



Ensuring Access to Quality Emergency Care for the People of Michigan

A White Paper by the
Michigan College of Emergency Physicians

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Michigan College of Emergency Physicians

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Mission Statement

The Michigan College of Emergency Physicians exists for the purpose of supporting quality emergency medical care and promoting the interests and values of emergency physicians.

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Table of Contents

Executive Summary..... 1

The Liability Environment..... 1

On-Call Physician Shortages..... 1

Physician Workforce Issues 2

Action Required..... 2

What is EMTALA?..... 5

Medical Liability Tort Reform: Impact at the State Level 7

Gross Negligence Standards 7

Gross Negligence Standard: Georgia Definition 8

Physician Workforce Issues: Retention in Michigan 8

Goals for Michigan and its Patient Population 9

Case Study: Texas..... 11

Background 11

Key Points of Legislation 11

Case Study: Georgia 15

Background 15

Key Points of Georgia’s Legislation 15

Results 17

Why Michigan SB 1110/HB 5698? 19

Fear of Malpractice Claims Affects Medical Care 19

Michigan and Medical Malpractice Reform..... 20

Impact on Access to Care..... 21

National Physician Workforce Crisis 21

On call shortages related to Emergency Departments and Specialty Care 22

Impact in Michigan of Predicted Physician Shortage..... 24

Economic Benefits for Michigan 25

Conclusion..... 27

Appendices..... 29

Executive Summary

The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) was passed to protect patient safety and to create an environment where patients in need of critical emergent medical care are medically assessed and stabilized, no matter their ability to pay.

The Liability Environment

An unanticipated result of this law was its contribution to the already high-pressure liability environment; trial lawyers use the situation created by the EMTALA law to bring lawsuits against hospitals and physicians responding to the needs of patients in emergency care situations.

In complying with the law, physicians and other care providers are put into a position where they must make critical decisions in a very short time frame, with no prior patient history, knowledge, or relationship – and then are held liable for not having this information. In the current liability environment, lack of information opens the door to legal action.

In addition to compliance with the federal EMTALA law, medical care providers are also subject to the laws of the state in which they practice. Without reasonable state level protections, the EMTALA mandate creates what could be perceived by medical professionals as an even greater risk of medical liability exposure, thus, discouraging them from settling and practicing in states that do not have protections in place.

One of the driving forces behind the medical care crises of lack of access to emergent care, specialized emergent care, and the nationally diminishing physician workforce is the current medical liability environment in which physicians and other health care professionals provide medical care. The fear of lawsuits across the medical spectrum has not only created a trend of defensive medicine, but discourages physician specialists from providing on-call services to emergency patients as an act of self-preservation.

On-Call Physician Shortages

Emergency departments are understaffed, trauma centers are closing, and access to emergency health services is declining. These changes are not just happening in rural areas, but in city centers across the United States. High risk specialties, such as those providing care in the areas of ophthalmology, orthopedics, and neurology, are opting out of providing on-call services to the emergency department. For example, if you need emergent care from a hand surgeon in Lansing, you will have to be sent to Grand Rapids, Ann Arbor, Detroit, or elsewhere; there are no hand surgeons willing to be “on call” in Lansing. A similar situation exists in Flint with ophthalmologic specialists.

By avoiding the emergency department, physician specialists and other healthcare providers can minimize exposure to liability, which is increased in emergent care situations because there is rarely a medical history of the patient available, and there is no pre-existing physician/patient relationship. The lack of specialty care in emergent care situations endangers patients’ long-term health and is detrimental to the recovery process. While under EMTALA patients are stabilized, they will not

necessarily receive the specialty care they require in critical situations, or specialty care will be delayed, negatively impacting patient outcomes.

This exposes emergency physicians to increased risk of liability because, as the providers of care in emergency departments, they do not have the choice of “opting out” of providing care to emergency patients. While other specialists can choose not to be on call, emergency physicians cannot. Whether a specialist is available or not, patients have a need for emergency care. At times, patients are forced to be transported many miles to receive the care they need because their physician will not take an on-call shift, or will not treat patients in the emergency department. This delay often places patients at greater risk.

Sometimes this care is related to previous treatment from another physician, but no matter the case, the patients still need treatment. Emergency physicians are put in the position of delivering emergency care to patients whose personal physicians and medical records are not available. The emergency physician must deliver care with little information and no previous patient relationship.

For example, if a patient has an eye treatment and then develops a complication, and the patient’s physician does not take emergency call, then the patient might be sent to another hospital for care. If this complication is severe and there is a delay in treatment due to transport to another facility, the patient’s chances of a positive outcome decrease. In the event the patient ends up losing his or her vision, the hospital and emergency department providing treatment then **become potentially liable for the care even though they did not initiate the care.**

It is becoming increasingly difficult for providers of medical care to function in this environment, and patients cannot receive even the safety net care that EMTALA was intended to protect. Reform of medical malpractice laws in the state of Michigan is necessary to ensure that those medical care providers that make up the important medical safety net are protected, and to ensure that a consistent quality of emergency care will be available to patients when it is needed most. Inclusion of a Gross Negligence Standard is vital to protect physicians and other health care professionals providing emergency care.

Physician Workforce Issues

The current liability environment in Michigan is causing the state to lose medical professionals to other states or other professions. The costs of practicing medicine in the state have become too high, and this is directly related to malpractice insurance and the cost of settling cases or losing a trial. Despite the fact that Michigan educates and trains a high percentage of the country’s physicians, many leave the state after completing their residency for states that have instituted medical liability reform.

Action Required

It is time for Michigan to adopt medical liability tort reform in order to address improved access to care, to maintain quality care, to retain physicians to serve our state’s patient population, and to decrease health care costs.

Specifically, a gross negligence standard should be adopted to provide special liability protection for physicians who assume the inherent risks of providing lifesaving emergency care. It is becoming increasingly difficult for providers of medical care to function in this environment, and patients often cannot even access the safety net care that EMTALA was intended to protect. Reform of medical liability laws in the state of Michigan is necessary to ensure that a consistent quality of timely emergency care will be available to patients when it is needed most.

Based on the significant positive effects of medical malpractice tort reform in states such as Texas and Georgia, the Michigan College of Emergency Physicians (MCEP) supports passage of Michigan bill SB 1110/HB 5698, which will offer similar protection to Michigan's medical care providers in emergent care situations, improve access to emergency care for Michigan residents, and reform the medical liability tort system in our state.

What is EMTALA?

The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by Congress in 1986, with the intention of preventing hospitals from transferring uninsured or Medicaid patients to public health facilities without at least providing a medical exam that confirmed they were stable for transfer.

Under EMTALA, an emergency medical condition is defined as “a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.” This applies to active labor in that the patient must be treated until delivery is complete, at which time, the patient and child may be transferred when stabilized.

As outlined by the American College of Emergency Physicians (see Appendix), “According to the law, EMTALA applies when an individual ‘comes to the emergency department.’ CMS [Center for Medicaid & Medicare Services] defines a dedicated emergency department as ‘a specially equipped and staffed area of the hospital used a significant portion of the time for initial evaluation and treatment of outpatients for emergency medical conditions.’ This means, for example, that hospital-based outpatient clinics not equipped to handle medical emergencies are not obligated under EMTALA and can simply refer patients to a nearby emergency department for care.”

A ramification of this federal law is that local authorities abdicated responsibility for public or charitable emergency care, placing the burden on hospitals and thus, the costs associated with it. The penalties for non-compliance are severe, including termination of the hospital's Medicare provider agreement, fines up to \$50,000 for hospitals, and fines of \$50,000 for physicians (including on-call physicians). Hospitals can be sued in civil court for actions related to EMTALA. Physicians, other than emergency physicians, can remove themselves from this liability by not providing on-call services to the emergency department.

Additionally, the law created new liability exposure, as trial lawyers learned that EMTALA obligates physicians to care for individuals that are high risk, using this as a basis for lawsuits that claim negligence in the delivery of emergent care. These lawsuits contributed to the increase in liability insurance rates, and added additional costs for both physicians and hospitals in trying to maintain insurance coverage and in defending their medical decisions.

EMTALA, while meant to prevent “dumping” of patients who could not pay, has shifted the burden of paying for emergency care to hospitals and physicians. Hospitals across the United States spend millions of dollars daily to deliver emergency care to the indigent that have no insurance, and are not even covered by Medicaid.

A law intended to protect the health of low income and indigent patients has become a legal quagmire and a financial burden for the medical profession and hospitals. These factors are weakening our health care system as more facilities succumb to cost pressures and are forced to limit services. The societal impact is only now coming to light.

Medical Liability Tort Reform: Impact at the State Level

In the March/April 2011 issue of *Radiology Management* magazine, tort reform is defined as “a civil wrong which causes an injury for which an individual can seek damages.” Under the broad area of tort reform, medical malpractice is simply one subset of this legal area.

However, what seems like a small subset of a larger area has a far-reaching impact on the health of the people of the United States, and in this context, the health of the people of Michigan.

Reform Supports Quality Care

Medical liability reform is having positive effects in states proactively addressing the impact of legal factors in the medical community. The experience of these vanguard states has been improved access to care, greater physician retention, decreased lawsuits, and lower health care costs. *There is no evidence that the quality of care has diminished.*

As demonstrated by these statistics from the Centers for Disease Control (CDC), mortality rates in Georgia and Texas either held steady or decreased slightly during the 2 to 4 years after reforms were enacted¹. (Texas enacted reform in 2003 and Georgia enacted reform in 2005.)

	Georgia	Texas	US Total	Georgia	Texas
1999	7.709	7.144	8.57	-10.0%	-16.6%
2000	7.802	7.191	8.54	-8.6%	-15.8%
2001	7.66	7.161	8.485	-9.7%	-15.6%
2002	7.625	7.163	8.473	-10.0%	-15.5%
2003	7.612	7.02	8.419	-9.6%	-16.6%
2004	7.386	6.817	8.165	-9.5%	-16.5%
2005	7.338	6.859	8.259	-11.2%	-17.0%
2006	7.277	6.725	8.104	-10.2%	-17.0%
2007	7.175	6.733	8.036	-10.7%	-16.2%

Gross Negligence Standards

Some states have enacted changes in medical liability tort law for those physicians providing EMTALA-related care specifically, and other states have enacted legislation which covers all physicians, including Gross Negligence Standards.

States that instituted Gross Negligence Standards protecting all medical personnel in emergent care situations have seen a positive impact on costs, lawsuits, retention, and quality of care. Protecting medical personnel from the threat of lawsuits by removing liability related to unknown medical histories increases the quality of care for patients in emergent care situations.

¹ Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2007. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2007 Series 20 No. 2M, 2010. Accessed at <http://wonder.cdc.gov/cmfi-icd10-archive2007.html>

When protections are in place, physicians and other medical care providers no longer fear exposure to liability related to emergency treatment of patients. Limiting exposure encourages more physicians across specialties to be on call, delivering necessary specialty care to patients more quickly, leading to better patient outcomes. As defensive medicine is reduced (such as admitting patients who could be safely treated as outpatients) so are health care costs.

