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**TESTIMONY OF DR. DAVID T. HANNAN, MD  
PRESIDENT, MEDICAL SOCIETY OF THE STATE OF NEW YORK**

**to a**

**SENATE HEALTH, INSURANCE AND CODES COMMITTEE HEARING**

**regarding**

**MEDICAL MALPRACTICE REFORM**

**December 1, 2009**

**Albany, New York**

Good morning. My name is Dr. David Hannan. I am a family physician in Marion, New York, and the President of the Medical Society of the State of New York. I am also the Chair of the American Medical Association's Council on Legislation. On behalf of MSSNY, I wish to thank you for holding this hearing to discuss this most critical issue facing not only New York's physicians and hospitals, but most importantly the patients who need the care we provide.

Initially, I would like to note that we recognize the very complex nature of this issue, and are committed to working with you to find a comprehensive solution to this long-standing problem. Certainly, we recognize that any realistic solution to this problem must be multi-faceted, encompassing litigation reforms, insurance reforms and patient safety reforms.

In each of the last two years, thousands of physicians across New York have boarded buses long before first light, and stood in the drenching rain and freezing cold on the steps of the State Capitol to demonstrate to their legislators the critical need for reforms to protect the ability of patients to access needed care. Why have they done this? Simply stated, they have done this to make very clear their concern that the care they and their colleagues provide to their patients is jeopardized because of rapidly rising overhead costs led by liability costs. These increases have been exacerbated because they are occurring against a backdrop of stagnant and in many cases decreasing reimbursement from health plans.

To make matters worse, physicians face a 21% cut in their Medicare reimbursement unless Congress acts to change the infamous Sustainable Growth Rate methodology used to set physicians fees under Medicare.

While Congress has intervened to prevent past cuts, Medicare physician reimbursement has essentially remained level since 2001 while all the other costs of running a practice have risen precipitously over the period of almost a decade.

As you know, in each of the last two legislative sessions, the New York State Legislature and Governor Paterson have enacted legislation that prevented for the 2008 and 2009 policy years the imposition of a medical liability insurance premium rate increase or the imposition of a surcharge to make up for past insurance company deficits. We thank you for taking this important action which prevented potential double digit premium increases and premium surcharges in each of these policy years. Had these increases been implemented, there would have been severe consequences to access to care in New York's world-renowned health care system. Many physicians simply would have been unable to pay for these significant increases on top of the already outrageously high premiums they must already pay.

However, while these freezes have been important to providing physicians some much needed stability, they have addressed only the symptom and not the cause of the problem. The freezes have bought us some time to work to find a real solution. It is essential that we do so.

When combined with the ongoing difficulty facing physicians in receiving fair reimbursement from both commercial health insurers as well as government-sponsored plans such as Medicare, any increases in liability costs will lead to a care access disaster in New York State.

We have been very supportive of efforts occurring at the federal level to increase access to affordable health insurance coverage. It must be made very clear, however, that failure to address the unsustainable cost of medical liability insurance will greatly undermine these efforts. You cannot have health system reform unless you assure an adequate supply of physicians to provide needed care to patients.

The double digit increases in medical liability costs which were prevented by the legislatively enacted rate “freezes” would have been on top of premium increases of 14% imposed on physicians for the 2007-08 policy year, and the 55-80% increases in premiums paid by New York’s physicians over the 5 years leading up to the 2008 “freeze”. Viewed from an individual physician’s standpoint, the premiums paid by many specialists in New York have reached level in **the hundreds of thousands of dollars**.

Even with the enactment of these “freezes”, for just a single year of coverage:

- a Long Island neurosurgeon pays over \$300,000;
- an Ob-GYN in the Bronx, Brooklyn, Queens and Staten Island pays over \$170,000; and
- an orthopedic surgeon in Westchester, Orange and Rockland Counties pays almost \$110,000.

Overall, from 2003-2008, liability insurance costs for ER physicians rose 72-80%, general surgeons 72-80%, neurosurgeons 72-80% internists 72-80%, radiologists 63-72%, and OB-GYNs 63-72% (see below chart).

