IOWA MEDICAL SOCIETY

MEMO

TO: Medical Malpractice Interim Legislative Study Committee
FROM: Victoria Sharp, MD, President, Iowa Medical Society
DATE: October 29, 2013
RE: Medical Malpractice Reform Efforts in Iowa

This memo is intended to familiarize the members of the Medical Malpractice Interim Legislative Study Committee with recent efforts undertaken in pursuit of meaningful medical malpractice reform in Iowa. Like many states, Iowa has seen spikes in activity surrounding this issue following crises in the professional liability insurance market. The most recent of these occurred in 2002. This memo will review the malpractice reform efforts of IMS over the past eleven years.

Note: Attachment A contains a description of the reforms discussed herein.

Iowa Needs Sensible Malpractice Reform

The assertion has repeatedly been made that a crisis does not currently exist in the medical liability insurance (MLI) market. It is true that Iowa's MLI rates have remained relatively stable in recent years. Unfortunately, these stable rates continue to be significantly higher than nearly all of our neighboring states *(Attachment B).* Malpractice cases in Iowa take longer to reach resolution and cost significantly more than several neighboring states including Minnesota, Nebraska, and Wisconsin *(Attachment C),* forcing physicians out of the exam room and away from their number one priority: caring for patients.

The effects of Iowa's unfavorable malpractice environment are evident in the fact that our state ranks significantly lower than neighboring states in the number of physicians per capita in a number of specialty areas *(Attachment D),* including Obstetrics and Gynecology (51st in the nation), Emergency Medicine (51st in the nation), General Surgery (45th in the nation), and Pediatrics (45th in the nation). These low rankings mean that patients in many parts of our state are not able to access care in a timely and convenient fashion. Women in rural Iowa often must travel long distances to receive proper prenatal care, particularly women with high risk pregnancies. The parents of an ill child may not have access to pediatric care and a patient in need of gall bladder removal may not be able to access care in his or her local community.

Meaningful malpractice reform can help address these patient access issues. Minnesota, which has had a Certificate of Merit statute in place since 1986, currently enjoys MLI premiums that are on average nearly 50% lower than those in Iowa and ranks 12th in the nation for the total number of physicians per capita compared to Iowa's 43rd ranking.

2002 & 2003 Malpractice Reform Efforts

In 2002, the St. Paul Insurance Company announced their voluntary and unilateral decision to withdraw from the Iowa insurance market. This move left 2,039 Iowa physicians – over a third of all active physicians in the state at the time – in need of a new professional liability insurer. The move caused great concern over the ability of Iowa's remaining liability insurers to absorb all of these physicians, as well as the facilities and midlevel professionals who also lost coverage. As a result, the Iowa Insurance Division (IID) scheduled a series of meetings to examine our state's professional liability insurance market, and the challenges faced by healthcare providers in obtaining and paying for medical malpractice coverage. In working with the Insurance Commissioner through this process, IMS put forward the idea of establishing a joint underwriting association in our state. The IID opted not to pursue this recommendation.

In the face of skyrocketing malpractice insurance premiums, the 2003 IMS House of Delegates adopted a resolution directing IMS to continue to pursue strategies to stabilize the medical malpractice insurance market in Iowa, including the creation of a joint underwriting association to fill coverage gaps. In response to this resolution, the IMS Board of Directors appointed an ad hoc committee to study and address medical liability in Iowa. This ad hoc committee, composed of IMS member physicians and a representative from the MMIC Insurance Group, met multiple times in the fall of 2003. The committee discussed reforms in the following areas:

- Reforming the legal system for medical cases
- Caps on Non-Economic Damages
- Fault-Based Compensation Systems
- No-Fault-Based Systems
- Alternative Dispute Resolution/Arbitration
- Patient Compensation Funds
- The Medical Injury Compensation Reform Act of 1975 (MICRA)
- Pre-Trial Screening Mechanisms such as Certificate of Merit
- Collateral Source Rule
- Joint and Several Liability
- Limits on Attorney Fees
- Asset Protection Mechanisms
- "Loss of Chance"

After extensive discussion, the committee made the following four recommendations to the IMS Board:

1) IMS support national efforts to secure Congressional professional liability reform, including caps on non-economic damages and monitor, and when appropriate support, state legislation to cap non-economic damages;

2) IMS explore, along with the Iowa Bar Association and others, potential changes in access to medical records to assist liability companies in lowering defense costs through easier and timelier access in medical liability cases;
3) IMS bring to the attention of the Iowa Insurance Commissioner relevant information on the national liability crisis and the impact on physicians from the first draft of the National Association of Insurance Commissioners Report; and
4) IMS explore changing the "loss of chance" from 1 percent in Iowa to a more reasonable standard as recommended by MMIC.

The committee's full report is included as *Attachment E* to this memo.

2004 & 2005 Malpractice Reform Efforts

In 2004, the Iowa AMA delegation, in response to an IMS House of Delegates resolution, submitted a resolution to the AMA House of Delegates asking the AMA to study the feasibility of seeking federal legislation for a tax-exempt alternative financing mechanism specific to physician groups' ability to retain earnings in a private professional liability trust solely for medical liability insurance coverage. The AMA Council on Legislation studied the issue and found that enacting such legislation would be a relatively straightforward process. The AMA Board of Trustees in 2005 recommended House of Delegates adoption of a policy supporting an amendment to the *Internal Revenue Code* to allow for the establishment of such tax-exempt professional liability trusts. Throughout 2005, IMS in conjunction with the AMA, advocated for Congressional action to enact such a measure. This proposal failed to gain support.

On the state level, IMS was among the organizations in 2004 that successfully advocated for passage of legislation to enact a cap of $250,000 on non-economic damages, similar to the cap in place in California since 1975. The bill included an exception to the $250,000 limit in cases where malice on the part of the defendant was proven. The legislation passed the House by a vote of 53 to 47 and the Senate by a vote of 27 to 21. However, when the bill arrived on his desk, Governor Vilsack vetoed it. In the message accompanying his veto of the bill, Governor Vilsack argued that such a cap would not reduce healthcare costs or increase the availability of medical malpractice insurance in Iowa.

IMS continued to actively lobby for enactment of a cap on non-economic damages through the 2007 Legislative Session. While successful in getting cap bills introduced in many of these sessions, 2004 marked the last year which saw meaningful legislative action in support of caps, until this most recent session.

Following the veto of the cap on non-economic damages, the governor convened a group of stakeholders to serve on a new Health Care Access Team. This group, which included representatives from IMS, the Iowa Trial Lawyers Association, the Iowa Dental Association, Wellmark, the Iowa Hospital Association, and the Iowa Insurance Division, was charged with finding ways to reduce health care costs in Iowa. As an outgrowth of these discussions, Governor Vilsack made three requests:

1) Physicians, lawyers, and insurance companies engage in a conversation about how to reduce costs surrounding medical liability issues without caps;
2) IMS submit a memo to the Governor outlining possible ways to reduce physicians' administrative burdens and costs; and
3) The Iowa Insurance Division investigate the feasibility of establishing a patient compensation fund in Iowa based upon the model in place in Wisconsin.

These requests led to the establishment of the IMS Liability Work Group, which was composed of members of the plaintiff and defense bar, physicians, and representatives of professional liability insurance carriers. Between June 2004 and February 2006, this work group looked at a number of reforms, including the following:

1) Extensions of the Statute of Limitations
2) "Stand Still" Agreements to Freeze the Statute of Limitations
3) Certificate of Merit
4) Mandated Mediation Panels
5) Patient Compensation Funds
6) Record Exchanges During Malpractice Suits

To help facilitate the work of this group, a smaller sub-work group was appointed to review these proposals and put forth recommendations. This sub-work group made the following four recommendations:

1) To develop and finalize a proposed agreement between parties to extend or freeze the statute of limitations in medical negligence cases under appropriate circumstances;
2) To draft a statement of principles/collaboration agreement between insurance carriers and attorneys to further the mutual exchange of information and include the information needed to investigate claims (medical records, expert opinions, patient authorization, damages);
3) To create future legislation to require a waiver/patient authorization to be served with the Petition at Law and a copy of the insurance policy limits served with the Answer (medical negligence lawsuits only); and
4) To educate providers regarding the release of medical records in a more timely fashion.

The full IMS Liability Work Group opted to pursue the first two recommendations, working to develop an "Agreement to Extend Statute of Limitations/Stand Still Agreement" document and an addendum to the "Principles of Cooperation," an agreement originally developed and approved by the Iowa Medical Society and the Iowa State Bar Association in 1992.

Concurrent to this work, IMS and the IMS Board of Directors studied the governor's proposal to develop a patient compensation fund based upon the model in place in Wisconsin. After extensive review, the IMS Board determined that, absent enactment of a cap on non-economic damages as was the case in Wisconsin, a patient compensation fund alone would not reduce physicians' medical liability

costs. In November of 2004, the Board adopted a white paper *(Attachment F)* laying out its reasoning for this determination, and suggesting that the state instead pursue a joint underwriting association and a Certificate of Merit requirement for medical malpractice cases. The Iowa Insurance Division investigation of patient compensation funds, as directed by the governor's Health Care Access Team, reached a similar conclusion with respect to the unlikeliness that a patient compensation fund would actually reduce providers' medical liability insurance costs.

2005 & 2006 Legislative Action

The 2005 General Assembly saw the introduction of several malpractice reform measures, including bills to enact a $250,000 cap on non-economic damages, enact a Certificate of Merit requirement, and create a patient compensation fund. Ultimately, none of these bills advanced; the legislature opted instead to form an interim legislative study committee to provide regulatory agencies and the General Assembly with possible solutions to alleviate problems regarding the availability and affordability of medical liability insurance in Iowa. This study committee met twice in the fall of 2005, with IMS providing extensive testimony at both meetings. Included in this testimony was a summary of the reform measures discussed by the IMS Liability Work Group. Following testimony from a number of interested parties and extensive discussion, the study committee tentatively agreed to ten recommendations for its report back to the General Assembly. They were as follows:

1) Incentivize physicians and other health providers to increase efforts to reduce medical errors.
2) Give immunity to healthcare providers who say, "I'm sorry."
3) Allow the statute of limitations in medical malpractice lawsuits to be stayed by an agreement of the parties.
4) Require insurance claims and income data from medical malpractice insurers.
5) Revise expert witness standards and limit the number of experts in a specialty area. Ensure medical records are accessible as soon as possible.
6) Provide a state tax credit to assist in paying the medical malpractice costs of specialty physicians in physician-shortage areas of the state.
7) Require criminal background checks (state and federal checks) for licensing new healthcare providers.
8) Include a provision in new legislation requiring a study of the effectiveness of the legislation, to sunset in three to five years.
9) Require a certificate of merit to be issued before filing or continuation of a medical malpractice lawsuit.
10) Consider a medical error reporting system, including an aggregate reporting system.

Ultimately, the committee members failed to reach a consensus regarding final language for its recommendations to the General Assembly. As such, no formal committee recommendations were submitted to the General Assembly; the committee opted instead to submit the testimony and minutes of the two meetings.

In preparation for the 2006 legislative session, IMS prepared draft legislation incorporating three malpractice reform measures: Certificate of Merit, a provider apology shield (commonly referred to as "I'm Sorry" protection), and strengthened expert witness standards. The 2006 session again saw the introduction of several medical malpractice reform measures, including the IMS-supported proposals, an Iowa Trial Lawyers Association-supported measure limiting medical record fees in malpractice cases, a bill to establish a $500,000 cap on non-economic damages, which the governor immediately vowed to veto, and a bill which sought to implement some of the tentative recommendations from the previous year's interim study committee. Following lengthy debate and negotiations, the legislature agreed to pass the provider apology shield language in exchange for new requirements for medical liability carriers to report claims data to the Iowa Insurance Division. The provider apology shield legislation passed the House by a margin of 74 to 21 and passed unanimously in the Senate; soon after, the governor signed the bill into law. This is the most recent productive malpractice reform measure to be enacted.