Increasing protections for all health care providers reduces liability insurance rates and allows hospitals to use funds previously assigned to insurance payments for the purchase of improved medical technology, the provision of additional services (such as clinics), and increased spending on charity care.

These positive benefits are the result of a Gross Negligence Standard that protects all health care providers (some states extend the Gross Negligence Standard to protect any product or service provider that could be held liable under tort law). A comprehensive Gross Negligence Standard definition could lead to relieving some of the burdens in Michigan's legal system by reducing the number of lawsuits filed if they do not fall within the definition.

Gross Negligence Standard: Georgia Definition

The Michigan College of Emergency Physicians supports the definition used in Georgia, which is part of the medical liability tort reform enacted in that state in 2005:

As a result of the medical malpractice tort reform legislation enacted in 2005, Georgia law provides that in an action involving a health care liability claim arising out of emergency medical care in a hospital emergency department, no physician or health care provider shall be held liable "unless it is proven by clear and convincing evidence that the physician or health care provider's actions showed gross negligence." O.C.G.A. § 51-1-29.5. In order to substantiate a malpractice claim relating to emergency medical care under the statute, the degree of proof must be by "clear and convincing evidence," and the degree of negligence established must be "gross negligence."²

SB 1110/HB 5698 is modeled after the successful Georgia law; this law will protect Michigan's health care providers and protect the "Achilles' Heel" of EMTALA-related care.

Physician Workforce Issues: Retention in Michigan

As the prediction of a national physician shortage looms, states are trying to retain doctors once they complete their training. As Michigan's physician shortage worsens, retaining and recruiting physicians is increasingly challenging; steps must be taken to create an environment that encourages physicians to establish practices in our state once they complete their training.

The greatest influencer of retention is completion of residency programs versus where physicians complete medical school – the national average for physician retention post-residency is 48%. States that have enacted medical liability reforms, such as Georgia and Texas, are among the states with higher physician retention rates.

² Arnall Golden Gregory LLP, Client Alert--GEORGIA COURT OF APPEALS DEFINES "GROSS NEGLIGENCE" STANDARD FOR EMERGENCY MEDICAL CARE, website: www.agg.com

Texas has had significant tort reforms in place for the longest period of time and has a 60% retention rate for physicians trained in their state. **Michigan has a 42% retention rate, significantly lower than the national average.**

Michigan ranks in the top 25% of all states in number of medical students trained at public institutions and in the top 20% of all states in the number of residents it trains through ACGME-accredited programs. And yet, **many of these physicians leave the state to practice elsewhere due to the liability climate.**

Goals for Michigan and its Patient Population

In states that have instituted medical liability reforms for which data is available, there is a demonstrated improvement in access to care, physician retention, number of lawsuits, and cost to the health care system as well as continued quality care.

These are results that will not only encourage physicians to locate in Michigan, but results that will provide a safer, higher quality health care environment for Michigan's patient population.

There are three key goals for medical liability reform in Michigan:

1. Increase the access to care by keeping physicians in Michigan and improving access to specialists for on-call emergencies.
2. Decrease health care costs, largely through decreasing the amount of defensive medicine.
3. Offer liability protection to all on-call physicians providing emergency care, not just emergency physicians.

For the sake of Michigan's patient population who need the EMTALA guaranteed medical safety net, and for those seeking accessible, high quality, and affordable health care, Michigan should follow the leads of Georgia, Texas, and other states in adopting tort reform measures that include a strong Gross Negligence Standard applicable to all health care providers in the state.

Case Study: Texas

Background

In the late 1990s and early 2000s, Texas had average claims against nursing homes of \$4 million; malpractice premiums were doubling every four years or so; and about 6,500 physicians were uninsured because insurance companies were leaving the state.

The Texas Public Policy Institute reported in 2008 that prior to the passage of tort reform in Texas the following situation had developed in the state:

Between 1996 and 2000, one of four Texas doctors was sued.

In the 10 years following 1989, the average medical liability award skyrocketed from \$472,982 to \$2,048,541. The percentage of such awards attributable to non-economic damages, which are intangible injuries like pain and suffering, increased from 35.7 percent to 65.6 percent. Between 2000 and 2003, 13 of the state's 17 medical insurance carriers pulled out of Texas.

Pre-reform, medical liability insurance rates were rising 15 to 20% per year.

In May 2003, the year major liability reforms was enacted, there were 35,723 in-state medical doctors. As of 2008, there were 46,632, a 30.5% increase.

Key Points of Legislation

Texas House Bill 4 passed in 2003 and capped noneconomic damages at \$250,000. The bill defined who is a physician and outlined an alternative way to define limits for damages in wrongful death suits. Damages are capped at \$500,000 per claimant, and the bill limited the insurer's liability not to exceed the liability of its insured. It includes mandatory jury instructions so that negligence is not determined based only on a bad outcome. Most importantly, the new law amended the "Good Samaritan" statute so that emergency care providers are only liable for civil damages for willfully or wantonly negligent acts, also known as the Gross Negligence Standard.

When the Texas Supreme Court struck down parts of the tort reform outlined in HB 4, Proposition 12 was drafted and presented to the voters of Texas in order to ensure the constitutionality of key reforms in HB 4. Proposition 12 amended the Texas Constitution so that noneconomic damages such as pain and suffering, mental anguish, and loss of consortium were capped at \$250,000. This also applies to all other types of cases.

Results

While insurance premiums across the board in the state of Texas have stabilized, individual physicians have seen **a reduction in their rates of 46.2%** since the passage of Proposition 12. This translates to a cost savings of \$1.9 billion.

Between 2003 and 2005, malpractice cases in Texas dropped by 50%, the number of insurance carriers increased, and the five largest insurers in the state announced rate cuts equaling \$50 million in savings to physicians and hospitals.

Hospitals are saving approximately \$100 million per year in the state. The availability of this money contributes to a safer, more stable and more accessible healthcare environment for the people of Texas. Rather than being spent on insurance premiums, this money is being spent on improved medical technology, improved patient care, and increased charity care by hospitals.

In a 2011 study reported in the *Journal of the American College of Surgeons*³, the authors theorized that medical liability reform reduces the risk of malpractice lawsuits in an academic medical center. The study compared malpractice prevalence, incidence, and liability costs before and after comprehensive state tort reform measures were implemented in Texas.

The study used two institutional databases: a surgical operation database and a risk management and malpractice database. Risk groups were divided into pre-tort reform (1992 to 2004) and post-tort reform groups (2004 to the present). The study reported the following results:

During the study period, 98,513 general surgical procedures were performed. A total of 28 lawsuits (25 pre-reform, 3 post-reform) were filed, naming general surgery faculty or residents. The prevalence of lawsuits filed/100,000 procedures performed is as follows: before reform, 40 lawsuits/100,000 procedures, and after reform, 8 lawsuits/100,000 procedures ($p < 0.01$, relative risk 0.21 [95% CI 0.063 to 0.62]). Virtually all of the liability and defense cost was in the pre-tort reform period: \$595,000/year versus \$515/year in the post-reform group ($p < 0.01$).

The study concluded that, "Implementation of comprehensive tort reform in Texas was associated with a significant decrease in the prevalence and cost of surgical malpractice lawsuits at one academic medical center."

According to a February 2012 report from the Texas Medical Association, Proposition 12 has had a significant impact on the state of medicine in Texas. In 2001, Texas licensed 2,088 doctors, the fewest in a decade; in 2008, the state licensed 3,621 doctors – the highest number of any year on record.

Texas physician workforce growth has outpaced population growth every year since 2007.

Between 2007 and 2011, Texas saw a 61% growth rate in doctors compared to the four years preceding the 2003 tort reform legislation, and during that same period, applications for new licenses in the state rose 83% compared to the four years prior to the passage of the 2003 tort reform legislation.

Importantly when confronting today's physician workforce issues, Texas is an example of increased access to care in rural areas. Rural areas in the state of Texas have added obstetricians, cardiologists, orthopedic surgeons, and even neurosurgeons. Significantly, related to EMTALA-related tort reform, 40 counties in Texas have added emergency physicians — 32 of those counties are rural.

³ [J Am Coll Surg](#). 2011 Apr;212(4):463-7, 467.e1-42; discussion 467-9.

Access to specialty care has increased significantly in the state of Texas as physicians practicing in high-risk specialties have returned to the state. **Overall, 24,584 physicians have been licensed in Texas since September 2003 when the tort reform legislation was enacted.**

Case Study: Georgia

Background

The physician practice environment in Georgia prior to passage of tort reform was an environment perceived as one in crisis. It affected physician behavior and clinical responsibilities, including an impact on treatment in emergency departments. The medical liability environment in Georgia prior to 2003 also affected decisions by physicians regarding the treatment of patients considered high risk.

In a study by the Georgia Board for Physician Workforce, they reported that, medical liability insurance rates rose 11% to 30% from 2001 to 2002. Certain specialties saw increases in the higher range; specialties affected included orthopedic surgery, neurological surgery, general surgery, and obstetrics and gynecology.

Significantly, in 2001 and 2002, malpractice claim payouts as a percentage of premium revenue increased more than 100%. The Georgia Department of Insurance reported that in 2001 alone malpractice claim payouts as a percentage of premium revenue were more than 133%.

Not surprisingly, the number of insurers writing policies in the state decreased. Between 2000 and 2002, 15 of the 20 insurers in the state of Georgia stopped writing policies.

The Georgia Board for Physician Workforce also reported that in light of the difficulty in securing medical malpractice liability insurance, many physicians were considering limiting the scope of their practice. For example, one in three obstetrician/gynecologists planned to stop providing high-risk procedures. Of radiologists surveyed, 40% were planning to eliminate high-risk procedures. (In this specialty, interpreting mammography carries the highest risk.)

The second largest impact of Georgia's medical liability crisis that was identified by the Georgia Board for Physician Workforce was on the delivery of health care services in the emergency department. Their survey discovered that 11.3%, or 1,750, physicians, had planned to or had already stopped providing emergency services in order to reduce their liability risk.

The survey revealed that 630 physicians, or 4% of the physician workforce in the state, planned to retire from the practice of medicine or to leave the state of Georgia and set up practice elsewhere.

Key Points of Georgia's Legislation

In 2005, Georgia enacted tort reform and medical liability reform, with the Gross Negligence Standard, for all physicians providing EMTALA-related care. While the Georgia State Supreme Court struck down as unconstitutional the \$350,000 per defendant cap on non-economic damages (see Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt, Case No. S09A1432), the bulk of the law remains intact, including the Gross Negligence Standard, which the Court upheld as constitutional.

The major provisions of the law that took effect are:

1. To change provisions related to apportionment of award according to degree of fault (including plaintiff's proportion of fault) and provide for severability.
2. To provide for periodic payment of damages over time.
3. To provide that certain statements of apology or similar statements by health care providers shall not be admitted as evidence in civil actions. *[See Sidebar]*
4. To change provisions to require an expert affidavit be submitted when filing cases related to medical malpractice.
5. To change provisions relating to establishment of liability and standard of care in certain actions relating to emergency health care.
6. To provide for defendants' access to plaintiffs' health information in medical malpractice cases.
7. To provide for provisions to govern vicarious liability of hospitals for healthcare professionals based on employment status (e.g., hospital employee versus independent contractor).