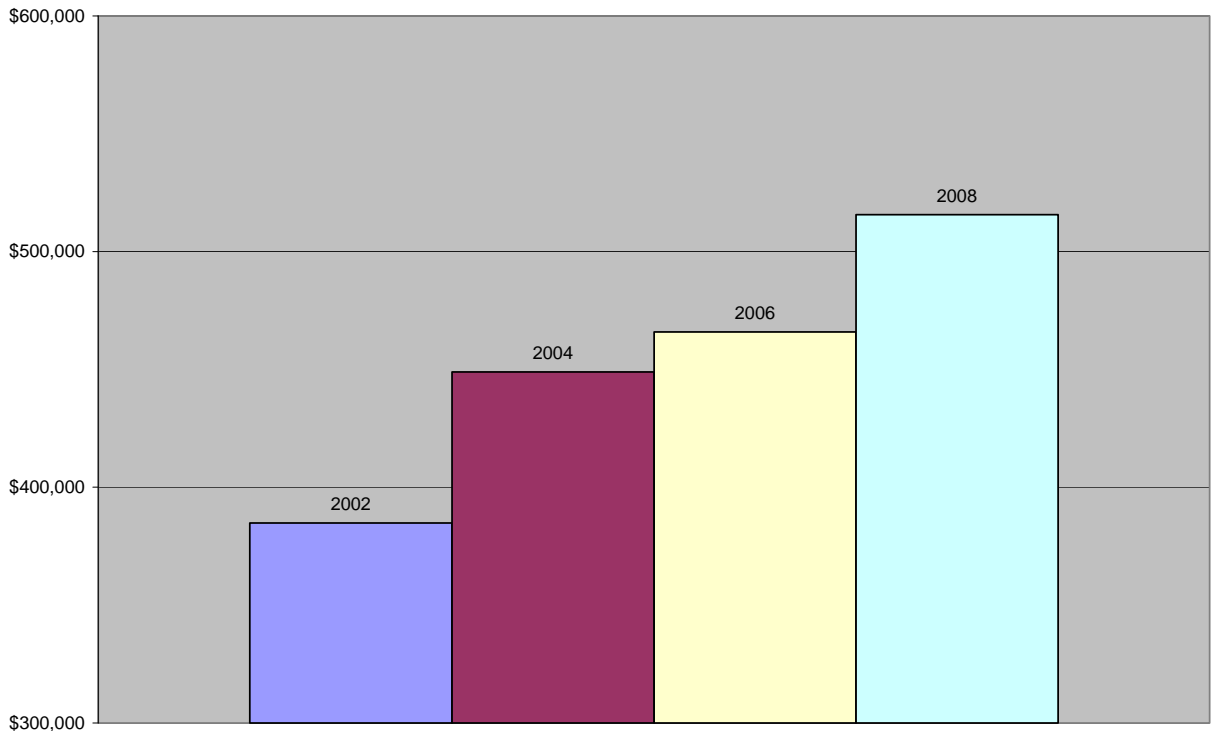
#### **MEDICAL LIABILITY PREMIUMS – OB-GYNs**

<b>OB-GYN</b>	<b>2002-03</b>	<b>2007-08</b>
Lower Hudson Valley, Manhattan	\$89,319	\$145,900 (+63%)
Outer Boroughs	\$100,904	\$173,065 (+72%)
Long Island	\$115,431	\$188,553 (+63%)
Poughkeepsie, Newburgh (mid-Hudson Valley)	\$54,829	\$89,561 (+63%)
Albany, Syracuse, Binghamton	\$32,539	\$53,151 (+63%)

