25, 2007, p. 1088-1089.

Key Finding: Malpractice Insurance Increases Do Not Decrease the Number of Doctors

Alleged doctor-shortage crises resulting from hikes in malpractice insurance rates crop up in fairly predictable cycles. Consider the following claim of the New York chapter of the American College of Obstetricians and Gynecologists (ACOG), as reported in the *New York Times*: "Nearly 10 percent of the state's approximately 2,000 obstetricians are abandoning baby delivery each year, converting their practices to gynecology or general medicine. The effect on prenatal care in the state has been compounded, many obstetricians say, by a tendency of doctors who remain in the field to avoid treating women whom they consider high risks."[54]

Although this ACOG message sounds strikingly familiar to alarms the group sounded in the summer of 2007, it is, in fact, from 1988.

The facts do not support the widely perpetuated myth that sudden hikes in malpractice insurance rates trigger physician shortages. In fact, the number of physicians who restrict or leave their practices in periods of rapid rate increases is no greater than the number who leave during normal, non "crisis" periods.

The Harvard School of Public Health's Michelle Mello and co-authors in a study funded by the Pew Charitable Trusts found that the number of physicians in "high risk" specialties in Pennsylvania who restricted or left their practices did not increase during that state's purported malpractice "crisis."[55]

Using the administrative records of more than 47,000 doctors, including medical residents, from a state-run insurance fund in which most Pennsylvania doctors must participate, Mello and her colleagues looked closely at the behavior of physicians during that state's so-called "crisis" in 1999-2002, when medical malpractice insurance premiums rose sharply.

Contrary to predictions based on earlier physician surveys, they found that only a small percentage of high risk specialists reduced their scope of practice in the crisis period. "What's more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion that did so during 1993-1998, before premiums spiked."

Below are a few further telling details on the study's findings:

- Fewer than 3 percent of high-risk specialists shifted annually from performing major procedures to only minor procedures or no procedures.

- Only 8.2 percent of specialists performing only minor procedures stopped doing any procedures, shifting entirely to evaluation and management.

- Most critically, the proportion of high-risk specialists who restricted their practices during the "crisis" period was not statistically different from the proportion that did so between 1993 and 1998, before premiums spiked.

- The number of high-risk specialists who stopped practicing in Pennsylvania altogether during that state's "crisis" period was more substantial: on average 15.5 percent left each year between 1999 and 2002. However, this percentage was not statistically different from the proportion of high-risk specialists who left the state during the pre-"crisis" period from 1993 to 1998, nor was it statistically different from the proportion of physicians in a comparison group of "low-risk" specialties who also left the state during the "crisis" period.

- Moreover, when new physicians coming into the state were taken into account, the overall supply of specialists in high-risk fields *did not decrease* during the "crisis" period, except in obstetrics-gynecology. The ranks of Pennsylvania Ob-Gyns dipped 8 percent from 1999 to 2002, but "this trend had begun before liability premiums soared, and it did not accelerate noticeably afterward. Further, the total number of physicians delivering babies, including family/general practitioners, did not fall significantly as a proportion of the population during the crisis," Mello and her co-authors wrote.

Don't Believe It: Why Doctor Surveys on Medical Malpractice Insurance Impacts Are Misleading

"Our analysis found more modest effects of the liability crisis on physician supply than have been suggested by physician survey studies, including our own," Mello observed. In Mello's earlier survey, "one-third or more reported their intention to retire or relocate their practices out of state within the next two years, and nearly half reported having reduced or eliminated high-risk aspects of their practices."

Mello and her co-authors identified several reasons why these survey results might have overstated the actual practice:

- Survey results may exhibit "response bias."

- Conducting surveys only during periods of "crisis" – in which doctors overestimate the impact of medical malpractice insurance rate hikes on their practices – does not afford a realistic comparison to baseline rates of similar changes under different conditions. (For example the 8 percent "crisis"-period decrease in the number of Pennsylvania Ob-Gyns

may have appeared significant in isolation but, in fact, turned out to be part of an ongoing trend.)

- Physician self-reports may inaccurately predict what doctors actually do in the future. "One study found that only 35 percent of surveyed physicians who reported an intention to cease clinical practice within three years actually did so," Mello and her co-authors wrote.

Pennsylvania's experience is a lesson for New York. New Yorkers should resist the temptation to be swayed by survey-based claims that high-risk medical specialists will be driven from practice or forced to make undesirable practice changes due to an increase in liability premiums. In fact, as this report demonstrates, the physician population in New York is growing both overall and in most key specialty areas.