2007 – 2012 Malpractice Reform Efforts

2007 marked the beginning of a period of relatively little progress in the pursuit of meaningful medical malpractice reform. Going into the 2007 legislative session, IMS shifted its malpractice reform efforts to focus entirely on enactment of a Certificate of Merit requirement. In addition, the Iowa State Bar Association and the Iowa Trial Lawyers Association put forth several measures that IMS opposed. These included bills to eliminate the statute of limitations and the statute of repose in medical malpractice cases, as well as bills imposing medical record fee limits and timeframes for record releases associated with malpractice litigation. A medical record fee bill was passed and signed into law in 2008.

In 2011, the House passed a Certificate of Merit bill by a vote of 62 to 31. In 2012, the Senate Judiciary Committee amended and passed the bill in a significantly weaker form, which never came before the full chamber for a vote.

2013 Malpractice Reform Efforts

IMS spent significant time prior to the 2013 General Assembly reviewing medical malpractice reform proposals from across the country with the intention of identifying meaningful reforms that would improve the practice environment in Iowa. Going into the session, IMS advocated for enactment of a Certificate of Merit measure as well as strengthened expert witness standards. Governor Branstad spurred additional action when, in his *Condition of the State Address,* he called for enactment of a cap on non-economic damages and a Certificate of Merit measure. IMS spent the session working with the Governor's office and legislative leaders to craft legislation incorporating five malpractice reform measures:

1) Pretrial Screening Panels
2) Certificate of Merit
3) A $250,000 Cap on Non-Economic Damages
4) Strengthened Expert Witness Standards
5) An Affirmative Defense for Evidence-Based Medicine

These five reforms were incorporated into the governor's proposed alternative to the Senate's Medicaid expansion legislation, and were a part of the final conference committee negotiations, which ultimately yielded the Iowa Health and Wellness Plan. In a similar manner to the 2005 legislative negotiations, the legislature again failed to enact any malpractice reform measures, opting instead to form this interim study committee to look at the effects of enacting a Certificate of Merit requirement or limiting the number of expert witnesses in a medical malpractice case.

IMS Recommendations

While disappointed that the interim study committee chose not to meet in person, IMS is pleased that the legislature continues to be open to discussion regarding the very real need for meaningful malpractice reform in Iowa. Reforms such as a Certificate of Merit requirement in medical malpractice cases have been in place in surrounding Midwest states and across the country for a number of years. These reforms have stabilized the medical liability climate in those states, helped with physician recruitment and retention, and freed medical professionals to focus not on litigation, but on their patients.

IMS supports a Certificate of Merit requirement and believes that such a measure will expedite legitimate claims resolution, while preserving an injured patient's access to the legal system. **IMS continues to believe this common-sense measure is sound public policy and urges the committee to recommend enactment of Certificate of Merit legislation in its report back to the full General Assembly.** IMS is not opposed to considering other reform proposals. Given the legislature's repeated lack of action on COM legislation, IMS would welcome a discussion regarding other reforms which might be of interest to lawmakers. In reviewing any reform proposal, IMS would place a strong emphasis on ensuring that the measure: 1) does not impose additional, burdensome requirements on providers; 2) does not deny patients with a legitimate claim of their ability to receive just compensation; and 3) reduces the number of meritless claims, which currently clog our legal system and unnecessarily force providers out of the exam room and surgical theater, and into the courtroom.

IMS encourages the committee to revisit the provisions of last session's House Study Bill 36, which would create an affirmative defense for the practice of evidence-based medicine. We are currently in the midst of a period of significant change for healthcare delivery in both our state and our country. As state and federal level reforms are implemented, physicians and the healthcare community at large are being asked to do more with less. New care delivery and payment models such as Accountable Care Organizations are pressing providers to help bend the cost curve for medical care, while maintaining and improving the quality of care. Physicians are on the front lines of care delivery. We know that often times a patient will request unnecessary and often expensive tests and procedures, many of which are medically unproductive and increase overall spending in the healthcare system. We also know that the average physician will spend 50.7 months, or approximately 11% of his or her career, with an on-going medical malpractice claim. By denying patient requests for medically unnecessary care, physicians can help control system costs, but doing so increases the likelihood of a malpractice claim being filed against them. Faced with this choice, many physicians will opt to order the unnecessary procedure, a practice known as defensive medicine. An affirmative defense for evidence-based medicine would allow

physicians to point to adherence to evidence-based medical best practices as a legal defense in the event that a suit is filed.

IMS also encourages the study committee to review the AMA *Standard of Care Protection Act* model legislation *(Attachment G)*. This measure clarifies that the standards and guidelines created as a result of state and national health system reform efforts are inadmissible as grounds for civil action against a physician. IMS supports efforts to reduce the practice of defensive medicine. Giving physicians the peace of mind to know that practicing good, evidence-based medicine is not grounds for legal action is critical. While state and national organizations have made progress in reaching a consensus on some evidence-based medical standards, others remain quite varied. As physicians, it is our responsibility to review the various medical best practices and determine which is most appropriate for our patients and their unique circumstances. Allowing a suit to be filed based solely upon a non-medical professional's assertion that a provider selected the wrong medical standard is simply inappropriate.

On behalf of the 6,400 physician and medical student members of the Iowa Medical Society, thank you for the opportunity to provide these comments to the Medical Malpractice Interim Legislative Study Committee. IMS stands ready to work with policymakers in the pursuit of a more equitable medical liability climate in our state, ensuring that Iowa's physicians are best positioned to continue providing high-quality care to all Iowans.

Attachment A

Medical malpractice reforms have been discussed and studied to varying degrees by IMS in the following areas:

Affirmative Defense for Evidence-Based Medicine – A relatively new reform, this measure, also known as a "safe harbor for evidence-based medicine," would allow providers accused of medical malpractice to use as a legal defense, the fact that the care they provided was in line with evidence-based medical practice guidelines.

Alternative Dispute Resolution/Arbitration – This reform takes medical malpractice cases before an arbitrator or panel of arbitrators instead of a judge and jury. Both sides argue their case in a manner similar to trial and the arbitrator issues a ruling which may be binding or nonbinding depending on how this reform is structured. In the nonbinding arbitration model, either party may reject the arbitrator's decisions and proceed to trial.

Asset Protection Mechanisms – Courts in every state have the ability, to varying degrees, to seize the personal assets of a physician to pay for malpractice judgments. Some states have enacted reforms to protect specific assets such as a physician's primary home, life insurance policies or retirement plans from seizure in cases of malpractice judgments.

Caps on Non-Economic Damages – First enacted in California in 1975, this reform places a limit on the amount of non-economic damages (damages for intangible damages such as "pain and suffering") a jury can award in a malpractice case. Depending on the state, caps can be a hard cap at a specific dollar amount ($250,000 and $500,000 have been suggested in Iowa) or caps can be indexed to adjust over time with inflation or to specific dollar amounts established in statute.

Certificate of Merit – This reform requires the filing of an affidavit from an expert which identifies the appropriate standard of care which the plaintiff alleges was breeched. Depending on the state, this can be required at the time of filing the suit or within a specified period of time (e.g. 90 or 180 days).

Collateral Source Rule – This rule states that in judgments award to injured individuals, their compensation will be reduced by the amount that they have received from third parties (such as insurers) for their injury or treatment. Many states have codified this rule of civil procedure in statute.

Expert Witness Limits – This reform proposal would seek to reduce medical malpractice suit costs by placing limits on the number of expert witnesses each side would be able to hire. Few states have enacted any such limit.

Extension of the Statute of Limitations – This reform was suggested by the Iowa Trial Lawyers Association during the work of the IMS Medical Liability Work Group between 2004 and 2006. Such an agreement, signed by both the plaintiff and the defense, would extend for a set number of days the statute of limitations in medical malpractice case.

Joint and Several Liability – This rule of civil procedure allows plaintiffs who receive a judgment in their favor to collect the full judgment from any of the providers found to be at fault, regardless of the level of fault attributed to that provider. Reforms in this area include limiting the amount recoverable from a provider to a percentage of the total judgment which is proportionate to that provider's level of fault.

Joint Underwriting Association – This state-sponsored insurance option is designed to help those providers who cannot find traditional medical liability insurance. Covered providers' premiums would be based upon their assessed liability risk; if premiums are insufficient to cover losses and administrative expenses, professional liability carriers would be assessed a share of the shortfall.

Limits on Attorney Fees – This reform limits the contingent fees a plaintiff's attorney may charge in an effort to reduce the incentive for attorneys to pursue non-meritorious claims and ensure a larger portion of judgments goes to the injured patient. Limits vary depending on the state and can be in the form of an across-the-board limit or a sliding scale limit percentage of the total judgment.

"Loss of Chance" – This legal doctrine applies to cases where patients' underlying medical conditions would have caused significant injury or death regardless of the actions of the provider. In states which recognize it for medical malpractice cases, the doctrine permits claims alleging that provider negligence diminished the likelihood that the medical outcome would have been better had the alleged act or omission of medical care not occurred.

Mediation – Similar to arbitration, this reform measure seeks to divert malpractice cases before they go to trial. Typically a confidential process, mediation allows for a structured conversation and negotiation whereby the hope is that the patient and the provider(s) are able to come to agreement either that the care provided was appropriate or that the parties involved will settle prior to court. Mediation can be a mandated step before trial or optional if both sides agree to participate.

Medical Injury Compensation Reform Act of 1975 (MICRA) – This package of tort reform measures, first passed in California, includes: 1) a hard cap of $250,000 on non-economic damages; 2) collateral source rule damage limitations; 3) a sliding scale for lawyers' contingency fees; 4) a 90-day advance notice for filing a claim; and 5) a statute of limitations that requires notification within 1 year from discovery and within 3 years of the date of injury.

Medical Record Fees – Reforms in this area pertain to limits on what a provider may charge for a copy of patients' medical records when they are released as part of a malpractice suit. Legislation passed in Iowa in 2008 capped litigation-related medical record fees at the same levels as the workers' compensation rate schedule.

Medical Record Release – Reforms in this area pertain to establishing timelines by which a plaintiff must submit a records release form and by which a provider must release a copy of the patient's records. The intent is to eliminate a potential delay in historically lengthy medical malpractice cases.

No-fault-based systems – This reform replaces traditional litigation with an administrative system where injured patients can apply directly, without an attorney, for compensation. A panel of medical experts reviews the case and decides on compensation irrespective of fault.

Patient Compensation Fund – This reform involves the establishment of a state-run fund which will pay a portion of malpractice judgments or settlements above a specified level. Participation in the fund may be voluntary or mandatory, and the fund may have a limit on the amount a fund pays out per case. Funds are financed by participating providers paying an annual assessment similar to their medical liability insurance premiums.

Pretrial Screening Panels – This reform has been enacted in a handful of state, most notably Maine. The measure requires that prior to going to trial, a medical malpractice case is reviewed by a panel, generally composed of attorneys and health care providers, to determine whether the case has merit. The panel proposed in 2013 incorporated additional restrictions and admissibility provisions in cases where the panel's findings were unanimous and one of the parties opted to still pursue litigation.

Professional Liability Trusts – This reform allows for the establishment of an individual trust account where providers contribute tax-exempt funds to be used solely for the purpose of professional liability coverage.

Provider Apology Shield ("I'm Sorry" Protection) – Approximately 36 states, including Iowa, have enacted some form of this reform. Depending on the state, the reform makes inadmissible in court apologies, and similar statements of sympathy or condolence. Some apology shields also extend to health care facilities.