Source: MLMIC

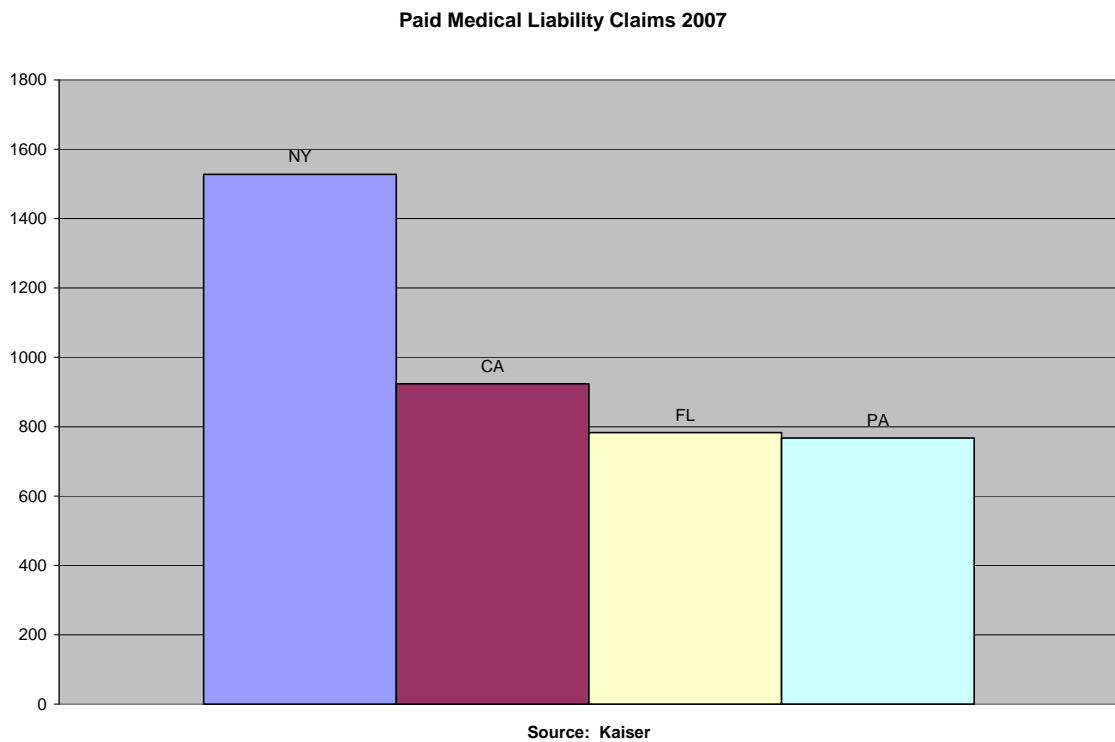
Since 2002, the average payout for medical liability claims for claims has increased steadily, from \$382,000 in 2002, to over \$505,000 in 2008.

Average Per Claim Payout--MLMIC 2002-2008



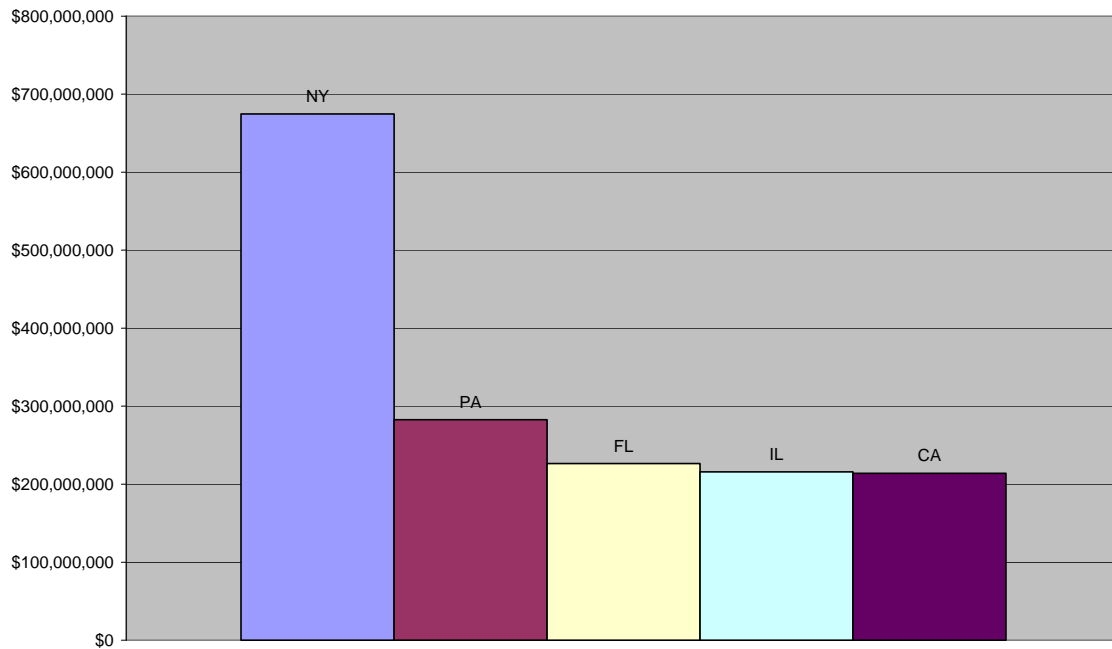
Malpractice payouts in New York State are far out of proportion to the rest of country. For example, according to Kaiser State Health Facts, In 2008, New York again had by far and away the highest number of paid medical liability claims (1,373) than any other state in the country, more than 50% more than California (900), more than 60% more than Florida (843), more

than 75% more than Pennsylvania (776), and nearly three times more than Texas (464). In 2007, New York State also had by far and away the highest number of paid medical liability claims in the country (1,528), almost 70% more than California (924) and twice that of Florida (783) and Pennsylvania (767).



