THE IOWA CLINIC®

October 29, 2013

Senator Robert Hogg

Representative Chip Baltimore

Medical Malpractice Interim Legislative Study Committee
Iowa State Capital
Attn: Rachele Hjelmaas
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1007 East Grand Avenue
Des Moines, Iowa 50319

Dear Senator Hogg and Representative Baltimore:

The Iowa Clinic is a physician owned multi-specialty group in Central Iowa, with more than 170 physicians and healthcare providers practicing in 40 specialties. Our mission is to provide excellence in healthcare through a patient focused, physician governed, multi-specialty clinic with a commitment to improving the health of the patients we serve with care and compassion.

As Temporary Co-Chairpersons of the Medical Malpractice Study Committee you have requested, in lieu of a meeting, information be submitted from stakeholder's on potential options for certificate-of-merit affidavits by plaintiffs and defendants in medical malpractice actions and limitations on the number of expert witnesses that may be called by both plaintiffs and defendants in such actions. We offer the following perspective to the discussion of continued reform to the medical liability system in Iowa.

A historical perspective shows that periods of significant instability in the medical liability insurance industry have occurred three times leading to reform and consolidation in the industry. We will not detail this history here, as it is well documented and well known, but simply state that while legislative reform in the past has been helpful and appreciated, new pressures within healthcare make further reform critical at this time.

Iowa Medical Liability Reform

The Iowa Clinic believes medical liability reform in Iowa is necessary to assure that the healthcare infrastructure remains viable as healthcare reform moves forward. The Department of Human Services, through their State Innovation Model grant planning, set a goal of reducing the rate of growth in total state healthcare spending to the Consumer Price Index within three years and reducing healthcare costs for providers participating in a Medicaid Accountable Care Organization (ACO) by 5-8 percent within three years. These critical changes in how healthcare is delivered to Iowans will impact the cost and manner of care delivery. The use of a multi-payor ACO and the emphasis on care-coordination requires we examine the medical liability "exposure points" and ways to minimize risk and maximize protections for physicians and allied professionals.

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One of the results of malpractice litigation is the practice of "defensive medicine", the over utilization of medical procedures, tests and imaging studies to "build the case" in support of a diagnosis or treatment. Such practice obviously increases the cost of a patient's medical care. Yet, as mentioned above, the new payment models and the focus on care coordination and accountable care organizations are all designed to limit and reduce over utilization, over hospitalization, and over testing, the very things that have, to an extent, grown out of the response to malpractice litigation. We are working diligently as a clinic to take cost out of the healthcare system and reduce these "overs", but it comes at the risk of being criticized and subject to suit for the failure to run one more test, stay one more day in the hospital, or take one more MRI scan.

Another concern is the recruitment of physicians and thus the availability and access to healthcare for Iowans. Insurance premiums and the climate of malpractice litigation in the state are only two factors in attracting and retaining physicians to practice here, but they are important in a state with lower income potential because of low reimbursement rates. There is and will continue to be a shortage of physicians in Iowa.

Iowa needs additional tort reform measures to improve the medical liability climate while preserving the patient's access to the legal system. Studies on medical liability reform demonstrate that capping damage awards, permitting or mandating collateral offset, and decreasing state statute of limitations significantly reduce claim severity and frequency.[1] Iowa does not have a cap on non-economic damages to limit the severity of claims and encourage settlement or a certificate of merit, to screen out meritless cases and reduce the time to litigate cases filed with the Court.

Caps on Non-Economic Damages

Caps on damages are successful in reducing costs that drive the medical liability system. The Medical Injury Compensation Reform Act (MICRA) in California has been studied extensively with consistent results that caps work and continue to work to provide predictability for non-economic damages that are difficult to quantify. The latest state to prove that capping non-economic damages is a solution to rising tort costs is Texas. Since September 1, 2003 the state has had a $250,000 cap on non-economic damages.

Milliman looked at the average amount of payments recorded in the National Practitioner Data Bank (NPDB) per physician for every state in the union, plus the District of Columbia, for the four-year period just prior to the imposition of the cap in Texas—1999 to 2003—and then again for the four years 2005 to 2009. The analysis ranked the results from each state, one being the state with the lowest payouts per physician and 51 being the highest. Texas ranked 34th during the 1999 to 2003 period, and fifth after implementing a damage cap, for a change in ranking of 29 – the largest drop in payouts per physician of any state between those two periods.[2]

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[1] Barker, D. Spring 1992. The Effects of Tort Reform on Medical Malpractice Insurance Markets: An Empirical Analysis. Journal of Health Politics, Policy, and Law 17:143-161.

[2] Karls, C. (April 11, 2011). New impetus to reform medical professional liability. BNA's Health Care Policy Report.

Twenty-six states have shown reduced costs and stabilized their medical liability system as a result of caps on non-economic damages: Alaska, California, Colorado, Florida, Hawaii, Idaho, Kansas, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia and Wisconsin.