Specialty Physician Medical Malpractice Tax Credit – This reform, discussed as a part of the 2005 legislative interim study committee work, would create a state tax credit to assist in paying medical malpractice costs of specialty physicians in physician-shortage areas of the state.

"Stand Still" Agreements to Freeze the Statute of Limitations – This reform was suggested by the Iowa Trial Lawyers Association during the work of the IMS Medical Liability Work Group between 2004 and 2006. Such an agreement, signed by both the plaintiff and the defense, would freeze for a set number of days the time remaining until the statute of limitations was reached.

Strengthened Expert Witness Standards – This reform proposal would make changes to the qualifications for persons named to testify as an expert witness in a medical malpractice case. Suggested reforms in this area include requirements that expert witnesses practice in the same specialty as the defendant and be in good professional standing with their licensing board.

Attachment B

Average Midwest Physician Liability Insurance Premiums

Iowa		Minnesota			South Dakota		
	Average Rate		Average Rate	Percent of Iowa Rate		Average Rate	Percent of Iowa Rate
Internal Medicine	$7,280.00	Internal Medicine	$4,202.00	57.72%	Internal Medicine	$4,477.67	61.51%
General Surgery	$27,895.67	General Surgery	$12,720.00	45.60%	General Surgery	$14,123.00	50.63%
OB/Gyn	$36,472.00	OB/Gyn	$20,627.67	56.56%	OB/Gyn	$20,733.67	56.85%

Wisconsin			Nebraska*		
	Average Rate	Percent of Iowa Rate		Average Rate	Percent of Iowa Rate
Internal Medicine	$5,765.17	79.19%	Internal Medicine	$3,836.67	52.70%
General Surgery	$18,148.83	65.06%	General Surgery	$14,241.00	51.05%
OB/Gyn	$25,730.67	70.55%	OB/Gyn	$18,797.33	51.54%

*Nebraska figures reflect premium as well as surcharge physicians pay into the state patient compensation fund.

IMS prepared document based upon the 2012 Medical Liability Monitor Annual Rate Survey. Figures shown reflect manual rates for specific mature, claims-made specialty coverage with limits of $1 million per claim/$3 million per year. Rates reported do not include other underwriting factors which can increase premiums.

Attachment C

Allocated Loss Adjustment Expenses

Physician Claims-Made
Closed Claims
Closed Years: 2008-2012

State	ALAE/Indemnity	ALAE/Closed Claim
IA	48%	$34,278
MN	29%	$22,550
ND	20%	$21,990
NE	59%	$14,458
SD	66%	$31,382
WI	65%	$13,417
Total	39%	$23,219

Notes:
Data as of 12/31/12
Source: MMIC Actuarial dB
Includes closed-no-pays

ALAE is a measure of the costs associated with the defense of a malpractice claim.

Attachment D

Physician Population Ratios and Rank by State, 2011

State	Estimated Population 7/1/2011	Patient Care DOs	Patient Care MDs	Total Patient Care MDs & DOs	Individuals Per One Physician	Physicians per 100,000 Population	Physician/ Population Rank
District of Columbia	619,020	81	4,140	4,221	146.7	682	1
Massachusetts	6,607,003	697	26,355	27,052	244.2	409	2
Rhode Island	1,050,646	211	3,561	3,772	278.5	359	3
New York	19,501,616	2,943	65,745	68,688	283.9	352	4
Maryland	5,839,572	621	19,929	20,550	284.2	352	5
Connecticut	3,586,717	426	11,777	12,203	293.9	340	6
Vermont	626,592	65	2,027	2,092	299.5	334	7
Pennsylvania	12,743,948	5,270	34,402	39,672	321.2	311	8
New Jersey	8,834,773	2,547	24,273	26,820	329.4	304	9
Maine	1,328,544	666	3,342	4,008	331.5	302	10
New Hampshire	1,317,807	263	3,526	3,789	347.8	288	11
Minnesota	5,347,299	565	14,758	15,323	349.0	287	12
Hawaii	1,378,129	161	3,723	3,884	354.8	282	13
Michigan	9,876,801	4,615	23,142	27,757	355.8	281	14
Ohio	11,541,007	3,841	28,418	32,259	357.8	280	15
Oregon	3,868,229	724	9,969	10,693	361.8	276	16
Illinois	12,859,752	2,179	32,953	35,132	366.0	273	17
Colorado	5,116,302	1,050	12,264	13,314	384.3	260	18
Missouri	6,008,984	2,019	13,541	15,560	386.2	259	19
Virginia	8,104,384	926	19,986	20,912	387.5	258	20
Wisconsin	5,709,843	859	13,807	14,666	389.3	257	21
Washington	6,823,267	924	16,513	17,437	391.3	256	22
Tennessee	6,399,787	633	15,523	16,156	396.1	252	23
Delaware	908,137	251	2,037	2,288	396.9	252	24
Louisiana	4,574,766	154	11,341	11,495	398.0	251	25
California	37,683,933	3,778	89,965	93,743	402.0	249	26
Florida	19,082,262	3,901	43,287	47,188	404.4	247	27
West Virginia	1,854,908	671	3,890	4,561	406.7	246	28
North Carolina	9,651,103	875	22,068	22,943	420.7	238	29
Nebraska	1,842,234	190	4,155	4,345	424.0	236	30
Kansas	2,870,386	696	6,010	6,706	428.0	234	31
North Dakota	684,740	64	1,535	1,599	428.2	234	32
Alaska	723,860	152	1,530	1,682	430.4	232	33
Arizona	6,467,315	1,617	13,132	14,749	438.5	228	34
New Mexico	2,078,674	268	4,423	4,691	443.1	226	35
Kentucky	4,366,814	486	9,276	9,762	447.3	224	36
South Dakota	823,593	128	1,709	1,837	448.3	223	37
South Carolina	4,673,348	481	9,897	10,378	450.3	222	38
Montana	997,667	146	1,993	2,139	466.4	214	39
Indiana	6,516,353	862	13,021	13,883	469.4	213	40
Texas	25,631,778	3,636	50,105	53,741	477.0	210	41
Georgia	9,812,460	813	19,599	20,412	480.7	208	42
Iowa	3,064,097	1,157	5,179	6,336	483.6	207	43
Alabama	4,803,689	418	9,501	9,919	484.3	206	44
Utah	2,814,347	355	5,415	5,770	487.8	205	45
Oklahoma	3,784,163	1,476	6,181	7,657	494.2	202	46
Arkansas	2,938,582	251	5,539	5,790	507.5	197	47
Nevada	2,720,028	526	4,597	5,123	530.9	188	48
Wyoming	567,356	84	978	1,062	534.2	187	49
Mississippi	2,977,457	338	5,003	5,341	557.5	179	50
Idaho	1,583,744	288	2,514	2,802	565.2	177	51

Sources: Table 1. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2012, U.S. Census Bureau, Population Division, released December 2012; *Physician Characteristics and Distribution in the U.S., 2013 Edition* , Division of Survey & Data Resources, American Medical Association, 2013. Patient Care MDs and DOs exclude Administration, Medical Teaching, Research and Other Activities; both MD and DO counts used herein exclude inactive, address unknown and not classified.

Prepared by Iowa Medical Society 02/13/2013

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Allergy and Immunology		Anatomic/Clinical Pathology		Anesthesiology	
	Individuals per Physician	Rank	Individuals per Physician	Rank	Individuals per Physician	Rank
Alabama	129,829	45	21,638	35	9,382	43
Alaska	103,409	32	38,098	51	8,043	30
Arizona	109,616	36	25,462	44	6,119	8
Arkansas	108,836	35	21,294	32	9,995	46
California	78,672	20	20,604	30	6,976	21
Colorado	57,487	7	20,384	29	6,172	10
Connecticut	53,533	5	12,902	6	5,702	7
Delaware	90,814	30	25,226	43	9,980	45
District of Columbia	44,216	2	8,719	2	3,497	1
Florida	86,738	28	21,586	33	6,803	19
Georgia	107,829	34	23,702	41	9,408	44
Hawaii	81,066	22	19,410	23	8,403	35
Idaho	121,826	41	37,708	50	13,198	51
Illinois	66,287	11	16,898	14	6,501	15
Indiana	127,772	43	23,273	37	6,165	9
Iowa	117,850	39	19,032	20	8,830	40
Kansas	82,011	23	19,009	19	7,212	24
Kentucky	62,383	9	20,994	31	7,634	29
Louisiana	71,481	14	19,634	25	8,456	36
Maine	120,777	40	24,603	42	6,813	20
Maryland	39,725	1	12,040	5	5,131	3
Massachusetts	53,282	4	8,682	1	4,553	2
Michigan	67,189	12	18,565	18	8,136	32
Minnesota	75,314	17	14,854	9	8,501	38
Mississippi	114,518	38	26,584	45	11,110	49
Missouri	69,069	13	17,120	15	7,521	27
Montana	83,139	24	28,505	47	7,229	25
Nebraska	76,760	18	15,225	10	7,113	22
Nevada	151,113	48	34,872	49	6,800	18
New Hampshire	77,518	19	16,269	12	6,275	12
New Jersey	51,665	3	19,898	26	5,345	5
New Mexico	159,898	50	19,610	24	8,808	39
New York	56,856	6	14,446	7	5,154	4
North Carolina	112,222	37	23,482	40	9,131	41
North Dakota	85,593	27	20,139	28	10,699	48
Ohio	84,241	25	16,630	13	6,591	17
Oklahoma	151,367	49	27,421	46	8,244	34
Oregon	107,451	33	21,732	36	6,331	14
Pennsylvania	71,595	15	14,699	8	6,293	13
Rhode Island	95,513	31	11,420	4	8,145	33
South Carolina	84,970	26	23,367	38	9,309	42
South Dakota	137,266	47	20,088	27	11,282	50
Tennessee	74,416	16	15,880	11	8,060	31
Texas	80,099	21	19,185	21	7,156	23
Utah	127,925	44	23,453	39	7,253	26
Vermont	125,318	42	9,494	3	5,645	6
Virginia	64,321	10	21,612	34	7,567	28
Washington	88,614	29	19,329	22	6,243	11
West Virginia	132,493	46	18,009	17	10,248	47
Wisconsin	60,104	8	17,955	16	6,556	16
Wyoming	283,678	51	29,861	48	8,468	37