Kaiser statistics also showed that New York State had the highest cumulative medical liability payouts in 2007 (\$674,683,750), more than two times greater than the states with the next highest amounts, Pennsylvania (\$282,611,000), Florida (\$226,487,600), Illinois (\$215,890,000) and California (\$214,115,050). In 2008, New York again had cumulative medical liability payouts (over \$640 million) that were more than two times that of Pennsylvania (\$280 million) and Florida (\$235 million), the second and third highest ranked states.

Cumulative Medical Liability Payouts 2007



Source: Kaiser

As was articulated in the notice of today’s hearing, this is a long standing problem that goes back decades. The medical liability insurance market in New York State has historically been tumultuous, marked by cyclical crises of monumental proportion for physicians, insurers and the public at large, followed by periods of relative stability albeit at or approaching the highest premium levels in the nation. A major problem is that there is a relatively few number of overall insureds when compared to the very significant numbers of physicians who are sued. This problem is even more dramatic for physicians practicing in specialties which treat a greater number of high-risk patients, such as neurosurgery, obstetrics, orthopedic surgery and other surgical specialists.

### **The 1970s Crisis**

Beginning in 1973, a series of events compromised both the availability and affordability of medical malpractice insurance. Back then, the medical

liability insurance market was largely divided between two companies - the Employers Insurance Company of Wausau and the Professional Insurance Company of New York. In the fall of 1973, Professional was placed in liquidation by the Department of Insurance. Soon thereafter, Employers announced its decision to withdraw from the New York medical liability insurance market. Shortly before the departure of Employers, The Medical Society of the State of New York (MSSNY) was able to secure an agreement with the Argonaut Insurance Company to insure MSSNY members at a rate 93.5% higher than Employers! Within six months, however, Argonaut sought to raise rates by an additional 196.8%. The Department of Insurance blocked the increase and Argonaut left the New York market.

For physicians, a crisis of monumental proportion was at hand. The frequency and severity of medical malpractice lawsuits were rising astronomically. No insurance company would write medical liability insurance. Physicians were faced with the prospect of practicing in New York's highly litigious environment without insurance protections, leaving themselves and their families vulnerable and exposed to financial devastation. This was not possible.

MSSNY, working closely with the Department of Insurance, successfully argued for the passage of legislation in 1975 which began to address the problem. It created the Medical Malpractice Insurance Association (MMIA), a joint underwriting association composed of all insurance companies writing liability insurance in New York. MMIA was required to underwrite medical liability insurance for New York physicians who needed it. During its years of operation, MMIA proved to be an important player in the medical liability insurance market and, for a critical period of time, was unique as an underwriter of both the primary market and later, the excess

market lines and later still, as a funding source for the excess liability insurance product.

However, many of MMIA's member insurance companies resented having to support a joint underwriting association and actually questioned its constitutionality. Recognizing the obvious disadvantages of purchasing insurance from an unwilling seller, MSSNY, through its leadership, and with the support of thousands of individual physicians, was a primary moving force in the creation of the Medical Liability Mutual Insurance Company (MLMIC) in 1975. MLMIC, a mutual company owned and managed by physicians, soon became the major medical malpractice insurer in New York State. By the end of the following year, MMIA insured 4,000 physicians, and MLMIC insured 16,000 physicians.

Simply creating an insurance vehicle, however, was only one of the steps which had to be taken to avoid a health care catastrophe at that time. Critical as well to assuring a steady physician supply in New York was the enactment of legislation in 1975 and 1976 that made several necessary changes in the laws defining the liability risk being insured against including refining the statute of limitations, the informed consent rule, permitting award offsets for collateral sources, requiring the Superintendent of Insurance to approve premiums, and putting into place some limitations on attorney contingency fees. The legislation also established in statute the physician disciplinary authority of the Office of Professional Medical Conduct as well as other steps directed toward enhanced quality. Once the crisis of 1975 was averted, several other insurers and risk retention groups entered the market to offer primary medical liability insurance. However, the situation was still very fragile and so the total number of carriers never reached a high level.