Michigan & "Apology Laws"

On April 19, 2011, Michigan Governor Rick Snyder signed SB 53, adding the state as 36th to enact an "apology law" for health care providers. These laws protect health care providers from malpractice repercussions if they wish to apologize to someone in their care.

From AAPC Physician Services as reported on their website: <http://www.aapcps.com/news-articles/No-Apology-for-New-Apology-Law.aspx>

While this law protects health care providers who wish to apologize to patients, it is representative of an overall need for reform of medical malpractice.

Importantly, the Georgia law includes a Gross Negligence Standard, which is outlined in **Section 10**; it defines the standard of evidence required against emergency physicians and other health care providers as follows:

In an action involving a health care liability claim arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, no physician or health care provider shall be held liable unless it is proven by clear and convincing evidence that the physician or health care provider's actions showed gross negligence.

The section includes specific instructions to be given to the trier of fact (judge and/or jury in legal proceedings) in emergency cases regarding the limited ability to gather information, a lack of a pre-existing relationship, and the "circumstances surrounding the delivery of the emergency medical care." The four items outlined are:

1. Whether the person providing care did or did not have the patient's medical history or was able or unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications;

2. The presence or lack of a preexisting physician-patient relationship or health care provider-patient relationship;
3. The circumstances constituting the emergency; and
4. The circumstances surrounding the delivery of the emergency medical care.

Results

After the passage of medical liability reform, with the Gross Negligence Standard, , the following results occurred:

1. The cost of premiums decreased an average of 18%; during the period 2005-2011, there were no premium increases.
2. The number of new medical liability lawsuits and claims declined by 30% after passage of SB 3.
3. The number of insurers writing new policies increased. As of 2009, eight (8) companies were writing new medical liability policies for Georgia physicians.
4. In 2011, 82.2% of residents who trained in Georgia, and attended high school in the state planned to practice in Georgia.

Since the law passed in 2005, doctors' liability premiums decreased 18%, and claims filings dropped 30% compared with annual increases in the state ranging from 10% to 27% between 2001 and 2004 (Medical Association of Georgia). Additionally, improvements in the liability climate helped attract some 1,000 new doctors to the state since 2005, many to underserved areas (Donald Palamisano, Medical Association of Georgia).

In 2010, the average retention rate based on where physicians completed their residency training was 47.8% in 2010 in the United States. **Georgia was above the average rate with 49.0% of its residency graduates practicing in Georgia**, ranking 17th out of 50 when compared to other states.

Why Michigan SB 1110/HB 5698?

Fear of Malpractice Claims Affects Medical Care

In a study published in the *New England Journal of Medicine* in 2011⁴, the study authors analyzed malpractice data from 1991 through 2005 for all physicians covered by a large professional liability insurer with a nationwide client base (40,916 physicians and 233,738 physician-years of coverage).

The study found the following:

Each year during the study period, 7.4% of all physicians had a malpractice claim, with 1.6% having a claim leading to a payment (*i.e., 78% of all claims did not result in payments to claimants*) [emphasis added]. The proportion of physicians facing a claim each year ranged from 19.1% in neurosurgery, 18.9% in thoracic–cardiovascular surgery, and 15.3% in general surgery to 5.2% in family medicine, 3.1% in pediatrics, and 2.6% in psychiatry. The mean indemnity payment was \$274,887, and the median was \$111,749. Mean payments ranged from \$117,832 for dermatology to \$520,923 for pediatrics. It was estimated that by the age of 65 years, 75% of physicians in low-risk specialties had faced a malpractice claim, as compared with 99% of physicians in high-risk specialties.

The study concluded that, “[t]he cumulative risk of facing a malpractice claim is high in all specialties, although most claims do not lead to payments to plaintiffs.”

However, even if most claims do not lead to payments to plaintiffs, resources must be spent dealing with the claim, up to and including jury trials. This is lost time and money for physicians and hospitals in an environment with sweeping national health care legislation pending enactment, and lower reimbursements from both insurance companies and the federal government supported programs.

While the payouts for malpractice claims may be small or non-existent, the data show that the fear by physicians of becoming a target of a malpractice suit is very real.

According to two studies published in the October 2011 *Annals of Emergency Medicine*, medical liability is a key reason physicians admit more emergency department patients and discharge them less:

1. A survey of 849 emergency physicians and patients in two inner-city emergency departments found that 11% of physicians reported "medico-legal" concerns as a primary driver for admitting patients with potential acute coronary syndrome (www.annemergmed.com/article/S0196-0644%2811%2900824-9/fulltext).
2. In another study, researchers compared admission rates for congestive heart failure patients in 27 emergency departments in New Jersey and New York between 1996 and 2010. The percentage of such patients discharged from EDs dropped from 24% to 9%. Concerns about medical liability probably were the reason behind the

⁴ "Malpractice Risk According to Physician Specialty," Anupam B. Jena, M.D., Ph.D., Seth Seabury, Ph.D., Darius Lakdawalla, Ph.D., and Amitabh Chandra, Ph.D., *N Engl J Med* 2011;365:629-36. Copyright © 2011 Massachusetts Medical Society.

decreased discharges, study authors said (www.annemergmed.com/article/S0196-0644%2811%2900907-3/fulltext).

Michigan and Medical Malpractice Reform

Medical liability reform is occurring across the country at the state level. While data is not currently available from each state, those that have the data and the track record of reform demonstrate the significant impact of these changes in the medical community. Looking to states such as Georgia and Texas, which have instituted broad medical liability reforms, provides examples of the long-term positive impact for physicians, hospitals, patients, and the community.

While Michigan has made some progress in the area of medical liability reform, the current situation regarding physician workforce issues, access to quality patient care, and maintaining the EMTALA safety net for those in need point to a pending crisis if action is not taken now to preserve a vibrant medical community in the state of Michigan.

The “Achilles’ Heel” of tort law in Michigan’s medical malpractice area is EMTALA-related care, which continues to expose the medical community to serious and significant liability in the treatment of emergency medical patients. This influences physician decisions regarding whether or not to practice in the state of Michigan.

The current status of tort law in Michigan does not just affect costs for physicians and hospitals; it also brings to light an influential factor when it comes to Michigan’s physician workforce. The state will continue to compete for physicians of all types, from general practitioners to specialists, as the entire country confronts the physician workforce shortage that is predicted over the next 10 to 20 years. The example of Texas demonstrates that offering increased liability protection to physicians, hospitals, and other medical providers increases access to the specialty care needed by patients in all medical situations within just a few years. In Georgia, the data demonstrate that reforms lead to higher retention of medical students and residents after they complete their training. Studying in Georgia leads to settling in Georgia in many cases.

While the Congressional Budget Office reported that liability reform does not demonstrate a significant reduction in the total national expenditure related to all health care costs, the Texas example demonstrates that money made available through reduced insurance costs and fewer malpractice suits leads to more spending for improved medical technology, improved patient care, and enhanced charity care, increasing access to care in the most vulnerable demographic groups. **This specifically relates to the young, the old and very old, and those residing in rural communities.**

The return on investment of money freed up from lower insurance payments and premiums leads to an improved medical environment for medical providers and patients.

The people of Michigan deserve the same type of care, access, and opportunities afforded to those living in Texas and Georgia. Enacting SB 1110/HB 5698 will create a similar environment in our state, and lead to the same benefits medically, economically, and socially.

Impact on Access to Care

National Physician Workforce Crisis

For years, many private and public sector organizations and agencies have predicted a physician shortage in the United States. As the population in our country ages – including physicians – many will require increased care while physicians begin to retire.

The American Association of Medical Colleges (AAMC) Center for Workforce Studies provides summaries of physician workforce studies as well as position statements on increasing the number of physicians through expanded medical education opportunities. Following are two summaries from the AAMC:

“The Complexities of Physician Supply and Demand: Projections Through 2025” – Association of American Medical Colleges (2008)

Using the most recently available data, a new report by the AAMC Center for Workforce Studies projects future supply and demand for physicians and concludes that a national shortage is likely driven by such factors as U.S. population growth, aging population and doctors, and increased physician visits, the demand for doctors will outstrip the supply through at least 2025. If physician supply and use patterns stay the same, the United States will experience a shortage of 124,000 full-time physicians by 2025. US medical schools are increasing their enrollment as recommended by the AAMC. The report concludes that while this increase is necessary, it will not be sufficient to meet future patient needs and demand. Actions beyond increasing the supply of physicians will be needed. Complex changes such as improving efficiency, reconfiguring health care delivery, and making better use of both physicians and other health care professionals will also be necessary.

American Hospital Association Professional Liability Insurance Survey, March 2003

Percent of hospitals in crisis states reporting specific effects of increased professional liability expenses:

- More difficult to recruit physicians, 53%
- Loss of physicians and or reduced coverage in emergency departments, 45%
- Negative impact on hospitals’ ability to provide services, 35%

Michigan (2006) – “Growth in Demand Will Outpace Growth in Supply”

A study by the Center for Health Workforce Studies at the University of Albany, State University of New York concluded that between 2005 and 2020, growth in the demand for physicians in Michigan will likely outpace growth in the supply of physicians.

Michigan is likely to face a physician shortage by 2020. The severity of this shortage is expected to be about 4,400 physicians, or about 12% of the number of physicians required to meet the forecasted demand for medical services in 2020.

The coming physician shortage is very real and is well documented. At the state level, efforts are being made to estimate state needs and create responses to improve physician retention. Many of these responses are based in the reform of medical liability laws, which is documented as an incentive to encouraging physicians to establish practices. Tort reform also seems to have an impact by increasing high-risk specialty practices, such as obstetrics/gynecology and emergency care because it lessens the exposure to liability by physicians in these practice areas.

On call shortages related to Emergency Departments and Specialty Care

In August 2003, the General Accounting Office (GAO) released a study titled, “Medical Malpractice: Implications of Rising Premiums On Access to Health Care,”⁵ in which they reported the following:

Our contacts with 49 hospitals revealed that although 26 confirmed a reduction in surgeons available to provide on-call coverage for the ER, 11 of these reported that the decreases had not prevented them from maintaining the full range of ER services. *(Consequently, 15 of the 49 hospitals contacted indicated that the reduction in on-call coverage in the ER had prevented them from maintaining the full range of ER services.)*

Because of the recognized limitations of Medicare claims data for these and other services, we used other methods to explore whether malpractice-related pressures had affected access to ER on-call surgical services and newborn deliveries and indeed found - and reported - evidence of access problems for these services in localized areas.

We confirmed instances in the five states where actions taken by physicians in response to malpractice pressures have reduced access to services affecting emergency surgery and newborn deliveries. For example, the only hospital in a rural county in Pennsylvania no longer has full orthopedic on-call surgery coverage in its emergency room (ER) because three of its five orthopedic surgeons left in the spring of 2002, largely in response to the high cost of malpractice insurance.