Certificate of Merit

Since 2004 the number of states with statutory guidance on certificate of merit has risen from 17 to 25. The purpose of a certificate of merit statute is the reduction and/or prevention of lawsuits brought without sufficient evidence of medical negligence. Even if a suit is subsequently dismissed the defendant physician has had to incur the time and expense of defending what perhaps should not have been filed in the first place. Within the past several months The Iowa Clinic has had a case dismissed by the judge at trial because the plaintiff did not present enough evidence to even generate a jury question that the physician was at fault and two other cases that were dismissed by the plaintiffs after filing but where significant expense in defense of the suits had been incurred.

One approach is to require that attorneys consult with an expert prior to the time of filing a complaint and file with the court a certificate of merit simultaneously with the complaint. The certificate of merit would clearly state the attorney has consulted with an expert qualified by knowledge, training and experience to evaluate the medical record and provide a written opinion that there has been a breach of the standard of medical care causing injury to the patient. If no expert is available to speak to the standard of care to support the claim, the claim will be unable to proceed.

Iowa Code section 668.11 requires the designation of an expert in a medical liability case within 180 days of filing the complaint. While many, if not most, attorneys handling plaintiff's malpractice cases obtain such expert reviews prior to filing suit, many cases are filed without an expert review finding evidence of medical negligence. This adds significant cost and delay – which also has a cost.

Earlier designation of an expert under this proposal will more quickly move the process towards resolution or trial. While only anecdotal, it is common practice that even the 180 day designation period is extended by court order. Physician's report that the most stressful event of their career is the time spent waiting for a medical negligence case to be resolved. A recent study found that the average physician spends 11 percent of his or her career practicing in the shadow of an unresolved medical claim.[3] Under the medical liability system now in place, claims can take an average of three and a half to five years to reach resolution.[4]

The March 2010 passage of the Patient Protection and Affordable Care Act (ACA) gave new prominence to certificate of merit statutes as a type of malpractice reform. The ACA created a program to reward states for implementing certain kinds of medical liability reform. The Department of Health and Human Services has established guidelines that allow incentive payments to states that enact medical liability alternatives such as certificate of merit laws, early offer laws, or both. The demonstration grants for the

[3] Frakes, M. The impact of medical liability standards on regional variations in physician behavior: evidence from the adoption of national-standards rules. Am Econ Rev. 2013;103: 257-76.

[4] Karls. id. (Based on Milliman analysis of nearly 80,000 individual medical malpractice claims.)

Patient Safety and Medical Liability Initiative support the implementation and evaluation of evidence-based patient safety and medical liability projects. The Agency for Healthcare Research and Quality funded seven demonstration grants totaling $19.7 million.[5]

Early Disclosure and Compensation Programs
Iowa has the underpinnings in place for healthcare providers to openly communicate with their patients when unwanted or unexpected medical outcomes occur. Mediation or alternate dispute resolution is available under the law for civil liability cases; and the "physician apology" or "I'm Sorry" statute was passed in 2006. Thirty-five states have similar laws to encourage direct and open communication by physicians when adverse events occur with patients and their family.

Early disclosure and compensation programs should be done in collaboration between physicians, medical liability insurers and hospitals and other facilities. Such programs involve early identification of adverse events and analysis on a case-by-case basis of the care delivered. The other key factor in these programs is the use of quality improvement mechanisms to prevent the event from reoccurring.

The purpose of early offer programs is to determine the cause of the adverse event, communicate the cause to the patient and family, apologize and offer compensation and follow-up care. Early adopters of this approach have reported reduced liability costs, but the extent to which these results stem from effective disclosure and apology practices, versus compensation offers, is unknown. Physicians, hospitals and medical liability insurers must consider this complex interplay as they implement similar initiatives.[6] Legislative encouragement and protection of such programs is an important component.

The Iowa Clinic respectfully submits this information with the belief that medical liability reform is needed to reassure Iowa physicians that claims can be resolved in a fair and expeditious manner that protects both the patient and the physician. Enactment of a cap on non-economic damages has proven time and again to be an effective means of providing stability to the system. A certificate of merit filed contemporaneously with a complaint will reduce the number of meritless claims which must be defended, the time spent in litigating these cases and thereby reduce costs in the system.

At The Iowa Clinic our commitment to our patients and our values are critical to the profession of medicine. Our people, education, quality and integrity form the cornerstones of our practice. It is our pledge to uphold the duties of our profession as we dedicate ourselves to healing those we serve.

Sincerely,

C. Edward Brown, CEO

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[5] *See* AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS, MEDICAL LIABILITY REFORM AND PATIENT SAFETY DEMONSTRATION PROJECTS (instituting a grant program for states and health care systems willing to undertake reforms), *available at http://www.ahrq.gov/legacy/qual/liability/demogrants.htm*

[6] Health Aff (Millwood). 2012 Dec;31(12):2681-9. doi: 10.1377/hlthaff.2012.0185.