



## RESIDENT PRESIDENT'S MESSAGE

### Health Care in America: A Liability Crisis?

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The American Academy of Emergency Medicine (AAEM) has been hesitant to support current health care reform legislation under consideration by Congress because of the failure to address shortcomings that exist in the current tort system. Much has been said by advocates and policymakers on both sides of the aisle on this issue. Some argue the "crisis" that many physicians believe is a reality is overblown, and making substantial changes to the system will not help the bottom line. Others argue that medical liability contributes both directly to the cost of health care in America and indirectly in the form of "defensive medicine." The position of AAEM is that tort reform should be an important component of the legislation currently working its way through Congress. This next look at Health Care in America focuses on the current tort system – where we are and where we are headed.

Though the Federal Government has the authority to make significant changes to the tort system, currently, most malpractice law has been determined by the individual states. In fact, most malpractice law has not been written by the state legislatures but instead determined by courts establishing legal precedent.<sup>1</sup> The terms "malpractice" and "tort" are often used interchangeably, when in actuality, medical malpractice is a piece of the broader body of tort law which deals with injuries sustained by individuals. Tort law is divided into three categories: intentional torts (such as assault), negligence (for example, medical malpractice), and strict liability (damages suffered from hazardous products).

To successfully bring a medical malpractice case under the tort of negligence, the plaintiff must prove five elements<sup>2</sup>:

1. Factual causation – the "cause and effect" linkage
2. Legal causation – in other words, the remoteness of the injury to the negligence of the physician (this is to prevent liability for consequences not foreseen by any reasonable person)
3. Duty – meaning, a doctor-patient relationship or, in the ED, anyone who registers seeking care
4. Breach of duty – for example, not meeting the standard of care
5. Damages – such as physical loss of function, emotional loss, or monetary loss

As opposed to in a criminal trial where the plaintiff must establish proof beyond a reasonable doubt, cases in the tort system must prove these five elements with a preponderance of evidence.

If the plaintiff is successful in a malpractice case against a physician, the jury may award both compensatory and punitive damages. Compensatory damages are economic (such as the cost of medical care and lost wages) and non-economic (such as emotional or psychological harm). Punitive damages are awarded in cases where the jury believes the physician acted recklessly.

With this backdrop of the current system of medical malpractice, in the context of broader health care reform, many have wondered what significant changes can do to change the bottom line. The non-partisan Congressional Budget Office (CBO) released an analysis of the economic effects of a tort reform package consisting of a \$250,000 cap on non-economic damages and a \$500,000 cap for punitive damages. They estimated these changes would reduce the total cost of U.S. health care spending by 0.5% yearly and reduce the federal budget deficit by approximately \$54 billion over the next ten years. The savings would come roughly equally from savings in malpractice premiums and indirectly from savings on defensive medical practices.<sup>3</sup>

The Federal Government stands to gain from medical malpractice reform because of the amount of money spent on Medicare, Medicaid and the Children's Health Insurance Program. Additionally, the CBO concluded private health care premiums would decrease slightly, and because health care benefits are paid with pre-tax dollars, the government would collect more tax revenue from higher taxable wages.

Despite the CBO's research, some key Senators and advocacy organizations argue the data is flawed and the government stands to save much less. Outspoken critics of the legislation such as Rep. John Boehner of Ohio argue the CBO data is conservative and the country can save much more. Prior CBO reports (including the frequently cited 2004 study) failed to find significant savings. However, the 2009 report included new data from academic studies as well as evidence from states such as Texas and California, which adopted the caps listed above. The major unknown in the debate is the extent to which malpractice reform will impact physician practice patterns. Will doctors order fewer tests? The CBO cited a 2007 study that found states with higher malpractice costs had physicians that ordered more lab studies and imaging tests when compared to doctors practicing in states with a friendlier malpractice climate.

The Congressional Budget Office report released in October is an important tool physicians can use to urge lawmakers to

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## RESIDENT EDITOR'S LETTER

### Balance Billing

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It was roughly one year ago that the California Supreme Court ruled in *Prospect Medical Group Inc. v. Northridge Emergency Medical Group* that physicians in California could not bill patients directly for the balance due after insurance reimbursement.<sup>1</sup> In a decision cheered by patient advocates and derided by most physicians (most of all those involved in the care of patients seeking emergency treatment),

doctors were left to battle it out with insurance companies if they felt that reimbursements were unfairly low.

First, let's start with a formal definition of balance billing. When anyone receives care, no matter how minor, a bill is generated – usually multiple bills – to account for hospital charges, equipment used and physician services. Typically, the charges represented in these bills are significant overestimates of what the hospital or physician group expects to collect. Insurance companies negotiate discounts of the charged amount and agree, or contract, with a hospital or physician to provide services at that discounted rate. If the hospital or physician were to then bill the patient directly for the difference between what the insurance company paid and what was initially billed, this would be balance billing.

Medicare and most insurance companies prohibit balance billing for elective services.<sup>2</sup> Part of the rationale is that a hospital or physician always has the option of refusing to accept the negotiated rate by refusing to see patients with a particular kind of insurance. In emergency care, however, the luxury of prescreening patients based on insurance does not exist. Emergency care must be provided under federal law – specifically the Emergency Medical Treatment and Active Labor Act (EMTALA).

What happens then, when insurance companies reimburse providers for emergency care at a rate that the providers deem unfair? In the past, emergency departments that were unsatisfied with the reimbursements provided by a particular insurance company would bill the patient directly for the difference. Because the bill generated by the emergency department was designed in anticipation of insurance discounting, collection of the balance from the patient could be viewed as a significant overpayment. Under the California ruling, the practice of balance billing for emergency services was forbidden. Doctors were entitled to a "fair" reimbursement for their services and could appeal to the insurance company but ultimately had to accept what was paid or pursue legal recourse. Theoretically, an insurance company could drop reimbursements to one cent on the dollar, and emergency providers would have to accept this or sue the insurance company (some would argue that MediCal already does this).<sup>3</sup>

Obviously, this is an unfair position in which to place California emergency providers. Our system of billing has not helped, though. If the amount the physician or hospital charged reflected a value closer to the cost of providing the services plus a reasonable profit rather than the current practice of charging based on expected reimbursements, then billing for the balance might be far less aggravating for patient advocacy organizations.

1. <<http://www.ama-assn.org/amednews/2009/01/26/prsa0126.htm#s1>>
2. <[http://www.businessweek.com/magazine/content/08\\_36/b4098040915634.htm](http://www.businessweek.com/magazine/content/08_36/b4098040915634.htm)>
3. <[http://www.foley.com/publications/pub\\_detail.aspx?pubid=5590](http://www.foley.com/publications/pub_detail.aspx?pubid=5590)>

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take malpractice reform seriously. Despite strong data from a non-partisan source, most political analysts believe it is unlikely that the current Congress will act. We are our best advocates, and many surveys of physicians suggest this is an issue we care about most. AAEM has voiced strong opinions on the importance of tort reform and in 2006 published a White Paper in the *Journal of Emergency Medicine*. The AAEM/RSA board will work with our committees and members to spread the word and advocate for this important issue. For more information, visit the AAEM/RSA website or read the White Paper at [http://www.aaem.org/positionstatements/tortreform\\_whitepaper.php](http://www.aaem.org/positionstatements/tortreform_whitepaper.php).

1. <<http://www.kff.org/insurance/7328.cfm>>
2. <[http://info.med.yale.edu/caim/risk/malpractice/malpractice\\_2.html](http://info.med.yale.edu/caim/risk/malpractice/malpractice_2.html)>
3. <<http://cboblog.cbo.gov/?p=389>>

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