Among several potential access problems we reviewed in Florida, the most significant appeared to be the reduction in ER on-call surgical coverage in Jacksonville. **We confirmed that at least 19 general surgeons who serve the city’s hospitals took leaves of absence beginning in May 2003 when state legislation capping noneconomic damages for malpractice cases at \$250,000 was not passed.** [Emphasis added.]

Hospital and local health department officials said that the losses of surgeons have caused a reduction in ER on-call surgical coverage at most acute care hospitals in the city; the health department official said patients requiring urgent surgical care presenting at an ER that does not have adequate capacity must be transferred to the nearest hospital that does, which could be up to 30 miles away. **Within the first 11 days after most of the physicians took leave, 120 transfers took place.** [Emphasis added.]

In September 2003, The Center for Studying Health System Change released a study titled, “Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places,”⁶ in which they reported the following:

Rather than treat patients in their offices, more physicians are referring patients to emergency departments. **And many physicians, especially those practicing in high-risk**

⁵ “Medical Malpractice: Implications of Rising Premiums On Access to Health Care,” General Accounting Office, August 2003 GAO_03-0836

⁶ “Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places,” The Center for Studying Health System Change, Issue Brief No. 68, September 2003, Berenson RA, Kuo S, May JH.

specialties, are unwilling to provide emergency department on-call coverage because of malpractice liability concerns. [Emphasis added.]

HSC researchers have identified a range of other emerging physician responses to malpractice insurance concerns across the country, including referring more patients to emergency departments, safety net hospitals and academic health centers; refusing to provide on-call emergency department coverage; and declining elective referrals from safety net providers.

Physicians' willingness to provide on-call emergency department coverage - a hospital's responsibility under the federal Emergency Medical Treatment and Labor Act, known as EMTALA - also has been affected by malpractice litigation concerns. Combined with the reality that many emergency department patients are uninsured, liability concerns have contributed either to certain specialist physicians either declining to provide on-call emergency department coverage or demanding payment from hospitals for taking calls or caring for uninsured patients in Phoenix, Orange County, northern New Jersey, Miami and Seattle. The converse is also true, with many specialists declining to accept elective referrals from emergency departments and safety net clinics and health centers, especially for uninsured patients. In some cases, physicians fear that low-income patients, with inadequate or no insurance, may not follow through on treatment, increasing the likelihood of a bad outcome and a malpractice claim.

In May 2006, the American College of Emergency Physicians (ACEP) released a study on shortages in emergency departments. The study was conducted to assess the effects and potential unintended consequences of changes made to the regulations governing the Emergency Medical Treatment and Labor Act (EMTALA).

The ACEP report showed that “on-call coverage in the nation’s emergency departments has deteriorated significantly since 2004.” Further,

The top five shortages were among the specialties of orthopedics; plastic surgery; neurosurgery; ear, nose and throat; and hand surgery. Seventy-three percent of emergency department directors reported problems with inadequate specialist coverage, compared with 67 percent in 2004. More specialists were negotiating for fewer on-call duty hours in 2005 — 42 percent compared with 18 percent in 2004. Forty-five percent of directors reported patients were leaving without being seen, compared with 29 percent in 2004. The percent of hospitals paying stipends to specialists, whether or not they see patients, more than quadrupled to 36 percent, compared with 8 percent in 2004.

Impact in Michigan of Predicted Physician Shortage

According to information released by the Michigan Blue Ribbon Workforce Committee:

The national study was commissioned by the Council on Graduate Medical Education (COGME) and found that the United States will have between 85,000 and 96,000 fewer physicians than needed by 2020. The American Association of Medical Colleges supports the findings of the national study.

The analysis completed by the Center for Health Workforce Studies, State University of New York, on behalf of the Blue Ribbon Physician Workforce Committee confirmed the results of numerous other studies. *Michigan will face physician shortages at almost twice the rate of the nation as a whole by 2020.*

Shortages of this magnitude will likely impact every person regardless of their income and insurance status in every community from the Upper Peninsula to southeastern Michigan. Shortages of certain specialties already exist and the shortage of primary care physicians is coming as soon as 2018. According to Medical Opportunities in Michigan, an online physician opportunity website maintained by the Michigan Health Council, hospitals already are reporting extended recruitment periods for some specialties.

Study Findings

- Michigan currently has approximately 30,000 “active” patient care physicians - i.e. those delivering patient care and will need 38,000 physicians by 2020.
- Michigan will be; 2,400 physicians short of the projected need by 2015 and 4,400 doctors short by 2020.
- Michigan primary care projections indicate that physician supply will be adequate to meet demand only until 2018, although this does not take into account access issues facing those who are uninsured or publicly insured.
- Michigan’s specialist projections indicate that a shortage had already begun when the report was released in 2006.

The predictions are startling and create a sense of urgency for the state of medical care in Michigan. The state must compete for the decreasing number of physicians in the country; data show that medical malpractice reform is a motivator for physicians to set up practice after completing their training. Treating the “Achilles’ Heel” of EMTALA-related liability is a first – and vital – step in addressing Michigan’s projected physician workforce shortage.

Economic Benefits for Michigan

The economic benefits of the health care profession in Michigan are far-reaching. Not only does it provide jobs for those in the profession, it contributes to the state's economy through purchases of goods and services – which also helps create jobs – while also playing a large role in the generation of the state's tax revenue.

Creating an environment that is attractive to, and supportive of, health care professionals helps stabilize the costs of medical care for businesses and individuals who need to buy health care insurance and/or purchase health care services. Increasing the options for those in need of care means increased access and more positive patient outcomes.

The Michigan medical community is an important contributor to the state's health, both physical and economic.

In March 2011, the Michigan State Medical Society, Michigan Health & Hospital Association, and the Michigan Osteopathic Association released a joint report titled, "The Economic Impact of Health Care in Michigan." Using data from 2009, the partnership discovered the following:

MICHIGAN'S DIRECT HEALTH CARE JOBS

- o With more than 546,000 direct jobs, health care exceeds the agricultural, educational and automotive manufacturing sectors as the state's largest employer.
- o Michigan's direct health care workers earn more than \$30 billion a year in wages, salaries and benefits.

INDIRECT AND INDUCED JOBS

- o About 522,900 Michigan citizens work in jobs that are indirectly related to health care or induced by the health care sector.
- o Michigan's indirect and induced health care workers earn more than \$20.6 billion a year in wages, salaries and benefits.

TOTAL DIRECT, INDIRECT AND INDUCED HEALTH CARE JOBS

- o Direct, indirect and induced health care jobs total about 1,069,300 in Michigan.
- o Wages, salaries and benefits for direct, indirect and induced health care jobs total more than \$51 billion in Michigan.
- o Currently, 11 of every 100 Michigan jobs are directly in health care and nearly 21 of every 100 are directly or indirectly related to or induced by health care.

Industry Direct Jobs

Health Care 546,000

Education 409,000

Automotive Manufacturing 119,000

Agriculture 82,000

Type of Health Care Jobs Direct Jobs

Hospitals 219,700
Offices of Physicians 151,500
Nursing and Residential Care 99,700
Home Health Services 41,200
Other Ambulatory Services 34,300

Indirect/Induced Jobs Total Jobs

Total Health Care Sector Jobs **546,400 + 522,900 = 1,069,300**

TAXES PAID BY HEALTH CARE EMPLOYERS AND WORKERS

o Michigan health care workers and their employers pay more than \$6.6 billion annually in federal and state taxes, which include Social Security, income, motor vehicle, sales, real property, personal property, corporate and more.

The data in this report demonstrate the strong and wide contributions made by the health care profession to the economy of Michigan. It is the largest employer in the state, and creates over 1 million jobs.

Tax revenues are buoyed by the health care profession as well, accounting for over \$6 billion annually in both federal and state taxes. Michigan benefits from the contributions of the health care profession by using this tax revenue to provide other vital social services to the people.

Taking steps to protect this vital aspect of Michigan's economy, such as enacting EMTALA-related liability reform like the Gross Negligence Standard, make sense economically as well as medically. Protecting physicians by addressing EMTALA-related liability reform to the laws of our state just makes good business sense.

Conclusion

The Michigan College of Emergency Physicians strongly supports restitution to injured patients affected by medical malpractice. EMTALA-related reform will not preclude injured patients from seeking redress for malpractice if doctors practice bad medicine. Physicians will still be liable for their actions and patients will still have legal recourse. The laws of the state apply to all, no matter their socioeconomic status. No one will be “locked out” of the system.

Progress has been made in addressing Michigan’s medical malpractice tort laws, but the continued liability exposure of EMTALA-related care drives up insurance costs for hospitals, physicians, and other medical care providers, thus discouraging medical professionals from locating to or remaining in Michigan.

While many states have already enacted medical liability reform to help preserve access to emergency care, the impact of EMTALA-related liability for all medical professionals has yet to be addressed in Michigan. This “Achilles’ heel” in Michigan’s medical liability laws exposes medical professionals to increased liability, making it difficult to obtain specialty care and difficult to manage complicated conditions in emergent care situations, leading to a weakening of the patient safety net intended by EMTALA. Quality of care in emergency situations is diminished, adversely affecting Michigan’s patient population.

With the pending physician shortage predicted for the United States, Michigan must take action to encourage a stable and accessible physician workforce to guarantee continued access to quality health care for the state’s patient population.

Addressing EMTALA-related liability and establishing a Gross Negligence Standard is vital to stabilizing Michigan’s physician workforce and ensuring access to quality health care for patients in emergency situations.

A protected, stable, and confident physician community brings wide benefits to the state of Michigan through accessible, high quality health care for its patient population, and a vibrant, strong economy through job creation and patronage of Michigan businesses. Through reform, we can strengthen the safety net for those in our state who are most in need.

Appendices

- a. Michigan SB 1110/HB 5698
- b. American College of Emergency Physicians EMTALA Fact Sheet
- c. Retaining Physicians Educated in Georgia Fact Sheet
- d. Summary of Findings of Michigan Blue Ribbon Physician Workforce Study
- e. Texas Medical Association: Proposition 12 Produces Healthy Benefits
- f. Georgia Tort Reform

SENATE BILL No. 1110

May 3, 2012, Introduced by Senators KAHN, CASWELL, JONES, COLBECK and MOOLENAAR and referred to the Committee on Insurance.