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

Prepared: Iowa Medical Society 3/8/2013

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Cardiovascular Disease		Child and Adolescent Psychiatry		Dermatology	
	Individuals per Physician	Rank	Individuals per Physician	Rank	Individuals per Physician	Rank
Alabama	17,156	31	65,804	42	37,238	35
Alaska	24,129	47	55,682	33	51,704	48
Arizona	16,168	27	56,731	34	27,520	22
Arkansas	18,139	34	68,339	44	38,163	37
California	16,990	30	43,018	21	22,619	8
Colorado	21,142	45	33,440	12	26,509	16
Connecticut	9,197	5	18,584	3	18,488	4
Delaware	12,108	11	45,407	23	43,245	43
District of Columbia	5,785	1	12,380	1	9,379	1
Florida	11,743	9	62,978	38	21,984	7
Georgia	17,939	33	64,134	39	33,720	31
Hawaii	19,973	37	20,267	4	25,057	12
Idaho	31,054	50	93,161	50	39,594	39
Illinois	13,396	14	54,261	31	27,655	23
Indiana	15,297	24	81,454	47	42,591	42
Iowa	20,703	42	65,194	40	37,367	36
Kansas	15,600	25	44,160	22	39,320	38
Kentucky	15,996	26	54,585	32	33,851	32
Louisiana	12,265	12	65,354	41	24,999	11
Maine	14,762	21	26,050	9	49,205	47
Maryland	10,541	8	21,789	5	20,418	6
Massachusetts	7,875	2	18,507	2	16,559	3
Michigan	14,419	20	49,138	28	26,912	19
Minnesota	12,523	13	48,612	27	24,087	9
Mississippi	21,117	44	85,070	49	58,382	51
Missouri	13,626	18	49,661	29	28,614	26
Montana	21,688	46	58,686	36	32,183	30
Nebraska	13,447	15	48,480	26	57,570	50
Nevada	19,854	36	85,001	48	40,597	41
New Hampshire	11,980	10	35,616	13	26,356	15
New Jersey	8,915	3	32,843	11	25,242	13
New Mexico	19,987	38	35,839	14	43,306	44
New York	9,004	4	22,997	6	18,626	5
North Carolina	15,103	22	41,600	17	26,809	18
North Dakota	25,361	49	31,125	10	40,279	40
Ohio	13,498	16	46,536	25	28,567	25
Oklahoma	20,345	41	78,837	46	48,515	45
Oregon	20,253	40	42,508	19	26,137	14
Pennsylvania	9,684	7	36,516	15	24,091	10
Rhode Island	9,298	6	23,878	8	15,919	2
South Carolina	17,373	32	38,623	16	36,511	34
South Dakota	20,088	39	45,755	24	27,453	21
Tennessee	13,502	17	68,815	45	34,781	33
Texas	18,574	35	52,524	30	32,040	29
Utah	25,128	48	61,181	37	26,803	17
Vermont	13,924	19	23,207	7	29,838	28
Virginia	16,779	29	41,775	18	28,739	27
Washington	20,803	43	58,319	35	27,964	24
West Virginia	15,204	23	66,247	43	48,813	46
Wisconsin	16,647	28	42,611	20	27,451	20
Wyoming	40,525	51	113,471	51	56,736	49

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

Prepared: Iowa Medical Society 3/8/2013

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Diagnostic Radiology/Radiology		Emergency Medicine		Family Medicine/General Practice	
	Individuals per Physician	Rank	Individuals per Physician	Rank	Individuals per Physician	Rank
Alabama	10,771	37	14,735	50	3,177	40
Alaska	12,480	49	6,641	8	1,505	1
Arizona	9,332	28	8,094	24	3,158	38
Arkansas	11,302	40	13,418	48	2,148	15
California	10,224	32	8,357	28	3,112	37
Colorado	9,457	29	6,316	7	2,203	17
Connecticut	6,069	3	7,567	16	5,684	51
Delaware	8,409	17	7,040	10	2,829	29
District of Columbia	3,620	1	3,458	1	3,241	41
Florida	9,022	23	8,963	32	3,106	36
Georgia	11,163	39	10,506	40	3,671	45
Hawaii	8,507	18	6,658	9	2,938	31
Idaho	11,312	42	8,292	27	2,161	16
Illinois	8,844	20	7,542	15	2,813	28
Indiana	10,360	34	10,262	39	2,466	24
Iowa	12,767	51	15,959	51	1,847	6
Kansas	9,055	24	12,372	46	2,050	12
Kentucky	10,599	35	9,683	37	3,012	34
Louisiana	10,010	31	7,929	21	3,170	39
Maine	9,226	26	5,582	2	1,506	2
Maryland	7,113	8	7,694	17	4,075	47
Massachusetts	5,142	2	5,852	4	4,449	49
Michigan	7,710	11	6,015	5	2,404	22
Minnesota	6,076	4	8,569	30	1,758	3
Mississippi	12,203	46	11,278	43	3,297	43
Missouri	8,209	15	8,969	33	2,847	30
Montana	10,285	33	8,908	31	1,983	10
Nebraska	8,857	21	13,065	47	2,002	11
Nevada	12,308	48	9,347	36	3,747	46
New Hampshire	8,085	13	7,488	13	2,316	21
New Jersey	8,143	14	9,687	38	4,203	48
New Mexico	12,227	47	7,904	20	2,269	19
New York	6,709	5	7,733	18	4,481	50
North Carolina	9,271	27	8,063	23	2,951	32
North Dakota	11,412	43	11,225	42	1,811	5
Ohio	8,555	19	7,360	12	2,656	26
Oklahoma	12,013	45	12,013	45	2,281	20
Oregon	9,080	25	6,025	6	2,254	18
Pennsylvania	6,786	6	7,257	11	2,458	23
Rhode Island	6,867	7	5,618	3	3,586	44
South Carolina	11,539	44	8,242	26	2,648	25
South Dakota	10,981	38	13,502	49	1,893	7
Tennessee	8,040	12	10,613	41	3,005	33
Texas	10,653	36	11,828	44	3,260	42
Utah	11,303	41	8,111	25	3,056	35
Vermont	7,202	9	7,932	22	1,795	4
Virginia	8,945	22	7,525	14	2,735	27
Washington	8,372	16	7,861	19	2,051	13
West Virginia	9,919	30	8,431	29	1,965	9
Wisconsin	7,358	10	9,284	34	2,102	14
Wyoming	12,608	50	9,301	35	1,943	8

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

Prepared: Iowa Medical Society 3/8/2013

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Forensic Pathology		General Surgery		Internal Medicine	
	Individuals per Physician	Rank	Individuals per Physician	Rank	Individuals per Physician	Rank
Alabama	1,200,922	39	9,081	30	2,547	35
Alaska	361,930	6	9,401	37	4,067	49
Arizona	497,486	14	9,252	36	2,332	27
Arkansas	734,646	27	10,924	46	3,701	48
California	685,162	26	9,584	41	2,012	19
Colorado	465,118	12	8,898	27	2,339	28
Connecticut	1,793,359	42	6,463	10	1,135	4
Delaware	227,034	2	8,332	22	2,384	29
District of Columbia	619,020	19	2,318	1	648	1
Florida	433,688	8	9,536	39	2,045	20
Georgia	654,164	23	9,408	38	2,421	31
Hawaii	*NA	47	7,786	19	1,650	10
Idaho	791,872	30	11,075	48	4,700	51
Illinois	642,988	21	9,218	33	1,655	11
Indiana	1,303,271	40	11,063	47	2,866	42
Iowa	437,728	10	10,676	45	3,530	46
Kansas	574,077	18	9,230	35	2,814	41
Kentucky	436,681	9	7,826	20	2,599	37
Louisiana	653,538	22	7,391	15	2,197	23
Maine	1,328,544	41	6,418	7	1,906	16
Maryland	343,504	4	6,327	5	1,196	6
Massachusetts	1,101,167	38	5,785	3	954	2
Michigan	897,891	33	7,499	16	1,812	14
Minnesota	534,730	16	8,461	24	1,980	17
Mississippi	2,977,457	45	10,447	43	3,316	45
Missouri	751,123	29	8,428	23	2,058	21
Montana	997,667	37	9,686	42	3,260	43
Nebraska	1,842,234	43	8,490	25	2,639	38
Nevada	453,338	11	12,593	51	2,471	33
New Hampshire	*NA	48	6,366	6	1,729	12
New Jersey	981,641	36	7,736	18	1,384	7
New Mexico	207,867	1	9,579	40	2,520	34
New York	513,200	15	6,488	11	1,163	5
North Carolina	742,393	28	9,003	29	2,253	24
North Dakota	684,740	25	6,460	9	2,394	30
Ohio	549,572	17	7,384	14	1,884	15
Oklahoma	3,784,163	46	11,467	49	3,302	44
Oregon	967,057	35	7,540	17	1,771	13
Pennsylvania	796,497	31	6,449	8	1,581	9
Rhode Island	350,215	5	6,004	4	1,120	3
South Carolina	467,335	13	8,752	26	2,684	39
South Dakota	*NA	49	8,319	21	2,582	36
Tennessee	426,652	7	7,087	13	2,006	18
Texas	625,165	20	10,526	44	2,760	40
Utah	2,814,347	44	11,976	50	3,665	47
Vermont	313,296	3	5,449	2	1,574	8
Virginia	675,365	24	8,935	28	2,083	22
Washington	852,908	32	9,221	34	2,257	25
West Virginia	*NA	50	6,921	12	2,460	32
Wisconsin	951,641	34	9,121	31	2,283	26
Wyoming	*NA	51	9,151	32	4,141	50

Prepared: IA Medical Society 3/8/2013

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

*NA: 5 states have no FOPs

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Neurological Surgery		Neurology		Obstetrics and Gynecology	
	Individuals per Physician	Rank	Individuals per Physician	Rank	Individuals per Physician	Rank
Alabama	58,582	32	23,899	32	8,297	34
Alaska	72,386	47	38,098	49	7,868	27
Arizona	59,883	36	20,023	16	8,443	37
Arkansas	55,445	27	29,683	43	10,495	49
California	60,879	37	23,392	30	7,415	22
Colorado	49,673	20	25,710	37	6,989	19
Connecticut	40,300	6	16,156	7	4,827	2
Delaware	69,857	44	22,703	25	8,037	30
District of Columbia	12,380	1	5,336	1	2,840	1
Florida	51,574	24	18,653	14	8,018	29
Georgia	69,592	43	28,691	42	7,189	20
Hawaii	106,010	51	27,563	40	5,915	9
Idaho	56,562	29	40,609	50	10,351	47
Illinois	49,461	19	20,576	18	6,656	13
Indiana	66,493	40	24,315	33	8,927	42
Iowa	85,114	49	25,534	35	11,830	51
Kansas	66,753	41	22,781	27	8,296	33
Kentucky	59,819	34	26,627	38	8,350	35
Louisiana	41,970	8	21,889	22	6,293	10
Maine	69,923	45	23,308	29	7,679	25
Maryland	36,727	4	13,272	5	5,118	3
Massachusetts	40,534	7	8,928	2	5,775	8
Michigan	57,091	30	19,558	15	6,651	12
Minnesota	49,975	22	15,148	6	7,993	28
Mississippi	55,138	26	28,629	41	8,706	39
Missouri	42,317	9	18,099	12	7,568	24
Montana	38,372	5	30,232	46	9,686	45
Nebraska	49,790	21	25,587	36	8,261	32
Nevada	104,616	50	35,790	48	9,315	44
New Hampshire	48,808	18	18,561	13	6,724	14
New Jersey	70,678	46	17,056	10	5,613	6
New Mexico	74,238	48	26,650	39	8,883	41
New York	46,655	14	12,485	4	5,413	5
North Carolina	57,447	31	21,737	21	7,235	21
North Dakota	62,249	38	29,771	45	11,412	50
Ohio	44,218	12	17,977	11	6,957	18
Oklahoma	51,137	23	32,343	47	9,932	46
Oregon	36,152	3	21,610	20	6,846	17
Pennsylvania	43,495	11	16,173	8	6,725	15
Rhode Island	35,022	2	12,361	3	5,227	4
South Carolina	67,730	42	29,767	44	7,513	23
South Dakota	43,347	10	22,878	28	10,425	48
Tennessee	45,713	13	22,775	26	6,823	16
Texas	62,364	39	25,303	34	7,796	26
Utah	58,632	33	23,850	31	8,822	40
Vermont	48,199	17	16,935	9	5,645	7
Virginia	55,509	28	21,554	19	6,458	11
Washington	59,853	35	22,153	24	8,434	36
West Virginia	47,562	15	22,082	23	8,588	38
Wisconsin	47,982	16	20,176	17	8,204	31
Wyoming	51,578	25	51,578	51	9,151	43