V. New York Doctors' Incomes Will Likely Be Unaffected By Rising Insurance Premiums

New York obstetricians say they are facing another crisis caused by increasing medical liability insurance premiums. The American College of Obstetricians and Gynecologists (ACOG) and the Medical Society of New York both say rising premiums will reduce the number of Ob-Gyns who can afford to practice. "We're seeing many Obs who aren't willing to stay in practice because they just can't afford it. Nationwide, malpractice-insurance premiums for Ob-Gyns constitute about 5 percent of expenses. In New York State, they are 36 percent," ACOG's Donna Williams said.[56]

Neither ACOG nor New York's Medical Society, however, have provided detailed information on the net income earned by Ob-Gyns in New York over the past fifteen years. Without that type of information, it is impossible to evaluate these claims.[57]

Understanding premiums' effect on medical practices requires comparing actual premiums paid with total practice expenses and net practice income, according to authors Marc A. Rodwin and colleagues in a significant analysis published in 2006 issue of *Health Affairs*.[58]

In a groundbreaking analysis of survey data conducted from 1970 to 2000 by the American Medical Association Center for Health Services Research and its successor, the Center for Health Policy Research, the authors concluded, "to paraphrase Mark Twain's comment on reading his obituary in a newspaper, the reported recent demise of medical practice as a result of rising malpractice premiums has been greatly exaggerated."

The points below were among the study's key findings:

- Premiums have consistently made up only a small percentage of total practice expenses (except in the area of anesthesiology, a specialty that has much lower-than-average expenses aside from premiums);

- Premiums increased between 1996 and 2000 but had little impact on total practice expenses or net practice income nationally, within regions, or within practice specialties; and

- Claims that the level of malpractice premiums justifies a tax credit (or other financial relief) to prevent physicians from leaving the practice of medicine are absurd, especially when physicians' income is taken into consideration. The average physician's income in 2003 was between the 95th and 99th percentile for all Americans.

A second study using different data came to a very similar conclusion. "Physician net incomes were not reduced by high or rising premiums, and that gross practice revenues were higher when premiums were higher," Mark Pauly and co-authors concluded in an article published in *Forum for Health Economics & Policy*.[59]

The study, which relied on the Medical Group Management Association's (MGMA) annual survey data of a large set of single specialty group practices for the years 1994, 1998 and 2002, reached the following conclusions:

- In a large nationwide sample of group practices, higher malpractice premiums did not depress physician net incomes; and

- By increasing prices and increasing quantity of profitable outputs, the physicians studied were able to offset the effect of higher premiums on their incomes.

VI. Recommendations

The following recommendations provide general input based on our research regarding ways that New York could alleviate its insurance-industry difficulties and improve its patient-safety record. The suggestions are not meant to be comprehensive.

Insurance

1. In a manner consistent with other health priorities, New York should restore the $691 million that was removed from the high-risk doctors' insurance pool in the 1990s. The resulting funds, if unneeded, should be kept in reserve to insulate the state against future malpractice insurance crises or used for patient safety initiatives to offset the fund's accommodation of high-risk doctors.

2. New York should consider mandating a minimum cost-of-living adjustment to the annual increase to medical malpractice premiums. This step could help to mitigate the cyclical nature of premiums in the state.

3. New York should ensure that its law guaranteeing the availability of insurance to licensed doctors does not require better-performing doctors – those who are able to obtain commercial insurance – to subsidize the premiums of very high-risk physicians. It should also re-evaluate the wisdom of – and the impact on patients of – its policy to insure all of the state's physicians, including those with very poor records.

Patient Safety

1. A new task force should be appointed to investigate ways to improve patient safety in New York. This task force should focus on malpractice trends among facilities, procedures and specialties to determine areas ripe for improvement and it should recommend corresponding best-practices. The task force should investigate the sources and causes of the inexcusable errors that Medicare has labeled "never" events – such as wrong limb surgeries – and adverse incidents resulting in deaths, which have claimed the lives of an average of 555 New Yorkers every year since 1999. It should make bold recommendations to reduce these incidents dramatically.

2. The state's licensing board should affirmatively confirm that physicians who are unable to obtain commercial insurance are suited to continue practicing medicine. On the whole, these doctors commit malpractice at an alarming rate. Although they make up only about 1 percent of the state's physicians and the premiums they pay have grown to nearly three times conventional malpractice insurance rates, these doctors were chiefly responsible for the roughly $500 million in red ink suffered this decade by the insurance program that covers them. The obligation of commercial insurance providers to cover the insurance program's losses is, in turn, largely responsible for their solvency problems.

   At a minimum, the administrator of the high-risk doctors' insurance program should have unrestricted authority to notify the state's licensing board about physicians who are ill-suited

to continue practicing. The licensing board should, in turn, be required to provide the insurance program with a written, public response.

3. New York's Department of Health's Office of Professional Medical Conduct should follow the recommendations of the state's comptroller. Namely:

   - The office should ensure that doctors meeting current medical malpractice criteria for investigation are, in fact, investigated;

   - The office should broaden the medical malpractice criteria it uses to launch investigations;

   - The office should develop a means to proactively identify potential incidents of medical misconduct, rather than relying on referrals from other agencies or medical malpractice records;

   - The office should establish proper information-sharing channels with other agencies; and

   - The office should ensure that investigations are completed in a timely manner.

Endnotes

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[11] *Id.*
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