A bill to amend 1961 PA 236, entitled
"Revised judicature act of 1961,"
(MCL 600.101 to 600.9947) by adding section 2912i.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 SEC. 2912I. (1) A LICENSED HEALTH CARE PROFESSIONAL OR A
2 LICENSED HEALTH FACILITY OR AGENCY IS NOT LIABLE IN AN ACTION BASED
3 ON MEDICAL MALPRACTICE ARISING OUT OF THE PROVISION OF EMERGENCY
4 MEDICAL CARE IN AN EMERGENCY DEPARTMENT OR OBSTETRICAL UNIT LOCATED
5 IN AND OPERATED BY A HOSPITAL, OR IN A SURGICAL OPERATING ROOM,
6 CARDIAC CATHETERIZATION LABORATORY, OR RADIOLOGY DEPARTMENT
7 IMMEDIATELY FOLLOWING THE EVALUATION OR TREATMENT OF THE PATIENT IN
8 AN EMERGENCY DEPARTMENT, UNLESS THE PLAINTIFF PROVES BY CLEAR AND
9 CONVINCING EVIDENCE THAT THE LICENSED HEALTH CARE PROFESSIONAL'S

1 ACTIONS CONSTITUTED GROSS NEGLIGENCE.

2 (2) IN AN ACTION DESCRIBED IN SUBSECTION (1), THE COURT SHALL
3 INSTRUCT THE JURY TO CONSIDER, IN ADDITION TO ALL OTHER RELEVANT
4 MATTERS, ALL OF THE FOLLOWING:

5 (A) WHETHER THE PERSON PROVIDING CARE HAD THE PATIENT'S FULL
6 MEDICAL HISTORY, INCLUDING KNOWLEDGE OF PREEXISTING MEDICAL
7 CONDITIONS, ALLERGIES, AND MEDICATIONS.

8 (B) WHETHER THERE WAS A PREEXISTING LICENSED HEALTH CARE
9 PROFESSIONAL-PATIENT RELATIONSHIP.

10 (C) THE CIRCUMSTANCES THAT CONSTITUTED THE EMERGENCY.

11 (D) THE CIRCUMSTANCES SURROUNDING THE DELIVERY OF THE
12 EMERGENCY MEDICAL CARE.

13 (3) AS USED IN THIS SECTION:

14 (A) "EMERGENCY MEDICAL CARE" MEANS BONA FIDE EMERGENCY
15 SERVICES PROVIDED AFTER THE ONSET OF A MEDICAL OR TRAUMATIC
16 CONDITION THAT IS MANIFESTED BY ACUTE SYMPTOMS, INCLUDING, BUT NOT
17 LIMITED TO, PAIN, OF SUFFICIENT SEVERITY THAT A FAILURE TO PROVIDE
18 IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT
19 IN SERIOUS JEOPARDY TO THE PATIENT'S HEALTH, SERIOUS IMPAIRMENT TO
20 BODILY FUNCTIONS, OR SERIOUS DYSFUNCTION OF A BODILY ORGAN OR PART.
21 EMERGENCY MEDICAL CARE DOES NOT INCLUDE MEDICAL CARE PROVIDED AFTER
22 THE PATIENT IS STABILIZED AND CAPABLE OF RECEIVING MEDICAL CARE AS
23 A NONEMERGENCY PATIENT OR CARE THAT IS UNRELATED TO THE ORIGINAL
24 MEDICAL EMERGENCY.

25 (B) "HOSPITAL" MEANS THAT TERM AS DEFINED IN SECTION 20106 OF
26 THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.20106.

27 (C) "LICENSED HEALTH FACILITY OR AGENCY" AND "LICENSED HEALTH

1 CARE PROFESSIONAL" MEAN THOSE TERMS AS DEFINED IN SECTION 5838A.

HOUSE BILL No. 5698

May 29, 2012, Introduced by Rep. Walsh and referred to the Committee on Judiciary.

A bill to amend 1961 PA 236, entitled
"Revised judicature act of 1961,"
(MCL 600.101 to 600.9947) by adding section 2912i.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 SEC. 2912I. (1) A LICENSED HEALTH CARE PROFESSIONAL OR A
2 LICENSED HEALTH FACILITY OR AGENCY IS NOT LIABLE IN AN ACTION BASED
3 ON MEDICAL MALPRACTICE ARISING OUT OF THE PROVISION OF EMERGENCY
4 MEDICAL CARE IN AN EMERGENCY DEPARTMENT OR OBSTETRICAL UNIT LOCATED
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6 CARDIAC CATHETERIZATION LABORATORY, OR RADIOLOGY DEPARTMENT
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1 CARE PROFESSIONAL" MEAN THOSE TERMS AS DEFINED IN SECTION 5838A.

ACEP

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Main Points

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay, but since its enactment in 1986 has remained an unfunded mandate.

The burden of uncompensated care is growing, closing many emergency departments, decreasing resources for everyone and threatening the ability of emergency departments to care for all patients.

Emergency physicians provide the most charity care of all physicians (AMA 2003).

ACEP advocates for recognition of uncompensated care as a legitimate practice expense for emergency physicians and for federal guidance in how fulfill the requirements of the EMTALA mandate in light of its significant burden on the nation's emergency care system.

Everyone is only one step away from a medical emergency.

What is EMTALA?

EMTALA was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Its original intent and goals are consistent with the mission of ACEP and the public trust held by emergency physicians.

Referred to as the "anti-dumping" law, it was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer. As a result, local and state governments began to abdicate responsibility for charity care, shifting this public responsibility to all hospitals. EMTALA became the de facto national health care policy for the uninsured. Congress in 2000 made EMTALA enforcement a priority, with penalties more than \$1.17 million, nearly as much as in the first 10 years (about \$1.8 million) of the statute combined (U.S. Department of Health and Human Services' Office of Inspector General [OIG]). Between October 1, 2005, and March 31, 2006, \$345,000 in fines were collected from 12 hospitals and one physician.

EMTALA requires Medicare-participating hospitals with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, national origin, race, creed or color.

A technical advisory group was convened in 2005 by the Centers for Medicare & Medicaid Services (CMS) to study EMTALA. The advisory group focused on incremental modifications to EMTALA, but also envisioned a fundamental rethinking of EMTALA that would support development of regionalized emergency systems. A new EMTALA would continue to protect patients from discrimination in treatment, while enabling and encouraging communities to test innovations in emergency care system design, for example, direct transport of patients to non-acute care facilities, such as dialysis centers and ambulatory care clinics, when appropriate.

The Institute of Medicine in 2006 recommended that the Department of Health and Human Services adopt regulatory changes to EMTALA and the Health Insurance Portability and Accountability Act (HIPAA) so the original goals of the laws are preserved but integrated systems may further develop.

How does EMTALA define an emergency?

An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs." For example, a pregnant woman with an emergency condition must be treated until delivery is complete, unless a transfer under the statute is appropriate.

What is EMTALA's scope?

According to the law, EMTALA applies when an individual "comes to the emergency department." CMS defines a dedicated emergency department as "a specially equipped and staffed area of the hospital used a significant portion of the time for initial evaluation and treatment of outpatients for emergency medical conditions." This means, for example, that hospital-based outpatient clinics not equipped to handle medical emergencies are not obligated under EMTALA and can simply refer patients to a nearby emergency department for care.

What are the provisions of EMTALA?

Hospitals have three main obligations under EMTALA:

Any individual who comes and requests must receive a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and treatment. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.

Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

A hospital must report to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.

What are the requirements for transferring patients under EMTALA?

EMTALA governs how patients are transferred from one hospital to another. Under the law, a patient is considered stable for transfer if the treating physician determines that no material deterioration will occur during the transfer between facilities.

EMTALA does not apply to the transfer of stable patients; however, if the patient is unstable, then the hospital may not transfer the patient unless:

- A physician certifies the medical benefits expected from the transfer outweigh the risks OR
- A patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer.

In addition, the transfer of unstable patients must be "appropriate" under the law, such that (1) the transferring hospital must provide ongoing care within its capability until transfer to minimize transfer risks, (2) provide copies of medical records, (3) must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer, and (4) the transfer must be made with qualified personnel and appropriate medical equipment.

What are the penalties for violating EMTALA?

Both CMS and the OIG have administrative enforcement powers with regard to EMTALA violations. There is a 2-year statute of limitations for civil enforcement of any violation. Penalties may include:

Termination of the hospital or physician's Medicare provider agreement.

Hospital fines up to \$50,000 per violation (\$25,000 for a hospital with fewer than 100 beds).

Physician fines \$50,000 per violation, including on-call physicians.

The hospital may be sued for personal injury in civil court under a "private cause of action"

A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover damages.

An adverse patient outcome, an inadequate screening examination, or malpractice action do not necessarily indicate an EMTALA violation; however, a violation can be cited even without an adverse outcome. There is no violation if a patient refuses examination &/or treatment unless there is evidence of coercion.

Who pays for EMTALA-related medical care?

Ultimately we all do, although EMTALA places the greatest responsibility on hospitals and emergency physicians to provide this health care safety net and shoulder the financial burden of providing EMTALA related medical care.

According to a May 2003 American Medical Association study, emergency physicians on average provide \$138,300 of EMTALA-related charity care each year, and one-third of emergency physicians provide more than 30 hours of EMTALA-related care each week.

Physicians in other specialties provide, on average, about six hours a week of care mandated by EMTALA, and on average incurred about \$25,000 of EMTALA-related bad debt in 2001.

Some health insurance plans deny claims for legitimate emergency departments visits, based on a patient's final diagnosis, rather than the presenting symptoms (e.g., when chest pain turns out not to be a heart attack). Some also attempt to require preauthorization before a patient can seek emergency medical care, resulting in denied payment. These managed care practices endanger the health of patients and threaten to undermine the emergency care system by failing to financially support America's health care safety net.

ACEP advocates for a national prudent layperson emergency care standard that provides coverage based on a patient's presenting symptoms, rather than the final diagnosis. In addition, health insurers should cover EMTALA-related services up to the point an emergency medical condition can be ruled out or resolved.

For more information, visit www.acep.org.



Georgia Board for Physician Workforce

State of Georgia

Data Brief: January, 2012

Retaining Physicians Educated in Georgia

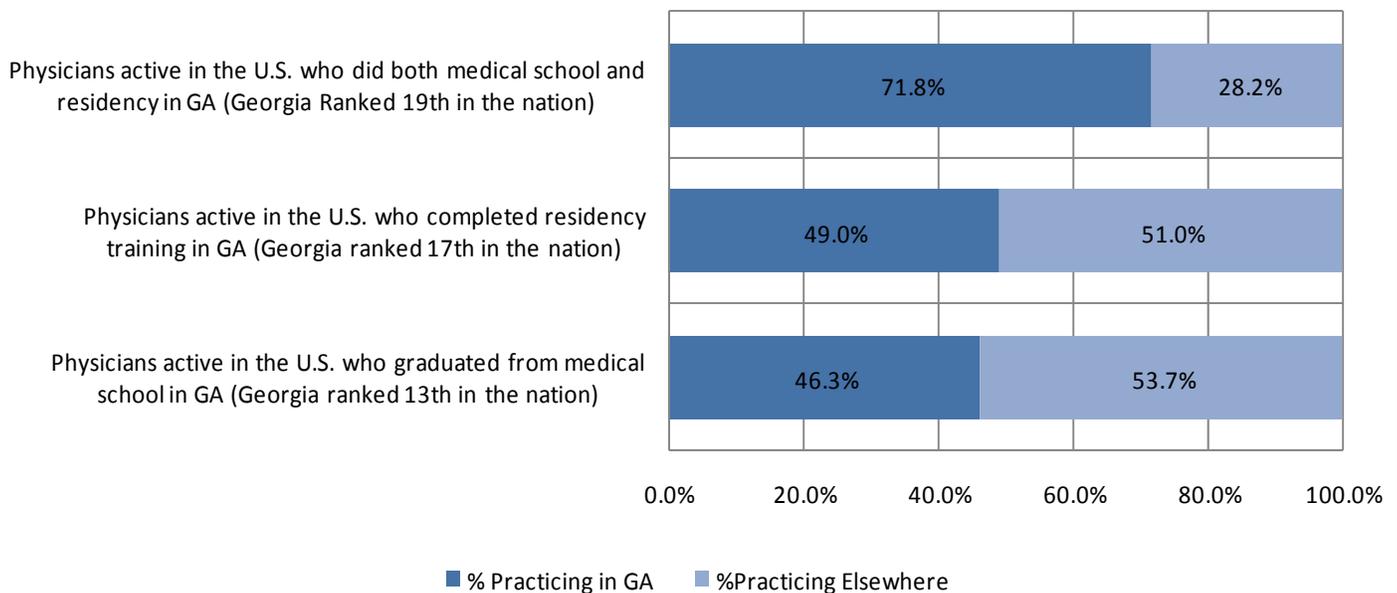
Understanding what goes into a physician's choice as to where to train and practice, can help Georgia maximize the return on their investment. Physicians have a choice in where they practice, but external factors, such as medical school admissions and the National Resident Matching Program, can influence where a physician ultimately practices.