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

Prepared: Iowa Medical Society 3/8/2013

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Occupational Medicine		Ophthalmology		Orthopedic Surgery	
	Individuals per Physician	Rank	Individuals per Physician	Rank	Individuals per Physician	Rank
Alabama	252,826	38	21,162	36	12,039	32
Alaska	361,930	48	24,961	47	9,163	8
Arizona	174,792	25	22,613	43	14,902	48
Arkansas	326,509	44	21,294	38	16,058	50
California	140,089	19	16,831	15	12,875	41
Colorado	78,712	1	18,673	27	10,593	15
Connecticut	123,680	9	12,241	5	9,439	10
Delaware	181,627	27	17,807	21	12,791	39
District of Columbia	123,804	10	5,952	1	6,317	1
Florida	293,573	41	15,133	11	12,705	37
Georgia	228,197	36	23,531	46	14,200	45
Hawaii	86,133	3	12,643	6	10,938	20
Idaho	226,249	35	26,843	49	11,394	23
Illinois	136,806	17	16,898	16	12,821	40
Indiana	130,327	13	22,784	45	13,381	43
Iowa	133,222	15	19,517	32	14,874	47
Kansas	205,028	32	20,357	34	11,528	26
Kentucky	181,951	28	22,626	44	13,233	42
Louisiana	152,492	21	14,076	7	10,841	18
Maine	88,570	4	19,537	33	9,356	9
Maryland	157,826	22	11,144	2	8,984	6
Massachusetts	173,869	24	11,883	4	8,857	5
Michigan	114,847	6	15,956	14	11,565	27
Minnesota	127,317	11	17,944	22	9,448	11
Mississippi	496,243	50	22,220	41	15,508	49
Missouri	133,533	16	17,673	20	11,600	29
Montana	199,533	30	21,227	37	9,593	12
Nebraska	368,447	49	18,992	28	10,901	19
Nevada	272,003	39	27,475	50	17,778	51
New Hampshire	329,452	45	19,380	30	8,085	4
New Jersey	200,790	31	14,204	9	11,429	24
New Mexico	129,917	12	26,312	48	11,946	30
New York	336,235	46	11,378	3	10,136	13
North Carolina	301,597	42	18,998	29	12,263	34
North Dakota	342,370	47	21,398	39	12,228	33
Ohio	117,765	7	17,355	19	11,282	22
Oklahoma	130,488	14	22,260	42	13,811	44
Oregon	214,902	34	14,878	10	10,775	16
Pennsylvania	179,492	26	14,097	8	10,412	14
Rhode Island	80,819	2	15,451	12	7,505	2
South Carolina	212,425	33	18,619	26	12,462	36
South Dakota	137,266	18	21,118	35	11,600	28
Tennessee	172,967	23	18,233	24	10,810	17
Texas	228,855	37	21,539	40	14,833	46
Utah	148,124	20	19,409	31	12,027	31
Vermont	313,296	43	15,665	13	7,932	3
Virginia	279,462	40	17,354	18	12,392	35
Washington	98,888	5	18,541	25	11,506	25
West Virginia	185,491	29	18,009	23	12,705	38
Wisconsin	118,955	8	17,095	17	11,109	21
Wyoming	567,356	51	40,525	51	9,151	7

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

Prepared: Iowa Medical Society 3/8/2013

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Otolaryngology Individuals per Physician	Rank	Pediatrics Individuals per Physician	Rank	Physical Medicine and Rehabilitation Individuals per Physician	Rank
Alabama	24,890	9	5,332	39	49,017	41
Alaska	22,621	5	5,484	41	48,257	39
Arizona	43,405	50	5,088	36	42,548	34
Arkansas	31,941	35	5,324	38	45,209	37
California	31,936	34	4,145	19	35,384	23
Colorado	28,112	22	4,377	23	25,971	12
Connecticut	23,597	6	3,119	8	36,229	25
Delaware	37,839	45	2,939	7	23,898	8
District of Columbia	10,492	1	1,159	1	16,290	1
Florida	31,489	33	4,714	27	38,241	28
Georgia	31,151	31	4,791	30	46,726	38
Hawaii	29,322	27	3,437	10	32,813	17
Idaho	39,594	48	10,488	51	40,609	32
Illinois	32,149	36	3,839	13	25,415	9
Indiana	36,202	44	5,541	42	44,029	35
Iowa	28,636	24	6,948	45	58,925	47
Kansas	28,994	26	5,416	40	37,278	26
Kentucky	33,082	41	4,731	29	41,989	33
Louisiana	19,062	2	3,988	17	33,392	19
Maine	37,958	47	4,443	24	33,214	18
Maryland	21,708	3	2,844	5	22,634	6
Massachusetts	24,653	8	2,366	2	21,734	5
Michigan	32,383	38	4,300	21	23,742	7
Minnesota	27,851	19	4,220	20	26,472	14
Mississippi	27,316	16	6,813	44	78,354	50
Missouri	27,564	17	3,820	12	34,337	22
Montana	32,183	37	8,384	49	49,883	42
Nebraska	26,699	13	5,089	37	48,480	40
Nevada	53,334	51	7,102	46	38,310	29
New Hampshire	31,376	32	4,144	18	39,934	30
New Jersey	32,481	39	2,934	6	18,678	3
New Mexico	41,573	49	4,949	32	59,391	48
New York	24,592	7	2,742	4	17,537	2
North Carolina	27,893	21	4,341	22	33,628	20
North Dakota	28,531	23	7,133	47	40,279	31
Ohio	29,517	29	3,476	11	30,532	16
Oklahoma	37,842	46	6,265	43	65,244	49
Oregon	25,283	11	4,866	31	35,817	24
Pennsylvania	26,550	12	3,964	16	20,101	4
Rhode Island	30,018	30	2,532	3	80,819	51
South Carolina	32,681	40	4,988	34	51,355	43
South Dakota	24,957	10	7,354	48	34,316	21
Tennessee	29,492	28	3,848	14	52,031	44
Texas	34,591	42	4,728	28	37,917	27
Utah	27,865	20	4,636	26	25,585	10
Vermont	22,378	4	3,405	9	44,757	36
Virginia	28,841	25	3,948	15	26,313	13
Washington	27,184	15	4,955	33	26,969	15
West Virginia	26,883	14	5,000	35	52,997	45
Wisconsin	27,584	18	4,514	25	25,605	11
Wyoming	35,460	43	9,782	50	56,736	46

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

Prepared: Iowa Medical Society 3/8/2013

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Plastic Surgery		Psychiatry		Pulmonary Disease	
	Individuals per Physician	Rank	Individuals per Physician	Rank	Individuals per Physician	Rank
Alabama	60,046	38	13,570	43	33,829	31
Alaska	72,386	44	8,937	19	55,682	50
Arizona	43,115	16	11,151	34	26,724	15
Arkansas	91,831	50	13,237	42	48,173	47
California	32,542	5	7,197	12	31,720	26
Colorado	47,816	25	8,852	18	24,836	12
Connecticut	36,599	8	4,557	5	18,207	4
Delaware	39,484	11	9,765	27	31,315	25
District of Columbia	15,476	1	1,997	1	9,523	1
Florida	30,483	3	11,231	35	26,320	13
Georgia	49,809	30	11,571	38	36,889	37
Hawaii	44,456	18	5,915	9	41,761	43
Idaho	75,416	46	20,304	51	40,609	42
Illinois	46,763	24	9,172	20	27,596	18
Indiana	62,657	41	15,778	50	35,034	35
Iowa	90,121	49	14,522	48	38,786	39
Kansas	42,212	15	9,380	24	32,618	28
Kentucky	46,455	23	11,255	36	29,506	22
Louisiana	48,155	26	10,189	30	26,753	16
Maine	73,808	45	5,879	8	19,537	6
Maryland	31,396	4	5,127	7	18,898	5
Massachusetts	32,871	6	3,509	2	16,601	2
Michigan	45,726	21	9,479	25	32,383	27
Minnesota	52,425	33	9,348	23	30,732	23
Mississippi	59,549	37	15,754	49	33,455	29
Missouri	42,021	14	9,916	28	28,079	19
Montana	62,354	40	12,167	41	39,907	40
Nebraska	59,427	36	11,442	37	34,115	32
Nevada	48,572	27	14,241	47	53,334	49
New Hampshire	48,808	28	7,844	13	26,356	14
New Jersey	38,081	9	6,833	10	20,886	9
New Mexico	76,988	47	8,382	15	42,422	44
New York	30,095	2	4,083	3	20,063	7
North Carolina	50,266	32	9,174	21	30,834	24
North Dakota	48,910	29	8,559	17	48,910	48
Ohio	44,907	19	9,923	29	27,284	17
Oklahoma	68,803	43	11,863	40	47,302	46
Oregon	50,237	31	8,428	16	33,637	30
Pennsylvania	43,347	17	6,975	11	20,456	8
Rhode Island	38,913	10	4,910	6	17,808	3
South Carolina	53,717	35	10,226	31	36,228	36
South Dakota	68,633	42	11,766	39	45,755	45
Tennessee	46,375	22	10,959	33	22,068	10
Texas	41,275	12	13,648	44	40,365	41
Utah	35,625	7	13,662	45	38,032	38
Vermont	78,324	48	4,508	4	24,100	11
Virginia	41,561	13	8,072	14	28,841	20
Washington	45,488	20	9,221	22	34,288	33
West Virginia	61,830	39	10,599	32	29,443	21
Wisconsin	52,869	34	9,760	26	34,605	34
Wyoming	141,839	51	13,838	46	70,920	51

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

Prepared: Iowa Medical Society 3/8/2013

Attachment D

Individuals per One Patient Care Physician, Ranking by State and Specialty, 2011

State	Urology Persons per Physician	Rank	Individuals per Physician	Rank	Individuals per Physician	Rank
Alabama	33,359	35				
Alaska	28,954	17				
Arizona	33,166	34				
Arkansas	36,732	46				
California	35,022	40				
Colorado	32,178	30				
Connecticut	25,259	10				
Delaware	34,928	39				
District of Columbia	10,317	1				
Florida	26,614	14				
Georgia	35,812	43				
Hawaii	29,959	22				
Idaho	36,831	47				
Illinois	28,963	18				
Indiana	36,202	44				
Iowa	35,629	42				
Kansas	31,543	27				
Kentucky	32,833	32				
Louisiana	23,703	7				
Maine	26,571	13				
Maryland	23,933	8				
Massachusetts	21,877	3				
Michigan	30,112	23				
Minnesota	29,873	20				
Mississippi	33,455	36				
Missouri	32,134	29				
Montana	31,177	26				
Nebraska	31,763	28				
Nevada	46,102	51				
New Hampshire	23,119	5				
New Jersey	23,686	6				
New Mexico	39,975	48				
New York	21,454	2				
North Carolina	27,893	16				
North Dakota	42,796	49				
Ohio	26,777	15				
Oklahoma	34,092	37				
Oregon	25,961	11				
Pennsylvania	26,222	12				
Rhode Island	22,840	4				
South Carolina	34,617	38				
South Dakota	30,503	25				
Tennessee	24,710	9				
Texas	35,600	41				
Utah	36,550	45				
Vermont	32,979	33				
Virginia	29,152	19				
Washington	32,492	31				
West Virginia	30,408	24				
Wisconsin	29,894	21				
Wyoming	43,643	50				

Sources: Physician Characteristics and Distribution in the U.S., 2013 Edition, Division of Survey and Data Resources, AMA 2013; U.S. Census Bureau Population Estimate as of 7/1/2011

Prepared: Iowa Medical Society 3/8/2013

Attachment E

IMS LIABILITY COMMITTEE

Committee Background and Proceedings:

> **RESOLUTION 03-06 – MALPRACTICE INSURANCE**
> **RESOLVED:** That the Iowa Medical Society House of Delegates refer this issue (medical professional liability) to the IMS Board of Directors with the intent of forming an ad hoc committee to address the crisis in medical liability in the state of Iowa.

