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**MEDICAL LIABILITY REFORM**

**POSITION PAPER**

The Iowa Osteopathic Medical Association (IOMA) continues to believe that medical liability reform is needed to ensure Iowans have access to highly qualified health care professionals. While professional liability insurance rates have been stable for the past several years, studies show that Iowa physicians pay on average the highest medical liability insurance rates of any of the surrounding states. This despite the fact that Iowa has consistently ranked as having one of the highest quality and most affordable healthcare systems in the country.1

High medical liability insurance premiums is one of the reasons Iowa struggles to attract and retain physicians. In national rankings of the number of physicians per capita, Iowa ranks 43rd overall, and 40th or below for 14 of the 25 most-common medical specialties.2

Iowa’s Medical Liability Climate is Worse Than Neighboring States

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| State | Average MLI Premium3 | Percent of Iowa Prem. | Caps on Damages | Certificate of Merit | Attorney Fee limits |
| Iowa | $20,496 | 100% |  |  |  |
| South Dakota | $17,036 | 83% | Yes |  |  |
| Wisconsin | $15,981 | 78% | Yes |  | Yes |
| Minnesota | $12,517 | 61% |  | Yes | Yes |
| Nebraska | $11,523 | 56% | Yes |  |  |

In addition to the cost of medical liability insurance, the current tort system imposes additional burdens on patients and health care providers. Iowa medical liability suits take longer to resolve and cost more to defend than in neighboring states.4

The average physician spends over 10% of his or her career with an on-going medical liability claim.5 Yet of the medical liability claims closed in 2013, 65% were dropped, dismissed, or withdrawn; of those claims that went to trial, 91% were won by the physician.6 The expenses associated with these claims adds an additional burden to the cost of providing healthcare. Additionally, defensive medicine, the practice of physicians fearful of a lawsuit performing unnecessary test just to ensure that even the most unlikely of findings is not missed, adds significant expenses to the health care system.

IOMA believes that medical liability reform improves the healthcare system.

Numerous studies have found that caps on non-economic damages improve access to patient care, reduce medical liability insurance premiums by 17% or more, and reduce overall costs to the healthcare system.7

States with malpractice reforms have seen an increase in the number of practicing physicians.8

Surveys of medical residents show that the malpractice climate of a location is an important factor in their determination of where to practice.9

The Iowa Osteopathic Medical Association proposes and encourages the enactment of these medical liability reforms.

**Caps on Non-economic Damages**

A $250,000 cap on non-economic damages brings predictability to the market, which lowers medical liability insurance premiums and reduces overall healthcare costs. This is one of the oldest medical liability reforms in the county and has been shown to improve the ability to recruit physicians resulting in increased access to care. Thirty five states have some form of this policy.

**Periodic payment of future expenses or losses**

The goal of a medical liability settlement or verdict should be to compensate the injured patient for their loss and provide for their future care. Granting a large single payment award to the patient carries with it the risk that the patient or more troubling, their caregiver, may inappropriately spend these funds. Allowing payments to be made over time provides assurance that funds will be available for the patient when they are needed. Additionally, it reduces the total cost of a settlement as a smaller amount of funds can be annuitized to provide the same total benefit to the injured patient.

**Offsets for collateral sources**

If the goal of a medical liability settlement or award is to, as best as possible, restore the patient to their condition prior to the injury that precipitated the claim, then all sources of restoration funding should be considered. Patients should not be allowed to "double dip" as this takes resources away from the health care system which could be used to the benefit of others.

**Limiting Contingency Fee Arrangements**

Current Iowa law cedes determination of appropriate medical liability contingency fee arrangements to the court on a case-by-case basis, which has proven ineffective in other areas of legal practice. By enacting uniform limits on these arrangements, we can create consistency across the state and ensure patients with a legitimate claim receive appropriate compensation. Twenty states have some form of this policy.

**Expanding Candor**

Enacted in 2015, Iowa’s *Candor* statute allows physicians to engage their patients in frank and confidential discussions following an adverse outcome. The statute is designed to speed patients’ access to information and help to maintain the physician-patient relationship. Since early 2016, a facility in Eastern Iowa has been piloting the *Candor* concept and has helped identify opportunities for expanding the statute by allowing more cases to qualify for this voluntary program and allowing more healthcare professionals to take part. Iowa is the third state to enact early disclosure legislation.

**Strengthened Expert Witness Standards**

By strengthening the standards for medical liability suits to require that expert witnesses are trained in the area of practice for which they are testifying and in good professional standing with their licensing board, we can assure that medical experts meet the same rigorous competency standards as Iowa’s licensed professionals, and continue our state’s reputation as a fair and honest legal system. Twenty eight states have some form of this policy.

**Certificate of Merit**

This reform requires, within ninety days of a plaintiff filing a suit, that a medical expert certify how the care in question failed to meet the appropriate standards of care. If an expert is unable to identify a breach in the standard of care, the case may be dismissed; this would clear meritless cases from the court docket and allow patients with legitimate claims to more quickly resolve their case. Twenty eight states have some form of this policy.

**Affirmative Defense for Evidence-Based Medicine**

Efforts to curb the growth in healthcare spending are placing greater pressure on physicians to avoid defensive medicine and provide more targeted care. Doing so vastly increases a physician’s liability exposure. An affirmative defense for the practice of evidence-based medicine creates legal protections for a physician to provide high quality, research-based care; reducing the need for duplicative or unnecessary medical testing and promoting the utilization of medical best practices. Iowa would be a national leader with this innovative new policy.

**Changes to the "Standard of Care" doctrine**

The doctrine of standard of care is well established in both statutory and case law. However, with advances in evidence-based care it has become clear that every patient is different and requires diagnosis and treatment tailored to their unique characteristics. We advocate for a new measure of the appropriateness of care known as "reasonable care". This would require all involved in the care of the patient to act as a "reasonable" provider would if presented with the same set of unique circumstances in the same patient. It would require experts who testify to be fully knowledgeable regarding the patient's prior health, the presentation of the patient, the socioeconomic factors of the patient, etc. In short, it is actually a higher, more patient-specific bar that the current "standard of care".

**Health Courts**

Medical liability claims are often complex, requiring both sides to spend considerable time educating jurors on the not only the details of the case at hand but also on the applicable concepts of medicine. This requires additional court time, and even then, it is difficult to know if the jurors truly understand the complex issues upon which they are asked to decide. Using special courts, in which cases are tried by judges with a higher level of medical knowledge, physician peers, and trained lay people would remove many of the barriers which prevent un-trained jurors for reaching a verdict which is fair to the patient and the health care provider.

1. Scorecard on State Health System Performance, 2015 Edition, The Commonwealth Fund.
2. Iowa’s Rank in Number of Physicians per Population, 2015 Edition, Iowa Medical Society.
3. Annual Rate Survey, 2016 Edition, Medical Liability Monitor.
4. Allocated Loss Adjustment Expenses, Physician Closed Claims 2008-2012, MMIC Actuarial Database.
5. On Average, Physicians Spend Nearly 11 Percent Of Their 40-Year Careers With An Open, Unresolved Malpractice Claim, January 2013, Health Affairs.
6. Professional Liability Insurance Indemnity Payments, Expenses and Claim Dispositions, 2004-2013. American Medical Association.
7. Medical Liability Reform Now, 2016 Edition, American Medical Association.
8. Impact of Malpractice Reforms on the Supply of Physician Services, 2002, *JAMA.*
9. Illinois New Physician Workforce Study, 2010, Northwestern University Feinberg School of Medicine.