Finally, it should be noted that, concurrent with the reforms enacted in 1975, Governor Carey created a commission (the Special Advisory Panel on Medical Malpractice, also known as the “McGill Commission”) that outlined a series of recommendations to reform the system for adjudicating medical liability claims. Interestingly the first recommendation of the 17 noted the fundamental instability of the medical malpractice market:

*“Inasmuch as the present tort law/liability insurance system for medical malpractice will eventually break down and costs have and will continue to rise to unacceptable levels, fundamental reform of the present tort law/liability insurance system should be undertaken. While the Panel does not recommend a specific compensation plan, the overriding concern should be to create a system of compensation for adverse medical outcomes resulting from medical treatment, whether or not caused by negligence. Such a system should be coordinated with other compensation systems and should limit compensation to the bona fide need of patients.”*

Obviously, this fundamental change was not made, thereby sealing our destiny to repeat over and over again the harsh consequences of a fatally flawed medical negligence adjudication system.

### **The 1980s Crisis**

Heavy litigation and skyrocketing rates marked the early and mid-eighties. Despite the changes in 1975 and 1976, the frequency of cases rose and at the same time, the severity of the awards increased substantially as well. As a result, by 1985, the rates had skyrocketed to a level of many times greater than they were in 1974, causing great concern within the medical community and among the public at large.

Moreover, physicians were also fearful that, despite the unconscionably high premiums for the policies they were purchasing, which covered up to \$1 million per claim, with an aggregate of \$3 million per year, such policies would prove to be insufficient in light of the growing number of multi-million dollar verdicts.

In response, a series of further reforms were enacted in 1985 and 1986, although the Legislature stopped short of enacting the one reform that would have, more than any other measure, stabilized the cost of medical liability insurance - a cap on non-economic loss. Among the reforms were measures such as the “Certificate of Merit” rule; some limitation on what had been overly expansive joint and several liability rules; and, of course, the creation of the Excess Medical Malpractice Insurance Program. One of the most important of the reforms enacted at that time was a provision to permit periodic payment of economic and non-economic future damages over \$250,000. Unfortunately, the benefit of this statute in placing some controls on the cost of liability insurance was “guttled” by an expansive interpretation by the Court of Appeals in the 2003 Desiderio decision. The subsequent statutory “fix” did little to restore the actuarial savings that had been thought to accrue from the statute when it was first enacted.

Yet despite these reforms, the problem relating to the cost of medical liability insurance still has not been addressed. We are again in an untenable situation because of this increase in severity of awards. If physicians cannot afford their malpractice insurance, they cannot practice.

### **Drivers of the Costs**

The enormous liability costs which threaten our state's health care system are driven by an unpredictable medical liability adjudication system. Numerous studies of New York's liability system, including the famous "Harvard study", have concluded that our justice system does not work in this area. There are many awards made despite the absence of any negligence whatsoever. Damage awards are inconsistent and excessive. Moreover, under the current system studies have shown that often those truly injured by negligence do not sue.

Unfortunately, the Harvard study has routinely been distorted for years by those who seek to prevent any changes to the current system for adjudicating medical liability disputes. While the study identified unacceptable levels of adverse events caused at least in part by medical negligence, the truly profound conclusion of the study was not its findings on the failings of the healthcare delivery system, but rather the failure of the tort system. While the study concluded that there were many more victims of medical negligence than actual lawsuits, it also concluded that over 80% of the persons who did file lawsuits were not the victims of negligence.

A 2003 article in the *Annals of Internal Medicine*, in commenting upon the Harvard Study, noted that investigators followed the malpractice claims identified in the Harvard Study for 10 years and determined that the only statistical significant predictor of a payout to the plaintiff was the plaintiff's degree of disability – not the presence of negligence. The findings of the Harvard Study were then replicated in a 1990s study of medical injury in Utah and Colorado. The findings of these two studies were, of course, the basis for the 1999 Institute of Medicine Report.

Commenting upon these studies in a 2004 *New England Journal of Medicine* article, David Studdent, Michelle Mello and Troyen Brennan stated the following:

“The overall picture that emerges from these studies is disheartening. When all patients with negligent injuries are considered, not just those who manage to seek compensation as plaintiffs, the findings from the studies in California, in New York and in Utah and Colorado are a searing indictment of the performance of the malpractice system. The data reveals a profoundly inaccurate mechanism for distributing compensation. It is also tremendously inefficient. Approximately 60 cents of every dollar expended on the system is absorbed by administrative costs (predominately legal fees) an amount that is twice the overhead for an average workers’ compensation scheme.”