As directed by House of Delegates Resolution 03-06 above, the IMS Board of Directors established an ad hoc committee to address medical liability in Iowa. The IMS Liability Committee was charged with studying and addressing medical liability in Iowa and making recommendations to the IMS Board. Members of the Committee included: Tom Throckmorton, MD, Chair; Mark Barnhill, DO; Susan Beck, DO; Kent Carr, MD; Kevin Cunningham, MD; Thomas Gellhaus, MD; Harold Miller, MD; David Oman; LeAnn Paulsen, IMGMA; and Steve Wanzek, MD. The Liability Committee met on August 27, 2003 at IMS headquarters with a follow-up conference call held on November 5, 2003 to discuss the draft recommendations.

At the August 27, 2003 meeting, Chair Tom Throckmorton, MD called the meeting to order and provided a brief overview of Resolution 03-06. Ross Rubin, JD, Vice President of Legislative Affairs at the American Medical Association (AMA), provided an AMA liability update. Dave Bounk, President, Midwest Medical Insurance Company (MMIC), presented on "Why have my premiums increased? – The Reality vs. the Myth." Denise Hill, JD, IMS Manager of Public and Regulatory Affairs, presented an overview of "The Iowa Landscape – History of Tort Reform." Jeanine Freeman, JD, IMS Vice President of the Office of Legal Affairs, updated the group regarding meetings with the Iowa Insurance Commissioner held in the summer of 2002. The presentations were followed by extensive committee discussion. Copies of the materials reviewed by the Committee, including the meeting minutes, are available from Karla Fultz McHenry, Vice President of Public Policy and Advocacy.

Reform Measures reviewed by the Committee:

- Reforming the legal system for medical cases
- Caps on noneconomic and punitive damages
- Fault-based compensation system
- No-fault-based system
- Alternate Dispute Resolution (ADR)/arbitration
- Patient compensation funds
- MICRA
- Pre-trial screening mechanisms such as a certificate of merit
- Collateral source rule
- Joint and several liability

- Limits on attorney fees
- Asset protection mechanisms
- "Loss of chance"

Committee Findings:

1. Many factors have contributed to increasing medical liability premiums, including:

   - Premium rates have not kept pace with losses.
   - Decreases in interest income. (The public perception that malpractice premiums have primarily increased to cover the losses that insurance carriers have suffered in the stock market is false.)
   - The increase in large jury verdicts in Iowa. (Due to increased medical inflation, increases in average income, juries that are generous about noneconomic damages, the recent bad economy, and higher lawyer and expert witness fees.)
   - The lack of insurance company capacity for writing large amounts of new coverage for physicians, forcing physicians into the nonstandard or excess market where costs are significantly higher.
   - Lack of cooperation between attorneys and insurers. (Iowa has higher indemnity costs and expenses per claim than some other states. An example is liability carriers with a case in Iowa must hire a defense attorney to get medical records. Plaintiff attorneys will not release the records directly to the insurance carrier.)
   - Increased reinsurance costs.

2. Iowa's health care infrastructure is struggling due to low reimbursement under Medicare and Medicaid and increasing medical liability premiums. Doctors are under pressure to keep up with the costs of practicing without relief while Iowa is showing signs of a struggling liability environment.

3. The Insurance Commissioner has determined that Iowa is not in a professional liability "crisis" at this time. The Iowa Medical Society does believe that Iowa's liability market is under significant stress. Under Iowa statute, a joint underwriting authority (JUA) is possible, but the mechanisms to implement the JUA, such as administrative rules, are not in place. IMS has asked for the Insurance Commissioner to begin the administrative rules process to put that mechanism in place, but to date, no action has been taken by the Insurance Division of the Iowa Department of Commerce.

4. Iowa is better positioned than many other states due to significant tort reforms enacted from 1977-1997. Iowa presently has the collateral source rule, permits ADR, has specific requirements for expert witnesses, has court review of attorney fees and punitive damages, and limits joint and several liability to economic damages. However, more reform is needed to make the medical liability insurance in Iowa affordable for physicians.

5. States that have a comprehensive combination of tort reform measures in place, including caps on noneconomic damages, are having the most success in holding down premiums (i.e., MICRA in California). States that have only a few tort reform measures in place without caps on noneconomic damages have had significant premium increases and are in a crisis.

6. There is no clear evidence that patient compensation funds (PCF) alone would be effective in keeping premiums down in Iowa without a cap on noneconomic damages. In every state where PCFs are successful in holding down premium costs, there is both a PCF and a cap on noneconomic damages. Further, physicians would likely be required to pay a fee to support the fund that could ultimately be used by the government for unrelated purposes, as was attempted in Wisconsin last year.

7. The Committee determined that there is no good data to establish that certificates of merit would decrease frivolous medical liability cases in Iowa or have much of an impact on liability insurance premiums.

8. IMS does not have sufficient resources to wage a full-scale public relations and grassroots campaign to secure state legislative caps on noneconomic damages. The political realities are that the trial lawyers in Iowa are a powerful lobby because of their level of contribution to candidates; and the Governor, when directly asked by IMS/IMPAC Board members, indicated he would veto any legislation that included a cap on noneconomic damages. In addition, the current-sitting judges on the Iowa Supreme Court, even if legislation were passed, would likely determine a cap on noneconomic damages to be unconstitutional.

9. Despite political roadblocks in the Senate, Congressional liability reform including caps on noneconomic damages is more probable than Iowa legislation. In Congress, the House of Representatives has passed tort reforms that include a cap on noneconomic damages. The battle for passage of liability reform is in the Senate. While Senate leadership and the President are supportive of tort reform, the Democratic minority, who are historically supported by the trial lawyers, are not supportive and have repeatedly filibustered, resulting in an impasse.

10. Liability carriers' defense costs could be lowered if there was easier access to medical records early in the liability claim process. Currently, defense costs are higher in Iowa because of the need to hire a defense attorney to acquire medical records. Plaintiff attorneys in Iowa have not been willing to release these records directly to the liability companies, resulting in increased costs per case.

Committee Recommendations:

1. That IMS support national efforts to secure Congressional professional liability reform, including caps on noneconomic damages. Due to current constraints, IMS should not take the lead in a state-level campaign to secure caps on noneconomic damages. However, IMS should monitor, and when appropriate, support state

legislation to cap noneconomic damages led by other stakeholders, such as the Association of Business and Industry, Iowa Medical Group Management Association, and the Iowa Hospital Association.

2. That IMS explore, with the Iowa Bar Association and other stakeholders, potential changes in access to medical records to assist liability companies in lowering defense costs through easier and timelier access to these records in medical liability cases.

3. That IMS bring the relevant information on the causes of the national liability crisis and the impact to physicians from the first draft of the National Association of Insurance Commissioners report to the attention of the Iowa Insurance Commissioner.

4. That IMS explore changing the "loss of chance" from 1% in Iowa to a more reasonable standard as recommended by MMIC. The Committee recommends further investigation before moving forward with legislative changes as the issue may involve significant resistance from various attorney groups and may not be an appropriate primary advocacy position.

Attachment F

IOWA MEDICAL SOCIETY

PATIENT COMPENSATION FUNDS

WHITE PAPER

Adopted by Iowa Medical Society Board of Directors
11/11/04

Research led by
Dana Birnberg, MA
Manager of Legislative Affairs

PATIENT COMPENSATION FUNDS

Background

Medical liability insurance (MLI) is back in the headlines and states are once again grappling with how to maintain the delicate balance between preserving access to health care and protecting compensation for injured patients. Eleven states including Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, New York, Pennsylvania, South Carolina, Virginia, and Wisconsin, have established state-run funds for medical injuries, commonly known as patient compensation funds (PCFs). These funds, which are often implemented as part of a broader tort reform package, have operated in states with varying degrees of success.

A recent report to the Ohio Legislature defined a patient compensation fund as a medical malpractice mechanism established by state law and designed to increase availability and/or affordability of medical liability insurance.[1] In practice, the state creates a fund that pays a portion of a judgment or settlement against a health care provider that exceeds a designated level – such as $200,000 per occurrence and $600,000 in aggregate. In some states, the fund limits the amount it pays on claims. For example, a PCF might only pay up to $1 million of a claim. The provider is responsible for carrying a pre-established base level of MLI and paying awards beyond the funds' maximum threshold, if one exists. Participation in a fund may be voluntary or mandatory and all states require provider-participants to pay annual assessments.[2]

Discussions regarding the effectiveness of PCFs have evoked fervent debate. Proponents argue a secondary line of insurance mitigates a MLI crisis by: (1) stabilizing private market premiums, (2) increasing availability of insurance, and (3) ensuring injured patients receive full compensation for their injuries. Others voice concern that implementing a PCF alone, instead of part of a broader tort reform package, does nothing to control provider MLI costs. They contend that establishing a PCF merely shifts a portion of costs from the traditional insurance market to the PCF, failing to address the root of the problem – the runaway litigation system.

This paper explores the value of a PCF as a solution to state medical liability crises. First, it examines the effectiveness of a fund in increasing the availability and the affordability of liability insurance. Next, it discusses a state's responsibility to structure the fund in a financially responsible manner. Finally, the paper proposes policy recommendations regarding Iowa's medical liability crisis and the implementation of a PCF.

The Issue: Increasing availability and affordability of MLI

The underlying rationale for implementing a PCF is that the private sector serves as an unreliable source of reinsurance for large MLI claims. Though large claims occur infrequently, insurers have a difficult time predicting whether losses are a random occurrence or a true shift in risk. Therefore, insurers are forced to either raise premiums substantially to insure against future losses or refuse to provide coverage altogether. As a result, the state intervenes and provides excess liability coverage. The outcome of this intervention is that, by limiting private insurers' liability, insurers can increase underwriting capacity and write additional policies.[3]

[1] Pinnacle Actuarial Resources, Inc., "Final Report on the Feasibility of an Ohio Patient Compensation Fund," 2003.
[2] National Governor's Association (NGA) Center for Best Practices, "Addressing the Medical Malpractice Crisis," http://www.nga.org/cda/files/1102MEDMALPRACTICE.pdf. 2003, p. 5.
[3] Frank Sloan, "Public Medical Malpractice Insurance," The Pew Charitable Trust's Project on Medical Liability in Pennsylvania, 2004, p. 31.

PCFs will not control costs

While an argument can be made that PCFs increase availability of private MLI coverage, it is difficult to argue that PCFs help reduce providers' overall medical liability costs. PCFs merely shift a portion of private MLI costs from the traditional insurance market to the state-run PCF. Providers still pay approximately the same amount in MLI expenses – only now to two insurers.[4] Depending on the administrative costs relating to the operation of the fund and financing decisions, providers' combined MLI premiums could even be higher than without the fund.[5] If policymakers intend to reduce provider MLI costs, then a PCF must be implemented in conjunction with other tort reform measures, such as upper limits on non-economic damage awards, commonly known as "caps."[6] Researchers from the Pew Trust's Project on Medical Liability in Pennsylvania contend that unless states have a cap on non-economic damage awards, providers will remain vulnerable to very high jury verdicts and increasing PCF assessments, and eventually it will stress the financial stability of a fund. They cite "continued provider vulnerability" as a structural weakness of PCFs.[7]

Two states' experiences with PCFs best illustrate the importance of implementing a cap in conjunction with a PCF. Wisconsin, which has a cap, operates a financially solvent PCF. Claims have remained relatively level in the last decade. In 1995, the fund incurred $24.1 million losses compared to $22 million in losses in 2003.[8] The Director of the Wisconsin Fund, Theresa Wedekind, recently attributed "Wisconsin's relatively stable medical malpractice environment" to "the non-economic damages and wrongful death caps."[9] PCF stability translates into savings for providers. A Legislative Fiscal Bureau report to the Wisconsin Legislature in 2001 noted that PCF participants saved approximately $67.7 million in medical liability fees as a direct result of the cap on non-economic damages.[10] Most states with PCFs have some type of a cap on non-economic or total damage awards. Only New York, Pennsylvania and South Carolina operate a PCF without a cap.