Data published by the Association of American Medical Colleges (AAMC), based on data maintained by the American Medical Association (AMA), give evidence that where physicians attend medical school and complete their residency, have influence where physicians practice. The Georgia Board for Physician Workforce (GBPW), through the Medical School Graduate Survey and Graduate Medical Education Exit Survey, have found that where students graduated from high school (ie, in state), and proximity to family also influence practice location. Through these surveys, the GBPW, has also documented that Georgia has been quite successful in retaining physicians that complete their residencies in Georgia whether they are from Georgia or another state or country.

⇒ 82.2% of the residents responding graduated from a Georgia residency program in 2011, and went to high school in Georgia, had confirmed practice plans to stay in Georgia.

⇒ 14.6% of the 2011 graduates from Georgia residency programs, who responded, graduated from international medical schools.

Physician Retention Rates by Education Location



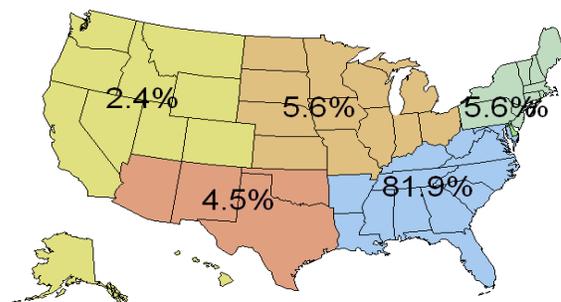
Retaining Physicians Educated in Georgia

The average retention rate based on where physicians completed their residency training was 47.8% in 2010 in the United States. Georgia was above the average rate with 49.0% of its residency graduates practicing in Georgia, and ranking 17th out of 50 when compared to other states.

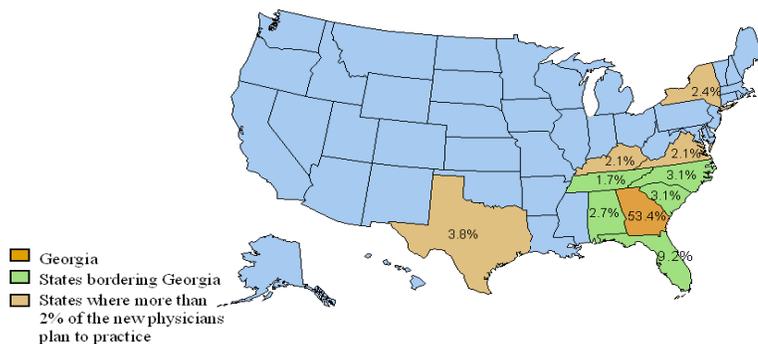
Of all the physicians in active practice in the United States in 2010:	Number of physicians in the U.S.	Number Practicing in Georgia	U.S. Rank
Number who did both medical school and residency training in GA	4,179	3,002	19th
Number who attended medical school in GA	11,545	5,343	17th
Number who did their residency training in GA	13,881	6,796	13th

New Physician Planned Practice Locations: Results of the Georgia Board for Physician Workforce Graduate Medical Education Exit Survey, 2011

Where responding graduates from Georgia's residency programs indicate they will practice. Overall percent by geographical region.



Where responding graduates indicate they plan to practice. Percent by Georgia, Georgia border states, and states with more than 2.0%.



Data Source: 2011 State Physician Workforce Data Book, Center for Workforce Studies, Association of American Medical Colleges, Published November 2011. Physician counts are from the American Medical Association Masterfile as of December 31, 2010. Georgia Board for Physician Workforce, Graduate Medical Education Exit Survey, 2011.

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 Cherri Tucker, Executive Director, Colette Jeffery, and G.E. Alan Dever, M.D., Ph.D., contributors.

Summary of Findings from the Study of Michigan Physician Supply ***Commissioned by the Blue Ribbon Physician Workforce Committee (membership listed below)***

Conducted by: *G. Forte and C. Roehrig, Center for Workforce Studies, Albany, N.Y. and Altarrum, Ann Arbor, MI*

- In 2004, the Blue Ribbon Committee on Physician Workforce commissioned a study of Michigan’s physician workforce for the future.
- The study was designed to allow comparisons between Michigan and the U.S. as a whole and was modeled after a national study by the same researchers.
- The national study was commissioned by the Council on Graduate Medical Education (COGME) and found that the United States will have between 85,000 and 96,000 fewer physicians than needed by 2020. The American Association of Medical Colleges supports the findings of the national study.

Methodology – Supply

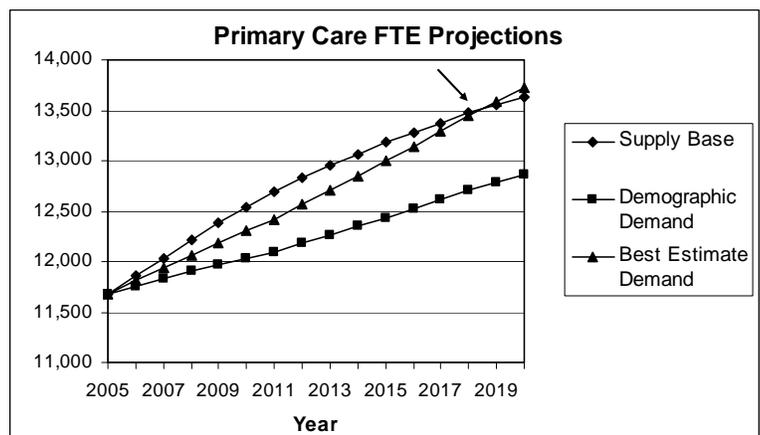
- The methodology of all physician workforce studies is based on the numbers of physicians (supply) calculated against demand for physician services.
- In both the national and Michigan studies, current physician supply was calculated from the AMA database of all licensed physicians (both D.O. and M.D.).
- The expected future production of physicians was calculated based on historic trends of medical school and residency data.
- Physician supply is adjusted for the increasing numbers of women entering medicine and the aging of the physician population (retirements).

Methodology – Demand

- Demand for physician services is based on a formula that takes into consideration the characteristics of the population (age, utilization, insurance type and status) and the physician use patterns of each age range.
- In the economic-trend-based forecast, a factor is added to account for the effect of increased income and advancements in medical technology on physician demand.

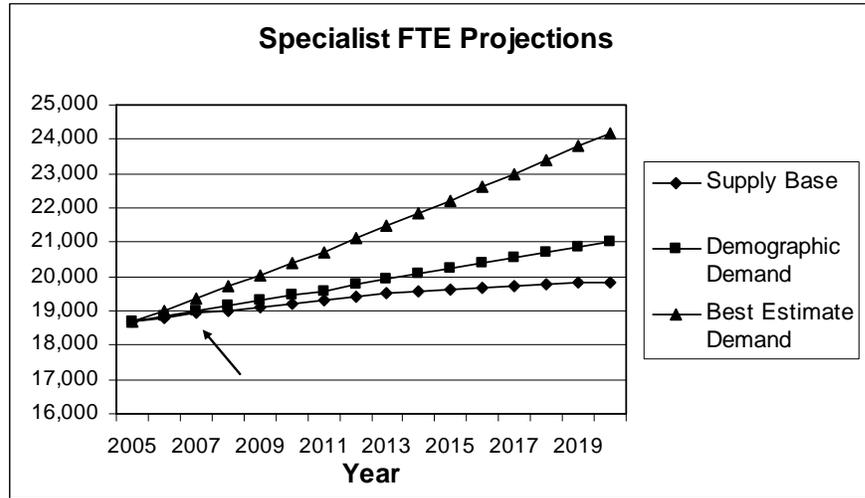
Study Findings

- Michigan currently has approximately 30,000 “active” patient care physicians - i.e. those delivering patient care and will need 38,000 physicians by 2020.
- Michigan will be 900 physicians short by 2010; 2,400 short by 2015; and 4,400 doctors short by 2020.
- Michigan primary care projections indicate that physician supply will be adequate for demand until 2018 although this does not take into



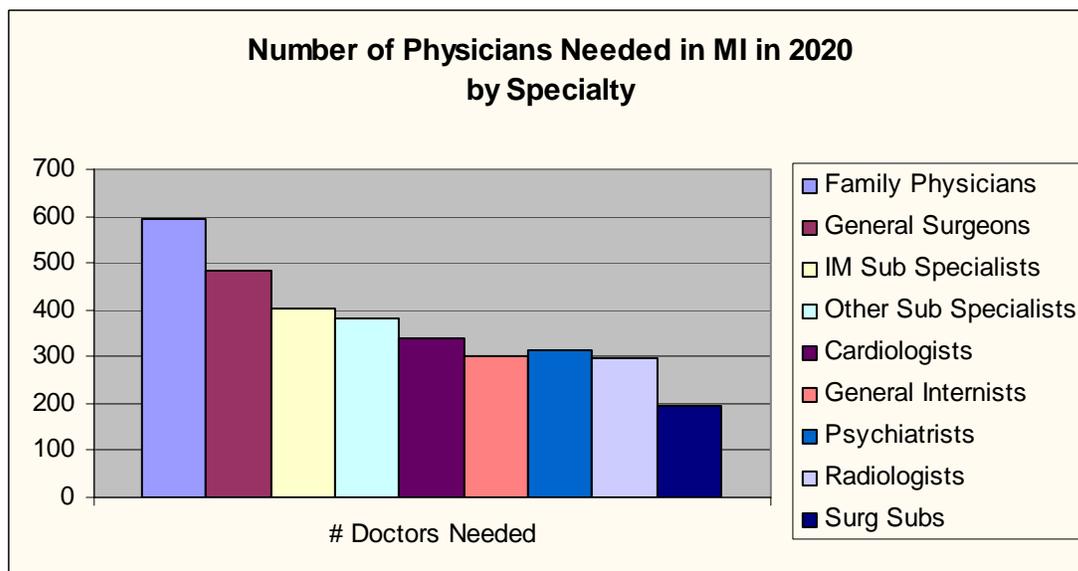
account access issues for those who are uninsured or publicly insured.