These findings were also found in a recent review of closed claims in the *New England Journal of Medicine*, where it was shown that, in more than 1 out of 4 claims, where the wrong result was reached, that is, a patient was awarded payment where no negligence was committed, or a patient was not awarded payment where there was negligence.

As a result of the randomness and unpredictability of the current medical liability adjudication system, settlements are often made even where no negligence has occurred. Physicians who treat the most high-risk patients are sued with astounding regularity in New York State. Every 5 years, nearly 65% of our neurosurgeons are sued, and nearly 50% of our OB-GYNs and surgical specialists.

Some might argue that doctors win most of these cases. However, even defense verdicts bring significant costs. While approximately 2/3 of all medical liability cases brought result in no payment, the costs of defending these cases are very substantial and significantly add to the astronomical cost of medical liability insurance. For example, MLMIC has spent over \$725 million in this decade alone to defend physicians and hospitals on whose behalf no payment is ever made to the plaintiff.

It is clear that the unpredictable nature of the outcome of medical liability lawsuits encourages the bringing of meritless litigation. To address the high cost of medical liability insurance in a meaningful way, we must address this fundamental problem.

### **Defensive Medicine Costs**

The problems of the medical liability adjudication system do not just impact physicians – they impact the cost of all health care to our entire society. This was highlighted by President Obama in a speech to Congress this past September in which he spoke of the connection between the threat of lawsuits and defensive medicine and unnecessary costs.

Studies have shown that billions of dollars in health care costs are unnecessarily spent each year due to the practice of “defensive medicine”, such as unnecessary MRIs, CT scans and specialty referrals. The costs of this phenomenon vary based upon the studies, but they are undoubtedly immensely significant. One 2002 study by HHS indicated that \$60-\$108 billion was spent on defensive medicine. A Lewin study concluded that \$36 billion could be saved over 5 years by reducing “defensive medicine” costs. Another study in 2007 (Baicker, Fisher and Chandra), looking at regional

variations in Medicare Part B spending, noted that a 10% increase in “malpractice pressure” is associated with a 1% per beneficiary increase in health care spending, and 2.2% per beneficiary increase in imaging costs.

More recently, a 2008 Massachusetts Medical Society study of eight specialties found that \$1.4 billion was spent annually in Massachusetts alone for “defensive medicine” purposes. And most recently, the Congressional Budget Office noted that meaningful medical liability reform could produce \$41 Billion in savings to federal health care programs. In fact, some have estimated that the CBO report actually significantly underestimated the extent of these savings.

At a time when our state is facing such a huge Budget gap, and is looking to find ways to reduce costs, we can no longer tolerate the excessive costs of a failed medical liability adjudication system. This failed system adds significant cost to our state Budget. In addition to defensive medicine costs, our State Budget subsidizes the failed medical liability adjudication system through higher Medicaid fees to hospitals to offset high liability costs, and aid to municipalities which must offset their own high liability costs.

Moreover, despite claims by some, the fear of the litigation system actually inhibits efforts to address system errors in a proactive way. New York, in particular, refuses to change laws which are unique to our State, and which exacerbate this problem. While hospital peer review proceedings are kept confidential from legal discovery, this immunity, incredibly, does not extend to a physician who subsequently becomes a defendant in a lawsuit. This greatly undermines efforts to improve quality care through a frank and thorough discussion of care provided, instead discouraging participation. As

stated by Dr. Troyen Brennan, one of the authors of the famous Harvard Study on Medical Malpractice, in a 2000 New England Journal of Medicine article:

*“Any effort to prevent injury due to medical care is complicated by the dead weight of a litigation system that induces secrecy and silence. No matter how much we might insist that physicians have an ethical duty to report injuries resulting from medical care or to work on their prevention, fear of malpractice litigation drags us back to the status quo. To address the problem of iatrogenic injuries seriously, we must reform the system of malpractice litigation.”*

We can no longer sustain such an expansive, inequitable and fatally flawed system if we wish to maintain a world-class health care system in New York. Cases where negligence has occurred should result in fair compensation to the injured plaintiff. However, we need a system which will more precisely assure that claims of negligence are paid and claims without negligence are not. We need a system of accountability which fosters a culture of quality improvement rather than blame. We need a system that is equitable, efficient and affordable. The current system is a complete failure because it does not meet these objectives to any acceptable degree.