In stark contrast to Wisconsin's success story is the Pennsylvania[11] experience. Pennsylvania operates a PCF without a cap on non-economic or total damages and is currently facing one of the worst MLI crises in the United States.[12] Since the mid-1990s, the state's PCF has rapidly increased annual assessments on medical providers, while it reduced provider excess coverage by increasing the threshold at which the PCF would cover a provider claim.[13] In the last few years, Pennsylvania PCF outlays have increased dramatically. In 1994, the Pennsylvania Fund paid $200 million in claims as compared to over $350 million in claims in 2001.[14] In 2002, the Pennsylvania Legislature voted to reconfigure and eventually dissolve the fund, leaving the payment of unfunded large liability claims from past incidents in question. Based on the

[4] Sloan, p. 36.
[5] Sloan, p. 38, 40.
[6] NGA.
[7] Sloan, p. 32, p. 40.
[8] Wisconsin Insurance Report, 2001.
[9] Theresa Wedekind, "Patient Compensation Claims Experience," WiscRisk, Spring 2004, Volume 4. Issue 1, p. 1.
[10] American Medical Association Advocacy Resource Center, "Guide to State Health Care Stabilization Funds," 2003, p. 5.
[11] Pennsylvania tort laws: (1) No cap on damage awards, unless, the defendant's percentage of liability is 60% or greater, then the defendant can be held jointly and severally liable, (2) joint liability reform, each defendant shall be responsible for several only and not joint, (3) collateral source rule reform, (4) no limits on attorneys fees, periodic payments permitted, (5) expert testimony required, (6) certificate of merit, (7) statute of limitations: no action may be taken more then seven years from date of incident, and wrongful death within two years of date of death.
[12] Randall R. Bovbjerg and Anna Bartow, "Understanding Pennsylvania's Medical Malpractice Crisis: Facts about Liability Insurance, the Legal System, and Health Care in Pennsylvania," The Pew Charitable Trust's Project on Medical Liability in Pennsylvania. 2003, p. 1.
[13] Bovbjerg and Bartow, p. 5.
[14] Bovbjerg and Bartow. p. 18.

Pennsylvania experience, Randall R. Bovbjerg and Anna Bartow concluded in their report "Understanding Pennsylvania's Medical Malpractice Crisis" that implementing a PCF in Pennsylvania *without adopting a cap on damages* exacerbated the state's liability insurance crisis.[15] Unless a state adopts a tort reform mechanism which will control for the size of jury verdicts, both MLI rates and state PCF assessments will continue to escalate.

Discouraging insurers from defending suits

The fact that a PFC does not control for escalating assessments is only one concern regarding implementation of a PCF in a state, which does not have a cap on non-economic damage awards. Frank A. Sloan in his report on public provision of medical malpractice insurance contends that enacting a fund – especially one in a state without a cap – could actually lead to an *increase* in MLI costs by discouraging private insurers from defending some claims. He argues that primary insurers in states without PCFs logically defend claims up to the point at which the last dollar spent on prevention equals the savings in payments to claimants. In a state with a PCF, insurers have less incentive to defend claims that exceed their pre-established policy limits.[16] In short, if a PCF requires/permits primary MLI coverage of $250,000, an insurer has little motivation to defend a provider against a $1 million claim if an insurer is only liable for $250,000 of the judgment.[17] Consequently, the lion's share of the judgment would be shouldered by the state PCF. Implementing a PCF in Iowa could take the burden of defending lawsuits out of the hands of insurers and place it squarely on the shoulders of the state.

State Accountability and PCF Financing

Even in states with an upper limit on medical liability, the structure of a PCF is vital to the long-term financial stability of the fund. Issues such as loss reserving practices, provider assessments and mandatory versus voluntary participation all directly impact the financial stability of a state PCF. In fact, concerns about the stability of financing a fund greatly contributed to then-Governor Terry E. Branstad's decision to veto a bill establishing a PCF in Iowa in 1988. In his veto message, Governor Branstad cited unease about the state's liability regarding the payment of claims should the fund become insolvent:

> Indeed Senate File 484 is simply bad public policy. It is fiscally unsound: its potential long-term impacts are frightening; and it forfeits the chance to obtain meaningful tort liability at this time and for the foreseeable future.[18]

With these concerns in mind, the following section explores how structural decisions impact the financial solvency of a PCF:

Loss reserving practices

Historically, states have insured against future claims in one of two ways: (1) collecting funds to pay claims as they are awarded, commonly known as "pay-as-you-go" financing or (2) collecting adequate funds to pay all losses and associated expenses from claims occurring during a policy year, whenever those amounts are actually spent.

Under the first approach, the PCF limits its assessments to amounts anticipated to be spent on claims and expenses in the following year; this method was employed in Pennsylvania. When a

[15] Bovbjerg and Bartow. p. 17.
[16] Sloan, p. 41.
[17] Holger Sieg, "Estimating a Bargaining Model with Asymmetric Information: Evidence from Medical Malpractice Disputes," *Journal of Political Economy,* 2000, 108(5); p. 1006-21.
[18] Governor Terry E. Branstad, Veto Message, Senate File 484, May 13, 1988, p. 181-185.

provider pays an annual assessment, participants are not buying coverage for the current year; rather, they are paying for losses incurred in previous years that have since come due.[19] This approach has appeal to state lawmakers because it initially helps solve short-term crises in availability of excess coverage without imposing high premium assessments. Practically speaking, losses tend to be low in the first few years, because most claims have not yet been resolved. Later, however, losses generally escalate, and PCF administrators are forced to raise premiums to keep up with claims' payments.[20]

The second financing method mirrors a standard loss reserving policy; this method is used in Kansas, Wisconsin, and New Mexico. Under this financing system, actuarial evaluations guide states in setting annual assessments, which ostensibly provide for all losses from claims filed in that year. While this funding method is more fiscally sound, it is subject to strong political pressures. First, stakeholders may not choose to follow actuarial recommendations, which often mean large increases in health provider assessments.[21] Also, unless PCF revenue is statutorily protected, dollars may be taken from the fund and used for other state programs. Such was the case in 2003 when the Wisconsin Governor proposed taking $200 million out of PCF reserves to subsidize Medicaid.[22]

Determining provider assessments

States vary on how provider assessments are estimated. Some states tie the assessment to a provider's primary insurance premium, which includes an experience rating based on past claims history. States may require a provider to pay a percentage of their primary coverage premium or it may average three leading insurers' rates for providers in the same specialty or discipline. Other states permit fund directors to set the surcharge based on their own methodology. For example, a director may implement a fee structure, which takes into account the risks associated with a provider's specialty and/or geographic location. While setting the surcharge directly gives the fund more control over surcharge rates, tying the surcharge directly to the provider's premium integrates a provider's past claims history into the calculation.[23]

Using an "Iowa rating" instead of caps

Recognizing that the political landscape in Iowa makes liability caps unlikely, Iowa leaders have suggested artificially lowering PCF assessments as a means of reducing provider MLI expenses. This proposal recommends the state insurance commissioner set provider surcharges based on Iowa's past *loss experience*, which has been lower than some other states. An Iowa rating system would permit the commissioner to deviate from private insurers' rates, which have been statically calculated by actuaries.

While the intent of this proposal is admirable, the risk of underfunding the PCF is of great concern. While the fund must not overestimate Iowa provider risk, collecting too few dollars to finance claims could result in injured patients not receiving the settlements they deserve. In addition, this proposal assumes that Iowa's jury verdicts and defense costs *are lower* than in other states. In fact, while Illinois may have larger jury verdicts and defense costs, Nebraska, Wisconsin, and Minnesota's costs are lower than in Iowa. Further, even if the size of verdicts in Iowa remains relatively constant, one or two aberrant judgments could bankrupt the fund. Finally, if the fund becomes insolvent, the state and/or providers would have to pay the claims. This has been the case in Pennsylvania and Florida. In order to dissolve the Pennsylvania fund

[19] Alfred E. Hofflander and Blaine F. Nye, "*The Medical Malpractice Insurance in Pennsylvania,*" The Mac Group, 2000, p. 21.
[20] Sloan, p. 39.
[21] Sloan, p. 42.
[22] American Medical Association News, "Wisconsin governor proposes raiding patient compensation fund," April 7, 2003.
[23] AMA, p. 6.

by 2009 and reduce the fund's enormous debt, Pennsylvania officials have been forced to decrease the excess coverage offered by the fund, increase provider assessments, and divert $10 million from a separate state automobile fund.[24] In other words, physicians currently in practice in Pennsylvania are being forced to pay down the fund's debt without reasonable excess coverage in return. This intergenerational discrimination arguably deters younger providers from entering practice in the state and encourages older providers to retire early or move elsewhere.[25] Assessing surcharges based on an "Iowa experience," rather than actuarial assessments would likely underestimate the possibility of future losses and cannot ensure providers' assessments will not escalate in years to come.

Voluntary participation in a fund – adverse selection

Finally, a state's decision to make participation mandatory or voluntary also has a direct impact on the financial stability of the fund. One of the challenges with voluntary participation is attracting and keeping low-risk physicians in the fund. As surcharges increase or the insurance market softens, low-risk providers may opt to purchase excess coverage in the traditional insurance market or forgo excess coverage altogether. This adverse selection decreases the pool of providers over which the risk is spread and could potentially lead to the fund covering only high-risk providers. This adverse selection of participants would potentially drive up surcharges and eventually lead to chronic fund deficits.[26]

Most states, however, shy away from mandatory participation requirements. Louisiana, Nebraska, and New Mexico adopted a creative method of encouraging voluntary participation. These three states, which do not have general caps on non-economic damage awards, have enticed low-risk providers to their fund by tying a *cap* on non-economic or total damages to fund participation.[27] This solution permits fund participation to remain voluntary while avoiding the problems of adverse selection, as most providers are likely to join.

In Nebraska, the fund works as follows: the PCF, established under the Nebraska Hospital-Medical Liability Act, requires members to provide proof of financial responsibility and pay an annual surcharge.[28] Physicians establish their financial responsibility by obtaining professional liability insurance in the amount of $200,000 per occurrence and $600,000 in the aggregate; hospitals establish their financial responsibility by obtaining insurance in the amount of $200,000 per occurrence and $1,000,000 in the aggregate. Once a health care provider has qualified under the patient compensation fund rules, the fund becomes the exclusive method of recovery, unless a claimant has elected in writing prior to treatment not to be subject to the provisions of the PCF.[29] The total amount recoverable for claims against a PCF member resulting in injury or death is $1,250,000 – or $1,000,000 if the occurrence took place prior to 1993. The liability of a single qualified health care provider is limited to $200,000 per patient. The excess liability fund pays the damages in excess of $200,000 for each defendant, up to the amount of the cap. [30]

[24] Pennsylvania Medical Society. "Strong Strides in Medical Liability Reform & Practice Economics: 2004 Progress Report and Strategic Plan for 2005," 2005.
[25] Sloan, p. 44.
[26] Sloan, p. 38.
[27] AMA, p. 2.
[28] Neb. Rev. Stat. § 44-2824 (Supp. 1996).
[29] Neb. Rev. Stat. §§ 44-2821 and 44-2840 (1993 & Supp. 1996).
[30] Neb. Rev. Stat. § 44-2825 (1993).