- Michigan's specialist projections indicate that we will see a shortage beginning in 2006.

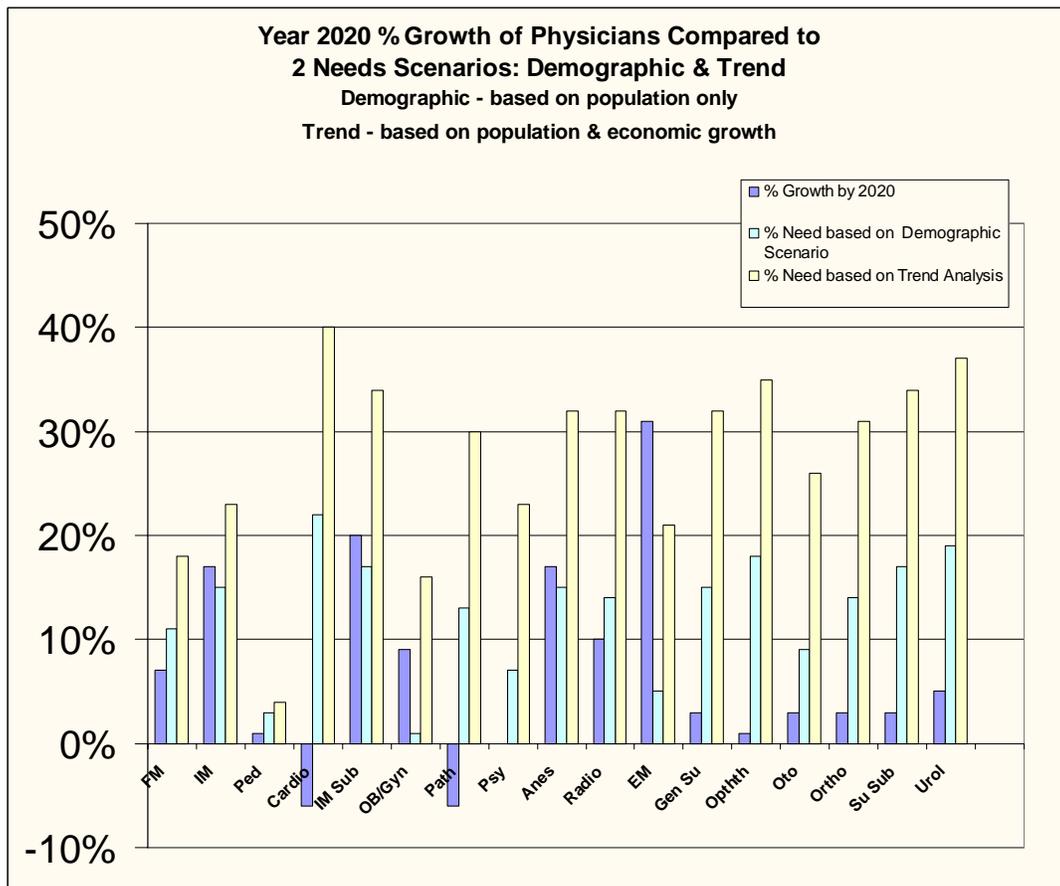


Types of Physicians Most Needed by 2020

- The study provided a list of specialties that are forecast to face the greatest shortages. The list is provided below:
 - Family Physicians
 - General Surgeons
 - Cardiologists
 - Internists
 - Psychiatrists
 - Radiologists
- Other surgical specialists will be needed as well including: urology, otolaryngology, ophthalmology, neurosurgery, abdominal surgery, transplant surgery, and thoracic surgery.



- The model used to forecast the future demand for physicians in Michigan considered the following demand determinants:
 - Physician utilization rates by age, gender, practice setting, insurance status, location of service (rural and urban), and physician specialty.
 - Size and composition (age, gender, and location) of the population of the state and sub-state regions.
- For the state-level demand forecasts, the baseline model assumed that there would be no significant changes to the health care delivery system in Michigan throughout the forecast period. This model is referred to as the demographic model.
- Scenarios allowing for variation in the level of insurance in the population; variation in the age-specific utilization of physician services; the elimination of excess, unnecessary physician service provision; and the effect of the economy on the demand for physicians were also developed. The latter scenario, referred to as the trend scenario model in recognition of Richard Cooper's Trend Model upon which it is based, was determined to be the most likely demand scenario.
- From the chart below, you can easily see the disconnect between the growth in supply and the growth in need under either the demographic or trend need scenarios.



National Comparisons and Contributing Factors

- Health care delivery and medical education is a huge employer in Michigan. Not only can Michigan boast of four medical schools, but the American Hospital Association has identified Michigan as the 7th largest “teaching hospital” state.
- Michigan is 9th in the U.S. in number of general hospitals.
- Michigan is losing physicians after graduation at much the same rate as are many of the northern states. New York has a very similar problem, despite being the largest producer and trainer of physicians in the U.S.
- Physicians are being drawn away from Michigan to warmer climates and stronger economic growth areas.
- Michigan is going to experience a more severe shortage of doctors than is the nation as a whole. The U.S. is going to be 7.9% short, and Michigan is going to be 11.9% short. (*Formula: divide the number of doctors the state (or the nation) is projected to have by 2020 by the number of doctors needed in the state (or the nation) = percentage short*)
- On the basis of population alone, Michigan should only experience a shortfall of 2814 physicians by 2020; this study projects Michigan shortfall at 4,400 physicians by 2020.

Blue Ribbon Physician Workforce Committee Members

Michigan State University College of Human Medicine
 Michigan State University College of Osteopathic Medicine
 The University of Michigan Medical School
 Wayne State University School of Medicine
 Council on Graduate Medical Education – rep: Henry Ford
 Hospital
 Council on Graduate Medical Education – rep: Ingham
 Regional Medical Center
 Michigan Department of Community Health

Michigan Department of Labor and Economic Growth
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[Texas' Landmark Medical Lawsuit Reforms Resolved by the Courts](#)

[TMLT Cuts Premiums Again](#)

Proposition 12 Produces Healthy Benefits

Improving access to medical care is critically important to all Texans.

- This is especially true for children, pregnant women, the aged, the poor, those in an emergent condition and those in rural Texas.

Charity care has greatly increased since the passage of the 2003 reforms.

- Charity care rendered by Texas hospitals rose 24-percent in the six years following the passage of lawsuit reform as the state's non-profit hospitals saw their charity care costs increase 36-percent. But for the 2003 reforms, this \$594 million increase in charity care expenses would have left many Texas hospitals with the stark choice of turning away charity care patients or closing their doors altogether.

House Bill 4 (the 2003 medical liability reforms) has a track record of improving access to medical care.

- 2001: Texas licensed 2,088 new doctors, the fewest in a decade.
- 2008: Texas licensed 3,621 new doctors, the highest number of any year on record.
- The Texas physician workforce has outpaced population growth every year since 2007.
- Overall, Texas has enjoyed a 61 percent greater growth rate in newly licensed physicians in the past four years compared to the four years preceding reforms.
- Since 2003, Texas has added nearly 5,000 more physicians with in-state licenses than can be accounted for by population growth.
- According to the most current data available from the U.S. Department of Health and Human Services, Texas ranks tenth nationally in percentage growth of patient care physicians (2003- 2008), up from 23rd just five years previous.
- Using the most conservative figure available, Texas has added enough direct patient care physicians since 2003 to provide 10.5 million more patient visits this year than likely would have occurred without liability reform.
- The Texas Medical Board has received 83% more applications for new licenses in the past four years than in the four years preceding reform.
- The ranks of high risk specialists have grown more than twice as fast as the state's population.
- Pediatric sub-specialists have grown ten times faster than the state's population.
- The number of geriatricians has more than doubled.
- Amarillo, Texas lost 26 physicians in the two years preceding reforms. Since reforms, Amarillo has gained 60 physicians.
- 24,584 new physicians have been licensed in Texas since Sept. 1, 2003.

Dynamic Texas Physician Growth Due to Liability Reform



1.

1 / 29

Physician growth is not limited to metro Texas.

- The ranks of rural obstetricians have grown nearly three times faster than the state's rural population.
- Since 2003, twenty-seven rural Texas counties have added at least one obstetrician, including nine counties that previously had none.
- Forty counties that did not have an emergency medicine physician now do. Thirty-two of those counties are rural.
- Sixteen counties that did not have a cardiologist now do. Fifteen of those counties are rural.
- Forty-eight counties have seen a net gain in orthopedic surgeons since 2003. Eight counties that did not have an orthopedic surgeon in 2003 now do. Six of those counties are rural.
- Twenty-four rural counties added at least one general surgeon and eleven counties added their first general surgeon.
- Four Texas counties added their first neurosurgeon and two of those counties are rural.

Doctors are bringing critical specialties to underserved areas.

- Since the passage of reforms, the Rio Grande Valley has added 239 physicians. The growth rate of the physician workforce in both counties has outpaced population growth.
- Jefferson, Nueces and Victoria counties saw a net loss of physicians in the eighteen months prior to tort reform. Currently, all three counties are producing impressive gains; adding much-needed specialists and emergency medicine physicians.

Premiums are stable and declining.

- All major physician liability carriers in Texas have cut their rates since the passage of the reforms by more than 30 percent.
- Nearly half the doctors insured in the Texas commercial market have seen their premiums slashed more than 50 percent.
- Thirty-four rate cuts have occurred in Texas since the passage of the 2003 landmark reforms.

Reductions in premiums since the passage of Prop. 12 and respective savings:

- Texas doctors have received, on average, a 46.24% reduction in their liability premiums since 2003 resulting in \$1.9 billion in reduced premiums. Premium reductions include both rate cuts and dividends. This number does not include premium reductions for hospitals and nursing homes.

Claims and lawsuits in most Texas counties have been cut in half.**Harris County Medical Liability Lawsuits**

- 2001: 441 - 2004: 204 - 2007: 217
 - 2002: 550 - 2005: 256 - 2008: 219
 - 2003: 795* - 2006: 248 - 2009: 198
 - 2010: 234 - 2011: 221

*Denotes rush to the court house to beat effective date of new laws.

Competition in the Health Care Liability Market is Increasing,

Since the passage of the 2003 reforms, Texas has added:

- Four new admitted, rate-regulated carriers: Advocate MD of the Southwest, Medicus Insurance Company, Medical Liability Insurance Company of America and the Physicians Insurance Company.
- Thirty-eight risk retention groups, captives, surplus lines and other unregulated insurers.

Hospital Savings

- Texas hospitals are collectively saving roughly \$100 million a year on their liability premiums.
- Hospitals have re-invested their liability savings into new technology, patient care, patient safety and have increased charity care by more than a half billion dollars annually. Without reforms and the attendant liability savings, these achievements would have been impossible.

Changing Texas' proven reforms will hurt access to medical care.