Among the initiatives we support include:

## **LITIGATION REFORMS**

### **✓ Alternate Resolution Forums**

MSSNY supports legislation to resolve medical liability claims in more objective, less expensive forums, such as special health courts or

a No-Fault system for claims involving neurologically impaired infants and emergency department care. As stated above, the current civil justice system routinely yields awards in lawsuits where there has been no negligence. Alternative forums for adjudicating claims have long been a key recommendation of special government task forces examining this issue.

✓ **Medical Expert Witness Reform**

MSSNY supports legislation to reform the use of expert witnesses in medical liability actions. A recent article in *Health Affairs* concluded that the tightening of rules with respect to who can serve as an expert witness in a medical liability action has been effective in other states as part of an effort to contain medical liability insurance costs.

Under current New York law, the identity of an expert who will testify in a medical liability action is shielded. Incredibly, no other state has such a rule, and medical liability cases are the only civil actions in New York where this rule is applied. Specifically, legislation should be enacted that would require the identity of an expert witness in a medical liability action to be disclosed prior to trial.

Moreover, MSSNY supports legislation to require that an expert witness be practicing in the same or similar specialty as the physician against whom the suit has been filed. Over 20 states have enacted reforms which place meaningful requirements on the qualifications of an expert witness in a medical liability action.

MSSNY also supports legislation to establish a new category of physician misconduct for physicians who provide scientifically unsupportable testimony in any proceeding, whether civil or administrative.

✓ **Certificate of Merit Reforms**

MSSNY supports legislation to require that a physician consulted for a Certificate of Merit be identified, be of the same specialty as the physician against whom the suit is filed, and be required to file a merit certification statement. Current law allows an attorney filing a medical liability action to attest in the Certificate of Merit that he or she consulted with a physician who concurred that there is a reasonable basis to bring the action. However, the benefit of this law in limiting the bringing of meritless actions has been minimized because the physician with whom the attorney consulted remains anonymous.

Such a law would reduce some of the needless cost that is incurred by plaintiffs in pursuing and defendants in defending frivolous litigation that otherwise should be kept out of the courts. Fourteen states have enacted laws that go well beyond New York's "Certificate of Merit" Law", and require an affidavit of merit be signed by a health care provider in order for a medical liability claim to go forward.

It should also be noted that contained within the health system reform legislation that just passed the United States House of Representatives was funding for states that adopt certificate of merit and/or "early offer" laws.

✓ **Participation in the HHS Demonstration Project**

In a speech to Congress this past September articulating the need for comprehensive health system reform, President Obama initiated a grant program to provide funding to States and to health systems for demonstration programs that will improve patient safety and reduce medical liability lawsuits. We urge New York State to apply to the Office of Health and Human Services to obtain such a grant.

✓ **Reasonable Cap on Non-Economic Awards**

MSSNY supports legislation to enact a \$250,000 cap on non-economic damage awards. Many studies have shown that the most effective way to reduce liability insurance costs is through some limitation on the extent of non-economic damages awardable. There are 30 states that have enacted some form of a cap on non-economic awards in medical liability actions, including more heavily populated states such as California, Florida, Illinois and Texas.

The effect on premium has been significant. For example, it should be noted that California physicians pay far less than what New York physicians pay for liability premiums. The highest rate paid by an OB-GYN in New York State in the voluntary market, \$194,935 (PRI – Long Island), is more than twice as high as the highest rate paid by an OB-GYN in California, \$89,953 (Norcal – Los Angeles and Orange Counties). In Texas, physicians have seen significant reductions in their liability insurance costs since the enactment of a cap in their state in 2003, as well as a significant increase in physician license applications.

✓ **Reducing Frivolous Lawsuits**

MSSNY supports legislation or other regulatory action which would assure that penalties are imposed on those who bring frivolous medical liability actions. New York law permits the imposition of a \$10,000 fine on an attorney who brings a frivolous action. However, the penalty is rarely imposed despite the fact that an overwhelming majority of malpractice claims filed result in no payment to the plaintiff. MLMIC has spent over \$725 million in this decade alone to defend physicians and hospitals on whose behalf no payment is ever made to the plaintiff. These costs could be significantly reduced if the standards for establishing a frivolous suit cause of action were made more reasonable, and the law rigorously enforced. It would also reduce cost to plaintiffs by discouraging the bringing of clearly meritless litigation.