Better solutions for Iowa

The limitations of a PCF with uncapped liability and the very real possibility that such a mechanism threatens to worsen Iowa's medical liability condition, leads the Iowa Medical Society (IMS) to oppose the creation of a PCF at this time. A PCF carries significant financial risk for both the State of Iowa and health care providers. Even if Iowa policymakers structure the PCF to: (1) insure the fund against future claims; (2) establish adequate member assessments commensurate with fund risk; and (3) mandate participation to avoid adverse selection issues, a PCF implemented without a cap on non-economic damages will not control provider costs. Consequently, IMS suggests that, if the State of Iowa's goal is to increase availability of MLI, the state should consider other alternatives, such as a joint underwriting association (JUA) or a certificate of merit (COM).

Joint underwriting association (JUA)

A JUA, which is a public entity, is designed to specifically help those providers who cannot find MLI coverage. Unlike a PCF, which targets all providers regardless of their risk level, a JUA only serves those who have been forced out of the private MLI market. JUA members pay premiums based on their assessed liability risk. In contrast to a PCF, which holds providers solely responsible for revenue shortfalls, a JUA would share the costs associated with the public provision of MLI between insurers and providers. If JUA premium income is insufficient to cover losses and administrative expenses, insurance companies would be assessed a share of the shortfall.[31] The creation of a JUA would serve the same purpose as a PCF, to increase insurance capacity; but unlike a PCF, it would more fairly distribute the costs among stakeholders.

Certificate of merit (COM)

In addition to a JUA, there are other tort reform measures, which could mitigate the medical liability situation in Iowa more effectively than a PCF. For example, policymakers might choose to address the costly issue of plaintiffs filing lawsuits before an exhaustive review of their case has been conducted. Many of these cases are eventually withdrawn or dismissed; however, their defense is costly to insurers and drives up MLI premium rates. In response, 17 states adopted certificate of merit requirements in medical liability actions.[32] The goal of such provisions is to deter plaintiffs from filing unnecessary claims. Each state requires the plaintiff to provide certification that an expert has reviewed the case and that the expert has concluded there is some basis for the claim. In a number of states, the expert must provide the certification; in other states, the attorney must certify that the expert has reviewed the claim. The content of the certification also varies. Some states require specificity concerning the standard of care, how the defendant breached that standard, and how the breach caused the plaintiff's injury; others simply require a statement that, in the expert's view, the claim is justified.[33]

Plaintiffs' lawyers have an incentive to bring strong rather than weak cases – because they are paid only if they obtain a settlement or judgment. However, some plaintiffs' lawyers do not have sufficient expertise in the medical liability area to make this determination.[34] Realistically, a certificate of merit requirement is unlikely to change how plaintiffs' lawyers with expertise in

[31] Sloan, p. 1.

[32] Certificate of merit requirements applicable to medical malpractice actions exist in Colorado, Connecticut, Florida, Georgia, Illinois, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Texas, and West Virginia.

[33] Catherine T. Struve, "Expertise in Medical Malpractice Litigation: Special courts, screening panels, and other options," The Pew Charitable Trust's Project on Medical Liability in Pennsylvania, 2003, p. 56.

[34] Struve, p. 55.

medical liability evaluate cases, because those lawyers already seek expert advice when evaluating a potential claim. However, it induces other attorneys to obtain expert validation prior to filing a claim. In this respect, the certificate of merit requirement is a useful way to inject expertise into the process of case selection by inexperienced plaintiffs' attorneys, decrease the number of unnecessary lawsuits filed, and reduce or eliminate unnecessary defense costs. [35]

Few empirical studies have been conducted regarding the effectiveness of COM provisions, because COM provisions are most often implemented along with other tort reform measures, making the effect difficult to isolate.[36] Though not an empirical analysis, a comparison of the Midwest Medical Insurance Company's (MMIC) claims histories in Iowa – a state without a COM provision and in Minnesota – a state with a COM rule – indicates a COM is an effective means of reducing unnecessary lawsuits. MMIC data reflect that plaintiffs in Iowa do file more unnecessary lawsuits. MMIC officials contend this rarely happens in Minnesota where there is a certificate of merit requirement. They attribute the reduction of unnecessary cases, in part, to the implementation of a COM.[37]

Iowa providers are committed to continuing to provide Iowans with quality and affordable healthcare. However, the rising costs associated with practicing medicine in Iowa – both low reimbursement for Medicare and Medicaid and high MLI premiums – are making it increasingly difficult for providers to afford to continue to practice in Iowa. We urge policymakers to consider a JUA/COM as possible remedies to the medical liability crisis in our state.

[35] Struve, p. 54.
[36] Laura L. Morlock, and Faye E. Malitz, "Short-Term Effects of Tort and Administrative Reforms on the Claiming Behavior of Privately Insured, Medicare, Medicaid and Uninsured Patients," U.S. Congress, Office of Technology Assessment. 1993 as reported in Struve, p. 50.
[37] Elizabeth S. Lincoln, Letter to Iowa State Representative Rob Hogg, September 22, 2004.

Policy consideration if implementing a PCF: The Iowa Medical Society recognizes that state leaders may choose to implement a PCF in Iowa. The following section provides a list of policy considerations regarding implementation of this mechanism:

- PCFs in states without caps may improve insurance availability but nevertheless be expensive for policyholders. Funds are typically funded from premium income, not from state subsidies. Providers, therefore, are responsible for paying both premiums to the state PCF and to private primary insurers.

- State-sponsored excess coverage could actually drive up non-economic damage awards. Without a PCF, a primary insurer defends claims up to the point at which the last dollar spent on defense equals the savings in claims payments. With a PCF, primary insurers have less incentive to defend claims that exceed their policy limits.

- Assessing surcharges based on an "Iowa experience," rather than actuarial assessments would likely underestimate the possibility of future losses and does not ensure providers' assessments will not escalate in years to come. The only mechanism which can control providers' MLI premium rates is establishing an upper limit on non-economic damages.

- In the first few years of a pay-as-you-go PCF financing system, losses tend to be low because most claims have not yet been resolved. Later, as losses inevitably mount, PCF directors will be forced to raise participant premiums precipitously or risk jeopardizing the solvency of the fund. States should adopt a financing mechanism which insures against future losses rather than paying losses as claims are resolved.

- PCF revenues must be statutorily protected to ensure the fund cannot be raided to pay for other state programs. The dollars collected must be used to pay claims to injured patients.

- Voluntary PCFs are vulnerable to adverse selection, which dramatically increases the funds' risk exposure. In states where participation in the PCF is voluntary, a provider can avoid a full assessment by not renewing after the PCF becomes expensive. Providers who are at low risk for future claims will drop out of the PCF at that point, leaving only high-risk providers enrolled. Incentives such as tying a cap on non-economic damages to participation help increase provider participation.

Attachment F

November 23, 2004

The Honorable Thomas Vilsack
Office of the Governor
The State Capitol
Des Moines, IA 50319

Re: Opposition to the Enactment of a Patient Compensation Fund (PCF) in Iowa

Dear Governor Vilsack:

Recently the Iowa Medical Society (IMS) Board of Directors met to discuss the concept of implementing a patient compensation fund in Iowa. After a lengthy discussion, the Board concluded that a PCF would not address Iowa's medical liability insurance (MLI) crisis and voted to oppose the implementation of a PCF in Iowa.

Without a cap on non-economic damage awards, a PCF would not reduce Iowa physicians' overall liability costs. Under a PCF, Iowa physicians would remain vulnerable to very high jury verdicts which would eventually threaten the stability of the fund.[1]

Researchers have found that PCFs operating in states without caps can improve insurance *availability* but nevertheless are expensive for policyholders. Physicians still pay approximately the same amount in MLI expenses – only now to two insurers. Depending on the administrative costs relating to the operation of the fund and financing decisions, providers' combined MLI premiums could even be higher with the PCF than without the fund.[2]

Researchers also suggest that state-sponsored excess coverage could drive up non-economic damage awards. Without a PCF, a primary insurer defends claims up to the point at which the last dollar spent on defense equals the savings in claims payments. With a PCF, primary insurers have less incentive to defend claims that exceed their policy limits and fund administrators do not have the resources to vigorously defend claims.[3]

The manner in which states insure the fund against future risk is also of concern to fund stability. When states choose to keep assessments low initially by assessing provider rates according to the amount anticipated to be spent on claims and expenses the following year, they are forced to raise participant premiums later as losses inevitably mount. A more expensive, though fiscally responsible financing structure requires states to adopt a financing mechanism which insures against future losses rather than paying losses as claims are resolved. However, unless the funds are statutorily protected, these dollars may be raided to finance other state programs.

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[1] Frank Sloan, "Public Medical Malpractice Insurance," The Pew Charitable Trust's Project on Medical Liability in Pennsylvania, 2004, p. 32, p. 40.
[2] Sloan, p. 38, 40.
[3] Sloan, p. 41.

Finally, mandatory or voluntary participation requirements impact the revenue stream. Mandatory participation forces those with clean claims histories to subsidize physicians in more risky specialties or those with past claims filed against them. In contrast, voluntary PCFs are vulnerable to adverse selection which dramatically increases the funds' risk exposure: physicians who are at low-risk for future claims drop out of the PCF if participation becomes expensive, leaving only high-risk providers enrolled.

IMS recognizes and appreciates your efforts to find a mutually agreeable solution to the state's medical liability insurance crisis. A PCF carries significant financial risk for both the State of Iowa, Iowa's physician community and – by extension – our patients. The limitations of a PCF with uncapped liability and the very real possibility that such a mechanism threatens to worsen Iowa's medical liability condition, leads the IMS to oppose the creation of a PCF at this time.

Please know that our interdisciplinary efforts to address Iowa's liability crisis continue. We are hopeful that we can achieve consensus with attorneys on methods to minimize defense costs and other variables that put pressure on medical liability premiums in our state.

Again, thank you for keeping this important issue at the fore of your agenda.

Sincerely,

Charles M. Helms MD

Charles Helms, MD
President

Mariannette J. Miller-Meeks

Mariannette J. Miller-Meeks, MD
Chair

Attachment G

IN THE GENERAL ASSEMBLY STATE OF _____

An Act

To Enact the Standard of Care Protection Act

Be it enacted by the People of the State of _____, represented in the General Assembly:

Section 1. Title. This act shall be known as and may be cited as the "Standard of Care Protection Act."

Section 2. Purpose. The Legislature hereby finds and declares that:

(a) As health system reform is implemented at both the federal and state levels, physicians may face additional liability exposure related to federal guidelines in state civil actions.

(b) Such federal guidelines include:

(i) Health care quality measures;

(ii) Payment adjustments for health care-acquired conditions;

(iii) Hospital value-based purchasing;

(iv) Value-based payment modifier under the physician fee schedule;

(v) Hospital readmissions;

(vi) Clinical and community preventive services;

(vii) Payment adjustments under federal programs, including but not limited to, the Meaningful Use of electronic health records, Physician Quality Reporting System, including Maintenance of Certification (MOC) Program, and e-prescribing.

(c) Additional liability exposure could lead to more civil actions against physicians, increased medical liability insurance premiums, and reduced access to health care for patients.

(d) There are efforts at the federal level to prevent these provisions from leading to additional physician liability exposure, but the legislation has not been enacted to date.

(e) States have the constitutional authority to amend their statutes to prevent the use of such provisions in medical liability actions brought under state law and should do so in order to prevent their liability climate from deteriorating for physicians, which would have a negative effect for patients.

Section 3. Requirements. A physician's failure to comply with or a physician's breach of any federal statute, regulation, program, guideline or other provision shall not:

(i) Be admissible;

(ii) Be used to determine the standard of care; or

(iii) Be the legal basis for a presumption of negligence

in any medical liability case in this state.

Section 4. Effective Date. This Act shall become effective immediately upon being enacted into law.

Section 5. Severability. If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.