- CHRISTUS Spohns' Westside Corpus Christi clinic serving the indigent and its Diabetes Excellence Program are funded by the hospital's medical liability savings. Take away the savings and the programs are jeopardized.
- Driscoll Children's Hospital in Corpus Christi used its liability savings to open satellite clinics in the border cities of Brownsville and McAllen. Take away the savings and the programs are seriously jeopardized.
- Kelsey-Seybold Clinic in Houston is using its liability savings to fund an electronic medical record. This electronic medical record will eliminate sources of medical error due to illegibility, monitor for medication allergies and alert the prescribing physician about drug interactions. It also allows results to be graphed to show doctor and patient trends over time and will reduce the cost of health care through more efficient handling of medical information. This electronic medical record investment would not be possible without the savings achieved by medical liability reform.

Updated Feb. 8, 2012

Related Information

- [Chronology of Rate Cuts By Texas Medical Professional Liability Carriers](#)
- [Dramatic Gains in Access to Care](#)
- [Physician Growth by County](#)

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Georgia Board for Physician Workforce Medical Liability & Tort Reform in Georgia January 2011

On March 22, 2010, the Georgia Supreme Court ruled that the \$350,000 per defendant cap on non-economic damages in medical malpractice suits was unconstitutional based on an individual's guaranteed right to a jury trial. However, there are other important elements of Senate Bill 3 that remain intact.

This fact sheet examines the following:

1. What are the key components of Georgia's tort reform legislation (SB 3), which went into effect July 1, 2005?
2. What was the practice environment like prior to passage of SB 3?
3. How has the environment changed since passage of SB 3?
4. What are the potential implications of the Georgia Supreme Court's ruling on the physician workforce, health care industry, and consumer access to health care?
5. What are possible next steps for Georgia?

1. What are the key components of Georgia's tort reform legislation (SB 3)?

Georgia Tort Reform

Senate Bill 3, which went into effect July 1, 2005, sought to do the following:

- To limit non-economic damages in certain actions relating to health care (\$350,000 cap).
- Change provisions related to apportionment of award according to degree of fault (including plaintiff's proportion of fault) and provide for severability.
- To provide for periodic payment of damages over time.
- To provide that certain statements of apology or similar statements by health care providers shall not be admitted as evidence in civil actions.
- To change provisions to require an expert affidavit be submitted when filing cases related to medical malpractice.
- To change provisions relating to establishment of liability and standard of care in certain actions relating to emergency health care.
- To provide for defendants' access to plaintiffs' health information in medical malpractice cases.
- To provide for provisions to govern vicarious liability of hospitals for healthcare professionals based on employment status (e.g., hospital employee versus independent contractor).

2. What was the practice environment like prior to passage of SB 3?

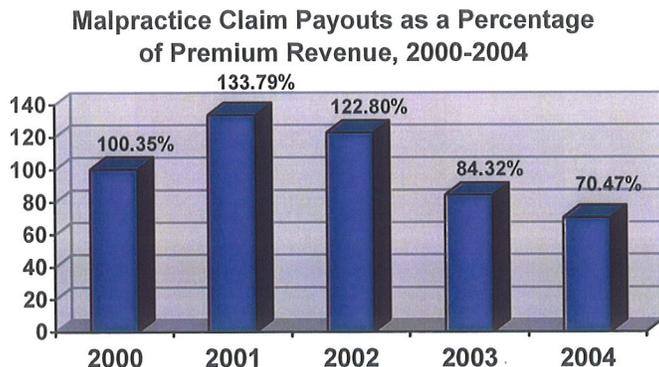
The Georgia Board for Physician Workforce (GBPW) published a primary study entitled: "The Effect of the Medical Liability Insurance Crisis on Physician Supply and Access to Medical Care in Georgia" in January 2003. Then in January 2004, the GBPW published a follow-up fact sheet. The original study and follow-up were done to gather information on the availability, cost, and coverage levels of medical liability insurance. The original study and follow-up also sought to provide information on the effect of the medical liability crisis on physicians' practice behaviors and clinical responsibilities, including providing medical services in emergency rooms and acceptance of high risk patients.

The 2003 study and 2004 follow-up survey are the sources for information on the practice environment in Georgia prior to tort reform.

- **Cost of medical liability insurance was rising – Yes.** Physicians in the specialties of obstetrics/gynecology, orthopedic surgery, neurological surgery, neurology, general surgery, and anesthesiology, who participated in the GBPW's study, reported increases in cost of 30% or more during the time period 2001-2002. Physician respondents in other specialties reported increases ranging from 11% to 30% during the same period.

- **Payout amounts for medical malpractice claims were increasing** – Yes. The Georgia Department of Insurance provided information on malpractice claim payouts expressed as a percentage of revenue collected from premiums.

January 2011



The graph reflects that payout amounts as a percentage of premium revenue topped 100% in 2000, 2001, and 2002. Payout rates decreased, but remained high in 2003 and 2004. Overall, the amount of payments as a percentage of premium revenue was notably high prior to the passage of tort reform.

Source: Georgia Insurance Department

- **Number of insurers writing new policies was decreasing** – Yes. As reported by the GBPW in its primary study, 15 of the 20 active insurers stopped writing new medical liability insurance policies in Georgia between 2000 and 2002.

Availability of medical liability insurance was deemed a problem for many physicians in Georgia prior to passage of SB 3. Thirteen (13%) percent of respondents to the GBPW's study indicated that they had difficulty finding medical liability insurance and 20% reported changing insurance carriers during the previous year. Orthopedic surgeons had the most difficulty, with 29.6% reporting difficulty finding insurance and 38.6% reporting that they changed insurance carriers during the last year. Obstetrician/Gynecologists and anesthesiologists also had high percentages of physicians reporting problems with availability of medical liability insurance.

- **Physicians were reporting plans to discontinue high risk procedures, stop providing emergency room coverage, retire early, and/or leave the state** – Yes.

Limiting the scope of practice was by far the largest effect of the medical liability insurance crisis on access to medical care reported in the GBPW's study. An estimated 17.8% of physicians, more than 2,800 practicing physicians in Georgia, were expected to stop providing high risk procedures in their practices during the next year in order to limit their liability risk. High risk procedures varied by specialty, but included procedures such as delivering babies, reading mammography tests, performing complicated surgical procedures, and handling trauma cases.

- Nearly 1 in 3 obstetrician/gynecologists and 1 in 5 family practitioners reported plans to stop providing high-risk procedures during the next year as a result of the medical liability insurance crisis.
- Close to 40% of the responding radiologists reported plans to stop providing high-risk procedures. In the practice of diagnostic radiology, interpreting mammography scans carries the highest liability risk.

Reduced coverage of Emergency Room Services was the second largest effect reported in the GBPW study, with 11.3% of physicians, more than 1,750 physicians, reporting that they had stopped or were planning to stop providing coverage of emergency room services in order to reduce their liability risk.

- Nearly 1 in 3 plastic surgeons and 1 in 4 orthopedic surgeons indicated that they had stopped or planned to stop providing ER coverage as a result of the medical liability insurance crisis.

Retire from clinical practice or relocate their practice to another state – 4% of practicing physicians in the survey, equating to an estimated 630 physicians in Georgia, planned to retire from clinical practice or leave the state in response to the medical liability insurance crisis.

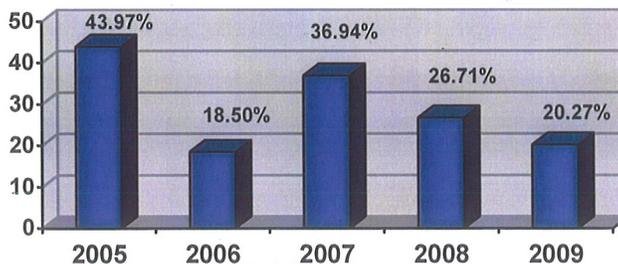
3. How has the environment changed since passage of SB 3?

- **Cost of premiums decreased after passage of SB 3 – Yes**

- Georgia adheres to the “File and Use” approach to regulating medical malpractice insurance. This approach requires that insurers notify the state of rates at least 45 days prior to their use, but does not require specific approval. (O.C.G.A. 33-9-21) This type of regulation is utilized by a total of 23 states. (Source: Research Synthesis Report No. 8, The Robert Wood Johnson Foundation, Understanding Medical Malpractice Insurance: A Primer. January 2006, page 2)
- The Georgia Department of Insurance reports most companies have not instituted a rate increase since 2005 and some companies have even reduced their rates.
- MAG Mutual's insured Georgia physicians have seen an average 18% reduction in the cost of their insurance and premiums have not increased since 2005 when SB 3 went into effect.

- **Payout amounts for medical malpractice claims decreased after SB 3 went into effect - Yes**

Malpractice Claim Payouts as a Percentage of Premium Revenue, 2005-2009



Source: Georgia Insurance Department

The graph reflects malpractice claims activity (i.e., award payouts) as a percentage of total premium revenue. There was a significant decrease in 2006 before rising again. Overall, the amount of payments as a percentage of premium revenue has remained lower since tort reform was passed in 2005.

- MAG Mutual reports a 30% reduction in new medical liability lawsuits and claims since SB 3 passed.
- However, MAG Mutual has experienced a slight (4%) increase in severity (money paid out), primarily due to the constant rise in the cost of future medical care (“medical inflation”), which is factored into payments made to plaintiffs

- **Number of insurers writing new policies increased - Yes.** According to the Georgia Department of Insurance, there were 8 admitted companies writing new medical liability policies for physicians in Georgia in 2009.

- **Impact on physician workforce –** Without conducting a follow-up study of the physicians who reported plans to retire, leave clinical practice, or move to another state, the actual impact is unknown.

- Additionally, data from the Georgia Composite Medical Board on the number of new physician applicants during CY 2001-2009 was inconclusive because the number of applications appears to have been trending up since 2001. The two peak years with the largest increases in new applicants were 2003 and 2009.

4. What are the potential implications of the Georgia Supreme Court's ruling on the physician workforce, health care industry, and consumer access to health care?

The potential impact is unknown at this time. The appeals process may take years. Therefore, this topic would require further study in the future.

5. What are possible next steps or alternative approaches for Georgia?

- Pursue a Constitutional Amendment through the legislative process to allow for caps on non-economic damages. Also, pursue a Constitutional Amendment to allow tort defendants to reduce damages by permitting the introduction of evidence of payments to claimant from collateral sources (e.g., insurance). Both have been deemed unconstitutional by the Georgia courts.

- Consider utilizing screening panels. Screening panels are pre-trial panels staffed by medical experts to review potential liability cases before they proceed to court (utilized by 20 states).
- Explore the use of health courts whereby compensation decisions are based on an "avoidability" standard rather than a negligence standard. Compensation is determined by specially trained judges (rare – only done in Florida and Virginia).
- Promote use of arbitration and/or mediation to settle disputes outside the courts. Both approaches utilize a third party. Arbitration decisions are legally binding, but mediation results are not.
- The Georgia Supreme Court has upheld the tort reform provision that lawsuits against emergency physicians have to demonstrate that gross negligence was committed. This is a positive development that warrants continued support.