✓ **Immunity for Apologies**

MSSNY supports legislation to protect health care providers who express sympathy to a patient for an unanticipated outcome from having such statement used against the health care provider in any subsequent litigation that may arise. At least 27 states, including Connecticut, Illinois and Maryland, have enacted so-called “I’m Sorry” laws. The enormous liability exposure physicians face creates a situation where physicians are inhibited from expressing any sort of apology or remorse following an unanticipated outcome because of the fear of being sued. The purpose of an “I’m sorry” law is to encourage open communication between patients and their health care providers by removing some of the potential negative ramifications of a statement of remorse for an unanticipated outcome.

## **INSURANCE/STRUCTURAL REFORMS**

### **✓ Subsidization**

MSSNY supports legislation to provide a state-funded subsidy and/or a tax credit to defray the cost of medical liability insurance. For example, legislation passed the State Senate in 2008 to reduce from \$1.3 million to \$1 million the amount of coverage a physician needs to purchase in order to obtain state-funded Excess coverage. The legislation would have reduced physician liability premiums by 6-9%. MSSNY will seek passage of this or other similar legislation this year.

### **✓ Re-Creation of MMIA**

MSSNY supports legislation that would re-create the joint underwriting association, comprised of all insurance companies writing liability insurance in New York State, to cover the assigned risk pool for medical liability insurance in New York State. From 1975 to 2000, the Medical Malpractice Insurance Association (MMIA), comprised of hundreds of carriers with multiple billions of dollars in assets, underwrote the assigned risk pool. In 2000, legislation was enacted to permit the dissolution of MMIA and to create the Medical Malpractice Insurance Plan (MMIP) as the insurer of last resort. Membership in MMIP is now limited to medical malpractice carriers only. Three of these companies (MLMIC, PRI and HIC), furthermore represent 90% of market share, and assume that proportion of MMIP's deficit. This is not a tenable situation.

Due to inadequacy in the funding of the Excess Medical Malpractice Insurance Program, the current structure has severely impacted upon the financial stability of these carriers. This resulted in the

Superintendent of Insurance's articulation of the possible need for a physician surcharge. A surcharge, of course, would be unthinkable. Re-creation of the MMIA would more equitably spread risk associated with medical malpractice insurance and provide some stability to this market.

✓ **Periodic Payments Structural Reform**

MSSNY supports legislation to revise the method for structuring medical liability awards. Prior to 2003, all future damages awarded in a medical liability action exceeding \$250,000 were paid over time in periodic payments instead of one lump sum. This law reduced overall liability costs. However, in response to a Court of Appeals decision, legislation was enacted in 2003 that changed the upfront payout of future damages from \$250,000 to 35% of the future damages awarded. This seriously reduced the value of structured awards. MSSNY, therefore, supports legislation to change the lump sum payment threshold from 35% of the award to the first \$50,000 of the award.

✓ **Personal Asset Protection**

MSSNY supports legislation that provides greater protection of a physician's personal assets. Liability awards frequently exceed the insurance coverage physicians are able to purchase, placing the physician's assets in substantial jeopardy every time they treat a patient.

**DEFEAT OF ANY REGRESSIVE LIABILITY MEASURES**

The State Legislature and the Governor have temporarily averted a healthcare access disaster through the enactment of consecutive one-year

freezes on liability insurance premiums. We need reform now, and certainly we cannot tolerate any change in the law that would actually expand liability costs for physicians. Therefore, MSSNY strongly opposes all measures that would increase physician liability including:

- \* Legislation to create a “date of discovery” rule for the statute of limitations;
- \* Legislation to expand “wrongful death” damages
- \* Legislation to permit the awarding of pre-judgment interest; and
- \* Legislation to eliminate the limitations on attorney contingency fees;
- \* Legislation to expand damages against non-settling defendants; and
- \* Legislation to prohibit ex-parte interviews of non-party physicians in medical liability action.

Enactment of any one of these measure would devastate the physician community and the entire health care system.

We again thank you again for the opportunity to present testimony on this most critical issue. In summary, we need a system which provides greater accuracy in the assessment of liability. We need predictability. We need to enhance quality by removing the disincentives for reporting medical errors inherent in the current system. We are firmly committed to work with you to address patient safety issues.

We recognize that this problem is complex and requires a comprehensive solution. However, we can wait no longer. We urge you as strongly as we can to take action to address this problem now.